ROYAL COMMISSION INTO INSTITUTIONAL RESPONSES TO CHILD SEXUAL ABUSE

NEW SOUTH WALES OFFICE OF THE CHILDREN'S GUARDIAN SUBMISSION IN RESPONSE TO ISSUES PAPER 4

PREVENTING SEXUAL ABUSE OF CHILDREN IN OUT-OF-HOME CARE

Introduction

The Office of the Children's Guardian welcomes the Royal Commission's consideration of this critical issue.

Child sexual abuse most commonly occurs in the child's residence and is committed by a person known to the child. This is also true of the abuse of children and young people in out-of-home care (OOHC).

Children and young people in OOHC have often had difficult and traumatic lives and been subject to sexual, physical or emotional abuse and/or neglect within their family. This means they may be more vulnerable to sexual assault or exploitation in other settings, including OOHC.

The opportunistic nature of most child sexual assaults means risks in this area need to be proactively managed by all persons and agencies who play a role in the child or young person's life.

This paper addresses a range of strategies and issues relevant to preventing sexual abuse in OOHC, but particularly focuses on some areas in which the Children's Guardian has a role.

The NSW Children's Guardian and Office of the Children's Guardian

The Children's Guardian is established under the NSW *Children and Young Persons (Care and Protection) Act 1998* (the Care Act) as a statutory office that reports directly to the Minister for Family and Community Services and to Parliament.

On 17 May 2013, the Office of the Children's Guardian was established as a separate Division of the Government Service. The Office of the Children's Guardian, which supports the Children's Guardian in the exercise of her functions, is independent of the Department of Family and Community Services (FACS), but is located in the Family and Community Services cluster for administrative purposes. Prior to this, the Children's Guardian was supported by staff employed by the NSW Department of Education and Communities.

As this paper refers to a number of matters that occurred prior to the establishment of OCG, the term “Children’s Guardian” is used to refer to both the officeholder and the staff employed to support that office.

The Children’s Guardian’s role in OOHC is discussed throughout this paper, but the following outlines the Children’s Guardian’s key OOHC functions.

Functions prior to 15 June 2013

The Children’s Guardian’s principal OOHC functions under the Care Act, prior to 15 June 2013, were:

- to promote the best interests of children and young people in out-of-home care (s181);

- to ensure that the rights of all children and young people in out-of-home care are safeguarded and promoted (s181);

- to accredit and monitor the government and non-government designated agencies that arrange statutory out-of-home care (supported care must also be arranged by designated agencies) (s181);

- to register and monitor agencies that provide or arrange voluntary out-of-home care (i.e. care arranged by a parent, which primarily involves care provided to children and young people with disabilities) (s181);

- to develop statutory guidelines for the review of statutory care placements and the disclosure of statutory care placement information to parents and significant others (s150(4) and s149D).

The Children’s Guardian is also responsible for developing criteria for the accreditation of designated agencies for the approval of the Minister for Family and Community Services, in accordance with clause 48 of the *Children and Young Persons (Care and Protection) Regulation 2012* (the Care Regulation). The accreditation criteria are the *NSW Standards for Statutory Out-of-Home Care*, which include a number of standards directed at preventing child abuse in OOHC. The benefits of a standards based accreditation system for improving designated agency practices in preventing child sex abuse in OOHC is addressed in the response to question one of the Issues Paper.

While the Children’s Guardian primarily focuses on the policies, procedures and practices of the designated agencies that arrange the provision of OOHC in NSW, it also plays a positive role in individual care arrangements. It:

- approves and monitors statutory care residential placements for children under 12;

- monitors placements with non-designated agency special care providers; and

- identifies concerns about individual placements through its accreditation and monitoring functions and requests designated agencies to address those concerns, with more serious or systemic concerns also brought to the attention of FACS and the Ombudsman.

Section 180 of the Care Act excludes the Children's Guardian from investigating child deaths, these being functions of the coroner and Ombudsman, and investigating or resolving OOHC disputes that are subject to community services complaints under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA), these being functions of the Ombudsman. The Children's Guardian and Ombudsman have distinct but complimentary regulatory roles in respect to OOHC, as acknowledged by the 2008 *Special Commission of Inquiry into Child Protection Services in New South Wales* (the Special Commission), and work cooperatively in exercising their respective functions.

Additional functions from 15 June 2013

The *Child Protection Legislation Amendment (Children's Guardian) Act 2013* (the Children's Guardian Act) provided for the Children's Guardian exercising the following functions that are also relevant to the protection of children in OOHC:

- to establish and maintain a register for the purpose of the authorisation of individuals as authorised carers (addressed in the response to question one of the Issues Paper);

- to exercise functions relating to persons engaged in child-related work, including working with children check clearances, under the Child Protection (Working with Children) Act 2012 (the WWC Act) – function previously exercised by the Commission for Children and Young People (CCYP); and

- to encourage organisations to develop their capacity to be safe for children – function previously exercised by CCYP (this paper does not address this function, as the Royal Commission has released a separate Issues Paper on Child Safe Organisations).

The Children's Guardian Act also provided for the Children's Guardian exercising the following functions:

- authorising the employment of children under the age of 15, and child models under the age of 16, in prescribed types of employment (the Children's Guardian had been exercising these functions under the delegation of the Minister for Family and Community Services and Director-General of DoCS/FACS since 2003);

- developing and administering a voluntary accreditation scheme for persons working with persons who have committed sexual offences against children - function previously exercised by CCYP;

- developing and administering a voluntary accreditation scheme for programs for persons who have committed sexual offences against children - function previously exercised by CCYP.

The *Child Protection Legislation Amendment Bill 2013* (the 2013 Bill), introduced into Parliament in November 2013, provides for the Children's Guardian accrediting non-government adoption service providers, a function that it has exercised under delegation from the Director-General since 2005. The Bill also provides for the Children's Guardian monitoring FACS's provision of adoption services and developing adoption accreditation criteria, which are to be integrated to the greatest extent possible with OOHC accreditation criteria.

The Children's Guardian Act and 2013 Bill group like regulatory functions within a single body, where previously those functions were exercised by four bodies. This will allow the Children's Guardian to integrate the child safe organisation and Working With Children Check programs with its OOHC accreditation and monitoring programs, which should enhance child safety in NSW OOHC.

The remainder of this paper responds to the questions asked in the Royal Commission's Issues Paper.

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

In New South Wales, OOHC is arranged by designated agencies and provided by authorised carers (most carers are authorised by designated agencies, but some may be authorised by way of Family Court order or in accordance with certain supported care arrangements). In residential care, which comprises less than 3% of OOHC in NSW, designated agency employees care for children and young people.

Most state regulation of OOHC in NSW focuses on designated agencies, which arrange and supervise the provision of care. Designated agencies are therefore critical players in the regulation of the quality of OOHC in NSW and in developing cultures and systems that minimise the risk of sexual abuse in OOHC.

Strategies for keeping children in OOHC safe from sexual abuse

The following strategies contribute to minimising the risk of sexual abuse in OOHC.

Accreditation of OOHC agencies against standards

This paper discusses accreditation first, not because it is the most important strategy, but because it is one of the strategies that NSW uses to improve the quality of designated agency OOHC services. The Statutory OOHC Accreditation Program improves the ability of designated agencies to protect children and young people in care supervised by those agencies.

The Accreditation Program is the Children's Guardian's principal means of promoting and safeguarding the best interests and rights of children and young people in OOHC.

Accreditation is a structured means of providing recognition of an organisation's performance against relevant standards. While accreditation was originally developed for quality assurance purposes, it is increasingly being used as a driver to promote continuous improvement in the delivery of human services.

