Royal Commission into Institutional Responses to Child Sexual Abuse
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By email: solicitor@childabuseroyalcommission.gov.au

Statutory Victims of Crime Compensation Schemes Issues Paper

Dear Commissioners,

Thank you for the opportunity to provide a submission about statutory victims of crime compensation schemes.

Prompt handling of claims for victims compensation is a vital part of the effectiveness of any scheme to deliver redress. This is particularly so in New South Wales, given the emphasis in the Victims Rights and Support Act 2013 on the provision of services to address the immediate needs of victims.

As part of our role in scrutinising the child protection system in NSW, in recent years we have identified significant deficiencies in the arrangements for handling victims compensation claims on behalf of children and young people in statutory out of home care. Shortcomings have included significant delays in the identification of relevant claims and lodgement of claims; and a failure to lodge claims for certain young people before they leave care.

As discussed in our April 2014 report – Review of the NSW Child Protection System: Are things improving? – access to victims compensation for children and young people in statutory care continues to be a significant unresolved practice issue (copy attached, pages 16,17).

To inform the Commission’s deliberations in this area, I have also attached two other reports about related investigation and review work over the past five years. These reports are titled:

- The need to support children and young people in statutory care who have been victims of crime, June 2010
- The continuing need to better support young people leaving care, August 2013

If you have any queries about the information provided, or require further assistance, please do not hesitate to contact Steve Kinmond, Deputy Ombudsman and Community and Disability Services Commissioner, on (02) 9286 0987.

Yours sincerely,

Bruce Barbour
Ombudsman

16/6/14
Review of the NSW Child Protection System: Are things improving?

A Special Report to Parliament under s.31 of the Ombudsman Act 1974

April 2014
Review of the NSW Child Protection System: Are things improving?

A Special Report to Parliament under s.31 of the Ombudsman Act 1974

April 2014
Ombudsman message

The capacity of the child protection system to adequately protect children from harm is an issue of significant concern to the community. As the agency tasked with independently reviewing the delivery of community services in NSW as well as the deaths of children who die as a result of abuse or neglect, it is important that we report on matters arising from our work when it is in the public interest to do so.

This report is a follow-up to our 2011 special report to Parliament, Keep Them Safe?, which discussed a number of critical challenges that needed to be met as part of reforming the child protection system. Two and a half years on, we believe it is timely to re-examine a number of the significant issues canvassed in that report. This report is also intended to complement the Social Policy Research Centre’s comprehensive outcomes evaluation of Keep Them Safe.2

At the time we released Keep Them Safe?, the available data showed that only around one fifth of all reports assessed by Community Services as indicating risk of significant harm to children (ROSH) were receiving a face-to-face response.3

In relation to this issue, Community Services acknowledged that its capacity to respond to children at risk of significant harm was inadequate. In our 2011 report, we identified the need for Community Services to focus on improving its productivity, including by systematically collecting and utilising data to drive greater efficiency. We also highlighted the importance of ongoing transparency by Community Services in relation to its ROSH response rates and related issues, such as the filling of vacant caseworker positions.

This report outlines our analysis of recent data provided by Community Services on ROSH response rates and caseworker numbers. We also discuss a number of issues relating to the quality of intra and inter agency child protection practice.

In a number of our recent reports4 we have highlighted poorly integrated and inefficient service systems in local communities. In addition to discussing weaknesses in past interagency initiatives, this report also explores place-based reform of the delivery of community services, particularly in relation to high-need communities.

As we have previously stated, there will continue to be waste, inefficiency and poor ‘return on investment’ until more wholesale reform of the service system occurs.

Bruce Barbour
NSW Ombudsman

1 NSW Ombudsman, Keep Them Safe?, August 2011.
2 The evaluation aims to identify whether outcomes for children, young people and their families have changed since the introduction of Keep them Safe (KTS), and the extent to which this can be attributed to the KTS reforms. It will also examine why identified reforms have been successful or not, within available information, to inform future decisions about initiatives and preserving gains. We understand the evaluation will have a particular focus on the new reporting threshold and structured decision-making tools. The SPRC is due to report to the NSW Government by mid-2014. www.keepthemsafe.nsw.gov.au/kts_evaluation. Accessed 14 March 2014.
3 This data was for the period ending 31 December 2010.
4 NSW Ombudsman, Inquiry into service provision to the Bourke and Brewarrina communities, December 2010; Addressing Aboriginal disadvantage: the need to do things differently, October 2011; and Responding to Child Sexual Assault in Aboriginal communities, December 2012.
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Chapter 1. Keep Them Safe? – what we found in 2011

The legislative and structural reforms introduced in 2010 following the Wood Special Commission of Inquiry into Child Protection Services in NSW (the Wood Inquiry) were intended to allow Community Services to concentrate its efforts on seeing children most at risk of experiencing serious harm.

The suite of *Keep Them Safe* reforms introduced substantial changes to the systems for reporting concerns about the safety, welfare and wellbeing of children and young people. They include:

- Raising the threshold for reporting concerns to Community Services from ‘risk of harm’ to ‘risk of significant harm’.5
- The introduction of Child Wellbeing Units (CWUs) in the three government agencies responsible for the majority of child protection reports to the Child Protection Helpline (CWUs are currently in place in Police, Health and Education).6
- Simplifying information exchange provisions to allow information relating to the safety, welfare and wellbeing of children to be readily exchanged between certain human service and justice agencies, and other prescribed bodies.7
- The establishment of Family Referral Services (FRS) to improve access to services for vulnerable children, young people, and their families who fall below the threshold for a statutory child protection response, but would benefit from accessing local services – including case management, housing, childcare, playgroup, drug and alcohol counselling, mental health, parenting education and respite care – to address current problems and prevent the escalation of risk.8

Our 2011 report, *Keep Them Safe?*, examined whether the post-reform capacity of the child protection system to respond to reports of children at risk of significant harm (ROSH) had improved as a result of the increased reporting threshold.

We found that in the first 11 months of the new system,9 the number of ROSH reports referred by the Child Protection Helpline to other parts of Community Services for action was more than 100,000 (53%) less than it had been before the Wood Inquiry began.10 However, despite this significant drop in demand, the number of ROSH reports that received a face-to-face assessment during the same period dropped by over 50%.11 In fact, only 21% of all ROSH reports were recorded as receiving a face-to-face response. In addition, the data showed that although the number of reports which were closed due to ‘competing priorities’ dropped by almost two-thirds,12 the closure rate due to competing priorities remained unacceptably high at 25% of all reports screened in at the Helpline.

While in our 2011 report we outlined our concerns about these findings, we also acknowledged that the ROSH response rate is not the only indicator of whether the child protection system is functioning effectively. We stressed that an efficient child protection system must be able to identify those children who are most in need in order to direct an appropriate level of resources to this group. While a single piece of intelligence may justify determining that extreme risks exist, an effective intelligence-driven child protection system involves the systematic analysis of risk-related information held by key agencies, including identifying each agency’s ‘high-end users’.13 We argued that this approach is consistent with the notion of ‘shared responsibility’ which was central to the recommendations of the

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5 Two new legislative grounds for mandatory reporting were introduced relating to non-enrolment or habitual non-attendance at school and giving explicit recognition to the cumulative nature of harm.

6 These units assess whether the concerns identified by their staff need to be reported to Community Services, and identify potential responses by the agency or other support services to help these families. CWUs also provide advice to frontline agency staff about child protection issues and discuss options for assisting the child or young person and their family.

7 The object of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1993* is to facilitate the provision of services to children and young people by agencies that have responsibilities relating to the safety, welfare or well-being of children and young persons, by authorising or requiring those agencies to provide/receive information that is relevant to the provision of the services, and to take reasonable steps to coordinate the provision of the services.

8 FRSs are implemented by NSW Health. Families can self-refer to the FRS, or may be referred by staff from agencies or NGOs – including by mandatory reporters on advice from a CWU. After initially being trialled in three locations, there are now four FRS in the Greater Sydney area, and a further seven FRS around rural and regional NSW.

9 From 46,757 in 2006-2007 to 19,826 for the 11 month period following the introduction of the new threshold.

10 From 201,208 in the year before the Wood Inquiry to 95,491 between 24 January and 31 December 2010.

11 From 46,757 in 2006-2007 to 19,826 for the 11 month period following the introduction of the new threshold.

12 From 77,386 in 2006-2007 to 24,268 in the 11 month period following the introduction of the new threshold.

13 Justice Wood specifically recommended that government agencies identify their ‘high-end’ users and provide these families with an integrated case management response.
Wood Inquiry. We recommended that the Department of Family and Community Services (FACS) provide public advice on whether it intended adopting an intelligence driven child protection system, and if so, how this would be done.

In Keep Them Safe? we specifically identified the need for a clear policy and practice framework to be developed by the Department of Premier and Cabinet (DPC), together with FACS and other human service and justice agencies, for improving the response to vulnerable older children and adolescents, particularly in circumstances where there is cogent evidence of serious physical or sexual abuse; significant risk of death from abuse, neglect or suicide; and/or a lack of the basic necessities of life. We observed that ROSH report data indicated a higher level of priority was being accorded to young children requiring immediate intervention. By contrast, a higher proportion of reports about adolescents were often receiving no response. We noted that this approach was often justified by Community Services on the basis of the need to make decisions about relative risk, and the fact that generally, younger children will be at greater risk.14

We also identified that more work was required to establish a clear policy and practice framework for responding to habitual non-attendance at school. Following the Wood Inquiry, the Children and Young Persons (Care and Protection) Act 1998 was amended in January 2010 to include educational neglect as a risk factor, which warrants a report to Community Services when it is significant. In Keep Them Safe?, we noted our concern that at the time, less than 10% of these ROSH reports were receiving a face-to-face assessment. In a number of reports since Keep Them Safe? we have continued to highlight the significant risks associated with educational neglect, and the role that various agencies – Education, Police, Community Services and the NGO sector – could play in tackling this problem.15

At the time of our 2011 report, Community Services acknowledged that the capacity of the child protection system was inadequate and advised us of its plan to address this problem. The plan involved strategies aimed at maximising caseworker time in the field and improving overall productivity. In addition, Community Services committed to employing a full complement of caseworkers by January 2012.

We recommended that FACS develop an action plan for publicly reporting on its progress in relation to response rates for ROSH reports, and the related productivity and efficiency outcomes achieved through its Action Plan to Improve Capacity in Child Protection.16 In doing so, we also recommended that public reporting should include details of the number of filled caseworker positions against Community Services’ funded staffing establishment (by region), and advice on its progress in recruiting caseworkers to rural and remote areas and in retaining experienced staff in these locations. We also highlighted the need for DPC, along with FACS and other human service and justice agencies, to examine how they could better deliver on the concept of shared responsibility in a range of contexts, including responding to ROSH reports and providing better support to high-risk adolescents.

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14 We reiterated the need for a comprehensive and integrated response to highly vulnerable older children and young people in two subsequent confidential reports provided to Community Services in 2012: Review of a group of school-aged children from two Western NSW towns: Towards intelligence driven child protection and Service provision challenges in responding to very vulnerable older children and young people.

15 NSW Ombudsman, Addressing Aboriginal disadvantage: the need to do things differently (2011); Review of a group of school-aged children from two Western NSW towns: Towards intelligence driven child protection (confidential report – 2012); Responding to Child Sexual Assault in Aboriginal Communities, December 2012.

16 One of the four key pieces of work under Community Services’ Action Plan involved commissioning Ernst and Young consultants in 2011 to undertake a detailed review of caseloads and workload management.
Chapter 2. Progress made since our 2011 report

2.1. Improving the rate of face-to-face assessments of ROSH reports

Since our last report, Community Services has lifted its annual rate of face-to-face assessments of ROSH reports from 21% to 28%.\(^{17}\) While there is still a significant gap to bridge before the response rate is at an acceptable level, we acknowledge that some progress has been made against this key measure.

Community Services has attributed its increased capacity to undertake face-to-face child protection assessments to a number of factors, including:

- upgrading IT systems and reducing administrative tasks to allow caseworkers to spend more time with families, and
- streamlining caseworker training and introducing new professional development mechanisms such as coaching/mentoring to enhance career development and retention of front-line staff and managers.

At the time of our earlier report, many of the other reforms designed to support the introduction of the higher threshold for mandatory reporting – such as information exchange mechanisms, Child Wellbeing Units and referral pathways – were relatively new. Some, like the structured decision-making tools used by caseworkers, were still being put in place. According to Community Services, its frontline managers believe that these reforms have better equipped practitioners operating across the human services system to respond more effectively to risk in individual cases, and have encouraged greater collaboration between agencies. We understand that the KTS Outcomes Evaluation will be examining this issue.

2.2. Enhancements to IT systems

In *Keep Them Safe?*, we argued that Community Services could improve its productivity through enhancing the functionality of its database, the Key Information and Directory System (KiDS). The Wood Inquiry identified the need to improve business processes to reduce caseworker hours spent recording data on KiDS. Since our 2011 report, Community Services has continued to re-design and upgrade the KiDS system and has also developed a range of aggregated reports through its Corporate Data Warehouse. These enhancements are positive and should be broadened. Some of the more significant enhancements include:

- Removing the Initial Assessment field on KiDS (which was duplicated in the Contact Record field) has enabled more efficient recording of ROSH reports at the Helpline – creating a saving of 14 minutes per completion of each ROSH record – which translates to a saving of 260 caseworker hours overall.\(^{18}\)
- The partner agency e-reporting trial was expanded – this allows mandatory reporters to more easily make ‘on-line’ non-imminent harm reports to Community Services. The number of e-reports increased from 243 in 2008-2009 to 13,524 by 2012-2013. Among other benefits, e-reporting has led to time savings for Helpline staff. It is anticipated that e-reporting will be available to all mandatory reporters in the first half of 2014.
- A Caseworker Mobility trial also commenced in October 2013, involving 50 caseworkers from eight business units. Each worker has been allocated an iPhone and iPad to allow them to type up case notes/make referrals/conduct research if they are waiting for lengthy periods at police stations and hospitals. Additional IT enhancements are planned to allow caseworkers access to selected KiDS information while in the field.\(^{19}\)

As well, iPhones will soon be distributed to frontline staff to improve efficiency and productivity, as well as communication between staff and clients.\(^{20}\)

Our 2011 report observed that extracting critical historical information from the KiDS system was difficult and time consuming. We noted that for a user to learn about a family’s child protection history, they often have to spend hours navigating numerous data fields. We drew attention to the benefits of providing caseworkers with a reporting tool that delivered consolidated history reports quickly, noting that this tool could save caseworkers significant time and improve the quality of casework decisions.\(^{21}\)

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\(^{17}\) The face-to-face response rate to ROSH reports increased from 21% in 2010-2011 to 28% in 2012-2013.

\(^{18}\) The upgrade was released in November 2012.

\(^{19}\) NSW Department of Family and Community Services’ response to Ombudsman request for information, 24 December 2013.

\(^{20}\) Advice provided by the NSW Department of Family and Community Services, 25 March 2014.

Recently, Community Services has advised us that it is now progressing a ‘child on a page’ report that will support more efficient risk identification and management by bringing together key information in one place. This information will include material relating to the child’s:

- parents/care-givers
- siblings
- past reporting and safety issues (and related decisions), and
- connection to any individual recorded as causing harm to them.

Community Services has stressed that while the tool could potentially achieve efficiency savings, it should be seen as complementing, rather than replacing, a more comprehensive history check. Furthermore, Community Services believes that it is likely to save time in pointing caseworkers to where they need to look for specific pieces of information, and in certain cases, in the preparation of documents. It is encouraging that Community Services is progressing this work and we believe it should continue to receive priority.\(^\text{22}\)

### 2.3. Stronger governance and accountability mechanisms

Community Services has significantly improved its capacity to measure, monitor and report on issues which impact on its ability to respond appropriately to ROSH reports. In particular, it has:

- developed the capacity to accurately report on funded and actual staffing numbers \(^\text{23}\)
- developed lead performance indicators for managers and executives
- established a regular schedule of distributing data to managers and executives to help them identify emerging issues, monitor performance against outcomes and drive continuous practice improvements
- implemented a programme for driving ongoing improvements to the quality of its data collection, reporting and performance monitoring
- begun developing a workload management tool that will enable the calculation of accurate and meaningful measures of caseload/demand, benchmarks and performance, and
- refined its resource allocation modelling to determine demand and resource requirements for each district. \(^\text{24}\)

In addition, Community Services has changed its internal governance and accountability arrangements through the implementation of a new Performance Reporting Framework and a substantially enhanced Quarterly Business Review (QBR) process. The framework consists of indicators and reports on the operation and performance of each district – broken down for each Community Service Centre (CSC) and specialist team – supported by detailed data drawn from Community Services. An important feature of the current QBR is the requirement that District Directors come together with FACS senior executive to report on progress – thereby allowing districts to benchmark their own performance and share good practice initiatives. The implementation of the Performance Reporting Framework and renewed QBR process is a significant initiative that should enable District Directors to be both accountable and supported in performing their critical leadership role.

The alignment of FACS boundaries with the 15 local health districts in NSW, and the related creation of the FACS District Director positions which occurred in September 2013, also has the potential to result in greater efficiency and flexibility in the use of resources across CSCs. \(^\text{25}\) These District Directors are now responsible for implementing child protection, disability and housing policy for their area. In addition, the decision by FACS to share common district boundaries with Health should facilitate more integrated service planning and responses to vulnerable children and families.

Community Services has also made significant progress in providing to the public meaningful data. For the first time, its Annual Statistical Report for 2011-2012 included data on the different levels of response to ROSH reports. \(^\text{26}\)

In the middle of 2013, Community Services published its first Caseworker Dashboard, which covered the June 2013 quarter. The dashboard provides a snapshot of the Community Services caseworker workforce and ROSH response.

\(^{22}\) NSW Department of Family and Community Services response to Ombudsman request for information, 12 March 2014.

\(^{23}\) ‘Funded staffing numbers’ refers to the number of full-time equivalent (FTE) caseworkers funded in the Community Services budget. Actual staffing numbers refers to the number of FTE employees working as caseworkers excluding those on extended or parental leave or occupying positions funded by specific time limited funding. Advice provided by NSW Department of Family and Community Services response to Ombudsman request for information, 10 December 2013.

\(^{24}\) NSW Department of Family and Community Services response to Ombudsman request for information, 24 December 2013.

\(^{25}\) In September 2013, the former region/area director positions that existed within each of the individual FACS agencies were replaced with 15 district director positions which now have broader FACS-wide responsibilities but over a smaller geographical area which aligns with local health district boundaries.

\(^{26}\) NSW Department of Family and Community Services, Annual Statistical Report 2011-12, 2013 p.52.
rate data by district. Another two dashboards, for the September and December 2013 quarters, have since been released. As a result, the public now has access to data that spans more than three years, on many important aspects of Community Services’ work. We acknowledge the agency’s considerable efforts to improve transparency and accountability in relation its performance through developing, and publishing, the Caseworker Dashboard.

Community Services has told us it will continue to refine its data collection and performance measures. In this regard, Community Services has made some progress on setting average caseload and case completion targets, and developing the capacity to be able to identify, and report on, families/sibling groups which are the subject of risk of significant harm reports. One measure of sibling groups is already available in the Performance Reporting Framework and Community Services has leveraged off the caseload review work undertaken by Ernst and Young to develop better measures of caseworker productivity. However, it has advised our office that it needs to continue to develop and refine its data collection in these areas before it can use the related reporting tools more widely.

Improvements to Community Services’ information systems and governance structures, and the accountability mechanisms which underpin them, lay the foundation for a more effective child protection system. We will continue to closely monitor progress in relation to Community Service’s work to determine average caseload and case completion targets, and its ability to identify, and report on, families/sibling groups which are the subject of ROSH reports.

While Community Services acknowledges that further work is required to better understand and measure the productivity of its workforce, the evidence demonstrates that it is now better equipped to assess, and accurately report on, its capacity to meet demand.

2.4. Sharing responsibility for responding to vulnerable adolescents and educational neglect

2.4.1. Vulnerable adolescents

It is apparent that ROSH responses to vulnerable adolescents remain inadequate, two and a half years after we raised this issue in Keep Them Safe?. On average, 31% of children under 12 received a face-to-face assessment, compared with only 22% of adolescents in 2012-2013.

Having raised the need for a clear policy and practice framework to improve responses to vulnerable older children and adolescents in Keep Them Safe?, in July 2012 we prepared a confidential report for FACS called – Service provision challenges in responding to very vulnerable older children and young people. In direct response to this report, FACS established the ‘Vulnerable Teenagers Review’ — now known as Better Lives for Vulnerable Teenagers – which recommends strategies to reduce the number of older children and adolescents who are re-entering the Juvenile Justice system, are affected by homelessness, or are entering out of home care.

Our ongoing work in relation to this cohort culminated in a comprehensive recommendation in our December 2012 report, Responding to Child Sexual Assault in Aboriginal Communities, which called for the provision of an integrated, multi-agency response to vulnerable older children and young people. However, despite in-principle cross government support for a senior group to be established to develop and implement a coordinated strategy for vulnerable young people – and a range of other recent initiatives developed by FACS and other agencies aimed at better responding to the needs of this cohort – there is still no overarching framework to guide the delivery

27 In Keep Them Safe? we highlighted the importance of Community Services capturing outcomes by family/sibling groups given that interventions are targeted towards families rather than individual children. While FACS has acknowledged the value of this type of data, it has also highlighted that identifying outcomes for family/sibling groups is not straightforward nor is it captured consistently across jurisdictions. Community Services advised us that it ‘continues to work towards improving reporting of such information, locally and in line with national data projects currently in progress’. The analysis of family/sibling group data prepared by Community Services was used by the Wood Inquiry and in connection with various Keep Them Safe? projects such as Family Case Management. This data has also been used to inform two pieces of work: the Sibling Safety Policy (2010) and the Sibling Case Coordination Trial which ran for 12 weeks in Metro West Region in 2011. NSW Department of Family and Community Services response to Ombudsman request for information, 10 December 2013.

28 Ernst and Young, Child Protection Caseworker Caseload Review. Report prepared for the Department of Family and Community Services, 3 June 2011.

29 NSW Department of Family and Community Services response to Ombudsman information request, 24 December 2013.

30 NSW Ombudsman, Service provision challenges in responding to very vulnerable older children and young people, July 2012.

31 NSW Ombudsman, Responding to Child Sexual Assault in Aboriginal Communities, December 2012. Recommendation 64.

32 These initiatives include a state-wide Adolescents with Complex Needs Panel; Child Protection Adolescent Response Teams (work intensively with young people aged 12 to 17 to maximise the likelihood of them remaining with their families, by providing child protection case management and specialised advice), Youth Hope (a voluntary service which targets 9 to 15 year olds who have been assessed as being at risk of significant harm and need support to remain at home); Youth on Track (an early intervention scheme which targets young people who are at risk of long term involvement in criminal behaviour). Other relevant initiatives include Connected Communities, a strategy which positions schools as community hubs that will deliver a range of services from birth, through school, to further training and employment in a number of complex communities; concurrent reviews of the Young Offenders Act 1997 and the Children (Criminal Proceedings) Act 1987; and a review by DAG&J into diverting Aboriginal young people from the criminal justice system.
of services which are provided to high-risk adolescents. As a result, these initiatives are not being delivered in a coordinated, integrated way.\textsuperscript{33}

In the absence of an overarching framework, the system will continue to be characterised by piecemeal service responses that result in young people continuing to get lost in the system.

2.4.2. Educational neglect

In relation to addressing educational neglect, progress has been made since our 2011 report. Measures to improve the way agencies identify and respond to educational neglect include: the development of better mechanisms for collecting and reporting data about school attendance; the commencement of a pilot interagency partnership program led by the Department of Education and Communities to test new collaborative approaches to students at risk of educational neglect; and a number of local initiatives aimed at strengthening collaboration between schools and Family Referral Services. We discuss educational neglect in more detail in Chapter 4.

\textsuperscript{33} This is the case even within FACS. There is currently significant work being undertaken in relation to youth homelessness, for example (through Housing NSW Going Home Staying Home Reform Plan), which does not appear to be appropriately linked with other work being progressed by FACS to response to vulnerable adolescents.
Chapter 3. Capacity to meet risk of significant harm demand

In this chapter we consider the data relating to Community Services’ current capacity to meet ROSH demand and how it varies between the 15 FACS districts. We discuss the progress Community Services has made in filling vacant caseworker positions and the locations where the vacancy rates remain persistently high. In addition, we examine Community Services’ systems for assessing the productivity and overall performance of its districts. Finally, we outline what is required to reduce the substantial gap in ROSH ‘supply and demand’.

3.1. Responses to ROSH reports

To determine the progress that Community Services has made since our last report, we asked for data on the number of ROSH reports screened in at the Child Protection Helpline in 2012-2013 at a state-wide, district and local level, and compared this to data for the previous two years. State-wide ROSH response data is presented in Table 1 below.\(^{34}\)

**Table 1: ROSH reports screened in at the Helpline by highest level of child protection assessment received**

<table>
<thead>
<tr>
<th>Highest assessment received</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Face-to-face assessment(^{35})</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SARA/SAS2 – completed</td>
<td>20,204</td>
<td>20.4</td>
<td>25,684</td>
</tr>
<tr>
<td>SARA/SAS2 – ongoing</td>
<td>380</td>
<td>0.4</td>
<td>742</td>
</tr>
<tr>
<td>Office based assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAS1 completed – other info or ref(^{36})</td>
<td>33,076</td>
<td>33.5</td>
<td>24,321</td>
</tr>
<tr>
<td>SAS1 completed – closed competing priorities(^{37})</td>
<td>15,570</td>
<td>15.8</td>
<td>31,661</td>
</tr>
<tr>
<td>SAS1 ongoing</td>
<td>2,159</td>
<td>2.2</td>
<td>1,609</td>
</tr>
<tr>
<td>Further assessment not required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open – no further assessment</td>
<td>1,098</td>
<td>1.1</td>
<td>1,055</td>
</tr>
<tr>
<td>Closed – no further assessment(^{38})</td>
<td>26,358</td>
<td>26.7</td>
<td>14,211</td>
</tr>
<tr>
<td>Total</td>
<td>98,845</td>
<td>100</td>
<td>99,283</td>
</tr>
</tbody>
</table>

3.1.1. Rate of face-to-face assessment of ROSH reports

Table 1 shows that since our 2011 report, the proportion of ROSH reports screened in at the Helpline which received a comprehensive face-to-face assessment\(^{39}\) increased from 20% in 2010-2011 to 28 % in 2012-2013. In addition,

\(^{34}\) NSW Department of Family and Community Services responses to Ombudsman requests for information: 10,12,18 and 24 December 2013.
\(^{35}\) Reports that receive a comprehensive assessment include not only face-to-face contact with the child and their family, but may also involve discussions with other agencies obtaining information from other sources.
\(^{36}\) This first stage of the assessment process occurs prior to a field response and generally involves office-based inquiries and information gathering, but no face-to-face contact with the child and their family. It may involve follow-up with the reporter or another agency involved with the family.
\(^{37}\) Community Services’ case closure policy specifies that in principle, all reports which reach a CSC or Joint Investigation response Teams (JIRT) should receive a comprehensive safety and risk assessment. The policy does, however, allow for reports to be closed at any time because the CSC has insufficient resources to respond. The basis for closing cases in these circumstances is the level and immediacy of risk to particular child in comparison to the level and immediacy of risk to other reported children in the context of the CSC’s capacity to respond. Our work illustrates that a matter can be closed regardless of whether the information at the time indicates that a child may be at risk of serious harm.
\(^{38}\) The closure of a case based on an assessment that the report does not warrant further action; for example, the concerns have been resolved, or having regard to the totality of the evidence, the veracity of concerns reported to the Helpline is not supported.
\(^{39}\) A completed SARA/SAS2.
the actual number of face-to-face assessments conducted increased by 46% (from 20,204 to 29,403 reports). This increase occurred against a backdrop of slightly rising demand: the numbers of ROSH reports that were screened in by the Helpline rose by 6% over the same period (from 98,845 to 104,817).

