

FAMILY IS CULTURE

REVIEW REPORT | 2019

INDEPENDENT REVIEW OF ABORIGINAL
CHILDREN AND YOUNG PEOPLE IN OOHC



Independent Review of Aboriginal Children in OOHC

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COVER ARTWORK

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FAMILY IS CULTURE

FINAL REPORT

INDEPENDENT REVIEW INTO ABORIGINAL OUT-OF-HOME CARE IN NSW

Professor Megan Davis, Chairperson

October 2019

25 October 2019

The Hon. Gareth Ward, MP
Minister for Families and Communities
Minister for Disability Services
52 Martin Place
SYDNEY NSW 2000

Dear Minister Ward

I am pleased to present to you the Final Report of the *Family is Culture: Independent Review into Aboriginal and Torres Strait Islander Children and Young People in Out-of-Home Care in New South Wales*.

As you are aware, the independent review included a contemporaneous analysis of the case files of all Aboriginal and Torres Strait Islander children and young people in out-of-home care between 1 July 2015 and 31 June 2016 (case files relating to 1,144 children and young people). I would like to record my gratitude for the cooperation of the former Department of Family and Community Services and in particular the Office of Senior Practitioner when undertaking these case file reviews. I would also like to record my appreciation for the guidance of the Aboriginal Reference Group. I also recognise the critical work of the large team of case file reviewers who assisted my team by reviewing the case files.

The completion of this report has taken longer than expected. The time required to carry out this work was underestimated and I thank the Minister/s for extending the deadline. Whilst I agree that improvements to this system should occur without delay I did not want to rush this process. The children in this cohort deserve to have their matters carefully considered, and the families affected by the child protection system deserve a report that applies the necessary due diligence to such an important piece of work. What we've found throughout this process is that this level of diligence is not always afforded to the Aboriginal families that encounter the child protection system in NSW. I'm glad to be able to say that in this process, the work done for families in our cohort was not done in haste but with care.

It is my hope that this Final Report will assist you in addressing the issues that are unique to Aboriginal and Torres Strait Islander children and young people in out-of-home care and their families, including reducing entries into care, increasing exits from into care and proper implementation of the Aboriginal Child Placement Principle.

Yours sincerely



Professor Megan Davis



Dedication

This report is dedicated to the 1,144 Aboriginal children and young people who entered out-of-home care between mid-2015 to mid-2016. Your stories will remain with us forever. We recognise you, your dignity and your identity as proud Aboriginal and Torres Strait Islander children and young people. We acknowledge your struggles and your resilience, and we are fiercely hopeful for your futures. We also acknowledge your places of belonging, and note you came from the following First Nations and clans:

Anaiwan, Awakabal, Barkindji (Paakantji, Baagandji), Biripi, Bundajalung (Bundjalang), Cape York Far North Queensland, Dharawal Nation, Dharug (Dharuk), Eora (Iyora, Iora), Gidabul (Gidabal), Gubbi Gubbi (Gabi Gabi), Gumaynggir, Gundidy, Gunditjmara, Gundungurra, Dunghutti (Dhangadi, Dungutti), Kamilaroi (Gamilaraay), Kanai (Gurnai), Kooma (Guwamu), Kunja, Murawarri, Narangga (Narrunga), Ngadjuri, Ngarrabal, Ngarrindjery (Narrinyari), Ngemba (Ngiyambaa, Ngiyampaa), Ngunawal Nation, Palawa, Pitjantjatjara, Torres Strait Island Clan Unknown, Wailwan, Wajuk (Whadjuk), Wangkumara, West Coast Clan, Wiradjuri, Wongaibon, Worimi, Yorta Yorta, Yuin, Ywemba Wemba (Wamba Wamba).¹

¹ The Review notes there are multiple names for each of these clans. For brevity, the Review has settled on the most commonly used names.

Acknowledgement

We recognise the Stolen Generations. We acknowledge the NSW Government Stolen Generations Advisory Committee which comprises representatives of Kinchela Boys' Home Aboriginal Corporation, Coota Girls Aboriginal Corporation, Children of the Bomaderry Aboriginal Children's Home Incorporated and the NSW/ACT Stolen Generations Council.