While accreditation is commonly used in Australia in respect of health, aged care and child care services, NSW is the only jurisdiction that has established an OOHC accreditation system, with the accreditation framework developed having regard to a number of OOHC accreditation models operating in Canada and the USA.

Organisations are required to apply to the Children's Guardian for accreditation to arrange the provision of residential care, foster care (including relative and kinship care), or both. Accreditation operates as a licence to arrange the provision of OOHC in NSW, as is the case in a number of Canadian provinces. The Children's Guardian also has a number of other powers common to licensing bodies, including powers to

impose, vary and revoke conditions of operation, and to remove or suspend an organisation from the OOHC sector.

All non-government designated agencies have been either provisionally or fully accredited by the Children's Guardian. Several Community Services units have been fully accredited, with the remainder of Community Services having interim accreditation in accordance with the *Children and Young Persons (Savings and Transitional) Regulation 2000.* Community Services is participating in an Accreditation Program that is designed to progress Community Services to full accreditation by 31 July 2015.

The Minister for Family and Community Services, upon the recommendation of the Children's Guardian, is responsible for approving accreditation criteria. The Minister has approved the *NSW Standards for Statutory Out-of-Home Care* as the criteria for accreditation. Those Standards, which are annexed to this submission, were developed by, and have been updated in consultation with, the OOHC sector and experts in standards design.

The NSW Standards are consistent with NSW care and protection legislation and broadly align with, but are more comprehensive than, the *National Standards for Out-of-Home Care*. The Children's Guardian contributed to the development of the National Standards which, although not developed for accreditation purposes, are designed to drive improvements in the quality of care and provide a framework for performance reporting.

The NSW Standards contain a number of standards and assessment criteria that promote designated agencies establishing and maintaining policies, procedures and practices to help protect children and young people in OOHC from child sexual abuse, in particular:

- Standard 3 – Child Protection – Objective: Children and young people are safe and protected from harm – Standard: Children and young people's wellbeing is actively safeguarded – all assessment criteria.

- Standard 2 – Building a Positive Care Environment – Objective: Children and young people receive appropriate care relevant to their circumstances – Standard: Children and young people are cared for in safe, nurturing environments which are tailored to their specific needs – assessment criteria 3 and 7.

- Standard 12 – Case Planning and Review – Objective: Children and young people have stable placements that meet their changing needs – Standard: Case planning supports stable placements that are responsive to the needs of children and young people – all assessment criteria.

- Standard 13 – Case Work and Monitoring Placements – Objective: Children and young people have stable placements that meet their changing needs – Standard: Children and young people are monitored and supported in their placements – assessment criteria 1, 2, 3 and 6.

- Standard 6 – Participation in decision making – Objective: Children and young people contribute to decisions relating to their lives – Standard: Children and young people are included in decision making processes – in particular assessment criterion 5.

- Standard 7 – Confidentiality and Privacy – Objective: The right to privacy and confidentiality underpins the organisation's practices – Standard: Privacy and confidentiality is maintained for each child, young person and their family – assessment criterion 4.

- Standard 17 – Assessment and Selection – Objective: Children and young people are cared for by skilled and caring adults – Standard: Appropriately skilled and experienced carers and staff are selected through fair and consistent processes – assessment criterion 4.

- Standard 18 – Training and Development – Objective: Children and young people are cared for by skilled and caring adults – Standard: Carers and staff have appropriate training for their role and are provided with opportunities for further professional development – assessment criteria generally, as child protection training is a key element of promoting child safety in OOHC.

- Standard 19 – Supervision and Support – Objective: Children and young people are cared for by skilled and caring adults – Standard: Carers and staff have supervision and support which is useful and timely to facilitate better outcomes for children and young people – all accreditation criteria.

- Standard 20 – Record keeping, Privacy, Confidentiality and Complaints for Carers and Staff – Objective: Management processes for carers and staff are accountable and fair – Standard: Record keeping systems in relation to carers and staff are thorough, confidential and reflect due process and procedural fairness – accreditation criteria 1, 2, 6, 7 and 8.

- Standard 21 – Governance – Objective: Organisations operate legally and ethically and in the best interests of their clients, staff and carers – Standard: The agency establishes and maintains a governing authority or committee with policies, systems and procedures that demonstrate accountability and good governance – accreditation criteria 3 and 4.

- Standard 22 – Strategic Planning and Evaluation Processes – Objective: Organisations strive to provide the best possible service to their clients – Standard: The governing authority maintains planning, evaluation and continuous improvement processes – all accreditation criteria.

The NSW accreditation system is sometimes incorrectly referred to as a "point in time" checking system. That is not the case.

As agencies cannot arrange the provision of OOHC until they are accredited, the Children's Guardian provisionally accredits agencies on the basis of their policies and procedures. Provisional accreditation is granted for three years and, after an agency receives its first OOHC placement, its practice is assessed over the course

of that provisional accreditation. This involves an average of nine assessment visits by Children's Guardian staff, where practice is assessed and feedback is given.

A provisionally accredited agency that moves to full accreditation may be accredited for 3 years. A fully accredited agency may be reaccredited for a period of five years. The Children's Guardian continues to have a monitoring role while an accreditation is in force and may conduct a number of visits during the course of an accreditation (monitoring is discussed in more detail in response to question three).

The accreditation process and the feedback the Children's Guardian provides to designated agencies through its accreditation and monitoring programs, is used by designated agencies to improve their OOHC policies, procedures and practices in child protection and other areas.

Accreditation focuses on the policies, procedures and practices of an agency – it looks at agency systems. It does not focus on the care provided to each child or young person placed with an agency, although Children's Guardian assessors consider agency practice in respect of individual cases in assessing agency systems. Feedback on these individual cases is provided and used by agencies to improve OOHC services for those children and young people.

In 2000, PriceWaterhouseCoopers prepared a Regulatory Impact Statement to the draft *Children and Young Persons (Care and Protection) Regulation 2000,* which concluded that a mandatory accreditation regime had the following benefits:

- ensuring a minimum and consistent level of quality care is provided to children and young people;
- the provision of a benchmark from which service providers may refer;
- a process which is transparent; and
- enforceability via legislation.

OOHC agencies were asked about the strengths and weaknesses of the Accreditation Program in a 2007 Questionnaire, as part of a broader review of the Program.

The Questionnaire responses showed that approximately 40% of OOHC agencies had no internal programs for reviewing their policies, procedures and practices before the Program was established. Agency responses to the Questionnaire also supported findings that the Program had resulted in:

- more child-focussed policies, procedures and practices;
- agencies developing their own internal quality assurance/improvement programs, supported by self-monitoring;
- greater consistency of practice across agency programs;
- improved agency documentation and systems;

- improved and more highly structured agency case management and casework;
- improved agency understanding of the reasons why certain documentation is needed to support quality practice;
- increased participation of children, young people and their families in OOHC decision making;
- increased attention being given to support services for children and young people;
- improvements to behaviour management and leaving care arrangements; and
- improved staff/carer training and development.

While the review found that the OOHC sector generally viewed accreditation positively, it also identified a number of weaknesses in the Accreditation Program.

The Accreditation Program originally had a pass-fail compliance, rather than strengths-based, focus. This focused agencies on processes, rather than outcomes, and had the potential to promote ritualistic compliance, rather than agency innovation and continuous improvement. As a result of the review, the Standards were amended to reduce duplication and to focus more on outcomes. The accreditation system was updated to encourage agencies to reflect on those outcomes and demonstrate their strategies for achieving them.