Although this improvement is encouraging, it is clear that the statutory child protection system is still struggling to meet the demands placed on it. As we discuss later in this section, although the rate of face-to-face assessment of ROSH reports is not the only measure of how the child protection system is responding to children determined to be at risk of significant harm, it is nonetheless an important indicator.

3.1.2. Cases closed due to competing priorities

As discussed earlier, in our Keep Them Safe? report we expressed the view that the 25% closure rate due to competing priorities which existed at that time was unacceptably high. For this report, we again analyse data relevant to this issue in order to ascertain whether there had been any improvement.

Table 1 on the previous page shows that the number of reports recorded as ‘closed – no further assessment’ has dropped considerably since 2010-2011– from 26,358 to 9,996. However, the number of reports recorded as ‘SAS1 completed – closed competing priorities’ rose considerably – from 15,570 in 2010-2011 to 40,555 in 2012-2013. Reports recorded as closed due to competing priorities now represent 39% of all ROSH report response outcomes.

Community Services advises that this increase is largely due to changes in the way case closure decisions are recorded at CSCs since we released our 2011 report; it does not reflect a significant change in the way these reports are actually being handled. Community Services has also advised that despite the ‘case closure’ labelling, some of the 40,555 reports recorded as having been closed due to competing priorities may, in fact, have received another type of response from either Community Services or other agencies. Furthermore, Community Services has noted that an initial Helpline determination of ROSH, does not necessarily mean that the related ROSH report requires a full safety and risk assessment. For example, additional screening and information collection processes that may occur at the local level could indicate that a full assessment is not required.

Therefore, while it is clear from the data that only 28% of ROSH reports received a full face-to-face child protection assessment from a Community Services caseworker in 2012-2013, the data do not allow the community to ascertain the true nature of responses given to the 39% of ROSH reports that were recorded as ‘completed – closed due to competing priorities’, nor the level of risk associated with such cases. In light of Community Services’ commitment to transparency in relation to its capacity to respond to children determined to be at risk of significant harm – and the increasing role of other agencies and non-government organisations in responding to this group – Community Services should enhance, over time, its capacity to collect, and report more meaningfully on, the nature of the actual response given to all ROSH reports – not just those that result in a face-to-face assessment by Community Services. For example, it would be useful to know whether the subject child and their family is already receiving appropriate support from an NGO service provider.

3.2. Caseworker numbers and vacancy rates

By the end of 2012-2013, Community Services had commenced using a Resource Allocation Methodology (RAM) to allocate caseworker positions. The RAM is designed to ensure that caseworkers are working in the areas where they are most needed and that resourcing decisions reflect changes in demand over time. The allocation of caseworkers to districts is based on the geographic distribution of demand (measured, in part, by the number of children the subject of ROSH reports).

As at 2013-2014, Community Services is funded for 2,068 full-time equivalent (FTE) caseworker positions. Of these positions, 1,728 are allocated based on the RAM; 1,669 are allocated to child protection, out-of-home care and Strengthening Families positions, and 59 are casework specialists. The remaining 340 positions fall outside the RAM and are in specialist business units such as the Joint Investigation Response Team (JIRT), the Child Protection Helpline and Adoptions.

40 This increase should be viewed in the context of Community Services conducting face-to-face assessments in response to 46,757 ROSH reports in the year before the Wood Inquiry (2006-2007). However at that time, the more comprehensive safety and risk assessment tool (SARA) had not been developed. NSW Ombudsman, Keep Them Safe?, August 2011, p.5.
41 Community Services has advised that although there is an apparent increase of 3 percentage points over the past two years in relation to this data, a detailed analysis of categories below SAS 2 is not recommended as there is variation in the way that CSCs have started to record data in this category since the introduction of Weekly Allocation Meetings. Advice provided by Community Services on 27 February 2014.
42 FTEs are calculated according to the number of hours worked. For example, a staff member who works a standard 35 hour week has an FTE of one. A staff member who works two days a week has an FTE of 0.4.
43 NSW Department of Family and Community Services response to Ombudsman request for information, 24 December 2013.
To understand caseworker vacancy rates, we asked Community Services for its most recent full year data (2012-2013) on the number of funded caseworker positions compared to the full-time equivalent caseworkers actually employed in each district/CSC. Community Services supplied the data according to current CSC/district groupings; that is, in accordance with the FACS boundary realignment which occurred three months later in September 2013.

The number of funded caseworker positions allocated to each district compared to the number of full-time equivalent positions filled on average for 2012-2013 is depicted in figure 1 below.

**Figure 1: Funded caseworker positions and average actual full-time equivalent caseworker numbers, 2012-2013**

Although Community Services had committed to employing a full complement of staff by January 2012, figure 1 shows that several districts were operating with significant vacancy rates in 2012-2013. The Caseworker Dashboards published by Community Services indicate that this has been the case for some time and is continuing to be the case.

The most recent figures for the December 2013 quarter show that Community Services’ increased efforts to recruit and retain caseworkers are starting to have an impact. These efforts include advertising campaigns, improved assessment of candidates and more pro-active management of secondments and other temporary arrangements.

The figures demonstrate that although full-time equivalent caseworker numbers declined slightly from 1,795 in the June 2012-2013 quarter to 1,790 by the end of the September 2013-2014 quarter, there was an increase of 44 caseworkers by the end of December 2013 – lifting the overall number of caseworkers to 1,834. Community Services has told us that it expects this increase in caseworker numbers to have an impact on activity rates and client outcomes from early 2014.

While this advice is encouraging, several districts still have high vacancy rates and there is some way to go before these districts will be close to achieving a full complement of staff. By the end of 2013, seven of the 15 districts had...
vacancy rates of 10% or less. Of the eight districts with vacancy rates above 10%, Southern district had by far the highest rate at 31%, followed by Northern Sydney at 20%; Western and Nepean Blue Mountains districts at 17%; and Murrumbidgee with 16.49

There has recently been significant public discussion about caseworker numbers. In accordance with our recommendations in Keep Them Safe?, Community Services has provided greater transparency in relation to caseworker numbers and vacancy rates through its publication of the quarterly Caseworker Dashboards. The most recent data shows that over a three and a half year period – from 2009-2010 to December 2013 – the vacancy rate dropped from 13% to 11%. However, the data also shows that during this same period, there has been a fluctuation in vacancy rates; for example, in 2011-2012 it was as low as 8.50

What is clear is that Community Services is now closely monitoring, and reporting on, its caseworker numbers. As the past fluctuations in vacancy rates demonstrate, Community Services’ ability and willingness to track filled caseworker positions is vital to maintaining a stronger capacity to respond to workload demand. As we also noted in our earlier report, it is critical that Community Services does not just focus on overall vacancy data; it needs to direct its attention to filling long-standing vacancies in those districts with significantly higher vacancy rates.

In rural and remote locations – such as Brewarrina and Walgett in Western NSW – where positions have been hard to fill, there would be merit in the creation of different types of roles that might be more likely to attract local applicants. For example, there may be scope for creating less technically challenging positions which are focussed on work that builds trust, provides practical support and monitors children’s safety. From our review of practice in other jurisdictions, we have been particularly impressed with the role that respected Aboriginal leaders play in certain communities in providing culturally expert advice and support to both families and child protection practitioners that is focussed on keeping children safe.51

3.3. Measuring productivity – factors to consider

In addition to data in relation to the rate of face-to-face assessment of ROSH reports, we asked Community Services to provide ROSH response data broken down by district and individual CSC/business unit.52 As figure 2 below shows, there are significant variations in the ROSH face-to-face response rate between districts. (Although we examined CSC level data, they are not published here.)

Figure 2: Proportion of ROSH reports which were screened in at the Helpline and then received a face-to-face assessment, 2012-2013

Figure 2 shows that in 2012-2013, nine of the 15 districts had a face-to-face assessment rate above the state-wide average, and six districts were below the average. The districts with the highest face-to-face rates were mostly outside

49 NSW Department of Family and Community Services, Community Services Caseworker Dashboard: December 2013 Quarter.
50 In 2010-2011 the vacancy rate was 9%; it then dropped to 8% in 2011-2012 and then climbed to 10% in 2012-2013.
51 In Queensland, the Child Protection Act 1999 (QLD) provides the legal framework for child safety services to work with Aboriginal and Torres Strait Islander communities. The Queensland Act stipulates that a ‘recognised entity’ – often an Aboriginal children’s service provider or an individual who is Aboriginal or Torres Strait Islander – be given the opportunity to participate in decisions that will have a significant impact on the child’s life.
52 Business units include for example: the JIRT, Intensive Family Based Services, Child and Family Regional (District) Units and Child Protection Adolescent Teams.
the Sydney metropolitan area, with the best performing being Southern NSW (39.2%) and Murrumbidgee (36.0%). The districts with the lowest rates were mostly in Greater Metropolitan Sydney, led by Nepean Blue Mountains (19.7%) and Western Sydney districts (18%).

It is interesting to note that, although Southern and Murrumbidgee districts had the highest rates of face-to-face assessment of ROSH reports in 2012-2013, they also had among the highest average annual vacancy rates during the same period. As noted previously, the most recent Caseworker Dashboard shows that Southern district still has by far the highest vacancy rate at 31% and Murrumbidgee is the fifth highest at 16%.

Although determining district/CSC productivity generally is not as simple as comparing the number of face-to-face assessments of ROSH reports against actual caseworker numbers, the significant variation in response rates between districts – particularly in the absence of any strong correlation with vacancy rates – suggests that CSCs/districts are managing their response to ROSH demand differently. If it is effectively utilised, the QBR process is well positioned to explore these variations as part of gaining a better understanding of local decision-making and workload management practices. More broadly, the QBR process should help to inform Community Services’ ongoing work in developing more sophisticated measures of caseworker productivity and outcomes. Although there is more that should be done to improve efficiency and related outcomes, Community Services is far better placed than it was at the time of our 2011 report to identify, and take action to remedy, poor performance and to improve its overall productivity.

In making these observations, we are mindful of the risks associated with viewing rates of face-to-face response to ROSH reports in isolation from other performance measures. We are also aware of the risks associated with failing to pay sufficient attention to ROSH response rates at each local CSC. The most recent results for Western district are relevant in this regard. The December Caseworker Dashboard shows that Western district had one of the highest rates of face-to-face assessment of ROSH reports in NSW. However, a number of the CSCs in the district continue to have a very low face-to-face response rate and significant staffing shortages.

In August 2013, we raised concerns with FACS about the impact of resourcing challenges in some parts of Western NSW on the quality of casework, noting that our investigations of four child deaths in the region over a two year period had identified serious, ongoing problems in the region – including inadequate responses to ROSH reports and a lack of professional supervision and support. In fact, over an 11 year period, approximately one third of the more than 40 formal investigations and inquiries we have conducted arising from child deaths have involved CSCs located in Western NSW.

For this reason, it is encouraging to see that the QBR process will include a range of qualitative as well as quantitative indicators, which can be applied to each and every local CSC and business unit. We discuss the issue of quality further in the next chapter.

As the rate of face-to-face assessment of ROSH reports is primarily concerned with recording whether a home-based assessment of risk has been conducted, the QBR process includes indicators to capture casework outcomes. As well as measuring the proportion of children at risk of significant harm who receive a face-to-face assessment, the QBR measures include:

- the proportion of children who are re-reported
- the numbers of out-of-home care entries and exits
- the proportion of unplanned placement changes, and
- the number of restorations and adoptions.

Community Services has advised us that the QBR process also takes into account the differences in the nature and complexity of the cases being handled by each district, particularly when certain CSCs have a high volume of Children’s Court work to manage in connection with out-of-home care entries. Other relevant factors include the geographic size, demographics and remoteness of particular CSCs, as well as particular factors for CSCs with significant Aboriginal populations; such as additional work associated with community/family engagement and cultural care planning. Community Services is also committed to refining its caseworker productivity measures and is building on the findings of the caseload and workload management review completed by Ernst and Young in 2013.

53 This data relates to the response rate to ROSH reports whereas the data published by Community Services in its Caseworker Dashboard reports on response rates to children and young people in ROSH reports.
54 Community Services has advised that these data are not directly comparable largely because caseworkers operate across various work streams, including child protection, Strengthening Families and out-of-home care, and their time is not only spent conducting face-to-face assessment work.
55 The period used in the dashboard is 1/10/12 to 30/9/13.
56 In 2012-2013, two CSCs had a rate of face-to-face assessment for ROSH reports of 6%, one had a response rate of 18%, and another had a response rate of 20%.
57 September 2010 to October 2012.
58 This figure relates to investigations and inquiries arising from child deaths involving Community Services’ handling of cases and does not include those inquiries/investigations into the handling of cases by other agencies.
3.4. ROSH demand – concluding comments

So far in this report, we have discussed the measures that are in place to improve Community Services’ performance in relation to responding to ROSH reports. In doing so, we have noted the improved response rate which has been achieved. However, Community Services is still only providing a face to face response to less than 30% of all ROSH reports.

We have also noted that through the QBR approach and IT enhancements, there is scope to drive further improvement of ROSH rates. However, what cannot be ignored is the fact that even Community Services’ best performing district is still only able to provide a face-to-face response to just under 40% of ROSH reports. Therefore, while Community Services has lifted, and will need to continue to lift, its capacity to respond to ROSH reports, the data strongly indicates that intra-Community Services productivity initiatives alone are unlikely to enable it to adequately meet ROSH report demand. Against this background, it is important to consider the role other agencies might play.

In our 2011 report, we acknowledged that addressing this issue of capacity also requires consideration of what other measures can be adopted to improve the overall effectiveness of the child protection system. In this regard, we noted that there is:

……the need for an ongoing debate about the roles and responsibilities of various agencies, [and that] it is important to stress the benefits of an ongoing examination of these challenging areas of practice. In doing so, our focus should always be on seeking to determine which agencies are best placed to respond, both individually and collectively.\(^{59}\)

At the time we released our report, Community Services acknowledged that the capacity of the child protection system was inadequate and advised us of its plans to address the capacity shortfall. In doing so, Community Services emphasised that exploring the capacity of any child protection system is a ‘complex issue of supply and demand which involves the service system as a whole, rather than the statutory sector in isolation.’

While agencies such as Police, Health and Education have long been involved in responding to vulnerable families, the Keep Them Safe reforms have to some extent formalised and expanded the role of these agencies in child protection through the establishment of Child Wellbeing Units and Family Referral Services and an expansion of universal health and early childhood services. The role of the non-government sector is also being expanded in a number of ways.\(^{60}\) We discuss these roles further in Chapter 4.

In the context of this changing environment, we believe that there is scope to improve the response to ROSH reports – and to vulnerable families more generally – by the direct involvement of other agencies. In adopting this position, we note that more effective collaborative work could potentially:

* improve the identification of those most at risk
* lift the direct response rate, and
* improve the effectiveness of the support provided to those below the ROSH threshold and therefore, potentially lower the number of ROSH reports over time.

However, in noting these possibilities, we acknowledge that it would be naïve to overstate a possible reduction in ROSH reporting rates, at least in the short-term. Furthermore, it is also important to recognise that if there is a substantial lift in the face-to-face assessment rate, the likely flow-on effect would be that Community Services and its partner agencies will be faced with an even bigger resource challenge – providing quality ongoing casework to a much larger cohort of at-risk families.

In our 2011 report, we also recognised that improving the effectiveness, and expanding the reach, of Community Services’ government and non-government partner agencies in relation to the ‘ROSH sphere’ will require an investment in building the capacity of these agencies. Meeting this challenge will also require an investment in the key ingredients of effective collaborative practice which are pre-conditions for yielding better results. Our work reviewing various interagency initiatives has repeatedly found that a significant number of these endeavours have failed to produce any tangible return because of a failure to properly invest in the essential elements of effective collaborative practice. Our findings are consistent with those of Kania and Kramer, who have accurately identified that: ‘[unlike most collaborations] collective impact initiatives involve a centralised infrastructure, a dedicated staff,

\(^{59}\) NSW Ombudsman, Keep Them Safe?, August 2011, p.16.

\(^{60}\) Following the Wood Inquiry, the transfer of most out-of-home care services from the government to the non-government sector commenced; there has also been an expansion of the range of NGO delivered early intervention and prevention programs; and a greater role in working with vulnerable families referred by the Health-led Family Referral Services. The Government’s current legislative reform agenda also envisages a further expansion of the sector’s role in delivering family preservation services which will see them working with families at the higher-end of the risk spectrum.
and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants.\textsuperscript{61}

Therefore, notwithstanding the scope for Community Services to further lift its own productivity levels and for other agencies to play an enhanced role in relation to very vulnerable families, we believe that the available evidence strongly indicates that the ROSH response rate will remain inadequate without the injection of further targeted resources and related capital investment in technology.

Chapter 4. Ensuring a quality child protection response

So far in this report, we have focused on the challenge of responding to ROSH reports. However, while it is clearly necessary to further improve the number of children at risk of significant harm who receive a child protection response, a separate issue relates to ensuring that the response provided is both appropriate and effective.

Through our review and investigative work, we have identified cases handled by Community Services that demonstrate evidence of: poor decision-making; failure to actively seek and/or exchange critical risk-related information; and poor collaboration between agencies. We have previously discussed these practice issues in various public reports, including our annual report and reviewable child death reports.

It is vital that Community Services is able to promptly and effectively respond to practice deficiencies as part of its overall framework for ensuring practice quality. In this chapter, we outline some of the more significant practice issues that remain unresolved. In doing so, we acknowledge the significant work which Community Services has undertaken to implement stronger governance mechanisms for tracking its performance and improving the quality of its casework practice. However, we note that Community Services’ quality assurance framework needs to be particularly effective in relation its capacity to independently audit and assess the quality of decision-making by CSCs/districts in high-risk practice areas.

We also recognise that practice quality is an issue for other agencies in carrying out child protection work along with Community Services.

Through Keep Them Safe, a range of initiatives aimed at strengthening cross-agency child protection work have been implemented. Despite this, we continue to identify common problems relating to joint responses to child protection cases. In many instances, these problems could have been avoided if there was more effective communication and collaboration between agencies in carrying out their shared role in protecting children. Given the significantly expanded role envisaged for the NGO sector through the changes to child protection legislation, it is now even more important for ongoing debate and analysis of what ‘shared responsibility’ should mean across the continuum of need.

In Part 1 of this chapter, we address ‘intra-Community Services’ quality and in Part 2, we discuss the need for a framework to drive collaborative interagency child protection work. Without effective interagency practice, we believe families with complex needs will not be provided with the quality service response they require.

4.1. Improving quality assurance within Community Services

Since we released Keep Them Safe?, Community Services has implemented several components of its system for improving the quality of its practice and measuring its performance. As we noted at the beginning of this report, the systematic reporting by districts against a range of qualitative and quantitative indicators through the QBR process provides a solid platform for Community Services to identify and address weaknesses in practice.

Underpinning the QBR, is the regular provision of data to districts to enable them to closely track and assess their own performance. Community Services has told us that the input of the Office of the Senior Practitioner (OSP) to the QBR process is a critical part of ensuring that practice issues identified through the OSP’s work with districts are considered in the QBR forum.

In this regard, the OSP has developed a self assessment model which will allow CSCs to measure their performance against a revised set of practice standards. We understand that these practice standards are due to be finalised and rolled out by the middle of 2014. The self assessment will be undertaken at a CSC level on an annual basis, and will allow CSCs – together with their district executive – to identify priority areas for improvement as well as areas of strong performance across the four areas of workforce, systems, practice and culture. Community Services has advised us

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62 The changes are contained in the Child Protection Legislation Amendment Act 2013.

63 In recent years, Community Services has captured information regarding the quality of service delivery via two primary processes: Quarterly Business Reviews (QBR) and CSC Reviews. QBR has been in place for approximately 10 years, with the current process capturing quantitative data analysis measured against targets and goals. CSC Reviews commenced in 2009 following a recommendation in Keep Them Safe that a trial of CSC quality review tools should proceed immediately with approved tools applied in each CSC in a timely manner. While an Ernst and Young audit report found that the CSC Review model was a sound process, they identified that CSC Reviews needed to be streamlined and greater linkages made with the planning, monitoring and review processes that were already in place. Until a streamlined review process is finalised, districts have been asked to not continue with the CSC reviews because the district resources required to support the former review function are not justified. Advice provided by NSW Department of Family and Community Services, 25 March 2014.
that the practice standards will be built into the QBR, with a view to incorporating both the qualitative and quantitative components of performance for each CSC and district, to create a more effective quality assurance model.\textsuperscript{64}

Community Services also undertakes more in-depth reviews of CSCs which are typically overseen by a District Director (Community Services) or the OSP (Director Practice Standards), in response to particular issues that arise. These reviews allow for a more in-depth examination of local business units following a request from a District Director or other senior member of the FACS Executive. This process requires the local unit to develop a plan for implementing agreed actions and reporting on progress against identified areas of concern.

The establishment of the OSP in July 2012 to provide leadership in child protection practice across Community Services is a significant development. The main functions of the OSP involve:

- implementing the Care and Protection Practice Framework\textsuperscript{65}
- providing support to the CSCs involved in the implementation of Practice First – a new principle based casework practice model\textsuperscript{66}
- reforming and improving casework practice and systems
- developing and implementing ‘action learning’ strategies for casework staff to address identified problems with practice
- monitoring and reviewing the impact of practice initiatives and system improvements
- providing expert advice and training to practitioners working with families experiencing drug and alcohol abuse, mental health issues and/or domestic violence, and
- reviewing all matters involving the death of a child (or sibling) in circumstances where there has been a report to Community Services within three years of the death, or where the child was in statutory care, and making recommendations to address identified practice weaknesses.

The office is led by an Executive Director and includes three separate units: Clinical Issues, Practice Quality and Child Deaths and Critical Incident Reports. The office is also supported in the field by eight regionally-based Directors (Practice Standards) who provide support to FACS District Directors and Community Services Directors/ Client Service Managers. Although the eight positions have been in place since 2007, they now report directly to the OSP through the Senior Director (Practice Standards).

While a number of the functions now performed by the OSP existed previously, bringing them together under one ‘umbrella’ provides significant scope for developing a more robust whole-of-agency quality assurance framework. In this regard, linking the work of the OSP to the QBR process is a positive development. However, to effectively capitalise on this, it will be essential to ensure that the OSP is well placed to independently identify, based on rigorous quality measures, when CSCs demonstrate high quality practice and conversely when improvement is required.

The Practice First initiative is an important element of the drive to improve quality and consistency throughout Community Services. The initiative is based on a multidisciplinary approach which emphasises collective decision-making through weekly case review meetings between caseworkers and specialist staff, and in many sites, other government and non-government organisations working with the involved families. It has a strong focus on enhancing practice culture through active engagement with very vulnerable and high risk families, based on building respectful relationships and preserving families where appropriate. Practice First was trialled initially in early 2012 in the Bathurst and Mudgee CSCs, and in December 2012 the model was extended to 14 other CSCs and a regional adolescent team. A further roll out to seven CSCs was undertaken in November 2013 taking the total to 24 sites across the state.

Although it is too early to reach any firm conclusions about the extent to which this new approach to improving casework practice will improve outcomes for clients, early results from the first formal review of the trial are positive.\textsuperscript{67} It has, for example, led to a significant increase in the number of home visits in trial regions; a similarly significant decrease in the number of ROSH re-reports for families whose case-plan goals were achieved; and widespread support among front-line caseworkers and managers.\textsuperscript{68} A further full evaluation is planned. We would expect that the ongoing implementation of Practice First will need to be informed by successful home-based service intervention models where strong evidence exists of good outcomes having been achieved for vulnerable children and families. In this regard, we note that evaluations of the US implementation of the SafeCare home-based model indicate

\textsuperscript{64} Advice provided by the NSW Department of Family and Community Services, 25 March 2014.
\textsuperscript{65} The Care and Protection Practice Framework is a high level document launched in December 2012 which describes Community Services’ mandate and approach to its work with children and families in NSW. It articulates the principles and values that underpin Community Services’ work and clarifies the knowledge and skills that are required for good casework practice.
\textsuperscript{66} We understand that 16 CSCs are currently involved in the trial and one regional adolescent team.
\textsuperscript{67} Professor Eileen Munro was commissioned to undertake a review of the model in 2013. The final report on the review will be released shortly. Advice provided by NSW Department of Family and Community Services, 24 December 2013.
\textsuperscript{68} NSW Department of Family and Community Services response to Ombudsman request for information, 24 December 2013.
its effectiveness in reducing child welfare recidivism and producing high client satisfaction among vulnerable families – including equally positive results for American Indian families.69 Recent advice from Community Services indicates that it has had discussions with the Parenting Research Centre and the US SafeCare program owners about developing an implementation proposal for the program in NSW.70

4.1.1. Significant unresolved practice issues

While the quality improvement strategies discussed above are impressive, Community Services must also be in a position to take effective action relating to discrete and significant practice shortcomings which come to light. Our concern in this regard relates to Community Services’ failure to take adequate and timely action on a number of significant practice issues our office – and other agencies – have highlighted in the past. To illustrate, we have outlined the following examples.

Chronic delays in the allocation and investigation of reportable conduct allegations

For some time we have been raising our concerns with Community Services about chronic delays in the allocation and investigation of reportable conduct allegations.71 The number of matters that had not been allocated for an investigation peaked at 209 in June 2013. Community Services shared our concerns, and in the second half of 2013, it implemented a strategy to address the delays. The strategy, which included the appointment of external investigators, was successful in almost halving the number of unallocated matters for investigation to 110 by the end of October 2013. Unfortunately, there has since been a steady increase in the number of matters that await an allocated investigator. At the time of writing, there were 141 of these matters – more than half of these matters were initiated more than six months ago.72

It is important to note that the fact that a matter has not been allocated to an investigator does not mean that no action is being taken to respond to the allegations.73 In this regard, Community Services has indicated to us that when an allegation is received it seeks to promptly put in place an initial risk management response. Furthermore, of the 141 matters not allocated to an investigator, 22 of these were unable to be progressed by Community Services’ investigators because of current police investigations.

Notwithstanding these qualifications, the number of matters that have not been allocated to an investigator is unacceptably high. Prompt investigative action is integral to effective risk management of these matters. For these reasons, Community Services needs to demonstrate an ongoing marked improvement in its performance in this area.

Access to victim’s compensation for children and young people in out-of-home care

In June 2010 we reported to Parliament on significant shortcomings in Community Services’ systems for handling victim’s compensation claims for children and young people in care.74 Our leaving care review the following year found that there were still significant delays in assessing and lodging claims for victims’ compensation and that this meant that some young people were being told after they left statutory care that they were now responsible for pursuing a claim.75 In October 2011, Community Services told us it had implemented new casework procedures in relation to the assessment and processing of victim’s compensation claims. However, in May 2013 we were advised by Community Services that the new procedures had not been operating effectively, and a new monitoring and reporting framework would be established to address this. We were later advised that Community Services had suspended this work because of changes to victim support under the Victims Rights and Support Act 2013, and that it will develop new practices to fulfil its responsibilities under the Act.

We were only very recently advised that Community Services has commenced a comprehensive review of its procedures to ensure that they meet the NSW Charter of Victims Rights, and the new application requirements for

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70 Advice provided by the NSW Department of Family and Community Services on 25 March 2014.