We thank you for meeting with us. Your stories, your concerns and fears and generous words encouraged the Review members during the most difficult days of our work.





National Apology to the Stolen Generations

Prime Minister (Hon Kevin Rudd MP): Mr Speaker, I move:

That today we honour the Indigenous peoples of this land, the oldest continuing cultures in human history.

We reflect on their past mistreatment.

We reflect in particular on the mistreatment of those who were Stolen Generations - this blemished chapter in our nation's history.

The time has now come for the nation to turn a new page in Australia's history by righting the wrongs of the past and so moving forward with confidence to the future.

We apologise for the laws and policies of successive Parliaments and governments that have inflicted profound grief, suffering and loss on these our fellow Australians.

We apologise especially for the removal of Aboriginal and Torres Strait Islander children from their families, their communities and their country.

For the pain, suffering and hurt of these Stolen Generations, their descendants and for their families left behind, we say sorry.

To the mothers and the fathers, the brothers and the sisters, for the breaking up of families and communities, we say sorry.

And for the indignity and degradation thus inflicted on a proud people and a proud culture, we say sorry.

We the Parliament of Australia respectfully request that this apology be received in the spirit in which it is offered as part of the healing of the nation.

For the future we take heart; resolving that this new page in the history of our great continent can now be written.

We today take this first step by acknowledging the past and laying claim to a future that embraces all Australians.

A future where this Parliament resolves that the injustices of the past must never, never happen again.

A future where we harness the determination of all Australians, Indigenous and non-Indigenous, to close the gap that lies between us in life expectancy, educational achievement and economic opportunity.

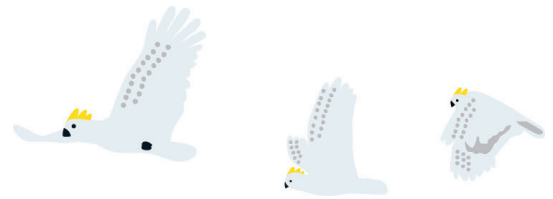
A future where we embrace the possibility of new solutions to enduring problems where old approaches have failed.

A future based on mutual respect, mutual resolve and mutual responsibility.

A future where all Australians, whatever their origins, are truly equal partners, with equal opportunities and with an equal stake in shaping the next chapter in the history of this great country, Australia.

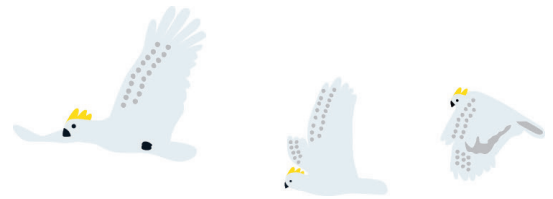
CONTENTS

Dedication	III
Acknowledgement	IV
National Apology to the Stolen Generations	V
Terms of reference	XI
Chairperson’s foreword	XII
List of submissions	XIX
List of figures	XX
Acronyms	XXVI
Definitions	XXVIII
Executive summary	XXX
List of recommendations	XXXIX
Part A Introduction to Review	1
1. Overview and key concepts	2
Background to the Review	2
Why this Review is unique	3
The history of child protection in NSW	3
Previous inquiries and reports examining the child protection system	8
<i>National inquiries and reports</i>	<i>10</i>
<i>New South Wales inquiries and reports</i>	<i>15</i>
Key concept: Intergenerational trauma	21
Key concept: Ritualism	25
2. Methodology	26
Design and development	26
Information gathering	29
Data analysis	32
3. Introducing the ‘Review cohort’	40
Background	40
Are the numbers of Aboriginal children entering care reducing?	42
Overview of the ‘review cohort’	44
What recommendations have been made in this Review?	48
4. The need for a new Aboriginal Quality Assurance Unit	51
Part B How the system works	55
5. How the child protection system works	56
Introduction	56
Risk of significant harm (ROSH) reports	57
‘Triage’ and allocation of the ROSH report	57
The initial field response—the safety assessment	58
The safety plan	59
The risk assessment	59
The family action plan	60
The risk reassessment	61
Parent responsibility contracts	62
Registered care plans	63
Temporary care arrangements	63
Removal of a child	64
The OOHC case plan	64
Restoration	65