The review also resulted in a move away from paper-based desk-assessments, to Children's Guardian staff visiting agencies, talking to staff and carers, and conducting onsite inspections.

These reforms were endorsed by the Special Commission and supported by those agencies applying for reaccreditation under the reformed accreditation system.

Accreditation systems are sometimes criticised for being resource intensive, but this is not the case where an agency delivers services in accordance with the required standards. The NSW OOHC Standards reflect statutory requirements and policy requirements determined by government. The costs associated with delivering services to a standard required by Parliament and the government should not be regarded as the costs of accreditation. In assessing the costs of an accreditation system, consideration also needs to be given to assessing the costs and effectiveness of alternative quality assurance and improvement systems.

Accreditation systems run the risk of being static and entrenching the status quo, once a certain standard has been achieved. Standards need to be updated as legislation and policy settings change and to reflect research findings. Continuous improvement principles should also be built into accreditation standards and agency governance systems to ensure that accreditation does not operate to limit ongoing service improvement. One of the outcomes of the 2007 review of the Accreditation Program was embedding requirements for strategic planning and evaluation

processes, within a continuous improvement framework, within the NSW Standards (Standard 22).

The Children's Guardian recruits accreditation staff with a mix of OOHC and assessment experience and adjusts its assessments on the basis of changes to policy and the advice of experts. The Standards have been updated on a number of occasions and will be further reviewed in light of the introduction of the *Child Protection Legislation Amendment Bill 2013*, which provides a welcome opportunity to strengthen standards around permanency and to integrate OOHC and adoption standards and accreditation frameworks.

Monitoring OOHC practices

The monitoring of carers and designated agencies is critical to preventing, detecting and responding to abuse in OOHC. Monitoring OOHC practices through the Children's Guardian's Accreditation Program is discussed above. Other monitoring arrangements are discussed in response to question three of the Issues Paper.

Strong governance and a culture of not tolerating abuse in any form

Designated agencies that have weak governance and that place their public reputation above the rights of children cannot effectively protect children and young people in OOHC.

It is critical that the boards or other governing bodies of designated agencies build an organisational culture that does not tolerate abuse in any form. Governing bodies need to actively oversight child protection systems, put in place Codes of Conduct that clearly articulate acceptable behaviour by carers and workers (see also the NSW Ministerial Code of Conduct for Authorised Foster, Relative and Kinship Carers), provide staff and carers with child protection training and support, establish accessible and transparent complaints systems, and establish carer/employee management systems that respond promptly to allegations of child abuse.

The NSW Standards recognise the importance of strong governance and an organisational culture that puts children and their protection first – in particular, see Standards 21, 22 and 3.

Promoting the rights of, and listening to, children and young people in OOHC

The *Charter of Rights for Children and Young People in Out-of-Home Care in NSW*, provided for under s162 of the Care Act, is provided to all children and young people over the age of six when they enter statutory care. It is provided in two age-appropriate comic book formats.

The Charter recognises the rights of children and young people in OOHC to be treated fairly, treated with respect, and to feel safe and not be abused. It also recognises the rights of children and young people in OOHC to complain, to take part in important decisions about their lives, to make choices about every day matters, and to say what they are thinking and feeling.

It is critical that children and young people in OOHC are made aware of their rights to safety and to speak out if those rights are violated. Designated agencies must develop a culture which empowers children and young people in OOHC and is responsive to their concerns.

Designated agencies and authorised carers have an obligation to uphold the rights outlined in the Charter. The Children's Guardian, through its accreditation and monitoring programs, assesses how these rights are promulgated, upheld and supported in OOHC (see NSW Standard 1).

One of the key principles that underpins the Care Act is that children and young people should be given an opportunity to express their views and those views should be taken into account when making significant decisions that affect them (see sections 10 and 9(b)). The Children's Guardian assesses how children are supported to participate in decision making (see NSW Standard 6), with the accreditation criteria for that Standard also focusing on how children are able to raise concerns, make complaints and have issues resolved in a timely manner. Standards 3, 7 and 12 are also relevant.

It is important that children have a relationship with a trusted adult who they can talk to about their care. This will generally be an authorised carer, but if there is abuse occurring within a household then they will need to be able to talk to a trusted caseworker. Caseworkers should have conversations with children in care that do not involve others who live with them.

Child centred practice

The key principle that underpins the Care Act is that "in any action or decision concerning a particular child or young person, the safety, welfare and well-being of the child or young person are paramount" (section 9(1)).

This principle can only be given effect if the child or young person is at the centre of decision-making. That means that agency systems and processes, including case management, need to be built around desired outcomes for children and young people.

The original NSW Standards were too process, rather than outcomes, focussed. The current Standards have encouraged agencies to place the child at the centre of their practices.

The strengths-based approach of the Accreditation Program encourages agency innovation in pursuing key outcomes for children and young people. Practice First, the OOHC case management model now being implemented by FACS, is also a strengths-based model that should increase the protection of children and young people in OOHC.

Placing children's needs at the centre of decision making informs all the NSW Standards, with Standards 3, 6, 12, 13, 21 and 22 of particular importance to providing for child centred practice.

Rigorous assessment and review of carers and their households

The Care Regulation provides that a designated agency cannot authorise a person as a carer unless the agency has determined that the person is suitable to be a carer.

A designated agency must be satisfied that the person has successfully completed the carer training required by the agency (carer training is addressed in response to Questions 5 and 6 of the Issues Paper). A designated agency must also estimate the risk to any child or young person in authorising the individual as a carer, including any risk arising from the particular place at which the authorised carer will be providing OOHC (this involves a home inspection) and the risk that the individual may be unable to properly perform the functions of an authorised carer.

However, the only legislatively required probity checks for NSW carers are Working With Children Checks (WWCCs), with other probity assessments, including national criminal record checks, left to designated agency discretion. Most designated agencies conduct national criminal record checks in addition to WWCCs, as this enables them to obtain and consider a person's criminal record (not including spent convictions) in the context of an authorised carer's duties and, in the case of relative or kinship care, a particular placement arrangement. Designated agencies do not receive such information from a Working With Children Check – they just receive information that the person is or is not cleared for child-related work. Beyond this, carer assessment arrangements vary considerably across agencies.

The Care Regulation also provides that a designated agency may, for the purpose of determining whether a person is suitable to be an authorised carer, make such inquiries as to individuals aged 14 years and above in the prospective carer's household, including a criminal record check and any other relevant probity check relating to the previous employment or other activities of such individuals.

Adult household members of authorised carers must have a WWCC clearance, or a current application for such a clearance, but, other than this, probity assessments of carer household members vary across the sector.

The government is currently developing a more comprehensive assessment framework for carers and their household members (aged 16 years and above), which will set minimum assessment requirements that will be consistently applied across all designated agencies.

The assessment framework is likely to provide additional protection to children and young people in relative/kin care. Probity and other assessments of relative/kin have historically not been as thorough as those for foster carers. The assessment framework will still enable emergency placements with relative or kin, but will provide that relative/kin carers and their household members must undergo the same level of assessment as foster carers in order to be fully authorised.

This is consistent with NSW having extended child-related prohibited employment arrangements to relative and kin carers under the WWC Act, which commenced on 15 June 2013. Prior to this, a person who was prohibited from working with children

under the *Commission for Children and Young People Act 1998* (CCYP Act) could still be authorised as a relative/kin carer.

The new assessment framework will be reflected in the NSW Carers Register, which is currently being developed by the Children's Guardian and is anticipated to be operational by July 2014.