71 Part 3A of the Ombudsman Act 1974 requires the Ombudsman to keep under scrutiny the systems that government and certain non-government agencies in NSW have for preventing reportable conduct and handling reportable allegations and convictions involving their employees. ‘Designated agencies’ must notify us of all reportable conduct allegations and convictions that arise inside or outside the employee’s work. Under section 25A of the Ombudsman Act, reportable conduct includes: any sexual offence or sexual misconduct committed against, with or in the presence of a child – including a child pornography offence; any assault, ill-treatment or neglect of a child; any behaviour that causes psychological harm to a child – even if the child consented to the behaviour.

72 Advice provided by the NSW Department of Family and Community Services, 25 March 2014.

73 In June 2012, the Prioritisation and Risk Assessment Tool (PRAT) was developed and approved with the following goals to: prioritise all unallocated matters against agreed criteria for priority allocation; liaise with regional stakeholders in promoting management of risk, pending the allocation of the matter to an investigator; and ensure a coherent and consistent strategy in the prioritisation of work to determine fortnightly allocation, Advice provided by Department of Family and Community Services, 25 March 2014.

74 NSW Ombudsman, The need to support children and young people in statutory care who have been victims of crime, June 2010.

75 NSW Ombudsman, The continuing need to better support young people leaving care, August 2013.
seeking support from Victims Services. A working party has been established to develop Community Services’ response to its responsibilities under the Charter. The first meeting of the working party was held on 17 March 2014. Community Services has indicated that it is continuing with its case file audit program of children aged 15 and above who are preparing to leave care (including children being case managed by the NGO sector), and has made changes to practice. In addition, Community Services is identifying all potential legal claims prior to young people leaving care. Our office will be keen to see whether these recent initiatives translate to improved practice in this important area.

**Unaccompanied children in homelessness services**

Following discussions with the peak body for youth homelessness\(^8\) in 2004, Community Services started to develop a policy for meeting the needs of unaccompanied children living in homelessness services. A consultation draft of the policy was released in early 2006; the same year we initiated a review of a group of children under the parental responsibility of the Minister and residing in refuge accommodation.\(^7\) We recommended that Community Services provide us with detailed advice about the progress it had made in settling the policy. Despite subsequently issuing several draft policy positions, a final policy was not endorsed. After commencing an investigation in 2009 in relation to Community Service’s handling of a placement involving an unaccompanied child in a refuge, we once again asked for advice about the unaccompanied children policy. We were only recently advised by the youth sector that Housing NSW (a separate agency within FACS) is now progressing work in this area.

After once again raising our concerns about delay with FACS, we were recently advised\(^9\) that an interim policy has now been released to inform the tendering approach for the *Going Home Staying Home* reforms to specialist homelessness services. An extensive consultation process is underway with FACS districts, peak bodies, youth specific specialist homelessness providers and other key stakeholders.\(^8\) The final policy is due to be implemented in July 2014. We will be examining the extent to which the new policy addresses the need to provide adequate support to vulnerable unaccompanied children in homelessness services.

**Failure to refer allegations of serious criminal child abuse to police**

Over a number of years, we have raised concerns with Community Services about the failure by caseworkers to report allegations to police in circumstances where the allegation does not meet the threshold for a response by the JIRT\(^6\) but there is evidence that the allegations nonetheless constitute serious criminal child abuse. While we have emphasised to Community Services on numerous occasions that it must take decisive and effective action to improve its practices in this regard, it has been slow to do so. Community Services first agreed in October 2010 to revise and clarify its procedures. Some 14 months later in January 2012, Community Services stated that it was trialling the new procedures in a number of high volume CSCs. More than a year later, we were advised that the trial had been completed and reviewed; and that a report would be submitted to the executive. However, in November 2013 – more than three years after agreeing to review its procedures – Community Services told us it was still in the process of ‘developing policies and procedural guidance to inform frontline staff when and how to refer matters to NSW Police or other relevant authorities.’ It also acknowledged that its existing procedures remained inadequate.

In providing a recent update\(^8\) to our office, Community Services acknowledged “the unacceptably lengthy delay in resolving this matter”. It has now reviewed current practices and has discussed the implementation of a new policy with the NSW Police Force. Additional meetings with Police have been arranged to identify the most efficient and effective way for Community Services staff to make reports to police in appropriate cases.

**Failure to determine current potential risk to children when assessing reports about historical allegations**

Since March 2010, we have raised concerns with Community Services about its failure to identify whether there may be current risks to any child or a ‘class of children’ when considering historical reports of child abuse made by victims who have since become adults. This is particularly critical in circumstances where the alleged offender is engaged in child related work or has direct contact with children in some other capacity. We noted that the Mandatory Reporter Guide (MRG) and Helpline Tool (used by Community Services staff in assessing whether reports meet the ROSH threshold) did not provide any guidance in this regard. In June 2011, Community Services finally agreed that the MRG required adjustment to address this gap. Throughout the remainder of 2011 and 2012, we had ongoing discussions with Community Services about the proposed changes to policy and procedures. Despite

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\(^{6}\) Formerly the Youth Accommodation Association, now known as YFoundations.


\(^{8}\) Advice provided by the NSW Department of Family and Community Services, 25 March 2014.

\(^{9}\) Community Services is undertaking a snapshot survey of this cohort of children to inform the final policy – survey results will be available in April 2014.

\(^{10}\) Allocations of child sexual assault and serious cases of child abuse and neglect are typically responded to in NSW by the JIRT. The JIRT aims to provide a collaborative interagency response to serious child abuse through the involvement of multiple agencies in order to address the safety requirements and therapeutic needs of the child, while simultaneously conducting a criminal investigation. Reports referred to the JIRT for assessment must meet the JIRT criteria.

\(^{11}\) Advice provided by the NSW Department of Family and Community Services, 25 March 2014.
advising Community Services in November 2012 that we were satisfied with the action taken to address the previous policy position, the updated guidance remained in draft form for a further six months. The ‘class of children’ definition for the Helpline Tool and the MRG has now finally been settled in accordance with our advice.82 The latest edition of the MRG has now been published.

Responding to child protection concerns involving registered child sex offenders

In 2010 we investigated a matter which revealed that Community Services had failed to adequately assess and manage the risk to a child whose mother was in a relationship with a registered child sex offender. Corrective Services had approved the man’s request to live with the woman and her child after seeking an assessment of the child’s safety by Community Services, which concluded that the mother was aware of the man’s criminal history and capable of protecting her daughter from harm. The man was subsequently convicted of several offences after the girl disclosed that he had persistently sexually abused her over a three-year period. Following our investigation and a roundtable we convened with Community Services, Corrective Services NSW and Police, Community Services agreed to prepare a document, in consultation with its partner agencies, containing guidance for the frontline staff of each agency about their respective roles and responsibilities in relation to managing child protection risks involving offenders on the Child Protection Register. However, the group was mostly inactive for two years.

While other important related initiatives have been introduced, the guide for frontline staff is yet to be completed almost three years on, despite us raising our concerns about this issue in our 2012 report on Aboriginal child sexual assault.83 Community Services has acknowledged that this important work has been ‘unacceptably slow’. Recently, it advised us that the stakeholder agencies are trialling an improved method for the referral of matters involving registered offenders, and that this will enable a final policy to be settled.84 Community Services is also exploring the issue of whether its own staff can develop the necessary expertise in assessing the risk of sexual assault posed by registered offenders.

While we appreciate the need to ensure that new policies and procedures are developed in a through a rigorous process, we are concerned that Community Services has taken so long to achieve real progress in this area in light of the very real child protection risks involved.

4.1.2. Enhancing accountability in relation to significant practice concerns

It is essential that Community Services’ overall quality assurance framework includes a focus on ensuring that policy and guidance for frontline practitioners is developed quickly and is well implemented. As illustrated above, important issues have been inadequately addressed for far too long.

The governance structure associated with the QBR process provides an ideal vehicle for Community Services’ senior executive team to track how significant systems and policy issues are being addressed, not only by districts but also by other business units with responsibilities in this area. There would also appear to be an opportunity to complement the analysis of performance data and related information conducted through the QBR, with a program of targeted ‘independent’ auditing under the leadership of the OSP, to determine whether CSCs are providing a quality service, as well as assessing performance in relation to identified priority areas.

For example, one area where the OSP could strengthen its oversight is ensuring that, at least in relation to serious practice issues, districts are implementing the recommendations it makes arising from its reviews of child deaths. At present, districts are responsible for deciding whether to implement the OSP’s recommendations and there is no formalised process to assess whether, and how, these recommendations are actioned. From our own experience in handling notifications of child abuse we know that high-level data will only provide part of the picture in relation to quality. For this reason, we believe that, in the absence of the OSP conducting regular targeted auditing, it will be difficult to assess the quality of decision-making within individual CSCs and their capacity to work effectively with other agencies in delivering integrated and effective child protection responses.

82 Both the MRG and Helpline procedure guide were adjusted to include references to historical allegations in accordance with our recommendations. These were included in the fifth edition of the MRG, released in May 2013. The Child Protection Helpline guidelines were progressively adjusted in the second half 2013.

83 NSW Ombudsman, Responding to Child Sexual Abuse in Aboriginal Communities, December 2012. See Chapter 17 and Recommendation 80 and 81.

84 In September 2013, the working group agreed that, over a six month period, Community Services, Corrective Services and Police would trial a procedure for exchanging and recording information on registrable offenders likely to have contact with a child in cases where the existing procedures of each agency do not sufficiently address safety and risk concerns. The working group proposed that Police and Corrective Services should report to the Helpline cases where a registrable offender is likely to have unsupervised contact with a child. The role of Community Services would be to assess the protective capacity of parents/care-givers. In cases where Police or Corrective Services are concerned that no adequate response has been made, they could contact a nominated senior officer in the FACS Complaints and Information Exchange Unit to escalate the matter. The FACS Complaints and Information Exchange Unit would then liaise with the relevant Community Service Centre to arrange appropriate action. Advice provided by NSW Department of Family and Community Services, 25 March 2014.
4.2. Improving the quality of interagency child protection work

In *Keep Them Safe?* we said that it would be essential to fully explore what shared responsibility means in practice. We also identified that the focus should always be on determining which agencies are best placed to respond to vulnerable clients, both individually and collectively. In this regard, we highlighted the need to reconsider the historic assumption that only a child protection worker can deliver an appropriate ‘child protection’ response.

It has been clear for some time that, given capacity constraints across the child protection system, more innovative approaches are required. There are a number of ways agencies can strengthen their practice and expand their roles to improve the responsiveness of the overall service system. In the following section, we discuss the roles that other agencies are playing in working with high-risk families and how within a ‘shared approach’ these roles can be enhanced and further clarified. In this context, we note that given the expanding role of the NGO sector in protecting and supporting children and their families it is vital that we continue to explore flexible and innovative shared practice responses. In this regard, NGOs will often be well placed to lead certain initiatives, particularly when they can leverage off the goodwill that they have built within the community.

In the second part of this chapter, we discuss the lessons learnt from past attempts at integrated case management and what is needed to ensure that opportunities to maximise the potential of a collective agency effort are not lost.

Our work continues to identify common and recurrent problems that demonstrate the need to enhance communication and related case management responses between agencies at the local level. These problems include:

- agencies failing to provide or request critical child protection related information between each other
- poor understanding by agencies of their respective and joint child protection responsibilities
- the failure of agencies to strategically involve each other in child protection matters at critical points in time, and
- poor documentation and record keeping.

Our consultations with frontline practitioners have indicated that collaboration between agencies often works better when clients are ‘below the ROSH threshold’, and that collaboration and information exchange becomes more limited when clients enter the ‘ROSH sphere’. This distinction between ROSH and non-ROSH can be counter-productive and lead to families falling through the cracks. Given the significant scope for collaboration between Community Services and other agencies in working with high-risk families, we believe a clear framework needs to be developed to guide interagency practice at both a local and central level to ensure that this work is of a high quality.

4.2.1. Enhancing the role of other agencies in responding to high risk matters

The NGO sector

Changes to the child protection system have led to an expansion of the roles and responsibilities of the NGO sector. For example, there is the ongoing transfer of out-of-home care placements to accredited NGO out-of-home care providers. More broadly, NGOs are increasingly working with families with complex needs, where risks to children are high.

The NGO sector is diverse, comprising agencies ranging from large multi-function organisations to very small providers – some agencies are therefore better equipped than others to take on more responsibilities. The proposed role for NGOs in monitoring parents’ compliance with court ordered undertakings and agreements entered into prior to formal court action, will have significant implications for the sector. In our view, ongoing NGO sector development will be critical to the success of these proposals. Relevant to this issue, ACWA – the peak association for child welfare agencies – has also identified the critical need to prioritise skills development to enable the NGO sector to take on the practice challenges inherent in the enhanced role envisaged by the proposed legislative changes.

Community Services has advised our office that it is developing an industry development framework, in partnership with the sector, to better articulate the roles and responsibilities of Community Services, industry bodies and NGOs to agree and support sector directions and priorities. The investment in a comprehensive industry development strategy for the child and family sector is a welcome initiative. The role played by the National Disability Service in sector development as part of bedding down the reforms to the disability sector has been important in strengthening that sector.

A decentralised service system must have comprehensive systems to monitor, and report on, the nature of outcomes delivered by funded agencies. As Community Services continues to devolve responsibility for out-of-home care and other child protection work to its NGO partners, it will be important to develop in partnership with the NGO sector,

85 In this respect, we note that the Industry Development Fund developed for the disability sector in NSW, has assisted the sector to prepare for the significant challenges involved in the implementation of the National Disability Insurance Agency.
a robust quality assurance framework to assess and drive ongoing improvements to NGO practice. For example, given the transition of out-of-home care to the NGO sector, Community Services is developing a Quality Assurance Framework to monitor outcomes for children in out-of-home.

We have also been advised that, through ACWA, the NGO sector will lead the development of a best practice framework that will incorporate policy, guidance on practice, research and training across a range of areas, including: working with biological parents, restoration, adoption, dispute resolution, and working within the legal system. ACWA has indicated that in developing the framework it will ensure a ‘high level of agency involvement and buy-in’. In this regard, it will be important for ACWA and Community Services to ensure that a strong partnership is developed between both Community Services and ACWA staff who are leading quality and efficiency initiatives.

In addition, Community Services has told us that it is already implementing a new contract governance approach that sets out clear expectations of NGO partners in relation to the delivery of services; and that active monitoring of performance and relationship management will be key components of the approach.

**Police**

Given that around 60% of ROSH reports made to the Helpline indicate possible criminal behaviour (including domestic violence, sexual and physical abuse), police are potentially well placed to gather information relevant to the assessment of a child’s safety and to pass on this information to Community Services. From our extensive oversight work in this field, we see considerable opportunity for improving the way police capture and share relevant child protection related information, and for enhancing the partnership between Police and Community Services (particularly for those matters where there are concurrent serious child protection and criminal conduct issues in play).

We have been exploring with Police and Community Services the potential for police to routinely provide better quality child protection related information to Community Services – and other agencies – in a range of contexts.

Community Services has recently agreed to include additional questions in the existing ROSH reporting tools used by police with the aim of ensuring better evidence is collected and provided when police attend family violence incidents, or when they are called out to visit families when Community Services lacks the capacity to do so.

Another issue Community Services and Police are currently exploring together is the implementation of a mechanism for identifying and flagging serious violent offenders (SVO) on the police database COPS. Under this proposal, any child risk assessment undertaken by police involving an SVO could potentially lead to an automatic notification to Community Services within 24 hours, together with advice that the individual is an SVO and the provision of relevant criminal antecedents. In addition, when they receive a child at risk report, Child Wellbeing Units and Community Services could also check with police whether a person has been flagged as a SVO and if so, request relevant details.

Collaborative work between Community Services and Police on this issue is encouraging and represents an important part of the development of an intelligence-driven approach to child protection practice. This issue is discussed in more detail later in this chapter.

In several of our public reports – and in recent discussions with Police and Community Services – we have also focused on the value of sharing information from police profiles that is highly relevant to significant child protection risks (particularly profiling by local police commands of high-risk domestic violence offenders and victims). Both agencies have agreed that more needs to be done to ensure that, at a local level, risk related information of this type is being routinely and systematically exchanged.

We have also identified that there is scope for police to improve the way that they conduct child protection related ‘welfare checks’. In reviewing a significant number of cases where welfare checks were conducted, it is clear that the quality of the information obtained by police – and their related practice – varies greatly. In our view, clearer guidance and support for police in this challenging area of practice is required. This should include, but not be limited to, ensuring that Community Services and other agencies provide critical contextual information to police when requesting a welfare check.

Finally, our discussions with Community Services and Police have highlighted the need for police to be able to quickly access any child protection information which might be held by Community Services at the time that they are responding to domestic violence and other incidents. When police attend homes in response to criminal matters that may also involve potential child protection risks, they do so without necessarily even knowing whether there are...
any children in the home. While in some cases this can be gleaned from the visit, this will not always be the case. Therefore, it is worth considering whether certain designated police positions could be given direct access to the KiDS system. This would not only assist in identifying children in the home, it would also provide Police with relevant child protection information associated with household members. However, it needs to be recognised that providing police with direct access to the KiDS system would require legislative change.

Education

For more than five years, we have been highlighting the important role of schools in identifying and reporting cases of habitual non-attendance at school. In recent years, there has been a greater level of national recognition of the need to tackle this issue. However, as with other complex child welfare issues, school staff alone will often not be in a position to address the entrenched problems facing many of the vulnerable children and families they come into contact with.

The death from starvation of a seven year old girl known as Ebony in 2007 highlighted the importance of an effective interagency approach to child protection and was one of the main catalysts for the Wood Inquiry. One important outcome of this Inquiry was the establishment of habitual non-attendance at school as a specific statutory ground for reporting concerns to Community Services. Our review of that case identified extreme educational neglect as a recurrent and escalating risk indicator for Ebony and her siblings. 90

Since then, in a number of reports we have continued to identify the strong link between educational neglect and other child protection risks. In our 2012 report Responding to Child Sexual Assault in Aboriginal Communities, we observed that a high proportion of Aboriginal children reported as victims of sexual assault had records of lengthy school absenteeism and suspension. 91 Our 2012 confidential report of our review of a group of school-aged children from two Western NSW towns also found a strong correlation between children's non-attendance at school and their identification by police as being ‘high risk’. 92 In addition, a failure to adequately respond to educational neglect has been a significant factor in a number of child deaths from abuse and neglect that we have investigated over recent years.

A range of measures have recently been introduced in an attempt to improve the way that Education and other agencies identify and respond to educational neglect. Education has acknowledged the concerns we have previously raised about the inadequate collection and reporting of data about school attendance and suspensions. 93 These inadequacies create a lack of transparency about individual schools and communities where non-school attendance is a significant problem.

Since our 2011 report, Education has published the attendance rate of every mainstream school annually on its website. In addition, it has made a range of improvements as part of the integrated learning management program that is progressively being rolled out to public schools in 2014. 94 As part of a recent functional realignment, Education has established a child protection team bringing together its child protection policy, school attendance and out-of-home care units. It is expected that this will enable a more coordinated approach to policy and practice. Education has also improved its annual child protection training module which is undertaken by all staff in child protection related positions, and is working with other agencies to develop an online resource to improve awareness of, and the response to, educational neglect. 96

Education has also improved the advice it provides to Home School Liaison Officers (HSLOs) about their child protection responsibilities, and has reported a large increase since 2009 in the number of students supported by HSLOs and Aboriginal School Liaison Officers. 96 As well, Education has noted that according to a KPMG

91 Our report found that almost a third of Aboriginal students from the 12 communities we reviewed had missed 30 days or more of school in 2011, including three schools where more than 80% of Aboriginal students missed 30 days or more of school. We also looked closely at the child protection and education histories of 46 Aboriginal children from the 12 target communities who had been the subject of a sexual abuse report. This showed that 61% had missed 30 or more days of school in the six months before the incident and 19% had been suspended at least once in the same six month period; and 67% had missed 30 or more days of school in the six months after the incident and 38% had been suspended at least once in the same six month period. NSW Ombudsman, Responding to Child Sexual Assault in Aboriginal Communities, December 2012, Chapter 5.
93 We discussed the inadequacy of data as well as the need to strengthen internal accountability and governance mechanisms for tracking the progress of individual schools and regions against these indicators in our 2011 report. Addressing Aboriginal disadvantage: the need to do things differently, as well as our 2012 report, Responding to Child Sexual Abuse in Aboriginal Communities.
94 Among other things, schools will now have the capacity to record and report on the number of overall school days missed by a student each year, the number of occasions a student has been suspended and the length of each suspension, the number of students who have missed 30 or more days of school each year, and whether an attendance improvement plan has been developed. However, we note Education’s advice that the current LMBR scope for SALM does not include data capture regarding school attendance enforcement action under the Education Amendment (School Attendance) Act 2009.
95 We have been advised by Education that the training updates for 2013 and 2014 provided more specific information on educational neglect as well as a training module for principals to deliver to their school executive.
96 The number of students supported by HSLOs increased by approximately 60% from 2009 to 2012 (to 5,125 students in 2012) while the number of students supported by ASLOs increased by approximately 170% from 2009 to 2012 (to 524 students in 2012). Advice provided by Department of Family and Community Services to Ombudsman request for information, 24 December 2013.
evaluation, a substantial number of children in care are being better supported in the education system as a result of the establishment of the 10 new out-of-home-care coordinator positions which were recommended by the Wood Inquiry. However as we have previously observed, individual positions such as HSLOs and ASLOs cannot, on their own, adequately respond to educational neglect.

In 2013, in response to a report by this office, Education launched a pilot in Shellharbour and Cessnock to test new collaborative early intervention approaches to students at risk of educational neglect. In both areas, interagency committees, chaired by Education, have met at least monthly with the dual aim of identifying and responding to the underlying issues affecting school attendance and reducing the likelihood of child protection reports. The committees also have a role in coordinating case management for each family – in both pilot sites this has involved smaller subgroups having more detailed discussion of individual cases.

Separately, schools in Mount Druitt, Newcastle and Dubbo are involved in piloting a school-based partnership program with mental health services. Additionally, schools and other services in the New England North West, Murrumbidgee and Western region have been collaborating at the local level on a variety of new approaches to supporting vulnerable children. In a number of cases, this work is reportedly improving collaboration between schools, the Family Referral Service and broader service sector. While there is a need for ongoing review and reshaping of the service system to facilitate genuinely integrated service delivery to vulnerable families, these initiatives demonstrate scope for more effectively implementing the notion of ‘shared responsibility’ for supporting and protecting children.

While the implementation of the Connected Communities strategy, is not currently planned to be a vehicle for addressing educational neglect on a state-wide basis, it does provide the opportunity to test and develop innovative collaborative interagency work in this area of practice. The strategy – which involves the creation of ‘executive principal’ positions in 10 communities (involving 15 schools) across the state – positions schools as integrated ‘service hubs’ for providing support to all children and families in the involved schools from birth, through school, and on to training and employment.

Menindee Central School and the Department of Education – in conjunction with Police, Health, Community Services, and local NGOs – have already started to develop intelligence-driven strategies to build a more complete understanding of local child protection risks to inform and guide the work of Connected Communities in Menindee.

At a meeting in August 2013, the Executive Principal of Menindee Central School, explained how the school was working collaboratively with participating agencies in identifying key areas relating to student safety, welfare and wellbeing so as to maximise support and assistance. The school’s initial analysis identified a number of at-risk children and families. The information about these families which was held by other agencies, particularly Police, will enhance this analysis. This approach will ensure that a much more complete picture of the service needs of all students in Menindee – not just those who are at obvious risk of dropping out of school or becoming involved in offending – is available. After assessing all of the students and identifying children and families who appear to be at greatest risk, the next step is to again bring agencies together to share aspects of the analysis and to see who is best placed to provide support.

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97 We were provided with a copy of the evaluation report at the time of publishing this report. The evaluation report is currently being considered by our office.

98 NSW Ombudsman, Addressing Aboriginal disadvantage: the need to do things differently, August 2011 – Chapter 5; and Responding to Child Sexual Assault in Aboriginal Communities, December 2012, Chapter 19.

99 Community Services has advised us that there are currently 10 families involved in the pilot at Cessnock, and eight families at Shellharbour. We understand an evaluation will be carried out later in 2014. Advice provided by Department of Family and Community Services to Ombudsman request for information, 24 December 2013.

100 A local school reference group chaired by the local Aboriginal Education Consultative Group Inc. (AECG) and including members from the Parents and Citizens Association and other key stakeholders, has been established in each school community to work alongside the Executive Principal to guide the planning for the strategy in each school. This governance model is unique in that the local community, in partnership with the school principal, collaborate in a co-leadership role that is locally responsive to the students’ needs and aspirations. To assist the Executive Principal in connecting more directly with parents, the local community and key stakeholders, a position of Senior Leader, Community Engagement or Leader, Community Engagement has been established whose main purpose is to serve as a conduit between the local and broader community and key stakeholders and the school. Connected Communities schools will teach Aboriginal Language and Culture, aligned with the Government’s OCHR plan. Advice provided by the Department of Education and Communities, 12 March 2013.

101 Positive steps have been taken in a number of other Connected Communities schools: At Brewarrina Central School, the school is reviewing and reorganising its senior secondary curriculum and teaching style and they are seeing signs of increasing student engagement and building their capacity as learners. The school is also working with agency partners to provide a co-ordinated approach to youth issues. At Coonamble Public School, interagency support has been used to ensure families now have access to Birth Certificates for all children. The school is also working closely with health providers to provide family access to mental and physical health services within the school environment. Toomelah Public School has reported success in relation to its early years reading program and through the establishment of an adult learning centre for parents and other community members – 30 people have participated in two courses. Further courses are planned on how to help your child succeed at school, financial literacy, basic computing and build your own computer. At Moree East Public School, a focus has been on planning for the transition of children to school and has engaged with local preschools and early childhood centres to promote the school and build relationships with families early on. Advice provided by the Department of Education and Communities, 12 March 2013.

102 This was in accordance with the information sharing provisions contained in Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998.
Despite the encouraging developments referred to above, significantly more work needs to be done in the area of identifying and responding more effectively to educational neglect. Current data suggests that children the subject of a ROSH report because of educational neglect are still among those least likely to receive a response from the statutory system. In *Keep Them Safe?* we noted that reports about educational neglect received a very low rate of response by Community Services; in 2010, less than 10% of educational neglect ROSH reports received a face to face response by a Community Services caseworker (as compared to a figure of 21% for all reports).\(^{103}\)

The most recent data indicate negligible change in this trend; in 2012-2013 only 11% of educational neglect ROSH reports received a face to face response from a Community Services caseworker. However, in *Keep Them Safe?*, we noted the risk issues which are so often associated with educational neglect will only be properly addressed once we more fully understand the role that various agencies – such as Community Services, Education, Police, Health and the NGO sector – should play in responding to this issue.

This recent data serves to emphasise how critically important it is for those designing the community welfare system to continue to explore the most efficient and effective ways of providing a collaborative response to educational neglect and the other frequently associated risk factors. In addition, it highlights the need to improve data on working out a collective response to this issue – clearly, the data on Community Services’ ROSH response rate to educational neglect fails to provide an adequate picture of the actual support provided in these cases.

**NSW Health**

Together with Police and Education, NSW Health is one of the main reporters of ROSH matters to Community Services. The main issues reported by health professionals involve parental mental health problems, domestic violence, physical abuse, neglect and parental drug or alcohol use. This means, of course, that emerging and serious risks to children are frequently linked to complex health and behavioural problems within vulnerable families. NSW Health’s policies require health workers to take account of child protection and wellbeing issues in their dealings with clients whether they are children and young people or parents/carers.

