November 8, 2013

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

Re: Royal Commission into Institutional Responses to Child Sexual Abuse, Issues Paper 4: Preventing sexual abuse of children in out of home care.

Life Without Barriers appreciates the opportunity to provide a submission to the Royal Commission's fourth Issues Paper, *Preventing sexual abuse of children in out of home care.*

About Life Without Barriers

Life Without Barriers is a not-for-profit organisation, providing care and support services across Australia in urban, rural and remote locations, and in New Zealand.

Our community-based programs assist children, young people, adults, families and communities. We provide family support and out of home care, disability services, home and community care, and support to refugees and asylum seekers. We also work in the areas of mental health, homelessness and youth justice. Life Without Barriers' work is underpinned by a strong commitment to reconciliation and the delivery of culturally sensitive programs.

Life Without Barriers provides family support and out-of-home care across Australia, and in New Zealand. These services range from support to vulnerable families to strengthen and maintain their parenting role, through to foster, kinship and residential care for children and young people who are unable to live at home. We deliver meaningful outcomes for children, young people and families, with an emphasis on building safe, stable and nurturing relationships.

Life Without Barriers' individualised services provide people with the wraparound support necessary to achieve outcomes that are important to them. Based on our unique model of care, we have been at the forefront of extending foster care to include adolescents previously seen as unsuitable for family-based placements. Our services also encompass specialised programs to support children and young people in critical areas of development and through major transitions in their lives.

As an organisation that provides services to vulnerable client groups including children and young people in out of home care, people with disability, and refugees and asylum seekers, Life Without Barriers recognises that our first responsibility is to ensure the safety and wellbeing of the people who access our services. For children and young people in out of home care, including foster, residential and kinship placements, a fundamental aspect of this responsibility is to protect them from sexual abuse.

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Responses to consultation questions

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

The essential element for keeping children and therefore children in OOHC safe is for communities to adopt a comprehensive evidence-informed prevention and response strategy such as that outlined in Professor Stephen Smallbone's *Preventing Child Sexual Abuse*. Any individual organisational strategy is impacted by the community's adoption of such a broader comprehensive strategy. Additionally, it is affected by the community's willingness to invest in appropriate high quality OOHC for children unable to live with their parents. Notwithstanding this, there are a number of things an individual organisation can do to reduce the risk of sexual abuse in OOHC.

One such thing is for the organisation to recognise that any individual can, under certain circumstances, harm children in their care. This includes support staff, carers (and their families), natural families and other children in OOHC. Operating from this assumption means the organisation then shapes the position and the environment in a way that promotes protective factors, and reduces risk factors regardless of who occupies the position. It also means the organisation has processes in place to screen and assess potential employees before they join the organisation. While Life Without Barriers has a strong conviction that a network of targeted measures covering all dimensions of risk is the most effective strategy, we are not aware of the existence of a strong evidence base around any individual mechanism.

Agencies should employ linked processes and mechanisms to keep children and young people safe from harm from individuals; from the system and from acts of omission; and to help us respond appropriately to child safety concerns. This could include carer assessment together with background checks; codes of conduct and other mechanisms for creating a strong values based and child centred culture; casework practices such as the frequency of visits a child in OOHC receives from a caseworker and reflecting the risks associated with a particular placement; risk management planning and auditing as part of a continuous improvement approach; human resources strategies including carer-child ratios, low staff turnover, reporting lines that require supervision, mentoring and coaching; professional and carer development; complaints mechanisms; and remediating errors. Some of these processes are required by the relevant accreditation or licensing Life Without Barriers is required to meet.

Importantly, there should be strategies in place to assist children and young people in care report harm, make a complaint, provide input and feedback, voice a concern, and talk to a trusted adult. The ability of frontline workers to engage with children is a key aspect of creating an environment where children feel supported and safe to voice a concern. Appropriate competency requirements, professional development and other assertive measures should be employed, to assist frontline workers in honing their ability to build trust and rapport with children. Engaging with children and young people, building relationships, and asking the right questions are a core aspect of creating opportunities to identify factors in a placement that may suggest actual harm or risk of harm. They are also core aspects of encouraging and supporting the disclosure process as elaborated further in response to Question 8.