The Carers Register will be a centralised register of:

(a) persons who are emergency or fully authorised by designated agencies, or who have applied for authorisation, to provide statutory or supported OOHC; and

(b) their household members (excluding children and young people in OOHC).

A carer will not be able to be fully authorised until a designated agency certifies on the Register that all required carer, household member and household assessments have been completed. The Register will also contain details of WWCC applications/clearances and alert agencies in advance of WWCCs needing to be applied for (in the case of household members under the age of 18) or renewed.

The Register will record the outcomes of carer applications and the surrendering, suspension, cancellation and cessation of authorisations, as well as the outcomes of internal or Administrative Decisions Tribunal (ADT) reviews in these areas. The Register will also flag the existence of in progress reportable allegation investigations, and relevant finalised investigations (discussed further below).

The Carers Register will be maintained and administered by the Children's Guardian, which will be responsible for monitoring designated agency compliance with carer and household member assessment requirements.

The government will provide the Royal Commission with further information on the carer and household member assessment framework and the Carers Register after the government has had the opportunity to consider their final design.

Designated agencies should regularly conduct reviews of carers. Reviews should be conducted when major changes affect a carer's household. A new person residing in the household should trigger such a review and the Carers Register will ensure that persons who join a household during the course of an authorisation are subject to required probity checks.

NSW Standards 17, 2, 12 and 13 are of particular relevance of carer and household assessment and the review of care arrangements. Standards in this area will need to be updated following the introduction of the Carers Register.

Placement assessment

It is important that the needs of individual children and young people are considered in placing them in a particular care setting (see NSW Standards 2 and 11).

There may be particular placement settings where a child may be more vulnerable to abuse or may pose an abuse risk to other children. It is important not to ignore the risk of peer abuse, or to characterise all sexual contact between children and young people in OOHC as "normal sexual experimentation". There is extensive research that shows children and young people in OOHC have higher rates of sexualised behaviour than children in the general population. There are risks in placing children with sexualised behaviour in placements with other children, particularly younger children or children with particular vulnerabilities.

NSW Standards 2 and 11 are of particular relevance to placement assessment.

Active, engaged and supportive caseworkers

Children and young people in OOHC need positive and consistent relationships with caseworkers (and, in residential care, care staff). Caseworkers are key to identifying and managing any risks that may be present in an OOHC placement. Caseworkers should see children and young people in care on a regular basis and discuss safety issues with them and their carers. A strong caseworker-child relationship may reduce the risk of a child being a victim of abuse in care and increase the likelihood of a child disclosing abuse or behaviour that makes them feel uncomfortable.

In NSW, children and young people whose care is supervised by a non-government designated agency have greater caseworker support than children and young people whose care is supervised by FACS. This is evidenced in the Children's Guardian's Case File Audits and was acknowledged by the then Department of Community Services (DoCS) in evidence given to the Special Commission, and in the Special Commission's findings.

The NSW government policy of transferring children and young people in OOHC into care supervised by NGOs is strongly supported by the Children's Guardian. It will encourage greater and more consistent caseworker support and strengthen relationships between children and their caseworkers.

NSW Standards 12 and 13 are of particular relevance to case planning and review, case work and monitoring placements.

Connection with peers and community

Children and young people are more likely to be victims of abuse where they are isolated from their broader community and do not have relationships with trusted people who can support them. Children and young people will more successfully build these supports if they are in stable placements.

A number of the NSW Standards focus on building connections between children and young people and others in the community – see Standards 4, 5, 8 and 10.

School is often the place where children and young people develop key relationships and the NSW Ombudsman's report on *Responding to Child Sexual Assault in Aboriginal Communities* noted links between school non-attendance and child sexual abuse rates.

The NSW Department of Education and Communities employs ten OOHC Education Coordinators, who assist in coordinating educational supports for children and young people in OOHC.

Providing an environment where children and young people are encouraged to develop a broad range of peer and community supports is critical to building resilience and minimising the risk of abuse.

Staff and carer training and support

This is addressed in response to questions five and six of the Issues Paper.

Responding to allegations of abuse and other misconduct

Allegations that do not involve sexual abuse may indicate a risk of future abuse – for example, allegations involving grooming behaviour, exhibitionism or inappropriate touching. It is important that these allegations, as well as allegations of abuse, are able to be made confidentially and promptly investigated to reduce the risk of misconduct escalating to sexual abuse.

Children and young people, carers and agency staff need to be made aware of the avenues available for reporting abuse and other misconduct, including through formal agency complaints systems.

The NSW Standards address responding to allegations of abuse and other incidents, and providing an environment conducive to allegations being made, at Standards 3, 2, 6, 7, 5, 20 and 19.

Monitoring of placements is important following allegations of sexual abuse or misconduct in circumstances where the alleged perpetrator is a friend or family member of the carer. Carers may not be protective for a range of reasons, including not believing the allegation, being complicit in the abuse or misconduct, or having themselves been a victim of grooming by the perpetrator.

Allegations of abuse or other inappropriate conduct need to be taken seriously, with protective action a priority. The best interests of a child may require a child to be removed from a placement before an allegation is investigated.

All allegations of sexual abuse and sexual misconduct in OOHC should be reported to Police and, in NSW, to the NSW Child Protection Helpline within FACS. Agencies are also required to notify the NSW Ombudsman of reportable allegations involving agency staff or carers. Findings that an employee, carer or adult household member of a carer engaged in sexual misconduct against, with or in the presence of a child or young person in OOHC, including grooming, must be reported to the Children's Guardian for Working With Children Check purposes.

It is often difficult for smaller agencies to conduct an investigation into serious allegations involving staff or carers and to coordinate this investigation with any criminal and/or child protection investigations being conducted by police and child

protection authorities. Agencies must also understand the different standards of proof that apply in criminal and administrative investigations.

In NSW, the Ombudsman's Office oversights designated agency complaints systems and responses to allegations of sexual abuse and other reportable conduct in OOHC. The Ombudsman's Office is able to offer guidance and assistance to agencies during investigations and to help them navigate the complexities of concurrent criminal and administrative investigations. The Ombudsman may also make recommendations on investigation findings. The Ombudsman's independent oversight of complaints and investigations is a critical element of the NSW child protection framework.

One weakness of the NSW system is that most agencies do not deal with allegations against adult household members of carers under the reportable conduct framework.

The Carers Register, currently being developed by the Children's Guardian, will ensure that all current investigations into reportable allegations involving carers, and all finalised investigations that meet a threshold determined by the Ombudsman, will be flagged on the Carers Register. The Register will extend to investigations against adult household members of carers if they are brought under the reportable conduct framework. This will mean a carer will not be able to seek authorisation with another agency without that agency being aware of reportable conduct matters that need to be discussed with the agency responsible for the earlier reportable conduct investigation.

Information sharing

The safety of children in OOHC is a collective responsibility. All organisations involved in the life of a child or young person in OOHC should be able to share information on potential child protection risks associated with an OOHC placement.

Chapter 16A of the Care Act was introduced in response to the Special Commission's concerns about restrictions on inter-agency information exchange for child protection purposes. Chapter 16A promotes the exchange of information between prescribed bodies (which include NSW Police, FACS and organisations providing OOHC, health, education and children's services) where that information relates to the safety, welfare or well-being of a child or young person or class of children and young people.

One of the primary objectives of the Carers Register is to facilitate designated agencies sharing information about carers and household members. As OOHC transitions to the NGO sector, information holdings about carers and prospective carers, and their household members, become more fragmented. There is a risk that carers who have ceased caring for one agency as a result of concerns about their conduct or suitability will seek authorisation with another agency that has no knowledge of their previous care history.