Child protection and wellbeing is core business for NSW Health and there are a range of primary, secondary and tertiary health services providing a continuum of care in this area, including: antenatal and early childhood health services, sustained health home visiting, mental health and drug and alcohol interventions (including Whole Family Teams for families with children above the ROSH threshold), child protection counselling services, sexual assault services, New Street Adolescent Services and routine screening for domestic violence.

Our review and investigation work has identified a number of opportunities to improve child protection practice in the health sector. For example, we have highlighted matters where mental health services were not always cognisant of the support needs of patients as parents, and the possible impact of the parent’s mental health condition on children. As a result, we have recommended that NSW Health advises us of current and proposed strategies to promote a better understanding of, and more effective response to, the needs of children of a parent with a mental illness.\(^{104}\)

NSW Health has indicated that it demonstrates a strong commitment to this work through its state-wide implementation of the *NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010-2015*. Health has advised that the Framework – along with mandatory use of the state-wide mental health clinical documentation and the work of the ‘COPMI local champions’ – supports frontline clinicians to better recognise their patient’s parental responsibilities and the needs of their children, including providing guidance on assessing risk. NSW Health also provides ongoing workforce development via online training and face-to-face workshops for mental health and drug and alcohol professionals across NSW to improve their understanding of child protection issues.

We have also recommended that NSW Health undertake an internal review if a child dies in suspicious circumstances within 12 months of receiving care or treatment from a NSW public health facility.\(^{105}\)

Since 2010, significant work has been undertaken in establishing and strengthening Health’s systemic response to children at risk, including through the operation of its three Child Wellbeing Units\(^{106}\) and NSW Health funded Family Referral Services (FRS). The FRS network – currently operating in 11 metropolitan and rural/remote locations – was established to coordinate the referral of families and children who are identified as being at low to moderate risk and who do not require statutory intervention. However, we have been advised that higher risk children have been referred through five FRS trial sites which are hosting Community Services child protection caseworkers. FACS has told us that, as of late 2013, these sites have received about 300 referrals of children who have been assessed as being at ROSH with a designated response time of less than 10 days. It is important to stress that these were cases

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\(^{103}\) Data relates to the period 24 January – 31 December 2010.


\(^{106}\) NSW Health has three CWUs, which align with the existing NSW Child Health Networks, and are located in Dubbo, Wollongong and Newcastle.
that would not otherwise have received a face-to-face casework response. In our opinion, this work represents a welcome attempt to expand system capacity and trial new ways of working with vulnerable children and their families on a collaborative interagency basis.

It also more broadly points to the potential for building the capacity of the overall community service sector through the strategic placement of highly skilled Community Services’ personnel within the NGO sector. In particular, designated positions of this kind could play an advisory role and potentially provide support to NGOs – and other government agencies – in relation to:

- the handling of high risk cases
- improving the consistency of intra and inter agency decision-making
- strengthening the working relationship between Community Services and its partner agencies
- enhancing information exchange practices and collaborative practice more generally, and
- reducing the number of unnecessary ROSH reports made to the Helpline.

Therefore, against the background of the current inability of the child protection system to adequately deal with ROSH report demand, we believe that additional investment in positions of this kind could produce a strong return if they were to be effectively used. However, it is important to stress that any such appointments would need to involve individuals with excellent technical and capacity building skills, and they would need to be well supported by both government and non government partners.

4.2.2. Addressing identified problems in relation to integrated practice

Case management practices and systems which are truly integrated across government and non-government agencies are a critical component of shared responsibility, and a precondition for improving service responses to vulnerable clients who have needs that cannot be easily met by any one agency.

In Keep Them Safe?, we noted the importance placed on integrated case management by the Wood Inquiry when we discussed frequently encountered, complex and other 'high end' users of the service system. However, as we observed in our December 2012 report – Responding to Child Sexual Assault in Aboriginal Communities – current practices in relation to engaging high need families is often complex, inefficient and disjointed. That report strongly argued the need for NSW to move toward a more integrated approach to engaging high-need families, including through the development of a high level framework to support more efficient and effective place-based case management practices.

**Integrated case management programs**

In NSW, attempts to create more holistic responses to vulnerable children and their families have largely relied on the initiative of individual agencies investing in trials of integrated case management programs. In broad terms, these programs attempt to respond to the multiple issues affecting clients with complex needs by using various frameworks that try to deliver coordinated agency interventions. An active proponent of these programs is FACS, which has responsibility for the two leading programs in this area – Family Case Management and Supporting Children, Supporting Families (formerly known as the Anti-Social Behaviour Pilot Program). FACS also operates Complex Case Coordination Panels in a number of districts, which are intended to bring various agencies together to regularly review complex clients in circumstances where the existing service system is struggling to meet their needs.

The Supporting Children, Supporting Families (SCSF) program is the most far reaching integrated case management program with 17 sites across the state. A 2011 interim evaluation of the program confirmed that there had been disappointing practical outcomes from the program over its seven years of operation. As part of our review of school-aged children in Western NSW, we also consulted staff from agencies that participated in the program. In feedback provided in late 2011, they cited a number of factors that had impeded the effective coordination of joint casework.

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107 NSW Department of Family and Community Services response to Ombudsman request for information, 24 December 2013.
108 NSW Ombudsman, Responding to Child Sexual Assault in Aboriginal Communities, December 2012, p.197.
109 It was formerly managed by the Department of Premier and Cabinet but, approximately three years ago, responsibility for its operation was shifted to FACS.
110 The Magnolia Place initiative which is discussed in further detail in Chapter 6, involves the use of child protection workers to act as a linking point between the child services department and the more than 70 organisations involved in delivering services through the initiative.
111 The SCSF program was originally established by Police, Community Services and other agencies in Dubbo over eight years ago, as a forum to bring service providers together to coordinate interventions targeting young people with complex needs. Our initial observations of the Dubbo model were positive. See NSW Ombudsman, Working with local Aboriginal communities – Audit of the Implementation of the NSW Police Aboriginal Strategic Direction 2003-2006, April 2005.
112 Eastern Beaches, Blacktown, Campbelltown, Darling River, Lake Macquarie, Liverpool, Leichhardt, Macquarie Fields, Mt Druitt, New England, Port Stephens, Richmond, St Mary’s, Orana, Tuggerah Lakes, Parramatta and Wagga Wagga.
These included:

- poor preparation, with some agencies that have key casework responsibilities attending the meeting with insufficient or outdated knowledge of families’ circumstances
- agencies delegating attendance to inexperienced staff who lacked knowledge of the families and the authority to commit their agency to a particular course of action
- confusion about processes for identifying when, and in what circumstances, decisions about jointly managed cases should be escalated
- the development of a practice whereby agencies that nominate families for assistance were usually required to take on lead agency responsibility for the case, even if their agency had little direct involvement with the family and was not best-placed to coordinate the response
- the logistical difficulties associated with seeking the assistance of agencies that have few or no staff based in remote locations and haphazard attendance by some agencies, and
- basic program governance problems, including frequent changes in responsibility for chairing the meetings and for providing secretariat and other support.

Against the background of these (and other) concerns, we decided to initiate an inquiry into the operation of the program in 2012. In responding to our inquiry, FACS included a copy of an evaluation conducted by a firm of consultants in June 2012. The evaluation highlighted many of the same concerns that we had been raising around weak governance processes and poor accountability.

The other major integrated case management program, Family Case Management (FCM), began as a Keep Them Safe reform. Justice Wood made a range of recommendations for reforming the way that information about vulnerable children and their families is collected, shared and responded to (including that government agencies with child protection responsibilities should actively identify their ‘high end’ users and provide these families with an integrated case management response). An evaluation of Stage 1 of FCM, which operated in three regions, provides useful insights into integrated case management practice generally; particularly in relation to issues such as determining who should be targeted for assistance, and how.

Although FCM was established to identify ‘high end’ users and to provide them with integrated case management responses, an evaluation found that its trial sites in Western NSW experienced acute difficulty in getting families with complex needs to engage with the program. A number of inter-related factors contributed to this problem; including uncertainty about which families to engage; limits to the capacity of staff to case manage clients with multiple and complex needs; a lack of training; and local community distrust of participating services. In response, the FCM agencies shifted their focus to ‘medium users’ whose problems were less acute, but who were more willing to engage and who were easier to assist.

While shifting the focus of interventions from ‘high end’ to ‘medium’ users might have increased the likelihood of achieving positive outcomes, this approach failed to resolve the issue of how the families with the most complex needs should be managed and supported in each location. The program failed to deliver on its intended outcomes largely because it was not embedded within a broader interagency framework to identify, and respond to, the needs of vulnerable children and families across the continuum of need.

**Identifying the client base – using an intelligence-driven approach**

The ability of Community Services and other agencies to provide a quality response to families requires robust systems for identifying potential clients and the nature of client need. The systematic identification, sharing and analysis of information is also a critical precursor to the implementation of effective place-based solutions; we discuss this issue in the final chapter of this report.

*Keep Them Safe?* has had a considerable focus on improving information exchange between agencies, but the impact of these reforms has been uneven at best. While the inability to easily extract agency data about the use of the Chapter 16A provisions makes it difficult to assess the extent of their application, it is clear that the provisions have not been used in a systematic way to identify which children and families need support in individual locations and the kind of services they require as a result.

As we have previously noted, our *Keep Them Safe?* report specifically recommended the development and implementation of an intelligence-driven child protection system that promotes identifying, analysing, prioritising...
and acting on information held by agencies involved in child protection. Almost a year after our report was released, we completed a confidential review in 2012 of a group of 48 school aged children from two Western NSW towns. The purpose of the review was to explore the potential benefits of intelligence driven child protection practice and to inform the work being carried out by agencies in response to our 2011 recommendation.117

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### Our 2012 confidential report: Sharing responsibility for identifying and prioritising children at greatest risk

Using Education and Police records, we identified children who had missed lengthy periods of school through unexplained absences (at least 50 days a year) or suspensions, and/or had frequent contact with police because of their repeated exposure to violence and other risks at home or their own risk-taking behaviours, as well as those identified by either schools or police as being at particular risk. The group included 14 children on a ‘priority’ list created by local police analysts because of particular concerns about their suspected involvement in offending or because of incidents that highlighted specific child protection risks. The majority of the children were aged between 8 and 11 years old.

When we scrutinised the records that Police, Community Services, Education, Health and other agencies held about the children and others in their households, we found that most had been exposed to violence at home. The mothers of 46 children (96%) had been reported as victims of domestic violence, including the mothers of 26 children (54%) who had been the victim of 10 or more domestic assaults in the two year period checked. The fathers of 42 children (88%) had been criminally charged, some repeatedly. One father had accumulated 140 charges and 118 convictions over his lifetime, and another had 117 charges and 83 convictions. There were criminal charges against the mothers of 36 children (77%), and despite their young age seven of the children had also been charged.

Education records showed that 36 (75%) of the 48 children had been absent from school for 50 or more days in at least one of the years we checked, and 32 (67%) had been suspended at least once.

When we cross-referenced the agency information holdings on the 48 children we found that:

- For this age cohort, the children at greatest risk were readily identifiable through Education and Police records alone. There was also a high correlation between the children identified as being at risk due to school absences and/or suspensions and those identified as a ‘priority’ by police.
- Most were known to be at risk from an early age – 60% of the 48 children were aged two or younger when they were first reported to Community Services as being at risk, mostly because of their exposure to domestic violence.
- Those whose parents had extensive criminal records were among the children at greatest risk, as indicated by the high volume and seriousness of reported child protection issues. These children were also much more likely to be in statutory care or living in an informal care arrangement.
- All the children who were the alleged victims or perpetrators of sexual abuse had a range of other risk factors present – including disengagement from school, exposure to domestic and family violence, exposure to parental substance abuse and comparatively high numbers of abuse and neglect reports. These associated risks were present in all of the sexual abuse cases, irrespective of whether the abuse allegations had been substantiated.

From this work, it is clear that when we received the collective holdings about this cohort, rather than each agency’s holdings in isolation, the information painted a clear picture of the risks associated with the circumstances of each child and family. However, our review found that there was not an adequate system in place to systematically share and analyse the information held collectively by agencies. We also identified that both locations lacked a clear governance framework to facilitate this type of work.

The need for streamlined, effective and accountable governance structures was also recognised by the regional directors from Community Services, Education and Police who took part in our review. In emphasising the benefits of agencies coming together to share critical information on priority families, they highlighted the need for existing local governance structures to be rationalised. They commented on the program-centric nature of ‘existing case

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coordination bodies established for specific purposes, such as the Supporting Children, Supporting Families program or the Safe Families Case Co-ordination Groups’. And they expressed concern about the lack of an efficient mechanism for ensuring that vulnerable families from both communities were being identified and referred for help. They also saw the need to track whether identified families were receiving the assistance that they actually required, rather than having to adjust to suit the particular parameters of the programs on offer.

The regional directors concluded that:

There may be value in re-thinking and broadening case co-ordination for these remote communities so that they can address issues of child protection and safety more broadly. There is a need for a mechanism by which information about children and families can be appropriately shared in order to enable a coordinated and early response. Utilising a tiered approach more broadly within the community could reduce duplication of case co-ordination activities and improve early intervention outcomes. It is of course critical that we do not add another layer of coordination, but look to streamline and simplify.118

In response to our 2011 recommendation relating to this issue, an ‘intelligence driven child protection sub-committee’ was established in 2012 within the Keep Them Safe Senior Officers Group. The group met several times, and at its last meeting towards the end of 2012, agreed that there is potential to apply intelligence driven practice at all points in the child protection continuum. The group also noted a number of opportunities for carrying out further work in this area.119

As we noted earlier in this chapter, Community Services has recently commenced joint work with Police to identify and flag ‘serious violent offenders’. It has foreshadowed future work with Health and Education that will focus on including data that identifies risk on the WellNet information system (the Child Wellbeing Unit database).120 NSW Health has also been exploring the use of Patchwork – a web application ‘designed to transform the way governments interact with vulnerable families in maternal health, child health and youth services.’ As well as listing various services to allow practitioners to find an appropriate service for a client if they identify a referral need, the application allows practitioners to maintain a client list so that participating services can tell if any other services are engaging with their client.121

While these types of initiatives are critical, they should sit within a broader operational ‘intelligence’ framework. In this regard, business requirements need to be developed which provide guidance and accountability mechanisms to promote the systematic analysis and sharing of local information holdings between agencies. In addition, this work must be supported by adequate local governance structures. The resulting analysis from this type of work should then be used to inform related interagency case management work and service planning more generally.

As our school-aged children review demonstrates, this kind of work does not necessarily require sophisticated IT systems or major changes to agencies’ business environments (although sophisticated data solutions certainly enhance intelligence capacity).

We note that intelligence-driven child protection practice is beginning to be embraced internationally. The first conference on ‘intelligence-led safeguarding’ was held in the United Kingdom in late 2012. Early this year, a follow up conference was held to showcase the latest thinking around intelligence-led outcomes through multi-agency and integrated working, with a focus on systems for sharing data.122

The need for an overarching framework to drive integrated case management

In November 2012, Community Services advised us that to address the limitations identified through our reviews and other evaluations, they had decided to replace the various interagency case management programs – including SCSF, FCM, and Complex Case Coordination Panels – with a single framework known as Coordinated Approaches for Complex Clients.123 While noting that the general direction of the draft framework was positive, we expressed concern about it centering on FACS, rather than incorporating all relevant human service and justice agencies. We also questioned the adequacy of the proposed governance structure, noting that in all essential aspects, it was very similar to the structures that had already failed in connection with SCSF and FCM programs. During our discussions with FACS, we underlined the importance of any framework for integrated case management having more than just

118 Joint response provided by Community Services, Department of Education and Communities and NSW Police Force on review of school-aged children, 26 March 2012.
119 Most of these opportunities had been identified in our school-aged review work: for example, the enhanced use of risk information collected by NSW Health as part of their SafeStart and domestic violence screening; information from Education on truancy, non-enrolment and school absences; and police holdings on high risk adults. Department of Family and Community Services response to Ombudsman request for information. Advice provided by NSW Department of Family and Community Services, 31 January 2014.
120 NSW Department of Family and Community Services response to Ombudsman request for information, 24 December 2013.
123 On the basis of this commitment by FACS, we finalised our inquiry into SCSF in July 2013...
the ‘support’ of partner agencies and/or ‘linkages’ with related initiatives – instead, we stressed that it must be co-designed with human service and justice agencies and the NGO sector, and be integrated with existing and planned initiatives.

During 2013, we repeatedly sought advice from FACS about the status of the Coordinated Approaches for Complex Clients framework.\textsuperscript{124} In December 2013, we were told that in response to the May 2012 Commission of Audit’s recommendation for trialling a centralised Family Recovery Unit to provide intensive support programs for the highest risk multiple and complex needs families,\textsuperscript{125} the NSW Government was ‘exploring options for a more effective whole of government response to this cohort of families’.\textsuperscript{126} We have recently been advised that the development of the Coordinated Approaches for Complex Clients framework is in progress and that adjustments are being made to the framework to reflect the FACS localisation and other service system changes.

In January of this year, we received advice from FACS that Complex Case Coordination Panels of ‘some form’ continue to operate in 14 of FACS’ 15 districts. We were also informed that the panels are “under consideration” by a FACS-led interagency design group and that ‘subsequent steps require further understanding of whether the current approach needs to be revised, as well as the demonstrated effectiveness of the use of panels in providing better outcomes for complex clients, and an understanding of the approach to classifying complex cases across Districts.’\textsuperscript{127}

More recently, FACS provided us with details of a large number of examples of local integrated case management initiatives in which the Department is involved with other agencies. It is evident that many of these have evolved from practitioners’ demonstrating initiative and appreciating the importance of joint work in responding to the complex needs faced by many vulnerable children and families. This is very encouraging. However, what is still missing is a coherent framework that ensures the various integrated case management initiatives are informed by the core components of successful collaborative practice, that is:

- a clear and practical commitment to collaboration
- an agreed definition of the problem and the proposed solution
- a joint design and robust ongoing review processes
- strong governance processes to drive implementation, including but not limited to the technical skills to obtain evidence regarding implementation ‘success’ and the outcomes achieved, and
- collective responsibility for delivering results.

In the final chapter, we discuss the issue of collaborative practice in the context of broader service system reform at the local community level.

\textsuperscript{124} May, June, July and November 2013.
\textsuperscript{125} NSW Commission of Audit, *NSW Commission of Audit Final Report: Government Expenditure*, May 2012, p120.
\textsuperscript{126} Department of Family and Community Services response to Ombudsman request for information, January 2014.
\textsuperscript{127} Community Services, *NSW Ombudsman Outstanding Issues / Actions Update*, January 2014.
Chapter 5. Building an efficient service system

In *Keep Them Safe?* we acknowledged the critical need to look beyond the ‘ROSH horizon’. We observed that, in examining how to strengthen the child protection system, Justice Wood’s focus was not only on the need to improve the response to ROSH reports, it was also on the importance of investing in effective universal and early intervention services. Although this report has a strong focus on the ROSH-end of the system, it is widely recognised that effective universal services and targeted early intervention, especially in the early years of life, provide the best outcomes and return on investment – the more entrenched the indicators of disadvantage, the costlier the remedies.¹²⁸

In addition to ensuring that there is an adequate investment in universal and early intervention services, there is also the need to determine whether programs and service systems are actually delivering a return on investment. In Australia and elsewhere, there is understandable public support for ensuring that the expenditure of funds on community welfare initiatives results in solid outcomes.

Relevant to this issue is NSW’s recent rollout of social benefit bonds:

... a new financial instrument in which investors provide upfront funding to service providers to deliver improved social outcomes. If these outcomes are delivered, there are cost savings to government that can be used to pay back the upfront funding as well as provide a return on that investment.¹²⁹

The Council of Social Service of NSW (NCOSS) noted in a recent report that:

*At a time when the Government budget itself is under pressure, our report signals the importance of ensuring that programs intended to relieve cost of living impacts reach those who are really hurting, and provide sufficient levels of assistance relevant to the circumstances. The NSW Government commits considerable funding, across a range of portfolios, to such programs. Many would benefit from review to ensure they are appropriately targeted, reflective of current-day issues, delivering measurable results and using the most appropriate service delivery models.*¹³⁰

Against the background of the community’s desire to see positive outcomes from funded welfare initiatives, a particular focus of our work has been on the waste associated with poorly integrated and inefficient service systems operating in disadvantaged local communities. This system dysfunction has resulted in a failure to identify and meet the needs of vulnerable children and families; the continued funding of agencies that are failing to provide a good quality service; and the limited return on investment from a number of costly agency programs.¹³¹

We have repeatedly stressed that, on its own, the injection of additional resources will not guarantee improved outcomes for vulnerable children and families in high-need communities. And we have consistently reinforced that in order to make real, sustained inroads into disadvantage, the service system should be rebuilt to achieve a more targeted response to those communities and individuals most in need of assistance and support.

Since 2010, we have published a number of reports which have advocated for effective ‘place based’ models of service planning, funding and delivery – underpinned by a cohesive approach to local decision making by federal, state and local government agencies, key non-government agencies and community representatives. We have argued that implementing place based service delivery should involve:

- relying on evidence to identify need and to determine priority areas for funding, as part of an ongoing ‘whole of community’ service planning and mapping exercise
- funding services based on the priority areas that have been identified (and according to a rigorous procurement process that assesses the capacity of individual services to deliver)
- ensuring that the level and nature of services which are provided by funded agencies are tracked, and the related outcomes are monitored.


¹²⁹ FACS has entered into agreements to implement the Newpin SBB and the Benevolent Society (TBS) SBB. Under these bonds, which are the first of their kind in Australia, support will be provided to vulnerable families to either prevent children from entering care or safely restore children who are in out-of-home care to their family and thereby reduce the need for out-of-home care. The development of a third SBB is underway. The Newpin SBB raised $7 million in private capital for Unitingcare Burnside to deliver a restoration and family preservation program. The TBS SBB is a $10 million bond under which TBS will provide its Resilient Families program. Advice provided by NSW Department of Family and Community Services response to Ombudsman request for information, 7 March 2014.


¹³¹ NSW Ombudsman, Inquiry into service provision to the Bourke and Brewarrina communities (2010); *Addressing Aboriginal disadvantage: the need to do things differently* (2011); Review of a group of school-aged children from two Western NSW towns (confidential report - 2012); *Responding to Child Sexual Assault in Aboriginal Communities* (December 2012).
In addition, our reports have strongly emphasised the importance of well formulated and sophisticated community engagement strategies. We have also stressed the need for governance arrangements, and related accountability mechanisms, that are sufficiently robust to effectively drive ‘place-based’ work.\footnote{132}

In December 2012, our final report on the implementation of the NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal communities recommended that the Department of Premier and Cabinet (DPC), together with other key stakeholders, develop and implement a strategy for delivering effective place-based planning and service delivery within a number of high need communities.\footnote{133} In response to our audit, the NSW Government has committed to work with Aboriginal leaders to ‘design, develop and implement service delivery reforms in Aboriginal communities’. This work will be informed by the Local Decision Making Framework envisaged by OCHRE – the government’s plan for Aboriginal affairs – and the integrated service delivery approach being pursued as part of Connected Communities.

Since we first began arguing for an effective and collaborative place-based service delivery model in NSW, the ‘collective impact’ movement has been gaining momentum. The term ‘collective impact’ was coined in the US in 2011 and has been defined as:

\begin{quote}

a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organisations and citizens to achieve significant and lasting social change. The approach is premised on the belief that no single policy, government department, organisation or program can tackle or solve the increasingly complex social problems we face as a society.\footnote{134}
\end{quote}

Importantly:

\begin{quote}
The approach calls for multiple organisations or entities from different sectors to abandon their own agenda in favour of a common agenda, shared measurement and alignment of effort. It needs good data and good analysis of data at a local level; and it needs the skills, tools and practice knowledge of continuous quality improvement.\footnote{135}
\end{quote}

Perhaps the best known example of a large-scale collective impact initiative is Promise Neighborhoods, a US federally funded program to support a number of disadvantaged communities to improve educational outcomes for students through ‘wrapping’ children in education, health, and social supports by ‘effectively coordinating the efforts of schools, families, social services, health centres, and community-building programs.’\footnote{136}

A recently released report for the Benevolent Society about the critical need for continued investment in prevention and early intervention specifically endorses whole of community, place-based collective impact initiatives.\footnote{137} The Centre for Social Impact has articulated why the collective impact approach is potentially useful in the context of place based service delivery, observing that its underlying principles provide ‘guidance on how to collaborate and navigate complexity to achieve the intended social impact’ of initiatives.\footnote{138}

The desire to test this framework is evidenced by the growing number of Australian organisations exploring and promoting initiatives under the ‘collective impact’ banner. These organisations include United Way Australia, which has carried out considerable work on developing appropriate accountability and reporting mechanisms to enable better measurement of ‘community impact’. Their recent work in NSW involves supporting a series of Good Beginnings Australia programs in Claymore; establishing an Income Coalition with members from government, business and the community to support students transitioning from school to employment; and leading ‘90 Homes for 90 Lives’ – a cross sector partnership which aims to provide permanent exits from homelessness to rough sleepers in Woolloomooloo.

\begin{footnotes}
\item[132] In 2013, the KTS Interim Review report also recommended that ‘options for adopting a place-based model of co-located universal and targeted services’ be considered, and that the Outcomes Evaluation should examine ‘the effectiveness of efforts at fostering local coordination; the impact of interaction between services; and opportunities for restructuring groups of interdependent initiatives to improve local effectiveness.’ KTS Evaluation Steering Committee, Keep Them Safe: a shared approach to child wellbeing, Report of the Interim Review, 2013.
\item[133] NSW Ombudsman, Responding to Child Sexual Assault in Aboriginal Communities, December 2012. Recommendation 89.
\end{footnotes}
The Ten20 Foundation is another notable organisation seeking to apply a ‘collective impact approach’. It is partnering with a number of organisations to implement collective impact initiatives in 10 disadvantaged communities across Australia.\(^{139}\)

FACS and Education, as well as a number of non-government partners, have also become directly involved in this emerging area of practice through their participation in an action research project that seeks to examine the conditions required for achieving a collective impact approach to improving child wellbeing in disadvantaged communities.\(^{140}\) The project, led by Professor Ross Homel at Griffith University, will build and test the efficacy of a structured process – based on the CREATE framework\(^ {141}\) – for achieving collective impact in three locations: Wyong, Kempsey and Campbelltown.\(^ {142}\) One of the most significant aspects of the collective impact approach is its explicit acknowledgement that a supporting infrastructure is needed to achieve genuine collaboration.

In the US, this infrastructure has tended to be centralised in the form of ‘a backbone organisation with dedicated staff whose role is to help participating organisations shift from acting alone to acting in concert’.\(^ {143, 144}\) United Way Australia has in fact argued that the notion of a single backbone is not flexible enough for the Australian context, and that ‘the Australian model of collective impact is emerging differently where the backbone is made of…multiple parts who will share the weight and provide a flexible and sustainable base for impact’.\(^ {145}\)

Regardless of where the debate around the issue of ‘backbone’ organisation/structure leads us, as we have observed in the previous chapter, numerous interagency initiatives have failed because of inadequate governance arrangements and a lack of ‘on the ground’ support and/or expertise enabling a ‘common agenda, shared measurements and alignment of effort’.\(^ {146}\) In fact, even proponents of collective impact accept that delivering on collaborative practice that drives strong results is inherently complex.

We also note that the research suggests that the same core elements need to be in place to deliver effective collaborative practice, regardless of whether the objective is to implement a local ‘whole of community’ service system response or to provide a service response to a discrete issue which requires well coordinated cross agency work.