Carer assessment
Finding suitable people to support the needs and wellbeing of children in OOHC is an important aspect of creating a safe OOHC environment. This involves agencies undertaking a comprehensive suite of assessments to engage the right carers.

Pre-employment checks such as working with children checks are one aspect of determining the suitability of a potential carer. All states and territories now have some form of pre-employment checking and they form an important part of reducing risk.

An example of other assessment tools used is the Step by Step assessment, developed by the Association of Community Welfare Agencies in NSW.

Step by Step assesses the competency of potential carers across a range of dimensions including their motivations and attitudes to caring, personal resilience, capacity to work in a team, capacity to provide child-focused care and ability to provide a safe environment for children. Foster care assessment occurs over a number of interview sessions with the applicant, and includes their family and other household members.

Additional elements of foster carer assessments include a pre-service training workshop that provides potential carers with an understanding of the dimensions of care and caring, probity and background checks with the relevant authority, character reference checks and a home environment safety check.

Placement monitoring
Visits to children undertaken at regular intervals with a frequency that reflects the assessed risk of the placement also reduce risk in OOHC. Visits should be made within the home in the presence of the carer, and others outside the home without the carer present. This enables the caseworker to observe interactions between the carer and the child, and provides children with the opportunity to discuss their placement and any matters of concern in a neutral and confidential environment.

Separate advocates for children and carers
Based on placement type and other risk factors, where there is a conflict of interest between the same person acting as the advocate for the child and the carer, then the role should be assigned to two people – one who works with the child and one who works with the carer. In most cases a skilled caseworker will have the ability to work with both parties while maintaining the best interest of the child as paramount. In high-risk placements, a separate advocate for the child and the carer is a precautionary approach for assertively maintaining the best interests of the child (and the carer).

Complaints mechanisms
Life Without Barriers believes that providing children with the opportunity to make a complaint or voice a concern is a fundamental aspect of any strategy to protect children from sexual abuse. The existence of a complaints mechanism alone is not sufficient. An effective complaints mechanism is needed which is accessible to children; appropriate to their developmental stage; and one that they are aware of, and comfortable using. It also promotes a culture amongst staff and carers that children have the right to receive quality care.

Where appropriate, Life Without Barriers consults with external bodies regarding complaints processes. For example, in NSW Life Without Barriers' complaints system has been developed in

consultation with the Ombudsman. Other measures used to support an effective complaints system are complaints training for staff and establishing a Complaints Officer.

Internal compliance mechanisms
Internal audits should be used to check that the systems in place to protect the safety and wellbeing of children in OOHC, comply with requirements and prescribed service standards. This continuous improvement cycle helps us to understand and identify issues that expose children to risk.

Statutory reporting
The reporting of incidents (actual or alleged) that may constitute harm or a risk of harm to a child or young person is a statutory obligation of providers of OOHC. Failure to report such incidents may be viewed as grounds for disciplining staff members and a breach of the legal obligations of an agency or contractual obligations of a contractor. Frontline staff having a clear understanding of these obligations is a fundamental aspect of an organisational culture that protects children from harm.

Investigation of abuse in care
An agency investigation process is often required to complement existing statutory investigation processes. The paramount principle of any investigation is the safety and wellbeing of any child who may have been involved in alleged behaviour or may be at risk of harm. Natural justice and procedural fairness are underpinning principles of any sound investigative process - decisions about a child protection matter should be made in good faith and without bias, with consideration to any person whose interests will be affected by the decision.

Incident management
A systematic approach to client incidents is an important child protection risk management strategy that enables an agency to respond in an organised, consistent and timely way to both individual and collective matters. Particular significance must be ascribed to incidents that have resulted, or may result, in harm to a child or young person in care, as well as incidents that indicate a breach of the standards of care.