The Carers Register will include information about a person's authorisations and applications for authorisation, or household member status, with each agency with which they have had such contact. A designated agency will be able to view a

prospective carer or household member's history with other agencies on the Carers Register and, as part of the assessment process, will be required to seek information from any such agencies.

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?

While core OOHC child protection strategies were discussed in response to question one of the Issues Paper, the Royal Commission needs to consider the different application of some strategies within residential and family-based care settings.

Residential care

There have been numerous public reports of abuse of children and other vulnerable people in residential settings over the years.

Children and young people in residential care are likely to have increased vulnerabilities and sometimes challenging behaviours. The vulnerability of children and young people in residential care, combined with the residential care environment, presents particular challenges for keeping children and young people safe from sexual abuse.

Residential care is both a domestic and an institutional setting. It is both a "home" for children and young people and a workplace. Children and young people are cared for by staff and the child-staff relationship is different from a child-carer relationship. Children and young people in residential care may also have regular exposure to other adults who are not ordinarily present in other care environments, such as cleaners, drivers and other auxiliary staff.

It is critical that residential agencies have good employment screening, training and support systems to minimise child protection risks. This can be a challenge in residential agencies where casual staff make up a significant proportion of the workforce and there is high staff turnover. Residential agencies should focus on developing a stable and professional workforce.

The risks of abuse in OOHC can be minimised through strong governance and a culture of not tolerating abuse in any form.

Strategies that focus on the governance and culture of an organisation are likely to provide even greater benefits in a residential care setting, as a residential care agency has greater control over the workplace where care is provided than a foster care agency has over a carer's home. A residential care agency has regular contact with the staff that provide care and greater control over the care provided and the care environment.

Weak governance increases the risk of abuse not being reported to management or being covered up. There may have historically been an increased likelihood of agencies not responding to, or covering up, abuse in residential settings because the abuse is more likely to involve agency staff and expose the agency to public criticism and legal liability. The risk to reputational damage and legal claims may not be so

acute where care is provided by a foster or relative/kin carer who has considerably less contact with the agency than do agency staff, and who has legal responsibility for most aspects of the daily care and control of the children and young people for whom he or she provides care.

There is a greater potential for systemic abuse of children and young people in residential care, as the failure to respond to abuse in an institutional setting may create a culture of abuse that may affect a significant number of children and young people over an extended period of time.

Children and young people in residential care are less likely than those in home-based care to attend school or community activities where they can develop peer networks and relationships of trust. As outlined in response to question one, peer and community relationships may reduce the risk of abuse and encourage its reporting. Residential agencies should have a particular focus on assisting children and young people in their care to engage in educational and community activities, having regard to developmental and behavioural issues.

Children and young people in residential care are more likely than those in home-based care to have challenging behaviours, including sexualised behaviour. This, combined with the number of children in residential settings, means there is a greater need to consider peer protection strategies.

Such strategies may include higher levels of supervision and monitoring; the separation of older and younger children; the separation of male and female children; ensuring children have their own private safe space; ensuring the availability of psychological support; and behaviour management plans to address behaviours of concern. In some cases, intensive one on one care is required.

Consideration should be given to the design of the physical environment – while ensuring that children and young people are able to feel comfortable and “at home”, it is also possible to design environments that reduce the risks of children and young people being exposed to harm, through being isolated or unsupervised.

In NSW, residential services are subject to a higher level of state oversight than home-based services, with the Ombudsman and Official Community Visitors having particular powers in respect of residential services. This oversight increases the likelihood that incidents of abuse will be detected and appropriately addressed.

The Children’s Guardian also monitors residential care arrangements for all children under 12 years of age, with agencies required to provide the Children’s Guardian with reports on such placements every six months. The Children’s Guardian also monitors the suitability of all placements with non-designated agencies (sometimes children in OOHC with particular needs, often associated with disability support, will receive more appropriate care from a specialist provider).

Aboriginal relative, kin and foster care

There is a need to consider different strategies for preventing child sexual abuse of Aboriginal children and young people in OOHC. Aboriginal children and young people are significantly over-represented in reports of abuse and in OOHC.

A key element of the NSW OOHC system is the prioritisation of Aboriginal children and young people being cared for by family members, members of a broader kinship group, or other Aboriginal carers. New South Wales is expanding the number of accredited specialist Aboriginal OOHC agencies and facilitating partnership arrangements between unaccredited Aboriginal agencies and accredited OOHC agencies, with a view to the Aboriginal agencies being accredited over time. The NSW Aboriginal Child Family and Community Care State Secretariat (AbSec) is playing a critical role in this work.

The Children's Guardian strongly supports the Aboriginal and Torres Strait Islander placement and self-determination principles that are enshrined in sections 11-13 of the Care Act – they are critical in maintaining a connection between Aboriginal children and young people in care and their culture and community.

However, it follows that if child abuse is more prevalent in Aboriginal families and communities, then there are risks that need to be identified and managed when Aboriginal children and young people maintain close connections with family and community.

The NSW Ombudsman's January 2013 report, *Responding to Child Sexual Assault in Aboriginal Communities*, shows that child sexual assault cannot be addressed in isolation of underlying social and economic risk factors. It is clear that addressing these underlying risk factors is essential to tackle the root causes of child sexual assault in Aboriginal communities and that both a whole of government and whole of community response is required to address this issue.

There needs to be engagement with Aboriginal communities, and leadership from within those communities, to reduce child abuse. Strategies to build capacity and address social and economic risks, in partnership with agencies and communities, are likely to be more effective in reducing abuse in relative/kinship care. AbSec and specialist OOHC agencies play a critical role in reinforcing broader community efforts to respond to child sexual abuse within an OOHC setting.

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?

In considering models that check OOHC practice, it is important to distinguish between the practice of designated agencies and that of carers.

Most checking of OOHC practice at the carer level is conducted by the designated agencies that authorise those carers. Accordingly, designated agencies are critical players in the regulation of the quality of OOHC and in developing cultures and systems that minimise the risk of sexual abuse in OOHC.

The state focuses most of its monitoring and other regulatory activities on the OOHC practices of designated agencies, rather than individual carers. The purpose of this is to continually improve the capacity of designated agencies to effectively supervise care and to minimise and manage risks to the safety, welfare and well-being of children and young people in OOHC.

A well-designed checking system should integrate checks of practice at the individual child/carer and systemic levels. For example, systemic checks may identify individual cases of concern and there needs to be a mechanism for these concerns to be raised and addressed. Conversely, checks of practice in a particular care setting may highlight the potential for systemic risks. There needs to be effective communication between bodies with a checking role. The introduction of Chapter 16A of the Care Act has improved information sharing, as have MOUs between bodies with a regulatory role - for example, the Office of the Children's Guardian has MOUs with FACS (currently being reviewed to improve coordination) and with the Ombudsman/Official Community Visitors.

The primary reason for the establishment of the Children's Guardian was to establish a body, independent of DoCS, to exercise special guardianship powers in respect of children and young people in OOHC. The special guardianship powers of the Children's Guardian, which were never proclaimed, would have seen the Children's Guardian actively monitoring the OOHC provided to each child and young person and directing designated agencies and carers in the provision of that care.

The size of the OOHC sector in New South Wales made this approach unworkable. The Children's Guardian and DoCS submitted to the Special Commission that the level of monitoring required of a special guardian was not in the best interests of children and young people in OOHC. The Children's Guardian was concerned that such a role would undermine local responsibility for ensuring the quality of care, stifle designated agency innovation in improving OOHC services, and slow decision-making and responsiveness.