A further issue requiring consideration relates to the issue of leadership for this type of work. In this regard, it needs to be recognised that the best ‘leadership’ arrangement is the one which is ‘fit-for-purpose’. However, when the collective impact goal requires providing place-based ‘whole of community’ collaborative service delivery reform, we believe that, given the complex challenges which are integral to such reform, the leadership must ideally involve a strong partnership between the three levels of government, business/philanthropic sectors,\(^ {147}\) NGOs and the involved local community. In terms of the involvement of local community members, the research clearly demonstrates that without effective community/consumer engagement, both place and program based initiatives are likely to fail.\(^ {148}\)

Finally, it is important to stress that ‘herd-like’ adoption of ‘collective impact’, or other social program labels, does not guarantee success. It is the effective execution of sound principles and evidence-based practice that will lead to real and sustained outcomes. And we should not underestimate the complex challenges associated with successfully implementing large-scale collective impact or collaborative practice initiatives.

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\(^{139}\) Other Australian organisations working in this area include, Social Ventures Australia, Tomorrow Today Foundation, and Together SA.


\(^{141}\) The CREATE framework incorporates the principles of: collaboration underpinned by good governance and community empowerment; relationship-driven program delivery; early intervention/prevention; accountability in the form of a clear focus on measurable outcomes and shared responsibility; training and continuous skills development; and evidence-based practice. See Professor Ross Homel, Dr Kate Freiberg and Dr Sara Branch, ‘CREATE-ing community capacity: Enabling collaborative action around children’s needs’, June 2013. www.griffith.edu.au. Accessed 28 February 2014.

\(^{142}\) Project partners include: Griffith University, Pennsylvania State University, Mission Australia, The Smith Family, The Benevolent Society, The Australian Primary Principals Association, The Parenting Research Centre, Commonwealth Department of Social Services, NSW Department of Family and Community Services, NSW Department of Education and Communities, and Queensland Department of Education, Training and Employment.


\(^{144}\) This is likely to account for the significant level of expense associated with implementing collective impact initiatives in that country – which also has a significantly larger private investment base than Australia.


Recommendations

The following are the Ombudsman’s recommendations arising from this report. The Department of Family and Community Services should consult with key human service and justice agencies and the non government sector when implementing recommendations 3-5.

1. Within two months of this report, the Department of Family and Community must report to my office on whether it accepts and will adopt recommendations 2-6.

2. The Department of Family and Community Services should:
   a. Use its Quarterly Business Review process and the related work of the Office of the Senior Practitioner to continue to drive demonstrable improvements in accountability and business performance in the areas of output, quality and in addressing significant practice shortcomings (see sections 2.3 – 4.1.2).
   b. Continue to enhance Community Services’ information systems to support performance improvements – and related reporting – in the areas outlined in Recommendation 1(a) above (see sections 2.2 and 3.3).
   c. Lower overall caseworker vacancy rates and fill longstanding vacant positions in those districts with high vacancy rates (see section 3.2).
   d. Address the longstanding practice and systemic issues which CSCs in the Western District have faced (see section 3.3).
   e. Ensure that the ongoing implementation of Practice First is informed by a robust evaluation methodology that assesses whether strong outcomes are being achieved for vulnerable children and families (and that the Practice First initiative is being continually refined in light of evaluation results (see section 4.1).
   f. Enhance the capacity to record, and report on, the nature of responses being provided to all children the subject of ROSH reports – not just those that result in a face-to-face assessment by Community Services.

3. The Department of Family and Community Services should develop and implement strategies for expanding the collective reach in meeting ROSH demand. This should include identifying where further targeted resources and related capital investment in technology are required (see sections 2.4, 3.2, 3.4 and 4.2.1).

4. The Department of Family and Community Services should develop and implement interagency operational frameworks to:
   a. Enhance and more clearly define the role of partner agencies in relation to their work with high-risk families, and substantially strengthen their capacity in this regard (see section 4.2).
   b. Deliver a more effective and integrated response in relation to vulnerable adolescents and in the area of educational neglect.
   c. Improve the operation of integrated case management programs, particularly given the history of past failure in this area.
   d. Build an intelligence driven approach to child protection practice and embed this approach within interagency initiatives (see 4.2.2 of this report).
   e. Support the core components of successful collaborative practice, namely:
      i. a clear and practical commitment to collaboration
      ii. an agreed definition of the problem and the proposed solution
      iii. a joint design and ongoing review process
      iv. strong governance processes to drive implementation and the technical capacity to monitor outcomes, and
      v. collective responsibility for delivering results.
5. The Department of Family and Community Services and the NSW Police Force should work together to:
   a. Enhance the quality of information which police collect relating to child protection risks, through refining the ROSH reporting tool used by police.
   b. Develop and implement an effective system for defining, identifying and providing to Community Services information about ‘serious violent offenders’, when such information is relevant to risk of harm assessments (and related child protection casework).
   c. Assess whether certain designated police positions should have direct access to the KiDS system in order to enable police to quickly access child protection information held by Community Services at the time when police are responding to incidents that may involve serious risks to children.
   d. Develop improved guidance and related support to police in relation to their role in conducting child welfare checks.

6. The Department of Family and Community Services should report publicly every twelve months from the date of release of this report on its progress in implementing recommendations 2-5.

7. The Department of Premier and Cabinet should consider the observations made in Chapter 5 of this report as part of its ongoing work to develop and implement a place-based approach to service delivery.
The need to better support children and young people in statutory care who have been victims of violent crime

A report arising from an investigation into the NSW Department of Human Services (Community Services)

A special report to Parliament under section 31 of the Ombudsman Act 1974.

June 2010
The need to better support children and young people in statutory care who have been victims of violent crime

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June 2010
June 2010

The Hon Amanda Fazio MLC
President
Legislative Council
Parliament House
Sydney NSW 2000

The Hon Richard Torbay MP
Speaker
Legislative Assembly
Parliament House
Sydney NSW 2000

Dear Madam President and Mr Speaker

I submit a report pursuant to s.31 of the Ombudsman Act 1974.
I draw your attention to the provisions of s.31AA of the Ombudsman Act 1974 in relation to
the tabling of this report and request that you make it public forthwith.

Yours faithfully

Bruce Barbour
Ombudsman
Foreword

This report concerns my office's investigation into Community Services' handling of victims compensation claims for children and young people under the parental responsibility of the Minister for Community Services.

Victims of violent crime in NSW, including children and young people, may be entitled to apply for a range of services, support and financial compensation.

Community Services does not consolidate information on the reasons why children and young people are removed from their families and placed in care. Nevertheless, it is clear that many children are removed because of abuse. Prior to their removal from their families many of these children have been the victims of violent crime, and therefore possibly eligible for victims compensation.

In 2005, there were 10,041 children and young people in statutory care. By June 2009, this number had grown to 16,524. However, between 2005 and 2009 only 368 victims compensation claims were lodged by Community Services with Victims Services on behalf of children and young people in statutory care.

Our investigation found that there are significant deficiencies in Community Services' identification and handling of victims compensation claims for children and young people in out-of-home care. Despite the agency's obligations under the Charter of Victims Rights, children and young people who are eligible to make a claim are often not being identified. For those who are identified, Community Services' processing of their claim is often poorly handled.

I have decided to make this special report to Parliament because the issue is an important one. As the case examples in my report show, many of the children and young people who are placed in statutory care have had to deal with the most disturbing and horrendous situations. For many, their experience of violence will stay with them forever. It is completely unacceptable to deprive these children and young people of their entitlements because of administrative failure.

At a time of significant change in the way care and protection services are delivered in NSW, it is vital that those children and young people already in care, and those who enter care in the years to come, receive the supports and assistance they are entitled to.

Bruce Barbour
Ombudsman
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1. Introduction

In 2009, this office undertook a review of a group of young people who were turning 18 and leaving statutory out-of-home care. A number of these young people had been placed in care by the Children's Court because of serious abuse.

Victims of violent crime in NSW are entitled to make a claim under the state's statutory scheme for victims compensation. For children and young people who have been placed in care because of serious abuse, responsibility for making a compensation claim on their behalf falls to Community Services (formally DoCS).

Through our review of the support being provided to care leavers, we identified that many had not had an application for victims compensation made on their behalf during their time in care despite child protection histories indicating abuse prior to entry into care.

In response, we investigated Community Services' handling of victims compensation claims for children and young people in out-of-home care. Our purpose was to establish whether Community Services has the necessary systems in place to identify those children who may be eligible to lodge a claim and to process these.

This report outlines why there is a need for Community Services to significantly improve its handling of victims compensation for children and young people in statutory care.

1.1 The Department of Human Services, Community Services

Community Services is the agency within the NSW Department of Human Services with lead responsibility for providing funding, accommodation and support for children and young people who cannot live at home because of abuse or neglect.

As at 30 June 2009, there were 16,524 children and young people in NSW in this situation. Of these, 11,871 had final care and protection orders.

Although these children are referred to as being in statutory or 'out-of-home' care, most live with extended family or foster carers. These carers and family are authorised by either Community Services or by non government 'designated' agencies to provide such care.

1.2 Victims Compensation

The Victims Support and Rehabilitation Act 1996 provides a scheme of compensation and counselling for victims of violent crime in NSW.

Victims of crime, who have been injured as a result of the crime, are entitled to apply for a range of services, support and financial compensation. This includes children and young people.

The statutory scheme for victims compensation is government funded, and places the awarding of compensation in the hands of an independent tribunal – the Victims Compensation Tribunal. The scheme is administered by Victims Services which is part of the NSW Department of Justice and Attorney General.

Under the Act, injuries can be physical, psychological or offence based, which includes domestic violence and sexual assault. A person who is the victim of an act of violence is known as a 'primary victim'. A 'secondary victim' is a person who is injured as a result of witnessing an act of violence committed against another person or learning about such an act. A ‘family victim’ is defined as a member of the immediate family of a homicide victim. ‘Secondary’ and ‘family’ victims may be eligible to claim compensation.

Under the Victims Rights Act 1996, victims of crime in NSW have the Charter of Victims Rights to protect and promote their rights. The Charter sets out how government departments should treat and assist victims of crime. The Charter outlines 17 rights for victims of crime in NSW including their right to information about services and remedies, their right to access to services, and their right to make a claim for victims compensation.

1.3 Community Services' victims compensation policy and practice

Community Services' guidelines state that the agency has a responsibility to ensure that children and young people in out-of-home care who have been victims of crime receive appropriate support services. This may include making a claim for victims compensation on behalf of a child or young person. This responsibility
extends to those children and young people under the parental responsibility of the Minister for Community Services who are with carers supported by non-government agencies.

The Community Services guidelines clarify that a claim for compensation may be made without charges being laid in relation to the incident/s. A claim can also be finalised before an offender is identified or dealt with by a court.

Community Services caseworkers are expected to identify children and young people who may be eligible to lodge a claim for compensation and to refer these cases to legal officers. Where grounds for compensation exist, legal officers are expected to lodge an application with Victims Services, and to manage the application while it is before the Victims Compensation Tribunal.

The guidelines explain the agency’s obligations under the NSW Charter of Victims Rights to children and young people who have been victims of violent crime.

Where a claim is successful, the compensation payment for the child or young person is placed in trust with the NSW Trustee and Guardian, until they turn 18 or older.

1.4 Our concerns about Community Services’ actions to meet its obligations under the Charter of Victims Rights

As noted, in 2009 this office undertook a review of a group of young people who were turning 18 and leaving statutory care. A number of our reviews raised questions as to whether Community Services had adequate systems in place for identifying and progressing claims for children and young people in statutory care, who may be eligible for victims compensation. For example:

- In April 2007, a Community Services legal officer identified that a young person, who was then aged 15 and in care as a result of sexual abuse, was possibly eligible for victims compensation and that a claim should be commenced as soon as possible. The legal officer noted the claim had to be submitted to the Victims Compensation Tribunal before the young person turned 18. We reviewed the young person’s leaving care planning two months before she turned 18. Not only did we find that she did not have a leaving care plan, but also that Community Services staff responsible for her case management could not tell us what was happening in relation to the compensation claim. We subsequently established that a claim had not been submitted.

- In August 2007, Community Services lodged a victims compensation application on behalf of a young person, who was then aged 15. The application related to the young person suffering physical abuse and psychological harm between 1992 and 1999. The young person’s care order had been finalised when he was eight. It was unclear to us why there had been a seven year delay in submitting the claim. We were also concerned that the claim appeared to have been compromised by the delays because health and police records to support the claim were no longer available.

- In August 2008, a solicitor established that there were grounds to make an application on behalf of a young person who, at the age of seven, was placed in care following the non accidental death of her younger brother. She was subsequently indecently assaulted by a relative, who was her carer at the time of the assault. At the time of our leaving care review, Community Services had taken no action to progress a compensation claim on either ground on the young person’s behalf.

- At the leaving care planning meeting for a young person who entered care at the age of three, a Community Services manager identified that the young person’s caseworker should follow-up the possibility of a referral for victims compensation. At the time of our review, this had not occurred.

As a result of case examples such as these, we decided to look more broadly at the number of claims Community Services had made on behalf of the children and young people for whom the agency has responsibility. The following information is taken from Community Services’ annual reports and other information provided by the agency for our investigation.

- In 2005 there were 10,041 children and young people in statutory out-of-home care and in 2006, there were 10,623. In 2005/06, Community Services lodged 108 claims for children and young people under the parental responsibility of the Minister for Community Services.

- In 2007, there were 12,712 children in statutory care and by 2008 this number had grown to 14,667. In 2006/07, Community Services lodged 94 claims and in the 2007/08 financial year, 114.

- In 2009, there were 16,524 children and young people in statutory care. In 2008/09, the agency lodged 52 claims for compensation on behalf of children and young people in care.

As noted, data on the reasons why these children and young people were determined to be unable to live at home is not available. This is because this data is not aggregated by either the NSW Children’s Court or Community Services.
However, if data concerning risk assessment outcomes is considered, a significant proportion of the children and young people are likely to have been victims of violent crime prior to their entry into care. Of the 10,142 children and young people in NSW who had a finding of actual harm following comprehensive risk assessment in 2008/09, 1,957 (13.7%) had been physically abused, 1,644 (11.5%) had been sexually abused and 3,247 (22.7%) had suffered emotional abuse. 4,830 children and young people entered out-of-home care during that year.

In this context, the number of victims compensation claims being lodged by Community Services on behalf of the children and young people in out-of-home care – 368 over the four year period between 2005 and 2009 or an average of 92 each year – appeared small.

It concerned us that many children and young people in statutory care may not be benefiting from the statutory compensation scheme because Community Services is either not recognising that they are eligible to apply for compensation, or is failing to make timely applications to Victims Services on their behalf.
2. Our investigation

Because of our concerns, we decided to investigate Community Services’ identification and processing of victims compensation claims for children and young people who have been victims of crime and who are under the parental responsibility of the Minister for Community Services.

We notified Community Services of our investigation on 19 June 2009.

2.1 The investigation process

Our investigation was extensive and included the following steps:

- We identified a group of 95 children and young people, where documentary evidence indicated that they were likely to have been a victim of violent crime prior to their entry into care. This group consisted of 82 children and young people who we identified by reviewing Children’s Court records for children and young people who had care orders finalised between 2006 and 2007. We identified the remaining 13 children by reviewing the records of siblings of child homicide victims.

- We interviewed casework managers responsible for ensuring the 95 children and young people in the group receive appropriate support under the Victims Support and Rehabilitation Act 1996. Our particular focus was on financial compensation. We asked managers about any action taken to review whether each child or young person in the group was eligible to lodge a claim for compensation.

- For those children in the group who had been reviewed by Community Services and identified as eligible to lodge a claim for compensation, we collected information about Community Services’ actions to prepare an application for compensation and to lodge it with Victims Services.

- We asked managers about the systems and strategies in place at local Community Services offices to meet the agency’s obligations under the Charter of Victims Rights.

- Information in relation to the 95 children and young people from our interviews with casework managers was then collated quantitatively and qualitatively, to analyse the relevant issues. This analysis took into account legislative requirements and Community Services’ policies and procedures concerning victims of violent crime who are under the parental responsibility of the Minister for Community Services.

- We also asked Community Services to tell us about the strategies it has put in place to fulfil its responsibilities under the Charter of Victims Rights.

- We provided Community Services with our preliminary investigation report and sought the agency’s views on the accuracy of the information in our report, and on our findings, observations and provisional recommendations. Before finalising our investigation, we provided a draft of the investigation report to the Minister for Community Services. We finalised our investigation in May 2010.

During the course of the investigation, we consulted with the NSW Children’s Court, the NSW Children’s Guardian and the Department of Justice and Attorney General’s Victims Services. We asked for their views about strategies to ensure children and young people in care, who have been victims of violent crime, are appropriately assisted to apply for the services and support that they are entitled to.
3. What we found

3.1 Overall findings and observations

As noted, our investigation considered two issues.

The first was whether Community Services has adequate systems for identifying children and young people in statutory care who have been victims of crime in NSW, and therefore, eligible to apply for victims compensation.

Community Services told us that in recent years it has put in place a range of strategies to ensure victims compensation claims are made for eligible children and young people. The agency said that it had created legal support teams and tasked legal officers acting for Community Services to identify those children who may be eligible to claim for victims compensation as they enter care. The agency has also undertaken file audits of children and young people already in care and provided staff training on victims compensation.

Broadly, we found that these strategies have not had an identifiable impact on the number of victims compensation claims Community Services makes on behalf of children and young people in care.

The second issue we explored was whether Community Services has adequate systems to process compensation applications, once a child has been identified as eligible to claim. The evidence shows that it does not.

3.2 Community Services’ identification of potential victims compensation claimants

As noted, we identified a group of 95 children and young people, where documentary evidence indicated that they were likely to have been a victim of violent crime prior to their entry into care. We asked Community Services managers whether the children and young people in the group had been reviewed to determine their eligibility to claim victims compensation.

In some cases, our investigation prompted Community Services to undertake a review to determine eligibility to lodge a claim for compensation. Noting this, prior to the commencement of our investigation, less than half (40) had had their files reviewed for victims compensation purposes. This is despite most having been in care for two years or longer.

Table 1: Review of files to identify possible victims compensation claimants

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewed prior to commencement</td>
<td>40</td>
<td>42</td>
</tr>
<tr>
<td>of investigation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reviewed following commencement</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>of investigation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yet to be reviewed</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>95</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

In relation to the 60 children and young people whose files were reviewed either prior to or during the course of our investigation grounds were identified to lodge a claim for compensation in 82% of the cases.

Table 2: Grounds identified to lodge a claim

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grounds identified</td>
<td>49</td>
<td>82</td>
</tr>
<tr>
<td>Grounds not identified</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
3.2.1 Factors impacting on Community Services’ compliance with its obligations under the Charter of Victims Rights

While our group was limited in number, our interviews with departmental managers indicated a broader problem in relation to identifying children and young people in out-of-home care who have been victims of violent crime.

Over one third of the Community Services teams we interviewed in relation to the group of 95 children told us that they do not have adequate strategies in place to identify children and young people who have been victims of violent crime. Even when they said they had adequate strategies, we found children for whom these teams were responsible, had not been reviewed. Other teams said that they were unaware of Community Services’ arrangements with legal officers to identify potential claimants as they enter care.

One team we spoke with reported having over a hundred children and young people under their supervision who do not have an allocated caseworker and another team reported having hundreds of unallocated cases. Neither had a strategy for reviewing victims compensation eligibility for these children and young people, or for that matter any other purpose including whether they are being properly cared for.

Our investigation identified a number of factors that have had a bearing on Community Services’ failure to identify all those children and young people in care who are eligible to apply for victims compensation. These include staff not having read the relevant guidelines; staff not having an adequate understanding of Community Services’ responsibilities under the Charter of Victims Rights; competing casework priorities; children not having an allocated caseworker; inadequate file transfer arrangements between teams; and inadequate legal and casework resources. Some managers told us that they had not attended relevant training on victims compensation. Others said that they have not read the relevant guidelines. Some said that they could not even locate these on Community Services’ intranet.

**Case example 1**

Care proceedings for a child, born in 2001, were finalised in September 2006. Court records for the child state that Community Services removed the child on the grounds that she was at imminent risk of being physically assaulted by her mother. The records note that the police intended to charge the mother with assault of the child. A manager told us that the child’s files had not been reviewed to identify her eligibility to lodge a claim for victims compensation as case management priorities for the team did not include compensation.

**Case example 2**

A Community Services manager said that workload is so great that victims compensation has never been a priority and while the caseworkers generally know the guidelines and what is required of them, identifying potential victims compensation claims is not seen as a priority. The manager said some training was provided two to three years ago; however, the staff have changed a lot and more training is needed. Victims compensation will only be included as a case plan item for case conferences and case reviews if it has already been identified as an issue or if there is an application underway. The manager, whose team is responsible for children with an allocated caseworker including children in high cost placements, said her team has no system in place to identify children who may be eligible for victims compensation other than compensation being identified on the regional transfer pro-forma. However, this information ‘has never been paid any attention’ unless ‘there have been really extenuating circumstances’. Another manager from the same centre said that there is no system for identifying which of her team’s 400 unallocated cases may be eligible for victims compensation. The manager said victims compensation is not considered when cases are transferred from other teams within the centre.

The evidence we examined also showed that inadequate caseworker knowledge about the grounds to claim for victims compensation is resulting in potential claims being overlooked. This is particularly so in relation to psychological injuries and children who have been subjected to domestic violence.
Case example 3

Court records for a young person included a psychologist’s report which describes an extensive child protection history of the young person both witnessing assaults on his mother and being subjected to physical abuse. According to the Children's Court records we examined, this has resulted in him suffering severe trauma and significant psychological damage. Based on our interview with departmental staff, it appeared that they had formed an undocumented view that the young person was not eligible for victims compensation because his injuries were too minor. We identified that staff had overlooked or were unaware of the young person’s psychological trauma and injuries.

Despite Community Services’ advice about its requirement for legal officers to identify potential victims compensation cases when children’s matters are before the Children’s Court, the agency’s current guidelines in relation to victims of crime do not reflect this requirement. They currently vest responsibility for identification of potential claimants with ‘the caseworker’. As discussed below, caseworkers change as children progress through the care system. We found that in some cases this lack of specificity in the guidelines about roles and responsibilities is resulting in no one taking responsibility for identifying children who may be eligible to claim compensation.

The guidelines do not canvass Community Services’ responsibilities in relation to children and young people who were victims of crime in another state, prior to their entry into care in NSW. All states and territories in Australia have victims compensation legislation and schemes. In our view, if a child or young person is under the parental responsibility of the Minister for Community Services and was the victim of a violent crime in another state or territory, Community Services has a responsibility to lodge a claim for compensation in the appropriate jurisdiction.

We also found that the agency’s systems for recording and tracking victims compensation on children’s electronic and hard copy files are inadequate. Only some regions require the consideration of victims compensation when children’s files are transferred from one team to another. Legal officers do not enter information onto the electronic files used by caseworkers and caseworkers do not have access to the legal officers’ data base. In providing advice for our investigation, the only way Community Services could tell us how many compensation claims the agency had lodged in 2008/09, was to manually interrogate the legal officers’ data base.

3.2.2 Circumstances where children may not be identified as eligible to claim compensation

A number of managers told us that children and young people in statutory care who are placed with relatives are particularly likely to get overlooked in relation to victims compensation because these children will generally not have an ‘allocated’ Community Services caseworker, and their files sit in ‘resubmit’.

Our investigation identified other groups who are likely to get overlooked in relation to victims compensation.

Children in care who are supervised by child protection teams

Most Community Services offices have child protection and out-of-home care teams. When final care orders are made for a child, their file is generally transferred from a child protection to an out-of-home care team.

At the time of our investigation inquiries, child protection teams held the files for 12 of the 95 children and young people in our group. Prior to the commencement of the investigation the files of three of the 12 had been reviewed by Community Services for the purpose of identifying victims compensation eligibility.

Managers advised that four of the 12 children did not have an allocated caseworker.

The files of none of these four children had been reviewed for victims compensation purposes prior to the commencement of our investigation.

Three of the 12 children whose files have remained with a child protection team following finalisation of their care order, are no longer under the parental responsibility of the Minister. While they were in care, their cases were not reviewed for victims compensation purposes. The following case is illustrative.
Case example 4

Court records for a child show that sexual assault had left her with medical complications by the age of six. In mid 2007, she was placed under the parental responsibility of the Minister. In mid 2009, following an appeal, she was placed under the sole parental responsibility of her mother with Community Services’ supervision. The manager casework advised that the child’s file was reviewed in response to our investigation, to determine whether she may be eligible to claim victims compensation. The review identified grounds. Community Services has since written to the mother, advising her of her options to pursue a claim on the child’s behalf.

This does not mean that children whose supervision is transferred to an out-of home care team are guaranteed that their eligibility for victims compensation will be identified. Some of the out-of-home care managers we interviewed told us their focus is on finding and maintaining placements for children, not pursuing victims compensation. Other out-of-care managers said that unless a victims compensation issue is identified when files are transferred between teams, victims compensation will not be considered. This is because teams do not have access to the child protection files or because the teams do not review the child’s protection history when files are transferred. A number of managers also confirmed that children’s files often get transferred to out-of-home care teams without being allocated a caseworker.

Children whose carers are supervised by non government agencies

Fifteen of the 95 children in our group were placed with foster carers supervised by non government agencies. According to Community Services’ guidelines, the agency is responsible for identifying these children’s eligibility to apply for victims compensation. In 2008, 14% of children in statutory care lived with carers supervised by non government agencies.

Prior to the commencement of our investigation, the files of six of these 15 children had been reviewed by Community Services for victims compensation purposes. Most of the children who had not been assessed for victims compensation purposes did not have a Community Services caseworker. The following case is illustrative.

Case example 5

Court records for a child state that in August 2006, child protection caseworkers attended the child’s home before taking him to hospital. An affidavit to the court states medical assessment found he had extensive bruising, bite marks and circular burns. The child was placed in long term care through a non government agency. A Community Services manager told us her review of the child’s file for the purpose of our investigation identified that he had also sustained injury as a result of being shaken, possibly on more than one occasion. An application for victims compensation had not been considered. The manager said that as the child is placed with a non government agency, he does not have an allocated Community Services caseworker.

Young people supervised by Community Services' intensive support services

Eight of the 95 children and young people in our group were supervised by intensive support services. These were all young people with high support needs associated with challenging behaviours and social and emotional difficulties.

Prior to the commencement of our investigation, three had been reviewed for victims compensation purposes. One of these reviews was completed after the young person had left care.

The other two reviews had not been documented. We found both were inadequate.
Case example 6

The 2006 care application for a child recorded a history of 25 risk of harm reports including physical abuse and sexual harm ("sexual penetration"). At the time of our investigation the young person was being case managed by an intensive support service. A manager told us that the young person’s caseworker had formed a view that he would not be eligible for victims compensation.

In response to our investigation, the young person’s files were referred to an external legal officer for review. We asked Community Services to provide us with advice on the outcome of the legal review of the young person’s files.

The solicitor’s advice notes her opinion that there are several grounds which would support an application for victims compensation, noting that the young person had struggled with the effects of ‘physical, psychological and sexual abuse from numerous individuals’.

Young people leaving care

Eighteen of our group of 95 were aged 16 years or older at the time we initiated our investigation. In relation to these 18 young people, Community Services had reviewed the files of eight for victims compensation purposes.

Under NSW’s care and protection legislation, all agencies providing statutory care are required to prepare a plan for young people leaving care. The plan is meant to outline the type of assistance the young person may need once they have left care.

Some teams told us that they will consider the issue of victims compensation as part of the leaving care planning process.

There are many problems with this approach to victims compensation not least that leaving care planning does not occur for all care leavers. This aside, evidence of injuries may get lost or destroyed over time and after many years young people themselves may not be willing to participate in assessments to support a compensation claim.