Placement matching
Placement matching is a primary tool for OOHC risk management, particularly where multiple unrelated children share a placement. The existence and application of strict rules and risk criteria help to eliminate the likelihood of adverse outcomes in a foster care or residential care setting. Criteria for placement matching should include:

- Length of time in placement
- Age/sex of each child including carer's children
- Views of each child
- Physical environment of home and bedrooms
- Total level of physical care required (including high medical needs)
- Previous placement history (including siblings)
- Carer motivation and previous experience
- Patterns of behaviour of the child (where known)
- Individual care needs
- Swapping by related carers (respite specific)

Identification of safe people
Supporting children to identify safe people is another important risk mitigation strategy. Consistent with good case management principles, caseworkers should regularly be reviewing who a child's safe/support people are, and checking with the child they are clear and comfortable with this.

As an area of ongoing work, providers of OOHC need to critically assess whether we are communicating with children in a developmentally appropriate way about who their supports are, and how they can best access them over time if they are concerned about something. This needs to be balanced with avoiding children feeling unduly worried or insecure.

High staff turnover of frontline workers presents a challenge for children being able to establish positive and trusting relationships with carers, and hence the practice of identifying safe people. In relation to staff of residential OOHC settings, the high turnover of staff was an issue explored by the Queensland Child Protection Commission of Inquiry.

Promoting an open culture where children are supported to share their experiences and voice concerns is a key element of a safe OOHC environment. Relationships with external advocates, such as the CREATE Foundation is an example of a mechanism that supports this strategy. By actively facilitating connections with CREATE, children in OOHC placements are encouraged to express their voice in a safe environment with peers who share similar experiences.

Information sharing
The effective and timely exchange of information between OOHC providers, child protection authorities and police contributes to safer OOHC environments. Agencies need to recognise the importance of operating in the spirit of the legislative requirement by sharing all relevant information. While information sharing may raise concerns regarding privacy, these must be considered secondary to child protection concerns.

Respite
Respite is an environment that can pose risks to the safety of children. For example, assuming that a carer's sister providing respite care is a positive factor may ignore the potential risks involved. To establish whether such arrangements are positive, the agency should first assess how the respective carers would act if one of them had a concern about the other's behaviour.

The mechanisms outlined for OOHC should apply to respite care.

Remediating errors
No system, policy or practice will be free of errors so how organisations respond to errors can impact on risk. Organisations that proactively seek to identify errors at all levels should be creating safer and more secure OOHC environments. At the practice level, strategies such as reflective practice and regular supervision can be effective in identifying errors. At the policy and systems level a strong risk framework combined with regular reporting and auditing can proactively identify errors. Organisations that respond to errors in a defensive closed manner will increase the risk to children in OOHC especially when that error is identified by an external source. Agencies should have a process in place for reviewing the error; understanding what led to the error and why it wasn't identified by internal processes such as an audit or supervision; develop and implement a remediation plan; and review progress of implementation.

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

What we can say is that there is evidence to suggest that some OOHC settings are more predisposed to the occurrence of abuse, including sexual abuse than other settings. For example a recent paper (Euser et al. 2013) examining the comparative incidence of sexual abuse in residential care and foster care in The Netherlands found that children in residential care had the highest prevalence rates for sexual assault of any out-of-home care setting. Overall, children in out of home care were at an increased risk of sexual assault than the general population. For children in foster care, prevalence rates were found to be the same as the general population.

The Victoria Ombudsman's *Own motion investigation into Child Protection – out of home care* (2010) examined data from the Australian Institute of Health and Welfare (AIHW) regarding allegations of abuse in out of home care by placement type in Victoria. He reported that 35% of allegations related to children in residential care – a category of care that only accounts for 7% of the total out of home care population. In contrast, children in kinship placements were the subject of 3.5% of allegations of abuse, accounting for 40% of the total out of home care population.

Notwithstanding that the capacity to report may be a variable in these figures i.e. there is less scrutiny of kinship placements therefore abuse is less likely to be picked up on by caseworkers, it would seem reasonable to conclude that kinship placement is the safest form of care and residential care is the least safe. Such a conclusion is consistent with the probable role attachment plays in either reducing or increasing risk of harm to a child. The higher rates of sexual abuse by stepfathers and mothers' boyfriends compared to natural fathers, reinforces the positive role attachment plays in reducing risk.