The Children's Guardian's submission to the Special Commission noted:

> "*One of the problems with the current statutory child protection system is that broad, rather than targeted, reporting and monitoring arrangements are often favoured. This approach has the potential to overload decision making/review bodies with cases where no intervention is required, making it difficult to focus on those areas where attention is necessary.*"

Checks of OOHC practice should be proportionate to, and targeted on the basis of, risk. Resources assigned to monitoring/checking activities are ultimately resources directed away from direct service delivery.

The Special Commission recommended that the special guardian functions of the Children's Guardian be repealed.

There is no single right or wrong model for checking OOHC practice and a combination of complementary models should be adopted, as has occurred in New South Wales. It is submitted that the Royal Commission should focus on the strengths and weaknesses of systems for checking OOHC practices, rather than on the strengths and weaknesses of the particular component parts of those systems.

Different systems for checking OOHC practices will be suitable for different jurisdictions, influenced by a range of relevant factors, including:

- the size and composition of the OOHC population;
- the extent to which a government agency arranges the provision of OOHC;
- the number of agencies that arrange the provision of OOHC;
- the organisational maturity and capacity and governance arrangements of agencies that arrange the provision of OOHC; and
- the extent to which children and young people in OOHC, and their carers, have access to case management, caseworker, training and other supports.

The Special Commission acknowledged that non-government designated agencies in New South Wales were able to provide greater case management, caseworker, training and other supports than DoCS. It also noted:

> "*NGOs have smaller and less formalised management structures and often have greater capacity to implement reforms and innovative service models more quickly than government agencies.*" (para 16.321)

The Special Commission therefore recommended the transfer of most OOHC services to the non-government sector and the New South Wales government has been implementing that policy.

It follows that a key role of government in NSW is to check the OOHC practice of non-government agencies and that a key role of those agencies is to check the OOHC practice of carers, although there is obviously an appropriate role for government in some individual care arrangements as well.

The remainder of the Children's Guardian's response to this question addresses particular models for checking OOHC practice that are currently employed in New South Wales.

Accreditation

The Children's Guardian's checking of designated agencies' OOHC practices through the Statutory OOHC Accreditation Program was discussed in response to question one of the Issues Paper. Through the Accreditation Program, the Children's Guardian also considers and provides feedback on the care provided to some individual children and young people.

Children's Guardian's Case File Audit Program and risk-based monitoring

It was originally intended that the Children's Guardian would monitor every case plan and review for children and young people in OOHC, but the number of children and young people in care made this impractical.

The Children's Guardian instead established a Case File Audit Program to review a statistically valid sample (at statewide and agency level) of designated agency case files for children and young people in statutory OOHC. This was considered a more efficient and effective way of monitoring designated agency case management and planning, particularly as case files contain material that informs, but may not be evident on the face of, case plans or reviews.

The Case File Audit Program aims to focus the out-of-home care sector on achieving better outcomes for children and young people in care and has been the principal means by which the Children's Guardian has monitored designated agency compliance with care and protection legislation and the NSW Standards.

The Case File Audit Tool was developed by the Children's Guardian and PricewaterhouseCoopers (PwC). PwC also assisted with sample selection (for example, the 2010-2012 Audit examined a sample of 3903 case files in respect of approximately 12,000 children and young people in statutory care) and helped with the compilation of aggregated data.

There have been five Case File Audits since 2004. Each of those Audits has focused on the following four key areas:

1. **File Content and Structure** - files are expected to contain basic information in relation to the child or young person.

2. **Plan/Review content** - the placement of every child or young person in court-ordered out-of-home care is subject to review as prescribed by s150 of the Care Act.

3. **Participation and Information Sharing** - there are specific requirements for participation, information sharing and disclosure of information to children and young people, carers, parents and significant others under the Care Act.

4. **Aboriginal and Torres Strait Islander Principles** for placement, participation and self determination. Designated agencies must comply with the Aboriginal and Torres Strait Islander Principles as prescribed in sections 11-13 of the Act.

The fourth and fifth Case File Audits also respectively focused on health and education supports for children and young people in OOHC.

It is important to note that Case File Audits focus on documentation held on case files or that is otherwise easily accessible, and that there may be undocumented practice that is not captured. This is a weakness of this form of monitoring. However, there should be a strong correlation between actual practice and documented practice.

Since the Case File Audit was introduced, Children's Guardian auditors have noticed a marked shift in the focus of material held on case files. At the time of the first Audit, many case files focused largely on funding arrangements. Over time, this focus has shifted and case files now focus on the needs of the child or young person.

Upon completion of the Case File Audit, aggregated compliance reports and individual results for each file audited are provided to each designated agency on a CD-ROM. Post-Audit interviews enable agencies to identify any errors or omissions of the auditors. The Audit Results are used by agencies to reflect on and improve casework practice and management.

The individual results are used to inform specific actions to be taken in respect of individual children and young people in OOHC (for example, if a case file contains no record of immunisation, then the agency arranges immunisation for the child).

As part of the 2006/07 Audit Program, the Children's Guardian issued a Survey seeking feedback from the 50 agencies that participated in the Audit. 31 agencies completed the Survey. In summary:

- all respondents found preparing for the Audit very helpful or fairly helpful;
- 93% of respondents rated the Audit tool content as very good or fairly good;
- 94% of respondents used the Audit results to improve casework practice;
- 97% of respondents used the Audit results to change other aspects of their operations;
- 80% of respondents used the Audit results to report to their Board;
- 94% of respondents used the Audit results to tell staff how the agency is performing;
- 58% of respondents used the Audit results to undertake further research.

Case File Audit results have also assisted in informing government policy. For example, consistent Audit findings that non-government agencies have generally

performed better than Community Services in most practice areas helped inform the Special Commission's 2008 recommendation to transfer Community Services' OOHC services to the non-government sector. The 2008-10 Case File Audit results informed the NSW Health 2011 *Prevalence Study on the Health Care of Children in Out of Home Care in NSW* and the development of policies to improve health outcomes for children and young people in OOHC.

Case File Audit results have also been used for Keep Them Safe performance monitoring and in reporting on NSW performance against some of the National OOHC Standards.

However, it also needs to be acknowledged that the size and scope of Case File Audits makes them a time-consuming and resource-intensive monitoring tool.

The rapid expansion of the non-government sector means the next statewide Case File Audit is unlikely to be conducted for a number of years, as the Children's Guardian's monitoring activity needs to be better targeted to risk during the transition to NGO care. Factors such as changes to program design or agency governance, rapid agency growth, and issues raised by agencies, FACS, the Ombudsman and/or Official Community Visitors will inform the development of the Children's Guardian's risk-based Monitoring Program. The Children's Guardian is also updating its information exchange MOU with FACS to better support this approach and improve FACS/Children's Guardian coordination of monitoring activity.

Performance based contracting

In NSW, FACS manages OOHC placement contracts using the Performance Monitoring Framework. This Framework assesses performance against targets outlined within the service specification. The Special Commission endorsed performance based contracting and its associated reporting requirements. Performance based contracting is further discussed in response to question 4 of the Issues Paper.

Longitudinal study

Pathways of Care is a large-scale representative longitudinal study (2010-2016) that follows children and young people aged 0-17 years entering NSW statutory care for the first time. The study will collect detailed information about the characteristics and circumstances of children and young people on entry to care, their experiences in OOHC and their life course development to distil the factors that influence their outcomes. Reporting for *Pathways of Care* will begin in 2014, and findings will provide the knowledge to further strengthen the NSW OOHC system and improve the life opportunities for children and young people in its care.