6. How the Children's Court works	68
The 'care and protection' jurisdiction	68
Application for a 'care order'	69
The first return date	69
The second return date	70
Preparation for the placement hearing	70
The placement hearing	72
Variation or rescission of a care order	74
Breach of care orders	74
Appeals	75
Part C Key areas requiring significant structural change	77
7. Self-determination	78
What is self-determination?	78
The right to self-determination in international law	78
The right to self-determination and child protection	80
Recognition of the right to self-determination	80
The right to self-determination and the Commonwealth	82
Self-determination in Aboriginal child protection in NSW	83
<i>Inaccurate use of the term</i>	85
Stakeholder views	87
What do other jurisdictions tell us about child protection?	90
8. Public accountability and oversight	93
What is accountability?	94
Existing oversight bodies and accountability mechanisms	95
Stakeholder views	105
Key finding: Existing bodies and mechanisms are insufficient and ineffective in practice	106
Primary issues and concerns	108
Key recommendations for reform	125
Additional interim recommendations for reform	139
Concluding remarks	142
Part D Reducing entries into care	143
9. Getting early intervention right	144
Why early intervention?	144
A promising framework	146
Issues in practice	151
Stakeholder views	152
Case studies	153
Review data showing limited early intervention support	154
Addressing barriers to early intervention support	157
<i>A requirement to provide early intervention support</i>	158
<i>A duty to make 'active efforts'</i>	159
What type of support should be provided?	161
Interagency service provision	177
Caseworker training	179
Caseworker support	180
The need for more Aboriginal staff	182
10. Prenatal reporting and newborn removals	184
Introduction	184
Prenatal reporting	184

The nature and extent of prenatal reporting in NSW	187
Newborn removals	189
Stakeholder concerns	194
Data findings	195
Particular issues of concern	196
<i>Outdated and inadequate policy</i>	196
<i>Insufficient engagement with expectant parents</i>	198
<i>Post removal support for mothers and fathers</i>	200
<i>Section 106A of the Care Act</i>	201
11.Considering alternatives to removal	204
Requirement to take ‘least intrusive action’	204
<i>Data findings</i>	205
Existing alternatives to removal	206
Increasing the use of alternatives to removal	209
<i>Legislative obligation to consider alternatives to removal</i>	210
12.Improving entry into care practice	212
Safety and risk assessment	212
Issues with safety and risk assessment approaches in the department	213
<i>Data findings</i>	216
Safety Planning	218
<i>Data findings</i>	219
Discussion	219
13.Poor removal practices	221
Use of police in removals	221
Other examples of inappropriate removal practices	223
14.Recognising the harm of removal	226
Abuse in care	226
<i>Data findings</i>	227
Submissions and consultations	228
The urgent need for data	230
The broader harms of removal	230
The need for legislative reform	233
15.Care criminalisation	235
Background	235
Why are children in OOHC over-represented in the criminal justice system?	236
Submissions and consultations	238
The lack of support from the department	238
The response of the criminal justice system	241
The ‘Joint Protocol’	243
Increased focus on data and research	244
Part E Aboriginal child Placement principle	247
16.Introduction to the Aboriginal Child Placement Principle	248
Introduction	248
Background to the ACPP	249
The ACPP explained	250
<i>The five core elements of the Aboriginal and Torres Strait Islander Child Placement Principle</i>	251
Concerns about compliance with the ACPP in NSW	252
Examples of failure to implement the ACPP in practice	254
Lack of official training or guidance on the ACPP	255