Thus the most important strategy for keeping children safe in OOHC may be to vigorously adopt a hierarchy of care with kinship, then foster then residential care as the preferred form of care. Such a hierarchy should be reflected in legislation, accreditation, funding, casework standards and practice arrangements. Currently this is not the case.

Even if such a hierarchy was to be vigorously pursued risk mitigation strategies for each form of care would still be needed.

While a kinship placement, for example, may be the safest placement option abuse may still occur. Factors such as pressure from family members to make contact with a child and the implications of unauthorised or problematic contact mean that kinship placements can present risk. Further as noted by the Victorian Ombudsman, kinship placements generally have less rigorous monitoring and supervision than other placements, and this has implications for the likelihood of harm or risk of harm being identified and reported. In examining cases where sexual abuse had occurred in a kinship placement, the Ombudsman cited examples where screening of kinship carers had been inadequate or absent. A commitment to properly support and resource kinship placements should form part of the improvements to children's safety in OOHC.

Foster care placements are unlikely to share the same positive protective factor of attachment that a strong kinship placement will exhibit. Carer suitability assessments aim to partially counter this. There is better recognition within the OOHC system of the need to support and resource these placements compared to kinship placements.

A lack of attachment between carers/staff and children is most pronounced in residential care and strategies to minimise risk in this setting must address these implications, as well as the typically more challenging behaviour exhibited by children in residential care. Key strategies that agencies could employ in residential care include:

- Supervision by a House Manager who rotates around different shifts to observe each residential care worker's interactions with children.
- Clinician involvement in supervision and encouragement of reflective practice.
- Clear and explicit statements about the house "culture" – safety, respect for privacy, no hitting, no bullying, etc.
- House meetings where young people can raise issues and contribute to house rules.
- Staff training.
- Community Visitors.
- Minimum staffing levels.

The Victorian Ombudsman's report discussed the necessity of vigilant supervision of care as a core strategy for addressing the risk of abuse presented by carers. Citing a case of a residential care worker who sexually abused a child in their care, the Ombudsman noted that concerns were raised by other staff including observation of a lack of professional boundaries between the child and the care worker. Examples such as this illustrate the importance of having appropriate mechanisms for staff supervision in place; explicit codes of conduct; information for children on what constitutes unacceptable behaviour by staff and how they can voice concerns; and a strong culture that encourages and supports staff to report inappropriate behaviour.

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

As highlighted in Question 1, an internal and external audit mechanism (combined with reliable data reports) is a reasonable and effective approach. This is strengthened when the comprehensive audit mechanism triangulates the evidence through examination of policy documents, systems in practice and staff awareness.

Caution should be exercised around visits by 'strangers' to the children. Visits are unlikely to be frequent enough for a child to develop a trusting relationship and there is tension around telling carers you want them to act in loco parentis and then having people frequently visiting.

The recent Queensland Child Protection Commission of Inquiry for example recommended reducing the ambit of the current Community Visitor program in favour of directing resources to "ensuring regular contact and support for children and young people to reach their case-plan goals rather than on external monitoring of Child Safety practices" (p. 415).

Evidence of good carer assessment and having strong positive indicators like the 'openness' of carers, and children being well connected to other systems such as schools and recreation are of key importance when evaluating OOHC practices. Regardless of what model is employed, an important consideration is avoiding an emphasis on 'checking' at the expense of 'doing', including having an audit/supervisory program that takes finite resources away from frontline services.

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

Life Without Barriers supports having an independent regulator, as is the case in NSW. A key strength of this approach is that all OOHC placements, both government and non-government are independently regulated. This approach needs to be designed to avoid placing the regulator and funder at cross-purposes where the resulting compliance burden is greater than the funding allows for.

Life Without Barriers believes that an effective regulatory system focuses on understanding and accrediting the systems that agencies have in place and encouraging agencies to strive for best practice (this point is explored further in the response to Question 9).

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

When considering the priority that training around child sexual abuse should be given in relation to other training needs, it is important to appreciate the broader context of sexual abuse. People working with children therefore need firstly to develop an understanding of children and children's development, and from this to develop an understanding of trauma and then to understand sexual assault. In turn this requires the person to have an understanding of themselves; their attitudes towards, and beliefs about, children; the extent to which they believe the 'myths' surrounding sexual abuse; and importantly a capacity to regulate their own emotional response to trauma and abuse.