Often the young person will turn 18 before a claim for compensation is lodged. As a consequence, the responsibility for lodging the claim will be transferred from Community Services to the young person.

This seems to be an unfair burden to place on young people who more often than not will face significantly greater challenges in achieving a successful move towards independence and adulthood than their peers who have supportive families. Having their entitlements fully explored and executed before leaving care would enhance care leavers’ likelihood of successful transition to independence by providing them with financial support when they most need it.

Case example 7

Children’s Court records for a young person indicate that he was the victim of numerous violent acts prior to his placement in care. In the context of our investigation a manager told us the young person’s original files were sent for external legal review ‘some months ago’. The team received the results of the review a month after the young person turned 18. These indicate the file audit had identified possible grounds for claiming compensation. As the young person is no longer in care, a letter prepared by the legal officer was given to the young person, advising him that he may be eligible to claim victims compensation. The letter explains the process.

Community Services does not have any responsibility or power to act in relation to a legal claim for any child or young person no longer under the parental responsibility of the Minister.

Where Community Services has failed to meet its obligations to young people under the Charter of Victims Rights, there is a strong argument that while it does not have the power to act on their behalf, Community Services should provide whatever assistance is required to ensure individuals in this situation receive appropriate supports, including the support required to make an application for criminal injuries compensation.

In this regard we note that despite the existence of Ministerial guidelines that provide for young people to be followed up by designated agencies when they leave care, according to the managers we spoke with in the context of our review of leaving care planning and support, Community Services generally does not do this.
Family victims (immediate family of a homicide victim)

Of the 95 cases we looked at, 15 were family victims. We found nine had had their files reviewed to identify their eligibility to lodge a claim for compensation. The other six had not had their files reviewed for this purpose. We were told this was because the cases were either unallocated or the issue of compensation had been overlooked.

3.2.3 The adequacy of the reviews to identify grounds to claim for victims compensation

While our investigation did not focus on the adequacy of the reviews undertaken by Community Services to establish whether there were grounds to claim for victims compensation for the 95 children and young people in our group, we found that some of the reviews that reportedly had been undertaken were inadequate. This was because in some instances information about a child was overlooked when their file was being reviewed to identify grounds to lodge a claim for compensation.

Case example 8

In 2008, Community Services lodged an application for victims compensation on the ground that a girl’s sibling had been murdered. However, records available to this office indicated that the girl has an extensive history of abuse including sexual assault; physical abuse; exposure to severe domestic violence; and witnessing the sexual assault of her mother and another relative. In response to our investigation the manager advised that a legal officer would review the child’s file to assess her eligibility to apply for further victims compensation. The agency subsequently told us that additional grounds to lodge a claim for criminal injuries compensation were identified.

In other cases, new information about a child’s circumstances had become available but this did not prompt further review in relation to the issue of victims compensation.

Case example 9

In the case of two children we were told that at the time their files were transferred to the out-of-home care team in late 2006, no charges had been laid in relation to the death of a younger sibling and the police investigation concerning the death had not concluded. Their files were reviewed by a legal officer in April 2007, who provided advice that neither was eligible for victims compensation. However, when the mother was charged with the sibling’s murder in early June 2008, this did not result in further review for victims compensation purposes. The manager told us the office does not have a system in place to track criminal proceedings or changed circumstances.

3.3 Community Services’ processing of claims

In addition to examining Community Services’ action to identify children and young people who may be eligible to claim for victims compensation, our investigation also considered the agency’s actions to process applications once the initial step of identification had been completed.

We found that not only is inadequate identification by Community Services of potential victims compensation claimants a reason for the small number of claims, but delays by Community Services in processing claims is also likely to be a contributory factor.

Of the 40 children and young people whose files were reviewed prior to the commencement of our investigation, grounds to lodge a claim had been identified for 31 of the 40 children.

Of these 31 children and young people, application for compensation had been lodged for 11 children. The Victims Compensation Tribunal has settled five of these cases with compensation being awarded in each case.

We examined Community Services actions in relation to the remaining 20 cases where grounds to lodge a claim had been identified but an application for compensation had not been made.
We identified that in eight of the 20 cases, there had been significant delays between Community Services establishing eligibility to claim and processing the claim to the point where it can be submitted to Victims Services. Our analysis of these cases identified that the lengthy delays have been due to caseworkers either failing or being very slow to respond to legal officers’ requests for documents or other additional information; legal advice being mislaid or lost; requests for additional information being ignored; and actions not being recorded. The following case examples are illustrative.

**Case example 10**
The young person was removed from his parents when he was a toddler after he was admitted to hospital with extensive, life threatening injuries. He required surgery and remained in hospital for several months. In June 2008 the young person’s long term carer heard about victims compensation and requested his caseworker commence a claim for the young person. The young person left care in September 2009 without an application having been made. This was despite grounds to lodge a claim for compensation being identified by a solicitor one year earlier.

**Case example 11**
In September 2008, Community Services referred a child’s file to an external solicitor. In September 2009, the office supervising the child received the solicitor’s advice, which is dated November 2008. The advice noted the file review had identified grounds for pursuing statutory compensation. The manager we interviewed could not explain the delay and advised the CSC has now acted on the solicitor’s request for an additional report. In a statement of information, Community Services told us that the solicitor’s correspondence had been sent to an acting manager at the office supervising the child in November 2008. We were told the correspondence had been ‘mislaid’ and that ‘the Acting Manager Casework had only been recently appointed and may have been unclear of how to progress the Victims Compensation Claim’.

**Case example 12**
In May 2007, a child entered care at the age of four months with acute brain injuries and medical evidence suggesting the injuries had been deliberately inflicted. In March 2008, a care legal officer reviewed the child’s file and identified grounds for pursuing a victims compensation claim. When asked why an application on the child’s behalf is yet to be lodged, the manager casework opined that changes in legal staff may be a factor. Another factor was that Community Services did not know the extent of the child’s injuries. She advised that she had found it ‘really difficult to track’ progress of the matter. She subsequently told us that a legal officer had requested medical records for the child in September 2009. This action appeared to be in response to our investigation.

**Case example 13**
In mid 2007, a care legal officer reviewed the files of three siblings. The review identified that the three siblings are eligible to lodge a claim for statutory compensation. The ground of sexual assault was identified for all three children and physical assault for two. The manager told us that he understood the legal officer had experienced difficulties in determining which abuse incidents occurred in NSW; however, there was nothing on the file to explain the lack of progress in relation to the claim since mid 2007. None of the three siblings has had an allocated caseworker since late 2007 and one turned 18 in early 2010. The legal officer had recently requested an updated counselling report for two of the siblings. In response to our request to Community Services for an explanation about the delays the legal officer advised that due to leave and other work commitments during 2008 she did not ‘conduct a substantial review of the [siblings] files until April 2009’.

Put simply, the current situation means that significant numbers of children and young people who are, or have been, in care will suffer significant financial loss because of the failure of Community Services to ensure that timely and comprehensive victims compensation claims have been made on their behalf. In this regard we note that financial loss will be incurred when a claim is not made when it should have been, or when a claim is made but it is delayed because of inadequate administrative practice.
4. What Community Services told us in response to our findings

In early December 2009, we provided our provisional report and findings to the Executive Officer of Community Services and sought the agency’s response.

In February 2010, Community Services provided its response. On receipt of the response, we asked Community Services for additional information and documents. Some of the requested information was provided to us in April 2010.

We had made a number of recommendations in our provisional report. Community Services told us that in the main it accepted these. The Chief Executive said that her agency is committed to improving its practice and to monitoring its progress in this area. We were told that her agency was preparing an action plan to manage its handling of victims compensation.

In response to our request for clarification about how Community Services proposes to meet its obligations under the NSW Charter of Victims Rights in relation to all the children and young people who do not have a caseworker or who are placed with a non government designated agency, the agency said that ‘work is now commencing on the more detailed plan’ which will address this issue.
5. Concluding comments

As a result of the 2008 Special Commission of Inquiry into Child Protection Services in NSW, and the State Government’s acceptance of most of the inquiry’s recommendations, Community Services is at present focused on implementing significant changes to the child protection system in NSW.

The objectives of the changes are to make child protection a ‘shared responsibility’ with all relevant government agencies having prescribed responsibilities for ensuring the wellbeing of children. Community Services is now responsible for responding only to cases where there is risk of significant harm. Cases that do not meet the threshold for Community Services’ involvement are now being handled by police, health, education and other relevant agencies.

These reforms are meant to be supported by an expansion of early intervention services and an enhanced role for the non-government sector in the provision of a range of early intervention and out-of-home care services.

While the changes to the care and protection system are complex and far reaching, it is important that the work involved in their implementation should not distract Community Services from its responsibility to ensure the 16,000 plus children and young people currently in care, are appropriately supported.

Our findings show that Community Services currently does not have the necessary systems in place to ensure that all children and young people in its care, who are entitled to apply for victims compensation, are assisted to do so in a timely manner. It is also apparent from our recent examination of the support provided by the agency to young people leaving care, that this too is inadequate. This means that if children and young people are to be appropriately supported, their eligibility to apply for compensation must be identified well before they leave care.

These are significant challenges. Despite the agency’s advice that it is committed to improving its practice and to monitoring its progress in relation to its handling of victims compensation matters for children in its care, there is a real risk that the required changes to improve its practice in this area will not occur because of the broader inherent weaknesses in the out-of-home care system. Not least of these is the number of children and young people who do not have an allocated caseworker.
6. RECOMMENDATIONS

In my final report I have requested that Community Services provide me with detailed reports on its progress to implement the following recommendations:

**Recommendation 1**
Consider whether an amendment to s78 of the *Children and Young Persons (Care and Protection) Act 1998* – which would require care plans to consider the issue of victims compensation – is warranted. If so, Community Services should pursue this issue with the Minister for Community Services.

**Recommendation 2**
Review its practice guidelines in relation to children and young people who have been victims of violent crime. The review should ensure:
- a. the guidelines reflect the agency’s recent directive that legal officers are now required to identify children and young people with potential claims for victims compensation during care proceedings.
- b. the responsibilities of legal officers and other relevant staff, and the timeframes for identifying children with potential compensation claims, are clearly stated.
- c. the responsibilities and timeframes of legal officers and caseworkers for taking the claim forward once identified are clearly stated.

**Recommendation 3**
Consider whether its victims of violent crime policy and guidelines, are located in the most appropriate place on the agency’s intranet, to ensure optimum access to staff who need to access them.

**Recommendation 4**
Develop strategies to ensure all staff who have responsibilities under recommendation (2) above, have the necessary knowledge and skills to identify children and young people with potential claims.

**Recommendation 5**
Examine options to improve the functionality of KiDS in relation to victims compensation actions.

**Recommendation 6**
Ensure all regional file transfer checklists include victims compensation.

**Recommendation 7**
Ensure case review and case planning guidelines give adequate consideration to victims compensation.

**Recommendation 8**
Advise this office how it is monitoring, or how it proposes to monitor, the effectiveness of the system it has introduced to identify children who may be eligible to lodge a claim for victims compensation as they enter care.

**Recommendation 9**
Advise this office how it will meet its obligations under the Charter of Victims Rights to children and young people who have been victims of crime, who are currently under the parental responsibility of the Minister, and who:
- a. do not have an allocated Community Services caseworker;
- b. who are placed and/or case managed by a non government designated agency.

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1 I have requested the first of these reports by 30 July 2010, and the second by 30 November 2010.
Recommendation 10
Liaise with the Department of Justice and Attorney General’s Victims Services about any strategies arising from the implementation of recommendation (9) to ensure that:

a. Victims Services are able to manage and prioritise future claims;
b. agreement can be reached between Victims Services and Community Services about strategies to assist Victims Services deal efficiently with claims for children in care.

Recommendation 11
Clarify the support it will provide to children and young people in circumstances where the agency has failed, or fails in the future, to meet its obligations to children who are victims of violent crime, prior to their exit from statutory care.
We are planning for the future, and have printed this report on stock that is from accredited mixed sources which is FSC approved. Chlorine has not been used in the pulping process.
Executive Summary

All young people who are placed in out-of-home care have a statutory right to assistance when they leave care.

Designated agencies are required to develop and implement plans to assist those leaving care in their transition to independent living. The extent of this assistance will vary according to the young person’s assessed needs.

In 2009, our office conducted a review of leaving care arrangements and found poor compliance with the statutory scheme. Our review showed many young people were leaving care without plans or with plans that did not meet their needs.

In response, Community Services advised us of new practices and procedures designed to improve leaving care planning. However, they also reported that they were unable to provide evidence of improved compliance with their statutory responsibilities due to the limitations of their information system.

In light of this lack of accountability, we decided to conduct a follow up review to see if the situation for young people leaving care had improved.

We have now reviewed the situation of 90 young people who left care during the second half of 2011. We found no improvement since the 2009 review in the proportion of young people who left care with a completed leaving care plan, whether or not endorsed.

However, we did find a relatively substantial improvement in the proportion of plans that had been formally endorsed prior to the exit from care.

Notwithstanding this improvement, in 2011 – as in 2009 – a large majority of our review group left care without an endorsed leaving care plan. Without this endorsement, a young person is unable to access financial support to assist them in their transition to independence at the time they leave care. In 2011, this was the case for 80 per cent of the young people whose situations we reviewed.

Where leaving care planning did exist, close to half of the plans were inadequate and the majority were significantly delayed. For 16 of the 86 care leavers who were eligible for leaving care assistance, there was still no plan in place five months after they exited care.

We also identified particular concerns about timely identification of victim’s compensation claims for young people in care during our 2011 review. We first brought these matters to the attention of Community Services in 2009. It is positive that since then the agency has increased the number of claims lodged for children and young people in care. However – and notwithstanding changes to the statutory scheme for victims compensation in 2013 – it is also clear that there remain outstanding issues in relation to the prompt settlement of victim’s compensation matters well before young people leave care.

Over the next five to 10 years, responsibility for thousands of children and young people in care will transfer from Community Services to non-government agencies. Our review included 10 young people who, at the time that they left care, were in non-government out-of-home-care. None of this group left with an endorsed leaving care plan.
Irrespective of which agency has direct responsibility for a young person exiting care, it is vital that Community Services and the non-government sector establish systems (and related policy) that will ensure compliance with statutory obligations.

Equally, it is critical that Community Services and its partner agencies develop the capacity to demonstrate their compliance, by collating and reporting data on the preparation and implementation of plans in accordance with policy and practice.
1. Introduction

Part 13 of the Community Services (Complaints, Reviews and Monitoring) Act 1998 empowers the Ombudsman to review the situation of a person, or group of people in care.

This report details the observations, findings and recommendations arising from our review of a group of young people who left statutory care in 2011.

2. Background to the review

Designated agencies have responsibilities under the Children and Young Persons (Care and Protection) Act 1998 to prepare and support the young people in their care in leaving out-of-home care for independent living. The Act requires designated agencies to develop and implement a plan which identifies the assistance to be provided to each young person leaving care.

In 2009, against the background of concerns about the adequacy of leaving care planning,1 we reviewed the circumstances of a group of young people who were due to leave statutory care. Our purpose was to examine whether Community Services and other agencies were meeting their obligations to assist care leavers in their transition to independence.

In mid-2010, we reported that most of the review group left care without an endorsed plan in place. Where plans were developed, they often lacked an adequate assessment of the young people’s needs. We also identified a range of other problems, including inadequate after-care support.

In response, Community Services told us about action it was implementing or planning to implement to improve service delivery to young people leaving care.

We requested that Community Services inform us about the results of this work. In particular, we asked Community Services to report on whether it was meeting its obligations under the Ministerial Guidelines on the provision of assistance to young people after their exit from care. We asked for evidence in relation to this advice.

In the second half of 2011, Community Services advised us about the implementation of new case planning guidelines, a new case plan template, revised procedures and related training to improve service to care leavers. However, the agency could not tell us whether leaving care practice had improved.

Community Services told us that limitations in its information system made it difficult to report on the degree to which it was meeting its obligations to assist young people who have left care. In December 2011, the agency said it would be addressing these limitations in a computer upgrade due to take place in 2012.

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1 The 2007/08 annual report of the Office of the Children’s Guardian noted that leaving care planning was inadequate for a significant number of young people. The Report of the Special Commission of Inquiry into Child Protection Services in NSW (2008) said that more needed to be done to ensure care leavers are given adequate assistance.
We were concerned that – 18 months after we published our leaving care review findings – Community Services was unable to report on the number of young people leaving statutory care with an endorsed leaving care plan. We therefore decided to initiate a further review of young people leaving care, with a specific focus on establishing whether there has been a discernible improvement in practice in relation to young people having a leaving care plan at the time of their exit from care.

3. Legislation, policy and practice

Part 6 of Chapter 8 of the *Children and Young Persons (Care and Protection) Act 1998* describes the types of assistance that may be provided to a young person leaving care and requires designated agencies to prepare a leaving care plan in advance and implement it when exit occurs.

The legislation also provides for the Minister for Family and Community Services to publish guidelines outlining the circumstances in which assistance may be granted to care leavers. Published in 2008, the *Guidelines for the provision of assistance after leaving out-of-home care* (the Ministerial Guidelines) describe eligibility for assistance, leaving care planning processes, types and levels of assistance and follow up support.

According to the Guidelines, planning should occur at least 12 months before leaving care and the young person should be involved in the planning process. For young people with disabilities in care, a referral should be made to Ageing, Disability and Home Care’s Leaving Care Program when they turn 15, or two years before expiry of their care order.

However, both the NSW Standards for Statutory Out-Of-Home Care (2010) and Community Services’ practice guidelines (2011), specify that leaving care planning should commence for all young people in care when the young person reaches 15 years of age.

4. Methodology

4.1 Review groups in 2009 and 2011

Our 2009 review was based on scrutiny of arrangements for two separate samples of young people who exited statutory care within a five-month period in that year.

We looked at the situation of 51 young people three to four months before they left care. This review involved detailed examination of their agency files and was informed by interviews with caseworkers, managers, carers, other service providers, and in some cases, young people themselves.

We also looked at the situation of 73 young people who had left care in the three months prior to the commencement of our review. For this group our methodology was limited to a request to Community Services to provide a copy of each young person’s leaving care plan and planning minutes, or where their exit occurred without a plan, the reasons why this was the case.
In 2011, our focus has been to identify whether leaving care practice has improved so that more young people are adequately prepared and supported to exit care with an endorsed plan in place. Given this focus, we have used the more limited methodology described above, involving a request for copies of leaving care plans and an explanation for any cases where no plan was developed.

4.2 Young people who left care between October and December 2011

On 2 February 2012, we advised Community Services of our decision to initiate a review of young people leaving statutory care.

Pursuant to section 18 of the Ombudsman Act 1974, we asked the agency to provide a list of all young people who exited statutory care between 1 October and 31 December 2011, and the designated agency supervising each young person before and after leaving care.

We requested a copy of the leaving care plan and minutes of planning meetings for each young person, and their reference number on Community Services’ KiDS database.

We also asked Community Services for advice about whether each leaving care plan had been endorsed and, if not, why not. If any of the review group did not have a leaving care plan, we sought advice about why a plan was not developed before the young person turned 18.

On 9 March 2012, Community Services provided a list of 90 young people who exited care in the relevant period. For 80 of these young people, Community Services was the placement provider and for the other 10 care leavers, non-government agencies were the placement providers. The other requested information – including copies of leaving care plans – was provided in 10 instalments over a nine-week period ending on 29 May 2012.

For each of the 90 young people in the review group, we examined care plans and records of planning meetings where these were provided. We also accessed KiDS records for all 90 young people and identified basic demographic information, as well as information relating to their history in care.

We gave Community Services a draft of our report on 18 December 2012. We received the agency’s response to the draft on 7 May 2013. The response foreshadowed separate advice about Community Services’ handling of victims’ compensation claims; we received that advice in two instalments – on 9 May and 20 June 2013.

4.3 Additional information relevant to our review

Through the child death review and child protection work undertaken by our office, we became aware of a number of cases where the adequacy of leaving care planning was an issue. The relevance of these cases is outlined in section 10 of this report.

We also conducted consultations on leaving care issues with the Association of Children’s Welfare Agencies and their leaving care group, the CREATE Foundation and the Aboriginal Child, Family and Community Care State Secretariat (AbSec).

On 20 November 2012, we requested the Department of Attorney General and Justice to provide information relating to claims for victims’ compensation for children and young people in out-of-home-care. The Department provided information on 7 December 2012.
5 Circumstances of the care leavers we reviewed

Our examination of information for the 90 care leavers provided the following limited profile of their circumstances and characteristics:

- All but two turned 18 in the review period 1 October – 31 December 2011\(^2\)
- 46 (51 per cent) were male
- 25 (28 per cent) were Indigenous
- 12 (13 percent) were from culturally and linguistically diverse backgrounds
- 15 (17 per cent) had been in high needs placements
- At least 19 (21 per cent) had a disability and a further three had mental health problems
- At least 20 (22 per cent) had involvement with Juvenile Justice
- Seven (16 per cent) of the 44 young women in the review group had given birth while in care.

We did not seek to establish comprehensive profiles of the young people we reviewed. However, as indicated by the information outlined above and by comparison to the general population of young people in NSW, our review group comprised disproportionate numbers of young people who were Indigenous, had a disability, were parents or had been involved with Juvenile Justice.

6. Key findings and observations

Based on information provided by Community Services, four of the 90 young people who left care during the review period were ineligible for leaving care planning; the circumstances of these four young people are discussed in section 7. Our findings and observations therefore relate to the 86 young people who should have left care with a plan in place.

In 2011, Community Services prepared leaving care plans for 70 (81 per cent) of the 86 eligible care leavers. However, only 19 (22 per cent) of these young people exited care with an endorsed care plan. Endorsed plans allow the young person access to financial and other support. Thirty-one (36 per cent) exited care with a plan that had not been endorsed; and 20 (23 per cent) had a care plan completed only after they had already exited care

By way of comparison with the findings from our earlier review in 2009, Community Services had prepared leaving care plans for 73 per cent of the young people we reviewed and only eight per cent exited care with an endorsed leaving care plan. Forty-nine per cent exited

\(^2\) One young person turned 18 on 1 January 2012 and one left care on her 16\(^{th}\) birthday.
care with a plan that had not been endorsed; and 16 per cent had a care plan completed only after they had already exited care.

From these figures, it would appear that Community Services has improved in relation to the percentage of leaving care plans which are endorsed at the time of the young person’s exit from care; from 8 per cent in 2009 to 22 per cent in 2011. However it is of significant concern that in the vast majority of cases – 78 per cent of the cases we reviewed – Community Services is not meeting its legislative responsibilities to provide an endorsed leaving care plan to young people exiting care.

Moreover, in 2011, the percentage of young people exiting care with a completed plan (endorsed or otherwise) appears to be no better than in 2009; from 57 per cent in our 2009 review to 58 per cent in 2011. A greater percentage of plans appear now to be completed only after the young person has already exited care. This figure has risen from 16 per cent in 2009 to 23 per cent in 2011.

It is disappointing to report that, overall, there appears to be no significant improvement in leaving care practice since we examined arrangements for care leavers in 2009.

Table 6.1 Comparative data from the leaving care reviews for 2009 and 2011

<table>
<thead>
<tr>
<th>Young people who left care</th>
<th>2009</th>
<th>%</th>
<th>2011</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>With endorsed plan</td>
<td>6</td>
<td>8</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>With plan not endorsed</td>
<td>36</td>
<td>49</td>
<td>31</td>
<td>36</td>
</tr>
<tr>
<td>Plan completed after exit</td>
<td>12</td>
<td>16</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>No plan provided¹</td>
<td>17</td>
<td>23</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>Plan development dates unclear</td>
<td>2</td>
<td>3</td>
<td>86</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
<td>100%</td>
<td>86</td>
<td>100%</td>
</tr>
</tbody>
</table>

Among our key findings, we noted that:

1. Five months after the last of the 86 eligible young people exited care, 16 (19 per cent) still did not have a leaving care plan.

2. Of the 70 care leavers for whom a leaving care plan was provided, planning commenced in a timely manner for only 12 (17 per cent)⁴.

3. Most care leavers with a disability were appropriately referred to ADHC’s Leaving Care Program, but many of these referrals were significantly delayed.

4. Of the 70 care leavers with a leaving care plan, we considered that overall leaving care planning and support was inadequate for 32 young people.

5. Leaving care planning and support was inadequate for six of the seven care leavers who were in Juvenile Justice detention in the 12 months prior to their exit from care.

³ While 20 of the 90 young people we reviewed did not have a plan, four were considered ineligible for leaving care assistance.

⁴ We assessed timeliness of leaving care planning by noting the age of the young person when planning commenced and whether commencement occurred by their 17th birthday. For young people with a disability, we considered whether planning commenced at 15 years of age.
6. Identification and lodgement of victim’s compensation claims before young people leave care continues to be a significant concern.\(^5\)

Against the background of the ongoing transfer of out-of-home care services to the non-government sector, it is notable that none of the 10 young people in NGO placements left care with an endorsed leaving care plan. In addition, apart from not having endorsed plans, leaving care planning was considered inadequate for six of the 10 young people in NGO placements.

\(^5\) As identified in our Special Report to Parliament: *The need to support children and young people in statutory care who have been victims of crime*. June 2010.
7. Young people for whom no leaving care plan was developed

For 20 of the 90 care leavers in our review, Community Services provided reasons why leaving care plans were not developed.

As we have previously noted, in four cases the young people were ineligible under the Ministerial Guidelines, either because their time in care was less than the stipulated minimum of 12 months, or they were restored to family before the care order expired. We consider these to be reasonable explanations for the lack of development of a care plan.

In relation to the other 16 young people, notwithstanding the reasons provided by Community Services for the lack of a plan, we considered that leaving care planning should have occurred. We reached this conclusion on the basis of our assessment of KiDS records and after carefully considering Community Services’ explanation as to why the plans had not been developed. Our observations are set out below.

7.1 Profile of 16 young people not subject to leaving care planning

Of these 16 young people not subject to leaving care planning:

- 11 were male
- Four were Indigenous
- Two were from a culturally and linguistically diverse background
- Two were funded for high needs placements.

Of the 16 placements:

- 14 were case managed by Community Services
- Eight were kinship care
- Five were foster care
- One was residential care
- Two young people had self placed before turning 18.

Based on our review of care histories in KiDS, we assessed nine of the 16 placements as stable and seven as unstable. (We considered placements to be unstable if the young people had experienced multiple moves or periods of homelessness or transience).

7.2 Explanation provided by Community Services for lack of a plan

Community Services provided the following reasons for why all 16 young people left care without a plan.

Incarceration (1 case)

Community Services said one young person had no leaving care plan because of his periodic incarceration since 2009. The agency said a caseworker would ‘endeavour to involve [the young person] in the development of a plan following his release from custody.’

This young man turned 18 in December 2011. Our review of his KiDS records showed that there were contacts between Juvenile Justice and Community Services from at least December 2008 until November 2011. In the main, these contacts appear to have been
initiated by Juvenile Justice and related to the young man’s court appearances and release from custody.

During the young man’s final 12 months in care, Community Services’ records document a meeting with him and a Juvenile Justice worker in February 2011; a contact report by the same worker in May 2011, resulting in an outcome of ‘non-ROSH forward’ [to a CSC]; and a phone call between the worker and Community Services in November 2011, during the young man’s last few weeks in care.

Given these contacts and Community Services’ awareness of the young man’s situation, we could find no satisfactory reason why joint development of a leaving care plan with Juvenile Justice did not occur.

**Current competing priorities and agency error (7 cases)**

In four cases, Community Services attributed a lack of leaving care planning to current competing priorities.