Complaints and reportable allegations

OOHC practice issues may be identified through complaints and reportable conduct systems. In NSW, complaints about OOHC services and the complaints handling systems of designated agencies are monitored and oversighted by the Ombudsman under CS-CRAMA. The Ombudsman also keeps designated agency systems for

handling reportable allegations under scrutiny, and oversights those investigations, in accordance with Part 3A of the *Ombudsman Act 1974*.

The Ombudsman provides advice and recommendations to agencies on complaints/reportable allegation handling and decision-making. Agencies can use this feedback to address practice issues in individual cases and at a systemic level.

The Ombudsman refers serious and/or systemic issues arising from OOHC complaints/reportable allegations to the Children's Guardian. The Children's Guardian takes these matters into account in working with agencies on developing reaccreditation programs or performance improvement plans and has used its condition making powers to ensure particular performance concerns arising from complaints/reportable allegations are addressed. The Children's Guardian also refers relevant complaints/reportable allegations to the Ombudsman.

The Children's Guardian, in making accreditation decisions, also seeks advice from the Ombudsman on whether there are any complaints or reportable conduct performance concerns.

As discussed in the response to question one of the Issues Paper, the Carers Register being established by the Children's Guardian will flag carers who are subject to current reportable allegation investigations or who are the subject of certain reportable allegation findings.

The Ombudsman may now also refer complaint or reportable allegation matters relevant to the risk a person poses to child safety to the Children's Guardian for WWCC assessment purposes under the WWC Act.

Monitoring OOHC practice through formal reviews

The Ombudsman may, in accordance with s13 of CS-CRAMA, review the situation of a child or group of children in OOHC. The Ombudsman's Office uses its review powers to report and make recommendations on changes that the Ombudsman believes should be made to promote the welfare and interests of the child or group of children.

The Ombudsman, in accordance with Part 6 of CS-CRAMA, is also responsible for reviewing the deaths of children in care (the Coroner also has a role in this area).

The Ombudsman's review jurisdictions are critical components of the NSW system for checking and improving practices in OOHC.

Official Community Visitors (OCVs)

NSW OCVs, who are supported by the Ombudsman's Office, visit residential OOHC services. As noted earlier in this paper, less than 3% of children and young people in OOHC in NSW are in residential care.

OCVs may identify service concerns and help children and young people in OOHC to resolve individual issues of concern. OCVs, in considering service issues, have

regard to the NSW Standards and systemic issues identified by OCVs may be reported to the Children's Guardian. These issues are generally referred via the Ombudsman's Office.

The main strength of this approach to monitoring is that OCVs have wide powers to enter premises, speak to children and staff, and access records. The principal weakness is that OCVs generally do not have an opportunity to establish trusting relationships with children and young people in care and serious personal concerns may therefore not be disclosed to them. Care staff and caseworkers are more likely to establish such relationships.

Regular caseworker visits and contact

The most effective means of checking OOHC practice in individual care settings is providing for regular caseworker visits and contact with children and young people and their carers.

Other monitoring processes under consideration in NSW

Other monitoring processes that will be considered in NSW include a program of visiting children and young people in their placements based on the UK Ofsted Model and surveys of children and young people in OOHC, as has occurred in Queensland. NSW is also considering the use of mobile technology to survey children and young people about their care experience.

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?

and

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

As outlined in response to question three of the Issues Paper, there are a number of bodies that have a regulatory role in respect of NSW OOHC agencies. FACS regulates agencies through Service Agreements and contracts. The Children's Guardian accredits and monitors OOHC agencies, conducts WWCCs and is establishing a centralised Carers Register. The Ombudsman conducts inquiries, oversights OOHC complaints and reportable allegations, and reviews the death of children and young people in care. Official Community Visitors visit residential OOHC services.

This regulatory framework has been developed with regard to the history and characteristics of the NSW OOHC system. Other jurisdictions may have different regulatory needs.

The NSW regulatory framework for OOHC was considered by the Special Commission in 2008. The Special Commission found that the various regulatory roles were complimentary and, apart from recommending that broader child death review functions of CCYP be transferred to the Ombudsman's Office, endorsed the regulatory framework in place at that time.

The Special Commission found:

> "*The introduction of performance based contracting and its associated reporting requirements are necessary components of a robust and accountable government funded service system...* (para 25.35)
> ….
> *Finally, the functions of the Children's Guardian and those of the Ombudsman provide additional safeguards for monitoring the standards for the delivery of services to children and young persons in OOHC.* (para 16.24)
> ….
> *The Ombudsman and the Children's Guardian each have roles and responsibilities in relation to children in OOHC. The Inquiry has been informed and agrees that the legislative provisions for these roles and responsibilities ensure that the work of both agencies is complementary rather than duplicative. It accordingly does not suggest any change in these arrangements.*" (para 23.130)

The Children's Guardian believes that the OOHC roles of the Ombudsman and OCVs should always be exercised independently of FACS.

The separate roles of FACS and the Children's Guardian are best understood having regard to the history of OOHC regulation in NSW.

In NSW, there has always been a focus on home-based care, with a relatively small proportion of children and young people in residential care. The government has also always been a major provider of OOHC services. These two factors resulted in there being limited regulation of the OOHC system for most of the 20th century.

The *Child Welfare Act 1939* only regulated the small non-government residential OOHC sector, where homes provided care to children under seven years of age. The 1939 framework for regulating non-government OOHC agencies remained largely unchanged for almost fifty years.

NSW commenced regulating foster carers in 1966, but it was not until 1982, when the government expanded funding for non-government OOHC services, that legislation was introduced to regulate non-government agencies that arranged and supported foster care (the *Community Welfare Act 1982*). However, this legislation was never proclaimed and non-government agencies arranging foster care were not regulated until the commencement of the *Children (Care and Protection) Act 1987*.

The 1987 Act provided the first comprehensive framework for the regulation of OOHC in NSW, with private fostering agencies required to be authorised, and residential care services required to be licensed, by DoCS.

During the 1990s, the government withdrew from the licensing and authorisation of services funded under the DoCS Substitute Care Program, on the basis that funding agreements were sufficient to regulate these services. The problem with this approach was that DoCS funding agreements did not have a significant quality focus, with service delivery issues generally involving decisions about resources.

The problems associated with DoCS regulating OOHC quality were canvassed in both the 1992 Report of the Ministerial Review Committee established to review substitute care services in NSW ("the Usher Committee") and again in the 1997 Review of the *Children (Care and Protection) Act 1987*, chaired by Professor Patrick Parkinson ("the Parkinson Review"). Both reviews concluded that there was an inevitable tension between DoCS' role in managing resources and always acting in the best interests of children and young people.

Both reviews recommended the establishment of an independent Special/Children's Guardian for reasons including the separation of the government funder of OOHC services from the body responsible for ensuring the quality of those services.

The Parkinson Review also recommended the establishment of a standards based accreditation scheme. Importantly, the Review recognised that DoCS should be subject to this regulatory regime, particular as it was the major provider of OOHC in NSW:

> "*If the Department is to continue to be a major provider of substitute care services, then there needs to be a means of ensuring that it, along with all the*

other agencies, meets the same standards and is accountable outside of its own organisation for the quality of those services."