Anyone working in child sexual abuse should undertake and complete basic training which covers some of the above content. Examples of such training are the 4 day interagency workshop developed and widely implemented by the NSW Child Protection Council as part of NSW's response to the Premiers Taskforce on Child Sexual Assault in the late 1980's.

A key aspect for carer training is on understanding and responding to behaviour that has a trauma base. Carers need to be versed in using the environment a child is in as a therapeutic environment. Training of carers should encompass how to recognise the therapeutic opportunities that exist in the day-to-day interactions that we have with children and young people, and how to craft day-to-day interactions that provide the opportunity to be therapeutic.

Caseworkers should receive training in recovery approaches and how to facilitate the recovery of a child who has been abused. Another important aspect for caseworkers is how to support carers who are caring for traumatised children. Caseworkers must also be fluent in systems including the statutory child protection system, the court system, and associated processes such as children appearing as witnesses. Undertaking training with other agencies facilitates this systems understanding and helps build relationships across agencies.

Training that helps staff of regulatory bodies to better understand the reality of working with children and young people who have been sexually abused would contribute to more realistic expectations of what is possible to achieve with children in OOHC. For example, it is the exception for a young person to agree to counselling or therapy as part of their recovery from sexual abuse - the challenge for a regulator is to acknowledge what is possible , and for this to be

better reflected in recommendations, for example requiring a young person to see a counsellor, or go into therapy.

Regulators need to also be fluent in understanding the way in which the system operates, and the ways in which change can be implemented within the system. Recommendations regarding systems changes should be more closely grounded in evidence, consistent with the expectation that practitioners should be evidence informed in their work. Regulators also need to understand the science of implementation – with greater emphasis placed on training that enhances the capacity of regulatory staff to draw on this aspect when making recommendations or assessing practice.

While training is a key mechanism for learning and developing practice, it is important that it sits alongside a suite of other mechanisms such as working with more experienced practitioners, supervision, mentoring and engaging with current research.

Importantly there is an opportunity to explore how we can create career paths within the sector that provide greater encouragement and rewards for people to continue in practice roles. Encouraging skilled practitioners to remain in frontline roles rather than take up management roles has important implications for the capacity of agencies to respond to complex cases including child sexual abuse and to be able to provide mentoring and training to other staff. Strategies to encourage talented practitioners to stay in the field include the creation of senior practitioner roles, sabbaticals, and support for postgraduate study that is subsequently reflected in pay scales.

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

Children who engage in sexual offending behaviours should be placed with specialised professional carers who can assist them to manage their behaviour now and into the future. By definition, these specialised carers should receive a higher level of training and be subjected to a more rigorous selection process based on attitudes and values, and enhanced levels of supervision and support from the agency. They will effectively be employees rather than 'volunteer' carers who receive an allowance. This is currently not the situation as there is no provision for professional carers in the OOHC system.

There is a level to which sexualised child behaviours will be an expression of past trauma and accordingly all carers should be skilled in understanding and managing trauma and its outward expression. As such it should form part of the training to carers outlined in Question 5. Such material should provide carers with a basic understanding of some of the factors linked to the development of problematic and abusive sexual behaviour in children, the impact of those factors on children, and strategies for responding to sexualised behaviour. This can assist carers to know when to escalate the issue so those children whose sexualised behaviour is becoming entrenched, can receive more specialised help and placements can be more appropriately designed.

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

Life Without Barriers is not able to comment on the technical aspects of measurement, however to make any data meaningful it would be important that it be tracked over time or against the rate in other settings. Other data that could be revealing would be differences that may exist across types of OOHC, or vulnerabilities of particular age groups in OOHC.

Life Without Barriers does not support the proposition of using a form of exit interview for the purpose of capturing information on sexual abuse. Firstly, an exit interview is inconsistent with the way young people typically disclose information of this nature – children rarely make a first disclosure in a one off interview. Disclosure is a process that builds over time and is made to someone the child trusts. If the exit interview was conducted by someone the child did have a trusting relationship with, it could reasonably be assumed that any intention of disclosing abuse would most likely already have been acted upon.