Given that leaving care planning is a statutory priority that should be initiated from one to three years in advance of exit from care, it is unclear how a failure to develop a plan could be ascribed to current competing priorities.

In another three cases, the agency said plans were ‘mistakenly’ not developed or not completed. Community Services provided no information about the nature or cause of the errors.

**Care leavers’ failure to engage (4 cases)**

Community Services said it was unable to engage four young people in leaving care planning.

The agency said one young person had minimal contact with the CSC for the final two years of her time in care, as well as a history of not attending scheduled meetings.

In another case, Community Services advised that a plan ‘has not been completed due to [the young person’s] unwillingness to participate in the process. [The young person] has been advised that she is able to participate in the preparation of a [plan] when she so chooses.’

In response to separate inquiries we made in relation to a reviewable child death, Community Services told us that the Ministerial Guidelines do not specifically address circumstances where young people do not engage in leaving care planning and/or have complex needs.\(^6\)

We note however that sections 165(1) and (2) of the Act stipulate respectively that the young person should be consulted in the preparation of the leaving care plan and that the plan:

> ‘is to include reasonable steps that will prepare the child or young person and, if necessary, his or her parents, the authorised carer and others who are significant to the child or young person for [their] leaving out-of-home care.’

\(^6\) See section 10 for further discussion about Community Services’ advice about young people not engaging in leaving care planning.
In addition, the Guidelines explicitly envisage a role in planning for other people – including parents and significant others – and provide for authorised carers, in particular, to play a valuable role in this regard.

It is acknowledged that agencies may find some young care leavers difficult or even impossible to engage in planning their exit from statutory care.

However, given the scope to develop plans with contributions from a range of people, it appears to be inconsistent with the relevant legislative provisions (and related guidelines) to base a failure to prepare a plan solely on a young person’s failure to engage in the planning.

Furthermore, we found matters where CSCs persisted in the preparation of a leaving care plan despite their inability to persuade young people to participate in the process. In one such case the care leaver was a young man who came into Community Services’ care as an Unaccompanied Humanitarian Minor shortly before his 17th birthday. His leaving care plan included a summary of the circumstances of its preparation:

"Many attempts to engage [the young man] to develop his leaving care plan, however, he was in Adelaide and he told caseworker that he’s not interested. CW [caseworker] had tried to convince him and [he] said that he will contact CW once he comes back to Sydney. Many attempts were made with no success. It had been agreed with ARC [Aftercare Resource Centre] that [Community Services] will develop the leaving care plan in consultation with ARC in case [he] needs any services after he turns 18 years of age."  

**Agency difficulties in communication or contact (2 cases)**

For one young person, Community Services said a leaving care plan was not developed before his 18th birthday in November 2011, because of ‘communication difficulties’. The agency did not detail the difficulties but said it would attempt to schedule a meeting as soon as possible.

Although we noted that KiDS records for the young man included a ‘case meeting/case review’ that ‘proceeded as planned’ in January 2011, and a referral for victim’s compensation review in September 2011, we did not identify records relating to leaving care planning in 2011.

In another matter, Community Services indicated that a young person’s work commitments had prevented leaving care planning. According to KiDS records, a case meeting had been scheduled for the day before the young person’s exit from care but was cancelled ‘by other party’.

**Ongoing delay in provision of plan (1 case)**

A young person left care in late November 2011. More than four months later, Community Services told us that the designated agency – an NGO – had not provided the completed plan but would forward it as soon as possible.

**Young person’s departure from NSW (1 case)**

Community Services reported that a young woman left Australia three months before turning 18; the agency was later advised that she would not be returning.
We found a note on the young woman’s KiDS file indicating that Community Services planned to develop a ‘generic’ leaving care plan and close the file. However, we found no evidence that any planning had taken place. In our view, given that planning should have commenced well before the young woman’s last few months in care, her departure overseas did not justify the failure to develop a plan.

7.3 Assessment for victim’s compensation

Eight of the 16 young people without a plan appear to have been referred for assessment of eligibility to claim victim’s compensation. In four of these cases, the assessment identified grounds to lodge a claim; in two cases no grounds for a claim were identified; and in the remaining two cases the assessment outcome was unknown.

In relation to the four cases assessed as having grounds to claim victim’s compensation, we identified a variety of responses by Community Services to this assessment.

In one case, a Community Services legal officer identified a potential claim two weeks before the young person was due to exit statutory care; on the same day the agency requested the legal officer to pursue the claim but the records available to us did not indicate whether this was done.

In another matter, a Community Services legal officer informed the CSC by email that a claim for a young man could proceed if he was willing to discuss his experience as a victim of assault with a psychologist. The legal officer observed that the young man was due to leave care in about two weeks, so an application for counselling could be lodged concurrently with the compensation claim.

A week after the legal officer’s email, a manager casework instructed staff to document it electronically and noted that Community Services would not be acting on the claim because the young man

‘is disengaged from [the agency] and does not want us further involved so [the agency] would not be following up this claim at this time. He is [about to turn] 18 so realistically there is no real timeframe to engage him in counselling and a psychologist.’

The records available to us did not indicate whether Community Services made the young man aware of his potential claim, either before or after his exit from care.
8. Young people for whom a leaving care plan was developed

In line with our goal of determining whether leaving care practice has improved in recent years, we also identified the number of young people who left care with a plan.

For all these young people where a plan was developed – regardless of whether it was endorsed or completed at the time they left care – we also assessed the timeliness of planning: agency engagement with the young person in planning; adequacy of assessment of their needs; and adequacy of overall planning and support.

8.1 Timeliness – commencement of planning

As noted in section 3, policy and practice guidelines recommend that leaving care planning commences at least 12 months before leaving care occurs and significantly earlier in the case of young people with disabilities who may require ongoing support.

Our previous review found significantly delayed planning for most young people who exited care in 2009 with a plan in place. Of those plans that were documented before the young people turned 18, just under half were developed in the two months before that birthday.

Of the 70 care leavers in 2011 for whom a leaving care plan was developed by the time of our review, we found that planning commenced in a timely manner for only 12 (17 per cent) young people.  

For 58 care leavers (83 per cent) planning had not commenced within the appropriate timeframe. Among this group were 12 of the 13 young people in high needs placements. Of particular concern were significant delays in referral of some young people with a disability to ADHC’s leaving care program. We discuss this further in section 8.3.4.

As noted previously, 19 young people left care with an endorsed plan in place. Of the remaining 51 young people, planning commenced:

- within two months of exit from statutory care for five young people
- within six months of exit for 13 young people
- between six and 12 months before exit for 18 young people.

For the remaining 15, planning was underway more than a year in advance of exit.

Case study: Nicole

Nicole contacted Community Services six weeks before her 18th birthday to express concern about leaving care. According to the agency’s records, she was worried that leaving care planning had not started ‘because she needs to put supports in place’. Nicole had lived in a total of 16 placements since entering care as a five-year-old; few of the placements lasted longer than several months. In her last year in care, she lived with her child and partner in the home of one of his relatives. Three weeks before the exit from care, Community Services completed a leaving care plan that included financial support. The plan was endorsed nearly five months later.

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7 Timeliness is defined in footnote 4.
8 Assumed names have been used in the case studies.
Case study: Steven
Steven, a young man with intellectual disability and autism spectrum disorder, had been in care since the age of 13. He had three relatively stable foster placements. Although there was evidence of active casework by the CSC in the 12 month period prior to leaving care, leaving care planning was significantly delayed. Steven was not referred to ADHC until nine months prior to leaving care and the leaving care plan was only commenced 18 days before exit from care.

8.2 Engagement – of the young person, carer and others

The legislation requires the designated agency to prepare a leaving care plan in consultation with the care leaver. Furthermore, the Ministerial Guidelines provide for consideration of the involvement in planning of the young person’s parents, carers and significant others.

Community Services has provided advice that the Ministerial Guidelines do not specifically address those circumstances where a young person does not engage in leaving care planning. This advice is further discussed in section 10.

Our 2009 leaving care review did not focus on the adequacy of agency attempts to engage young people leaving care in the planning process. However, we did note Community Services’ advice that a small number of plans were developed after the exit from care, for reasons including that the agency had been unable to engage the care leavers previously.

In relation to our 2011 review, records indicate that of the 70 young people for whom a plan was developed during our review, 61 of them attended a meeting to discuss plans for leaving care. In four cases the relevant records do not document that the young person attended a meeting for this purpose.

In the remaining five cases, we have direct evidence that shows the young people did not participate in a planning meeting. Community Services was the designated agency for all of these young people. One young person was unable to communicate verbally as a result of a disability.

Case study: Kelvin
Community Services’ records note that it was unable to contact or locate Kelvin in the 12 months prior to him leaving care; however the agency’s records also indicate that he was in custody for most of this period and that Juvenile Justice reported in July 2011 that Kelvin had been released and had entered a residential rehabilitation program as part of his parole conditions for the three months before he turned 18. We were unable to find any evidence that Community Services had attempted to engage Kelvin in leaving care planning in the period of his detention or rehabilitation, although it appears that caseworkers tried to make telephone contact with him in the weeks before his care order expired. It also appears that Juvenile Justice initiated contact with Community Services around this time, to advise that Kelvin had exited rehabilitation and to enquire about aftercare supports. Community Services subsequently documented plans for a meeting in relation to leaving care but it is unclear if this took place.
Case study: Tim
Tim had multiple placements during care and lived at times in youth refuges, motels and on the street. His history also included violent behaviour, school suspensions and drug and alcohol abuse. Available records indicated that Tim’s most recent case meeting occurred when he was 16. We found no evidence of a leaving care planning meeting or any attempts by Community Services to facilitate discussions with Tim about leaving care planning and the financial supports available to him after his 18th birthday. However we did note records indicating that Tim had made requests for accommodation and financial support during his final 12 months in statutory care. In the same period, Community Services received two risk of significant harm reports raising concerns about Tim’s homelessness and risk of sexual harm. Although the agency did develop a leaving care plan, it was unclear whether Tim was aware of it.

We identified cases where carers or relatives participated in leaving care planning. For example, Steven, who has a mild intellectual disability and autism, was accompanied by his mother to a leaving care planning meeting. This initial meeting took place two months before the scheduled exit from care and followed a referral to ADHC’s Leaving Care Program in August 2011, more than two-and-a-half years later than required. Given the young man’s disabilities and the significantly delayed referral, it does not appear that Community Services made reasonable efforts to engage him in leaving care planning.

Gareth was a father with a history of multiple kin and foster placements. He attended the initial leaving care planning meeting shortly after his release from custody and four months after exiting care. Representatives of Juvenile Justice, Police and an NGO agency also attended the meeting. It was unclear to us why no attempts were made to engage Gareth in planning his exit from care until after his release from custody.

8.3 Developing and approving the leaving care plan
The Ministerial Guidelines state that a leaving care plan should be informed by a needs assessment; also, that beyond the provision of support in relation to planning, information, referral and follow up, further assistance – including financial assistance – is to be based on assessment of a care leaver’s needs and consideration of whether care leavers are at risk of not making a successful transition to independent living. Such consideration is to be based on a combination of indicators including the duration of care, number of placements, education, stability of accommodation, whether a young person has health problems such as drug addiction or mental illness, has dependents, or has criminal convictions.

These indicators are consistent with Community Services’ case planning framework – published in August 2011 – which includes a plan template featuring ‘well-being measures’ that guide case planning, including leaving care planning. Caseworkers are required to document relevant information against measures including ‘health’, ‘personal identity’, ‘living skills’ and ‘legal issues’.

8.3.1 Assessing the adequacy of leaving care planning
Our criteria for assessing the adequacy of planning were that:

- It focused on seeking to address the young person’s assessed needs
- Planning included consultation with other agencies, particularly where needs assessment identified this as necessary
The plan clearly identified roles and responsibilities for implementing the plan.

Although Community Services' case planning framework requires documentation on KiDS of an After Care Needs Assessment record, we found that few plans included a formal needs assessment. In order to assess whether the plan addressed the care leaver's needs, we therefore considered what records told us about each young person's circumstances—for example, whether they were still undergoing education at the time of exit from care, or had been in Juvenile Justice detention in the months before leaving care—and then considered whether, and if so how, the plans identified and sought to address their individual circumstances.²

Of the 70 young people with a leaving care plan, we considered that leaving care planning and support was inadequate for 32 young people.

Those young people with adequate plans included two who were subject to case management by NGOs and a further 36 care leavers in placements case managed by Community Services. Of those with inadequate plans, six young people were placed with NGOs and 26 were case managed by Community Services.

The following case study illustrates a number of common problems relating to the adequacy of planning generally:

**Case Study: Emma**

Emma entered care as a child aged nine, after exposure to domestic violence, educational neglect, poor supervision from carers and sexual assault. During her time in care Emma had multiple kinship and foster placements and was reportedly a regular user of drugs and alcohol. Community Services' records indicate that Emma was at risk of sexual harm: a contact report to the helpline raised concerns that she was engaging in prostitution in exchange for drugs at age 12. The records also indicate that Emma had a mild intellectual disability and mental health problems. She had her first child aged 15 and was pregnant with her second child in the 12 months prior to her exit from care. During this second pregnancy, Community Services received two Risk of Significant Harm reports and concerns for the child and unborn sibling, given Emma's ongoing drug use and transient living.

Despite Emma's significant vulnerabilities and the associated risks to her own children, the leaving care plan did not specifically address her needs in relation to parenting and childcare, or her capacity for independent living. The plan did not include a referral to parenting support services, despite the impending birth of her second child.

At the time of leaving care, Community Services had not completed the Leaving Care Plan. We found no evidence that Emma had attended a leaving care meeting. However, she did engage with Community Services one month prior to leaving care when she and her child were at risk of homelessness. Community Services provided assistance to secure accommodation but in our view did not use this opportunity to effectively engage Emma in leaving care planning and refer her to after care services or local support services. Emma abandoned the property shortly after exiting care.

²It is noted that timeliness was considered separately, and therefore, was not considered as a factor in assessing adequacy.
and ceased contact with Community Services. At the time of our review, records indicated she was engaged in transient living and heavy drug use and Community Services was initiating proceedings to assume the care of both children.

We noted that inadequate plans were produced for:

- Six of the seven care leavers who were in Juvenile Justice detention in the 12 months before exit from care
- 11 of the 21 Indigenous care leavers
- Four of the seven care leavers who were young mothers
- Nine of the 13 care leavers who were completing the HSC
- Six of the 15 care leavers for whom ADHC participated in leaving care planning.

8.3.2 Addressing assessed needs

We found that the overwhelming majority of plans addressed (to some extent) the young person’s need for accommodation, education and training, access to health services and financial support.

However, one quarter (25.7%) of the plans did not address provision of information about services and support or legal advice, notwithstanding that the Ministerial Guidelines stipulate that “written information about available mainstream and specialist resources, services and referral points should be provided to all” care leavers.

Accommodation

Having access to stable accommodation is a critical factor in achieving a successful transition to independent living. Records indicated that of the 70 young people for whom a leaving care plan was developed:

- 18 (26 per cent) remained in their placement on an unfunded basis
- 10 (14 per cent) remained in their placement with ongoing support
- 13 (19 per cent) moved to rental accommodation
- 12 (17 per cent) moved to live with relatives
- Two young people were living in refuge accommodation
- For 15 (21 per cent) young people, post-care accommodation was unknown.

In several cases, plans addressed the young person’s need for accommodation but planning in this regard was still inadequate.

Case study: Terry

During his five years in out-of-home-care, Terry, a young Indigenous man, had experienced periods of homelessness, stayed with family and friends, was briefly detained in a Juvenile Justice facility, and from age 16, lived independently. A leaving care plan was developed four months before Terry turned 18 and exited care. Although the plan provided for establishment costs for accommodation, it also noted that he should be registered with Housing NSW and identified youth workers as being responsible for completing this task. From available records, it was unclear to us whether this was done. Given his history of homelessness and transience, the plan did not adequately address Terry’s need for stable accommodation, including by means of a timely and completed referral to Housing NSW before exit from care.
Education

Care leavers may be eligible under the Ministerial Guidelines for further assistance with education and training via a payment of up to $500 per year for three years. Separately, where Community Services was providing financial assistance immediately before a young person turned 18, section 161(3) of the Act states that assistance may be continued if the care leaver is in fulltime study and remains in the placement.

In our 2009 leaving care review, we found significant variation in the arrangements made to provide ongoing financial support when a young person was staying in their placement and continuing schooling after turning 18. We identified similar variation in relation to our 2011 review, ranging from significant support to no support.

In one case, a student remained enrolled in a boarding college after turning 18 and Community Services committed to paying full time boarding fees. For another student, the agency approved the extension of care arrangements in the young man’s existing placement until he completed the HSC in 2012, around a year after his scheduled exit from care.

We also identified 10 cases where leaving care plans either did not address the issue of support for ongoing school education, or arrangements to implement support were unclear.

**Case study: Victoria**

Victoria chose to continue to live with her carer after turning 18. The leaving care plan documented a recommendation that the carer should continue to receive the care allowance while Victoria finished high school. However, six months after exiting care, we found no evidence in Community Services’ database that the recommendation had been implemented. The records showed that carer payments ceased on the day Victoria left statutory care.

**Case study: David**

David had been living independently in shared accommodation in the months before his departure from care; during this period he was continuing secondary studies – apparently at year 10 level – via distance education. Community Services made regular payments to support the studies during 2011 and the leaving care plan noted that David wanted to complete the HSC. However the payments ceased in December 2011; we found no evidence of education assistance after that time.

Financial support

Under the Ministerial Guidelines, after care financial support must be based on assessed need, consistent with the leaving care plan and approved by a Regional Director of Community Services.

In our 2009 review of leaving care, we found significant problems with Community Services’ processes for approving financial assistance to care leavers in a timely fashion.

In response, Community Services told us it would review its procedures and consider lowering the threshold of delegation for approval of financial assistance for care leavers. Subsequently, the agency’s review determined that there should be no change to the existing level of delegations. However, Community Services advised us that our concerns about
approval of financial assistance for care leavers would be addressed through revised leaving care procedures – published in September 2010 – and a new case planning framework.¹⁰

In relation to our 2011 review, we identified that 63 of the 70 plans addressed financial support. Of these, 17 were endorsed at the time the young person left care. Another 46 were either incomplete or not endorsed at exit, meaning that any funding specified in the plan could not be released to the young person.

We also considered whether the care leavers under review had an approved source of income at exit from care. Seven young people had no source of income and for 17 others, this was not documented.

The Ministerial Guidelines state that leaving care planning should include a particular focus on helping the young person to access appropriate income support ‘for which the young person may be eligible and the Australian Government’s Transition to Independent Living Allowance’ (TILA).

Records indicated that a TILA application had been made in only nine of the 70 cases. Of these nine, the allowance was paid in three cases. In 20 cases, we were unable to determine from records whether an application was made. In one further case, records indicate that the young person had exhausted the TILA payment before leaving care but was in receipt of a Centrelink Youth Allowance and Community Services’ Aftercare payment.

8.3.3 Consultation with other agencies

Where records indicated that interagency liaison or collaboration might be warranted in planning the transition from care to independence, we looked for evidence that this occurred. In a number of cases where we expected to see evidence of joint agency planning, we did not find it, most notably in relation to cases where young people were involved with Juvenile Justice.

Of seven young people who spent time in Juvenile Justice detention during the final 12 months in care, we considered that interagency consultation was not adequate in four cases; Community Services either made no attempt to engage Juvenile Justice in the leaving care process; or attempts were inadequate.

Case study: Mark
Community Services did not commence leaving care planning for Mark until he was released from incarceration – five months before he left care. Mark had been in custody 12 months prior to leaving care however there is no evidence of any contact with Juvenile Justice or Mark during this period and no evidence that either party was included in the leaving care process when it finally commenced.

8.3.4 Referrals to ADHC’s Leaving Care Program

Under the Ministerial Guidelines, specific provision is made for young people with a disability who are likely to have significant support needs on leaving care. In these cases, planning to address leaving care should commence between Community Services and ADHC at least two years before the exit from care. ADHC’s Leaving Care Program Guidelines state

¹⁰ Community Services correspondence to the Ombudsman dated 9 September 2011
that all eligible young people should be referred on turning 15, in line with the NSW Children’s Guardian’s Out-Of-Home-Care standards, or two years prior to expiry of their care order.

Of the 70 young people who left care with at least a partial plan in place, 19 care leavers had an identified disability. Twelve of these young people had an intellectual disability, (one severe, 11 mild or moderate) another had global intellectual delay and another developmental delay.

Fifteen of the young people with disabilities were referred to and accepted into ADHC’s Leaving Care Program; however, of the 15 referrals, six were significantly delayed.

ADHC was involved in leaving care planning for each of the 15; as we did not have access to ADHC’s records we did not assess the adequacy of the agency’s role in planning. However, for reasons including delayed referrals and failures to complete or endorse plans before the young people left care, we considered that overall leaving care planning and support was inadequate for six of these 15 care leavers including four of those in high needs placements. All six, however, were referred to aftercare agencies.

ADHC’s Leaving Care Program Overview (July 2011) notes that the program eligibility criteria are more inclusive than the eligibility criteria for other ADHC specialist disability services. Eligible young people must have a disability as defined by the Disability Services Act (DSA), and be considered by Community Services to be unable to restore to family or to continue in care without ongoing support.

Four young people with an identified disability were not referred to ADHC’s Leaving Care Program. Two of these young people had an intellectual disability; one had Aspergers syndrome and one had Aspergers and ongoing mental health problems. Records did not document why these young people were not referred for assessment.

We noted that records for one young person did not identify any disability but did document chronic mental health problems; leaving care planning records for this person included a reference to an application to Centrelink for disability support, although whether an application was lodged or approved is unknown. We considered that this young person may also have warranted referral to AHDC’s Leaving Care Program.  

8.3.5 Referrals to the Public Guardian

Young people who are eligible for ADHC’s Leaving Care Program may also require referral to the Public Guardian. Eligibility criteria – including a young person’s impaired decision making capacity as a result of disability – are outlined in an interagency protocol applicable to young people who are transitioning from the care of Community Services to that of ADHC.

The protocol’s purpose is to assist in the early involvement of the Public Guardian in the transition planning process; the document states that where possible, Community Services should make relevant applications to the Guardianship Tribunal two years before exit from statutory care; in most cases, this will be when the young person turns 16.

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11 People who have a disability caused by psychiatric impairment are included in the target group for services under the DSA.
12 Protocol between Community Services, ADHC and the NSW Public Guardian – June 2011
Among the 15 young people who were accepted by ADHC’s Leaving Care Program, 10 were also referred to the Public Guardian. Of the 10 referrals, seven were significantly delayed and occurred within the final nine months in care or, in two cases after exit from care. In at least four cases, Guardianship Tribunal processes were incomplete several months or more after the young person’s exit from care.

In one separate case, a young woman with intellectual disability was not referred to ADHC but was subject to a Community Services’ referral to the Guardianship Tribunal on the basis of her disability, transient living and drug use. This application – for financial management of the young woman’s affairs – was significantly delayed, occurring five months after exit from care.

### 8.4 Assistance with victim’s compensation

During our 2009 leaving care review, we identified significant shortcomings in Community Services’ handling of victim’s compensation claims for children and young people in statutory care.

In a subsequent investigation, we found major deficiencies in the agency’s systems for identifying and processing claims for children and young people who may be eligible for victim’s compensation. In some cases, extensive delays meant that claims were not lodged before young people turned 18, so responsibility for lodging a claim was then transferred from Community Services to the young people.

In response, Community Services told us it was taking a range of actions to address the problems we identified, including the use of a new case plan template with provision for a ‘measure of wellbeing – legal issues’ field that included victim’s compensation.

In our 2011 leaving care review, we looked for evidence in leaving care plans and other available records that young people’s case files had been assessed to determine eligibility for victim’s compensation and, where this was identified, a claim had been lodged.

In relation to those 70 young people for whom a leaving care plan was developed during the course of our review, we found that in 55 (79 per cent) cases, files had been referred for an audit of eligibility for a victim’s compensation claim; for 14 (20 per cent) young people, we found no evidence of a referral and in one case, we were unable to determine whether or not a referral was made.

In 24 cases, young people were identified as eligible to seek compensation and of these, we found evidence in 14 cases that an application had been lodged.

Of the remaining 10 cases, we found that Community Services wrote to five young people after they left care – and in a sixth case to the carer of a young person with significant disabilities – to advise them they were responsible for pursuing the claim. The agency warned in its correspondence that delay in proceeding might compromise a claim, as indicated in the examples below.
Case study: Tom
For Tom, who was incarcerated for part of his final 12 months in care, leaving care planning did not commence until after he turned 18. The plan documented victim’s compensation as an objective, noted that an audit had been done and that the matter would ‘need follow up by s/c [the subject child]. Under the heading of ‘tasks’ the plan noted that Tom was to contact Legal Aid to make a claim and that a caseworker would give him a solicitor’s letter. We found this letter and associated correspondence from Community Services in the file. The agency’s letter advised Tom that he had been identified – just before leaving care – as eligible to make a victim’s compensation claim, that he should contact lawyers, and that any ‘delay in obtaining legal advice and assistance might compromise your prospects of success in a future claim.’ Given that the leaving care plan and KiDS records also noted that Tom was not in contact with Community Services and his postal address was unknown, it is unclear whether he ever received the correspondence about victim’s compensation.

Case study: Chris
Chris, a young man with significant intellectual and physical disabilities, continued to live with his long-term foster carer once he left care, with support from ADHC; several weeks after he turned 18, the Guardianship Tribunal upheld an application by Community Services to appoint the carer as Chris’s guardian. Almost three months later, the agency wrote to the carer to advise that ‘some time ago we asked a solicitor [...] to conduct a [victim’s compensation] review [which] identified 2 sets of circumstances that indicated [Chris] may be eligible for compensation as a result of injuries he has suffered’. The letter also noted that at the time of the review, the agency shared parental responsibility for Chris, but since he was over 18, Community Services no longer had power to act in relation to a victim’s compensation claim. Further, the letter noted that if the carer wished to proceed with a claim, this should be done ‘without delay as the law presently provides that a Victims Compensation claim must be lodged within 2 years of an act of violence occurring.’ According to the records available to us, Chris had lived in his placement for 13 years; the injuries noted in the Community Services’ letter appear to have occurred in the period before his entry into care.

In another case, a leaving care plan for a young mother noted that she was sent a letter about victim’s compensation four days after her departure from care; the plan also noted that she had been ‘made aware of the possibility of having a Victims of Crime claim and the impact this would have on her receiving financial support from NSW Community Services if her claim/s were successful and she were to receive compensation.’

Another two cases related to young people in NGO placements in the same Community Services region. KiDS’ records indicate that files for the two were referred for legal audit on the same day in April 2011. One file was sent to a Community Services legal officer and the other was sent to a private solicitor. Both lawyers later identified grounds for a claim for victim’s compensation, however one leaving care plan failed to reflect this and the other did so with scant detail.

Case study: Bruce
Bruce’s files show that the day before his exit from care, Community Services instructed the private solicitor to pursue a claim on his behalf; on the same day, the agency wrote to Bruce about the claim and how to contact the solicitor. The
"legal issues" section of the leaving care plan stated that Bruce was currently paying off a fine of $700 and that he had been able to access 'Aboriginal Legal Aid'. In relation to 'actions required' the plan listed 'Victims Compensation Claim' and identified Community Services as responsible but provided no other information.