The Regulatory Impact Statement to the *Children and Young Persons (Care and Protection) Regulation 2000*, in discussing accreditation and conditional funding regimes, stated:

> "*A regulatory strategy that lacks any capacity to impose penalties or sanctions (other than the withdrawal of funding) may have serious limitations and do little to enhance the care and protection of children and young people.*
>
> *…… the current conditional funding regime is unable to provide the enforcement mechanisms that a statutory regime can provide to attempt to ensure the care and protection of children and young people.*"

The independent regulatory role of the Children's Guardian remains critical while FACS remains a significant provider of OOHC services. The Special Commission recognised the importance of external oversight of child protection (including OOHC) services, given the government's role in the area, endorsing the following 2005 statement of the Ombudsman:

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

FACS cannot be expected to independently assess its own performance against the NSW Standards. If FACS were responsible for setting and monitoring compliance with OOHC quality standards, there would be a real risk in an overall lowering of the standard of non-government services. Given the relative performance of FACS and the non-government sector against accreditation criteria to date, the Children's Guardian would be concerned if FACS performance becomes the bar against which satisfactory performance of non-government agencies is assessed.

The need for an independent Children's Guardian in NSW might be reconsidered when FACS ceases having any significant role as an OOHC provider and if the tension between funding and quality oversight responsibilities, identified by the Usher Committee and Parkinson Review, can be satisfactorily addressed.

The main strength of independent regulation is the accountability of government and government funded services. It also enables the child protection department to concentrate on its core child protection functions.

The main weakness is the potential for overlap of functions and the resulting duplication of effort and confusion this may cause in the OOHC sector. It will be particularly important for FACS and the Children's Guardian to be mindful of this as the FACS role is redefined as it moves away from OOHC service provision and the Children's Guardian further develops its risk-based Monitoring Framework. FACS

and the Children's Guardian are currently reviewing their MOU to improve coordination of their respective functions as OOHC services continue to transfer to the non-government sector.

The regular interaction and meetings between the Children's Guardian and Ombudsman's Office has successfully minimised any duplication in their regulatory activities.

Matters relevant to question 10 of the Issues Paper are also addressed in earlier sections of this paper.

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?

and

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

The Children's Guardian supports the NSW Government submission in response to questions five and six.

Children's Guardian staff, as part of the accreditation process, consider how agencies communicate child protection responsibilities under the Care Act, Ombudsman Act and WWC Act and information on the rights of children and young people to safety and freedom from abuse under the *United Nations Convention on the Rights of the Child* and the *Charter of Rights for Children and Young People in Out-of-Home Care in NSW*.

Children's Guardian staff also consider designated agency employee and carer training and development in child protection and other areas (see in particular NSW Standard 18 – Training and Development). They consider induction and orientation training, annual reviews of training needs and ongoing internal/external training, supervision and support). They encourage agencies to familiarise themselves with, and use, the Ombudsman's *Reviewing child protection policies – an agency self-assessment checklist*

Children's Guardian staff also hold discussions with agency management and employees to determine whether knowledge of their child protection responsibilities is evident.

Children's Guardian accreditation staff generally come from a child protection background, have received child protection training, and regularly discuss child protection issues. However, Children's Guardian staff currently do not receive specialist child protection training after joining the Children's Guardian. The Children's Guardian has held discussions with the Ombudsman's Office about staff receiving the child protection training that is regularly provided by that Office.

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?

The two nationally agreed measures for OOHC safety are:

- the proportion of children in OOHC who were the subject of a notification which was substantiated; and

- the proportion of children in OOHC who were the subject of substantiation and the person responsible was living in the household.

However, jurisdictions have different investigative practices and standards and rules for determining substantiation. This is a significant limitation of the current system and the development of national consistency in this area would be of benefit.

It is recommended that consideration is given to reporting on the number of allegations of sexual abuse in OOHC; the time taken to conduct investigations; and the action taken in response to allegations.

The Children's Guardian does not support formal interviews by OOHC agencies in which children and young people are asked if they have been abused. Such questioning can be extremely traumatic for children and young people. Instead, agencies should ensure children and young people are educated about their rights and provide an environment in which children and young people feel safe and supported in disclosing abuse.

However, providing an opportunity for young people to comment on their care experience generally as part of the leaving care process may provide an additional opportunity for them to raise issues of abuse, as well as providing agencies with other feedback that they can take into account in improving care arrangements.

In NSW, the Ombudsman's Office's oversight of child abuse allegations involving carers and agency staff and its ability to make recommendations in response to reportable allegations, complaints and inquiries, means the Ombudsman is ideally placed to monitor the manner in which agencies respond to child sexual abuse allegations.

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 Children's Guardian supports the NSW Government submission in response to question eight.

The Children's Guardian also notes there are internal review processes before a matter proceeds to the Administrative Decisions Tribunal (ADT) and the following comments of the Special Commission, made at para 23.183 of its report:

> "*The Inquiry examined a number of decisions of the Tribunal concerning applications for the review of decisions to revoke the authorisation of carers, or to remove children from the care and control responsibility of carers.213 The correctness of those decisions cannot properly be the subject of any comment by the Inquiry. However, the Inquiry's review does leave it satisfied that the ADT approaches its task appropriately and with considerable attention to the evidence and to the best interests of the child principles, such that there is no occasion to propose any alternative model for the review of decisions of the relevant kind.*"

An alternative process to ADT review might be review under the community services complaints jurisdiction of the Ombudsman. An advantage of this would be less expensive and legalistic reviews by a body with considerable expertise in making decisions in the best interests of children and young people. A disadvantage would be that the Ombudsman can only make recommendations, not enforceable decisions.

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?

The Children's Guardian strongly supports independent oversight of OOHC agencies' handling of allegations of child sexual abuse. Independent oversight encourages accountability, transparency and procedural fairness in investigations.

The Ombudsman's role in this area in NSW also promotes greater consistency in the handling of such allegations. The Ombudsman's Office provides valuable advice and assistance in this area and may assume responsibility for an investigation.

Consideration might be given to measuring:

- the number of independent body recommendations made in respect to the handling of allegations;
- the number of those recommendations that were accepted;
- the number of those recommendations that improved the quality of the investigation and action taken in response to the investigation's findings (would need to develop measurement criteria);
- the time taken to resolve matters after an independent body commences actively oversighting an investigation.

Qualitative feedback might be sought from agencies and JIRTs/Police.

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

Delayed reporting of child sexual abuse is common and provides for a number of evidentiary difficulties. Witnesses may be difficult to locate, have died or have limited recollection of relevant matters. Documentary evidence that may have given weight to an allegation may have been misplaced or destroyed.

It is important that designated agencies keep accurate and thorough records of children and young people's time in care. The Children's Guardian has noted significant improvements in this area over the last decade.

It is also important that those records are retained, with the increased use of electronic records making record retention easier than in the past.

Section 14 of the Care Act requires FACS to permanently keep all records made within FACS relating to the placement of Aboriginal and Torres Strait Islander Children and Young People in statutory or supported OOHC.

Section 170(1) provides, "Each designated agency must keep the records made by it in relation to the placement of a child or young person in out-of-home care for seven years after the designated agency ceases to be responsible for the placement of the child or young person."

Section 170(2) provides, "At the expiration of the seven year period or, if, within that period, the agency ceases to be a designated agency, it must deliver the records required to be kept under this section to the Director-General."

Section 170(3) provides that records delivered to the Director-General in accordance with s170 are State records for the purposes of the *State Records Act 1998*.

In February 2010, State Records NSW advised the Children's Guardian, *"Whilst as yet there is no established retention period for records of non-Aboriginal or Torres Strait Islander children or young people in out-of-home care (after their transfer to the DG), it is quite likely this would, at a minimum, be for the expected lifetime of the individual.*"

FACS would be able to provide the Royal Commission with information on its record retention policies.