Secondly, the proposition of an exit interview does not reflect the true nature of exiting care for all children. For some children their exit from care can be quite abrupt, others will continue to live with their carer. As such there isn't a universally consistent point of exit at which to conduct an exit interview.

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

The process through which allegations against carers are addressed differs across jurisdictions. Regardless of the relative merits of each approach, what is important is that all allegations are subject to robust and transparent investigations conducted by adequately skilled people. Findings from investigations are an important source of information for future carer assessment, and as such a key aspect of the investigations process is the reliable and central recording of findings. A key aspect of procedural fairness is carers having the opportunity to appeal findings with the investigating body.

Effective approaches to seeking disclosure of abuse from a child, generally require the capacity and the time to form a relationship with the child. As acknowledged in response to previous questions, disclosure is a process that develops over time rather than a one-off event, and as such a child will respond more effectively if there is time to build a relationship of trust. The person who is seeking the disclosure needs to be skilled in interviewing children, and would for example know how to avoid asking leading questions; how to invite the child to tell a story in narrative form; and to possess a range of age and developmental appropriate techniques. Approaches to seeking a disclosure from a child with a disability may require additional resources and skills.

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

Life Without Barriers unequivocally supports independent oversight of such a critical function - such as performed by the Ombudsman in NSW - and believes that it enhances the safety of children and young people in OOHC. This is particularly important in the context of the transfer of OOHC to the NGO sector in NSW and the varying capability and capacity of agencies to be able to investigate allegations in-house.

While there may not be an evidence base to support whether independent oversight contributes to the safety of children in OOHC, it should be noted that the Ombudsman's processes promote appropriate handling of allegations. Subjective measures such as interviews that explore practitioners', carers', children's views on the role of the Ombudsman in protecting the safety of children may yield useful qualitative data. Another qualitative mechanism would be to track beliefs around the effectiveness of independent oversight via a key informant study of a range of people who have experience of the system pre and post introduction of the Ombudsman in NSW.

It is also worthwhile considering that organisations and individuals who participated in a recent review into the Tasmanian child protection system raised the absence of independent oversight as a matter of concern. Submissions provided to Parliament of Tasmania's Select Committee on Child Protection (Parliament of Tasmania, 2011) identified the perception that "there is a lack of independent complaints mechanisms available" (p.72).

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

An essential attribute of any effective oversight mechanisms is to incentivise organisations to reach the highest standard they can, rather than focusing on the singular outcome of all organisations passing a minimum standard. A key aspect of this approach is fostering the capacity of organisations to be able to self-regulate and self correct, and be subjected to less oversight if they are performing well. As such it is important to have a responsive oversight mechanism that has the capacity to pull back where an organisation demonstrates good practices and robust internal systems, and ramp up in response to an organisation that may not be performing well in its management of risk. This approach can be seen, for instance, in the various levels of accreditation that the Child Guardian assigns to OOHC providers in NSW. Where an organisation is able to demonstrate sufficiently robust internal systems and capacity to manage risk, longer accreditation is granted.

It is also important that oversight mechanisms don't pull in different directions. It is confusing and difficult when agencies are being asked to implement contradictory recommendations or recommendations with conflicting objectives.

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

An implication where some or all of the records from the time an alleged offence occurred have not been kept, would be the lack of evidence to assist investigation of the abuse. Critical information for example could consist of time sheets or rostering charts that might corroborate an alleged offender's whereabouts at the time an alleged incident occurred. As such it is important to understand what records may be material to investigating allegations, and for this to be reflected in the legislation that governs record keeping. This could be assisted by a project to review existing investigations to identify which records have proved most useful in substantiating or not, the allegation.

Thank you again for the opportunity to provide feedback to the Royal Commission's fourth Issues Paper, *Preventing sexual abuse of children in out of home care.*

For any questions regarding this submission, please contact Andy Kilgour on 0428 419 250 or andy.kilgour@lwb.org.au

Sincerely,

Claire Robbs
Chief Executive
Life Without Barriers

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