Case study: Michael
Michael's records show that a Community Services legal officer identified grounds for a potential victim's compensation claim in July 2011. This advice was documented in KIDS on 5 August 2011 but we found no evidence of any further action after that date. Michael left care on 20 October 2011. His leaving care plan was developed by two NGO agency workers in consultation with the young man and his carers. Although the plan noted that a relative had been convicted in 2008 of assaulting Michael, it made no reference to the legal advice about victim's compensation, noting instead that there were no pending legal issues and 'nil' actions required. It was unclear whether the NGO as designated agency was aware of the results of the legal audit on Michael's case.

8.4.1 Data provided by Victims Services

In order to inform our assessment of the victims' compensation aspect of leaving care planning, we sought certain data from Victims Services within the Department of Attorney General and Justice.

Victims Services provided data by financial year for the period 2008/2009 to 2011/2012 on the success rate of applications for children and young people in care, compared to the success rate for all applicants for victim's compensation.

This data shows a significantly higher success rate for applicants in care; their success rate between 2008 and 2012 ranged between 73 per cent and 83 per cent of applications, compared to a success rate of 58 per cent to 61 per cent for all applicants.

Victims Services also provided data for the average age of children at the start and end of the period when they were subjected to violence, and their average age when a claim was lodged; the data covered the same four-year period, as indicated in the table below:

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Average age (in years) at start of act of violence</th>
<th>Average age at end of act of violence</th>
<th>Average age at lodgement</th>
<th>Number of claims lodged</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/2009</td>
<td>4.5</td>
<td>7.9</td>
<td>13.1</td>
<td>105</td>
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<tr>
<td>2009/2010</td>
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<td>8.4</td>
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<td>2011/2012</td>
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<td>8.3</td>
<td>13.8</td>
<td>395</td>
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<tr>
<td>2008-2012</td>
<td>5.5</td>
<td>8.1</td>
<td>13.6</td>
<td>1,330</td>
</tr>
</tbody>
</table>

The data shows that children were on average just over eight years old at the cessation of violence that was later the subject of a claim for victim's compensation; claims were lodged, on average, five and-a-half years after the cessation of the violence.

The tabulated data also shows that the total number of claims for children and young people in care has increased from year to year since the 2008/2009 financial year.
As noted previously, we alerted Community Services in 2009 to the significant problems we found in systems and practice for the timely identification and lodgement of victim’s compensation claims for children and young people in care. In 2010, Community Services advised us of action it was taking to improve its performance in this area (including ensuring that children with potential claims for victim’s compensation are identified during care proceedings).

It is encouraging to note that since we first brought these matters to Community Services’ attention, the agency has significantly increased the number of victim’s compensation applications for children and young people in care.

However, the data provided by Victims Services also indicates that there has been little change in the average age of young people in care when an application is lodged. Clearly, this is an issue that warrants attention and we will be keen to see further improvements by Community Service in dealing with victim’s compensation for children and young people in care, both generally and as an aspect of leaving care practice.

8.5 Care leavers at risk

Section 165 of the Act, provides the Minister with discretion to arrange or provide for such assistance to care leavers as is considered necessary, having regard to their safety, welfare and wellbeing. There is scope under the Ministerial Guidelines for provision of further assistance based on needs assessment for young people who are considered to be at risk of not making a successful transition to independent living.

Against this background, we noted correlations between various vulnerabilities for a significant minority of the 90 young people under review. These vulnerabilities included involvement in Juvenile Justice, parenthood, disability or chronic mental health problems, and high needs. We also noted the prevalence of Indigenous young people among those with various vulnerabilities.

For example, of the 19 young people involved with Juvenile Justice, five also had a disability and two others had chronic mental health problems. Of the seven young women who delivered a baby while in care, four had been involved with Juvenile Justice. More than half (10) of those involved with the Juvenile Justice system were Indigenous.

We assessed leaving care planning and support as not adequate for 13 of the 19 care leavers who had been involved with Juvenile Justice.

In relation to young people who become parents while in care, Community Services’ practice guidelines state that they are likely to require additional supports including links to supports for vulnerable families. Those with parenting responsibilities who are looking for employment, should be assisted to find suitable child care and access relevant Commonwealth subsidies and rebates. In addition, Community Services may provide financial assistance by paying security deposits required to secure a child care placement for care leavers looking for work.

Of the seven young mothers in our review group, three had their children removed from their care before their own care order expired.
We found that in only one of the seven cases did the leaving care plan adequately consider childcare and additional supports.

Case study: Alice
Alice, a young Indigenous woman, entered kinship care at the age of 16 years and gave birth to a child 11 months later. A leaving care plan was commenced in the final six months of statutory care: during this period, Alice and her baby moved into independent housing assisted by Community Services and Housing NSW and the plan noted the provision of financial support for the bond and household furniture. The plan also acknowledged that parenting assistance was required and referrals to local support services were made. Further, the plan noted that assistance would be provided to Alice to secure childcare so that she could return to TAFE and complete her education.

8.6 Indigenous care leavers
That our review sample included 25 (28 per cent) Indigenous young people is consistent with the disproportionate number of Indigenous children and young people in out-of-home care across New South Wales.

When we considered our findings in relation to Indigenous care leavers as a group, we noted the following:

- Of the 19 young people who left care with an endorsed plan, five were Indigenous.
- Of the 70 young people for whom a plan was developed during our review, 21 were Indigenous.
- Of the 16 young people who were eligible for a plan but for whom none was developed, four were Indigenous.
- Of the 21 Indigenous care leavers with a plan, planning and support was inadequate for 11 of them.

The data detailed above shows that 20 per cent of Indigenous young people exited with an endorsed plan, compared with 22 per cent of the entire sample.

However, of the 25 Indigenous young people, 15 (60 per cent) either left care with inadequate planning or were not provided with a plan; this is higher than the 52 per cent of all care leavers who had either no plan or inadequate planning.

For those 21 Indigenous young people for whom a plan was developed, we also took account of whether the plans addressed requirements relating to their cultural identity.

The Ministerial Guidelines emphasise that the establishment and maintenance of cultural links are often important to the long term development and wellbeing of Indigenous care leavers. This focus on Indigenous community and culture is reflected in a requirement in Community Services’ casework practice that Indigenous care leavers be encouraged through leaving care plans to establish and maintain links to their cultural identity.

In 18 of the 21 plans for Indigenous care leavers, their Indigenous background was acknowledged. Eleven of these 18 indicated that referrals to aftercare services were proposed or had been implemented. Of these referrals, four appeared to be intended to address the care leavers’ cultural needs; two young people were referred to Marungbai Aboriginal Aftercare...
Service, one young person was referred to ‘Aboriginal aftercare’ and another referral was to ‘Aboriginal link up’.

A number of other plans had insufficient information about the referral to allow us to assess whether it was intended to address, inter alia, cultural needs. In two cases, care leavers were referred respectively to the Indigenous Parenting Support Program and the Helping Hands Indigenous Housing Support Service.

During our leaving care consultation with the Aboriginal Child, Family and Community Care State Secretariat (AbSec), we were advised that it is AbSec’s understanding that, as with all other out-of-home-care services, Aboriginal services are not funded to provide caseworker support after young people have left care.

AbSec also told us that the Marungbai Aboriginal Aftercare Service – noted above – is funded to provide brokerage and advocacy services to Aboriginal and mainstream OOHC providers; the service is not funded to provide direct aftercare services and operates with one caseworker across the State.

Given the emphasis on encouraging Indigenous care leavers to maintain cultural connections, it is noteworthy that there is no funded specialist aftercare service operating in the State’s Western region, where there are disproportionate numbers of Indigenous people.

8.7 Use of plan templates

In early 2011, Community Services developed a new leaving care plan template for the purpose of documenting case plan goals, including leaving care. The agency subsequently advised us that use of the template would contribute to improved leaving care practice.13

However, our review indicates that the leaving care plan template has not necessarily ensured better compliance with the Ministerial Guidelines. While most Community Services Centres (CSCs) used the current leaving care plan template, the level of detail recorded in leaving care plans varies significantly.

In some instances, our review found that Community Service’s assessment of the young person’s aftercare needs was thorough and well-documented and addressed legislative requirements.

In a number of cases, the leaving care plans broadly addressed the types of assistance required, but provided insufficient detail around the key areas of financial assistance, setting up house, education, training, finding employment, legal advice, access to health services, counselling and support. For example:

Case study: Oscar
Oscar had been in care since two years of age and experienced a number of placements including foster and kinship care. In the 12 months prior to leaving care he became involved with Juvenile Justice and was detained for a period. During this time there was some communication between Community Services and Juvenile Justice about leaving care, though planning was significantly delayed. Oscar was then placed in Community Services’ foster care. Oscar had informed Community Services he was anxious about

13 We also refer to and quote this advice in section 10 of this report.
exiting care and about the possibility of being charged again at 18. His leaving care plan did not adequately address how he would establish accommodation, or find employment, counselling and support; nor did the plan provide information about key services or legal advice. The leaving care plan also failed to take account of some significant recent changes in Oscar’s circumstances, including his decision to cease TAFE coursework, leave his carer’s home and reside with peers.

The current Community Services leaving care plan template also includes a field for planned review dates. We discuss the scheduling of reviews in the following section.

8.8 Planned reviews of aftercare support

Under the Ministerial guidelines, designated agencies should offer follow up support to care leavers at regular intervals ‘in the years’ after their exit from care; this may include reviewing aspects of the leaving care plan and ongoing advice, support, advocacy and assistance.

Community Services’ current leaving care plan template includes a field for three ‘Planned Review Dates’.

As noted at section 8.7, not all Community Services’ plans used the current template. NGOs used their own formats. Overall, we found that of the 70 plans developed during our review, only 21 (30 per cent) included planned reviews scheduled to take place after exit from care.

Of the 49 (70 per cent) plans that included no planned aftercare reviews, we noted a small number that documented review dates that preceded the young person’s exit from care.

The Ministerial Guidelines also state that beyond general follow up and support, specific forms of assistance may be provided on the basis of assessed need. The guidelines state that where practicable, the young person should be referred to an existing service, which may include a funded specialist after care service.

Information provided by Community Services indicates that funded after care services are delivered by non-government organisations in six of the seven Community Services regions; as noted previously, the exception is the Western Region, where ADHC provides the only funded after care service.

Of those 70 care leavers for whom a plan was developed, 33 (47 per cent) young people had been referred to an aftercare service – 28 of these were to a funded service, including 15 referrals to ADHC.

Of the 37 care leavers who were not referred to an after care service, we identified some who declined a referral and others who planned to remain with their carer in stable long term placements; in some of the latter cases, information was given to the young person about support services they could contact in future.

In relation to Community Services’ Western Region – where no funded non-government after care service is available – we reviewed the leaving care plans for 11 young people. We found that a number of them had been referred to or were engaged with support services for a range of issues including psychological services, independent living skills, financial management and parent support.
We acknowledge that referral to an aftercare service is not required or necessary for all care leavers. However, among those care leavers not referred to an after care service were a number with significant needs. In our view, in these cases, an after care service could have provided assistance with the transition to independent living. The following example illustrates this issue:

*Case study: Tim*
Tim had been in care since the age of 13. He had a history of behavioural and psychological issues and drug and alcohol misuse, and had experienced chronic placement instability. In the 12 month period prior to his exit from care, he had lived with various family members, friends and at youth refuges. He had also contacted Community Services to report he was homeless having spent a few nights sleeping on a train. Community Services secured an overnight refuge placement. At the time of our review it appeared that stable long term accommodation had not been arranged. We identified a number of issues that needed to be addressed including a referral to an aftercare service to support Tim’s transition to independence.

9. **Leaving care and non-government agencies**

In March 2012, the NSW Government started a long term program to transfer children and young people in statutory foster care or relative/kinship care to accredited non-government organisations. The transfer is expected to take up to five years for non-Indigenous children and young people, and up to 10 years for Indigenous children and young people.

Contracts for NGO providers of out-of-home care include performance requirements relating to leaving care.

The 90 care leavers in our review included 10 in non-government organisation placements: of these, two young people left care without a plan. We reported on their cases in section 7.2 where we noted Community Services’ advice that the NGO had yet to provide a plan four months after one young person’s exit; in the other case, a plan was not developed because of unspecified agency error.

The remaining eight young people in NGO placements left care with a plan but none were endorsed. Of the eight plans which were not endorsed:

- Five plans were complete but not endorsed at exit
- Two plans were incomplete at exit
- One plan contained insufficient information for us to determine its status at exit
- Six plans were commenced when the young person was 17
- One plan was commenced before the young person’s 17th birthday
- One plan was commenced after the young person turned 18.

As noted at section 8.3.1, we assessed planning and support as inadequate for six care leavers in NGO placements, including a case where liaison and information exchange between the NGO, Community Services and Juvenile Justice appeared to be inadequate:
Case study: George
The leaving care plan for George noted that he had a long history of chronic drug and alcohol use, trauma and placement disruption, and significant involvement with Juvenile Justice, including several periods in custody prior to leaving care. However, the plan contained no information about the implications of chronic drug abuse for George’s future or how this might be addressed, other than noting that he could approach Community Health for counselling and rehabilitation ‘if he chooses to overcome his current addiction’. There was no indication that Juvenile Justice had been involved in the leaving care planning process, including by contributing to a needs assessment. Additionally, the plan did not address George’s educational needs, identify current or future sources of income, or develop firm plans for aftercare accommodation. The NGO completed the plan two months before George turned 18: one week after he left care, his file was referred for a victim’s compensation audit but the plan made no reference to victim’s compensation. The plan was endorsed nearly three months after his exit from care.

10. Ensuring that agencies meet their obligations on leaving care

As noted previously, Community Services has taken steps since 2010 to improve its handling of leaving care, including staff training in the use of a revised case plan template. In late 2011 Community Services advised us that the revised template would help the agency to:

... monitor and address its obligations to support young people during their transition to independence. The template is attached to a young person as a ‘case meeting’ record in KiDS. Once a young person turns 15 years of age, the case plan goal becomes ‘leaving care’ and the objectives and tasks in the case planning template are increasingly focussed on preparing the young person for independence at 18 years of age.

Community Services also told us that it provides its regions with regular ‘out-of-home care baseline data’ reports on children and young people in the parental responsibility of the Minister. The reports support regions’ ‘monitoring of progress and improves Out-of-home-care casework practice, including appropriate recording of the case planning template on KiDS.’

In subsequent advice, Community Services told us the reports are provided on a fortnightly basis and that they include data for individual CSCs for categories such as the number of all children and young people in care, and the number who are aged over 15 and who have a disability.

We then sought clarification from Community Services about its capacity to use out-of-home care data to identify whether young people have reached the age for commencement of leaving care planning. The agency informally confirmed that the data could be used in this way.

During the course of our 2011 leaving care review, in addition to the group under review, we took account of particular cases known to our office where a young person had left care either

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14 Community Services correspondence 25 November 2011
15 Community Services email communication 24 September 2012
before or after the period of our review. This information was obtained under the Ombudsman’s child death review and reportable allegations functions.

**Case study: Paul and Edward**

Two young people, Paul and Edward, were charged with a serious criminal offence in late 2010. Paul was in care and Edward had left care three weeks before the incident. Each had an allocated caseworker at the same CSC but we found no evidence of leaving care planning in either case.

We asked Community Services why leaving care planning had not commenced for Paul, prior to the alleged offence, when he was aged 17 years and six months. Community Services told us that for both young men, periods of incarceration and transience affected development of a leaving care plan; both were also difficult to engage. However, the agency also told us that best practice is to liaise with interagency partners to determine the needs of the young person and this appeared not to have occurred in either case.

We asked Community Services for information about its practice in relation to leaving care planning for young people who do not engage and/or have complex needs. Community Services told us that the Ministerial Guidelines do not specifically address circumstances where young people do not engage and/or have complex needs; however it said the guidelines do state that where a young person leaves care without a plan and later requests assistance, a leaving care plan should be prepared at that time. The Guidelines also allow provision of assistance beyond the age of 25, where formal leaving care planning has not been undertaken due to periods of detention for criminal behaviour.

Further, the agency advised that:

*In January 2012, [the] CSC identified that leaving care plans were not being prioritised at the CSC, particularly for unallocated cases. A system was then developed and implemented to address this. The system identifies young people in out-of-home-care over the age of 15 years (including over the age of 18 years) where leaving care plans have not been commenced or completed or where cases are unallocated. While this process was occurring, the CSC discovered that [Paul] did not have a leaving care plan and on 20 March 2012 commenced action to develop one with him.*

**Case study: Sophia**

Sophia made disclosures in September 2010 of longstanding sexual abuse by a male carer. At the time she was aged 16 and living in a kinship placement. Her disclosures were reported to Community Services and she participated in an interview with JIRT. Subsequently, Sophia said she did not want to proceed with investigation of the allegations. The matter was then accepted for investigation by Community Services’ Reportable Conduct Unit (RCU) and finalised in September 2012. Allegations of sexual misconduct against the carer were sustained.

*In its investigation report, the RCU noted that it found no evidence of a leaving care plan for Sophia, who turned 18 in March 2012. The RCU recommended that a leaving care plan be prepared for her and that her case be assessed for victim’s compensation.*

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16 Community Services correspondence 21 June 2012
At the same time, however, the RCU wrote to Sophia to inform her that it had concluded its investigation but was unable to disclose the outcome.

It was unclear to us how Community Services proposed to engage Sophia in leaving care planning without disclosing to her basic information that appears to have implications for both a potential victim’s compensation claim that she might have to pursue and issues of aftercare support.

11 Community Services’ response to our draft report

In May 2013 Community Services provided its response to our draft report.

In summary, the agency told us that its limited casework capacity affected the quality of leaving care planning and resulted in some young people remaining unsupported when they left care. Community Services said measures to address this problem were being focused on capacity building in non-government organisations as part of the transition of out-of-home care to the NGO sector: in particular, that the transfer of OOHC would increase the number of young people in placements with providers with enhanced capacity to meet the Children’s Guardian’s standards for leaving care planning.

Further, Community Services advised that young people who are already 15 will not be transferred to ensure continuity of care and case management by Community Services.

Separately, Community Services said continuing challenges for its Regions in ensuring that young people exit care with a plan in place include consistency of approach to planning for young people who are hard to engage, and local barriers to collaboration with partner agencies such as Juvenile Justice.

Community Services outlined what it called promising practices to improve leaving care planning and support, including:

- Monitoring the number and proportion of young people with leaving care plans through the fortnightly OOHC Quality Baseline Report
- Group supervision under Practice First in trial Community Services Centres
- Discussion and review at regular meetings of the Community Services-ADHC Memorandum of Understanding Senior Officers Group

The agency said it acknowledged our draft conclusion that improved monitoring and reporting is required in order to sustain and demonstrate substantial improvement in leaving care practice.

Further, Community Services said it had identified a number of immediate and longer-term actions to improve leaving care support. These are summarised below.

Immediate actions

Community Services told us it would amend the Ministerial Guidelines to: reflect an OOHC Standards requirement that leaving care planning commences when a young person turns 15; specify that plans should be prepared for young people who are hard to engage; and update information on the Commonwealth TILA payment.
The agency said it would consider lowering the delegation for approval of plans requesting aftercare spending of less than $3,000; and it would revise its Memorandum of Understanding with Housing NSW and Juvenile Justice on shared clients, to address issues raised by our review.

Community Services also advised that the OOHC Transition Program Office would establish a steering group to facilitate and coordinate training and development for issues including leaving care; and that the Association of Children’s Welfare Agencies would be engaged in activities to support sector development on leaving care.

The agency said each of these immediate actions would be completed by the end of June 2013.

Separately, Community Services reiterated advice to us that its common case plan template, and case planning and review procedure, ensure consistency in leaving care planning. Further, the agency said the template and procedure had in use for only eight weeks for the cohort in our review, so this might explain the problems we identified in relation to consistency.

Long-term actions

Community Services outlined actions to occur within two years, including use of annual case plan reviews to ‘populate’ information about the number of young people with leaving care plans on file. The agency said that case plans had been established as stand-alone records on KiDS since November 2012, so information about leaving care planning would be easier to obtain and improvements to the quality of planning would be easier to track.

Community Services also told us that it has strategies to improve leaving care planning for vulnerable care leavers; these strategies involve the use of MOUs with other government agencies and non-government OOHC providers, and related health and education referral arrangements. Community Services said it is providing information to NGOs to progress implementation of the interagency protocols and will hold related regional workshops in 2014.

Aftercare

Community Services told us it is considering more innovative models for care leavers to get aftercare support, given what the agency described as its ‘need to reduce [its] role in providing aftercare financial assistance in the context of the OOHC transfer to NGOs. It is also to ensure that the funding available provides an effective service to as many young people as possible during the years they are eligible for after care assistance.’

Community Services said it was consulting about future arrangements for aftercare support with aftercare services and peak bodies.

Victims’ compensation

Community Services told us that improved timeliness of leaving care planning would also assist with early lodgement of victims’ compensation claims for young people in care; it also said it would provide more detailed advice in this regard by way of a separate response to the
Ombudsman’s investigation into Community Services’ handling of victims’ compensation claims.

As noted in section 4.2, we have received this separate advice.

In summary, Community Services told us it conducted an audit in February 2012 of the effectiveness of a new procedure published in October 2011 for handling victims’ compensation claims for children and young people in care.

The audit found that the new procedure was not operating effectively because of reliance on other casework procedures – such as leaving care and case planning – that are not consistently complied with. As a result, some children and young people who were eligible for victims’ compensation were not being considered.

Further, the audit found that ‘referral pathways’ for identification of victims’ compensation claims [did not] ‘sufficiently capture’ children and young people case managed by NGOs; there was inadequate monitoring of performance in processing claims; and accountability for delays was not defined. Additionally, although training was delivered at each CSC, some staff were not ‘clear’ on the victims compensation process and did not view victims compensation as a priority.

In response to the audit findings, Community Services said it had intended to develop reporting and monitoring arrangements to ensure compliance with victims compensation processes, but it did not progress this work because of the introduction of a new victims support scheme in NSW. However, the agency said it would develop new practice to support its responsibilities under the Victims Rights and Support Act 2013. It did not indicate how it would handle eligible victims compensation cases in the meantime.

12 Conclusion

In our draft report, we observed that, for young people who left statutory care in the last quarter of 2011, the delivery of leaving care planning had not improved substantially since our review in 2009.

Although we found an improvement in the proportion of young people who exited care with an endorsed plan in place, four in every five care leavers did not have an endorsed plan in place on exit from care.

We found leaving care planning was characterised by delays in commencement and referrals, and extensive variations in the level of consultation with young people, and on the degree of detail in the plans. For a significant minority of care leavers, there was no planning whatsoever.

Among the particular concerns about adequacy of planning, we noted:

- Delays in assessing victim’s compensation, leaving young people to navigate the application process without assistance.
- Lack of consultation with other key agencies, in particular a failure to work with Juvenile Justice to develop plans for young people in custody.
A high proportion of Indigenous young people leaving care without adequate planning, including in relation to cultural identity.

A failure to provide ongoing support for young people completing their HSC – this is of particular concern given the disproportionate number of young people in OOHC who do not complete schooling.

A failure to address the specific circumstances and needs of high risk young people. We reviewed plans for young parents which did not consider their need for support in parenting; plans for care leavers with a history of drug and alcohol abuse that did not address their need for referral to drug and alcohol programs; and plans for transient care leavers that did not include assistance with accessing appropriate housing.

From the time of our previous leaving care review in 2009, Community Services has acted to improve its practice on leaving care. However, as we observed in our draft report, the findings of our follow up review demonstrate that the return on this investment has been insufficient.

As noted, in its response to our draft report, Community Services acknowledged that improved monitoring and reporting is required to sustain and demonstrate substantial improvement in leaving care practice.

The agency has outlined a number of short term and longer term actions to address the shortcomings we identified; these include fortnightly reporting on the number of young people with leaving care plans, changes to the KiDS system, revision of interagency agreements and protocols, and training on leaving care for non-government OOHC providers.

However, in its separate responses to our draft report and our work on victims compensation for children and young people in OOHC, Community Services also provided two distinct explanations for its performance on leaving care; these explanations concern capacity and compliance.

First, the agency said its limited casework capacity has affected the quality of some leaving care planning and, in some cases, left young care leavers with no support.

Second, an internal audit of new procedures for victims compensation claims found that these were not operating effectively, in part because Community Services workers do not consistently comply with associated procedures including those for leaving care planning.

These separate explanations for poor performance on leaving care planning warrant some discussion.

In relation to the capacity issue, it is notable that of our review group, Community Services identified current competing priorities as the reason that plans were not developed for only four of the 16 young people for whom no plan was developed. In other words, based on the agency’s advice to us, limited capacity to develop a plan prevented this from occurring for less than five per cent of our review group of 86 care leavers. Moreover, as we noted in our draft report, given that planning should occur up to three years before exit from care, it is unclear how failure to develop a plan can be attributed to current competing priorities.

More broadly, the issue of Community Services’ capacity to meet its statutory obligations on child protection – including in relation to OOHC – is one we have identified and raised repeatedly, including in our 2011 report Keep Them Safe? We discussed then the need for
improved data collection, monitoring and reporting as one element of measures to address capacity; we also noted Community Services’ advice that a key element of its plan to improve capacity related to the involvement of the non-government sector in the provision of OOHC.

Of itself, however, improved capacity will not lead automatically to improved compliance. It is concerning that Community Services’ audit in 2012 of a new procedure on victims compensation identified that the agency’s staff are not consistently complying with the procedures that govern their work on leaving care planning and case planning.

Considered together with the findings of our review, Community Services’ audit findings clearly demonstrate the critical importance of monitoring to ensure that both Community Services and its partner agencies in the OOHC sector comply with the leaving care provisions of the Care Act.

Community Services has outlined a range of measures to address the shortcomings in leaving care planning which we have identified. However, it appears that it has yet to establish a comprehensive plan for sector-wide reform. In particular, while the agency has said that the transfer of OOHC to the non-government sector will lead to enhanced capacity to meet the leaving care standards of the Children’s Guardian, it has not outlined how the sector’s performance will be monitored and reported.

For this reason, it is vital that Community Services closely involves both the non-government sector and the Children’s Guardian in the development of a systematic plan designed to achieve substantial and consistent improvements in leaving care practice, and to collect and report the evidence to demonstrate this.

13 Recommendations

Taking into account Community Services’ response to our draft report, I make the following recommendation.

Within three months of the date of receipt of this report, Community Services should provide a statement of information that:

1. Addresses the need for a uniform system across the OOHC sector to be developed which alerts caseworkers to the need to commence leaving care planning when a young person turns 15; allows for monitoring of key milestones including commencement, completion and endorsement of leaving care plans; and provides for ongoing collection of relevant local, regional and state-wide aggregated data on commencement and completion of leaving care plans for the purpose of compliance monitoring and for driving practice improvement.

2. Provides a copy of the revised MOUs between Community Services and Housing NSW and Juvenile Justice, and copies of all other MOUs and protocols between Community Services, other government agencies and NGOs that relate to strategies to improve leaving care planning for vulnerable care leavers.

3. Describes how the MOUs and protocols identified at recommendation 2, address the aftercare cultural needs of Indigenous young people.
4. Outlines the results of Community Services’ consideration of lowering the delegation for endorsement of plans where less than $3,000 in aftercare financial support is proposed.

5. Provides detailed advice about the nature, timing and intended outcomes of Community Services’ proposed reduction of its role in providing aftercare financial assistance (including the extent to which the agency intends to reduce its role as currently outlined in sections 4 and 5 of the Ministerial Guidelines).

6. Outlines the proposed new reporting and monitoring arrangements for ensuring competent and efficient practice in relation to the identification and processing of victims compensation claims.

7. Reports on Community Services consultations with the Children’s Guardian and the non-government OOHCE sector in developing and implementing initiatives relating to recommendations 1, 4, 5 and 6 above.

Steve Kinmond
Deputy Ombudsman
Community and Disability Services Commissioner