Limited and inadequate data about compliance with the ACPP	256
Aboriginal identification and ‘de-identification’	258
<i>Data and Review findings</i>	260
Implementing the Aboriginal Case Management Policy and Guidelines	264
The need for greater oversight by the Children’s Court	265
17. Partnership	267
Introduction	267
What is partnership?	267
Data findings	271
<i>Aboriginal consultation before children entered care</i>	272
<i>Aboriginal consultation after children entered care</i>	273
18.Placement	274
Introduction	274
Placement of Aboriginal children	274
Where are Aboriginal children placed?	275
<i>Data findings</i>	276
<i>Case studies</i>	277
<i>Discussion</i>	278
Placement instability	279
<i>Data findings</i>	279
<i>Qualitative research findings</i>	279
<i>The need to plan for a child’s first placement</i>	280
<i>Discussion</i>	282
Finding appropriate carers	283
<i>Reluctance to engage with the department</i>	283
<i>Poor family finding</i>	284
<i>Discussion</i>	286
Informal carer assessment	286
<i>Potential carers ignored or overlooked</i>	286
<i>Data findings</i>	288
<i>Discussion</i>	289
Probity checks for potential carers	292
<i>Working with Children Checks</i>	293
Formal carer assessment	299
<i>Data findings</i>	299
<i>Discussion</i>	300
<i>Lack of culturally appropriate carer assessment</i>	301
<i>No right of review of decision not to authorise a carer</i>	303
<i>Review of other decisions about authorised carers</i>	304
Supporting Aboriginal carers	305
<i>Data findings</i>	306
19.Participation	308
Participation of parents and kin	308
Children’s voices	309
Family Group Conferences	310
Submissions and consultations	312
Data findings	313
Child participation	314
Discussion	316
The requirement to offer alternative dispute resolution to families of	

children at ROSH	316
20. Connection to family, community, culture and country	320
Introduction	320
What is 'connection'?	320
Contact with family and kin	322
<i>Data findings</i>	324
<i>Discussion</i>	328
Siblings in separate placements	330
<i>Data findings</i>	332
<i>Discussion</i>	333
Cultural connection	334
<i>Cultural planning</i>	334
<i>Data findings</i>	338
<i>Discussion</i>	342
Part F Increasing exits from care	343
21. Restoration	344
Improving restoration practices	344
Restoration as the preferred permanency position	344
<i>Data findings: Low restoration rates</i>	346
<i>Data findings: Restoration goals</i>	347
<i>Data findings: Restoration casework</i>	348
<i>Discussion</i>	349
Restoration best practice	350
General barriers to restoration	352
Potential legal barriers	360
Restoration policies	365
22. Adoption of Aboriginal children in OOHC	371
What is adoption?	371
Aboriginal views on adoption	371
Can Aboriginal children be adopted?	373
The push for more adoptions of children in OOHC	373
The 2018 legislative reforms	375
Why increase adoption?	377
Data findings	379
Discussion	380
23. Reforming the Children's Court	381
Introduction	381
Improving the quality of evidence presented to the Children's Court	381
The Review's file review	384
A new, independent statutory body to conduct care and protection litigation	386
Application of the rules of evidence	387
Only specialist magistrates to hear care and protection matters	389
A separate court list for Aboriginal children and their families	390
Appendix	393



Terms of reference

Professor Megan Davis, Faculty of Law, University of New South Wales has been appointed by the NSW Minister for Family and Community Services to chair an independent review into Aboriginal and Torres Strait Islander Children and Young People in Out of Home Care in NSW. The Chairperson will conduct the following:

1. Oversee an independent review aimed at improved implementation of the Aboriginal and Torres Strait Islander Child and Young People Placement Principle (see Part 2), *Children and Young Persons (Care and Protection) Act 1998* (NSW) (the Act) and especially s 13 of the Act, with respect to the following matters:
 - a) Identify the reasons for the high and increasing rates of Aboriginal and Torres Strait Islander Children and Young People in Out-of-Home Care in NSW; and
 - b) Develop strategies designed to reduce the number of Aboriginal and Torres Strait Islander Children and Young People currently in Out-of-Home Care and entering care including improving pathways to family reunification.
2. The independent review will include, although will not be limited to, the following:
 - a) A contemporaneous review of case files for all Aboriginal and Torres Strait Islander Children and Young People in Out-of-Home-Care for the period 2015-2016, that will identify specific action for improved outcomes for the individual child or young person;
 - b) A consultation process including, but not limited to, Aboriginal and Torres Strait Islander Children and Young People in Out of Home Care, their families and communities, Aboriginal and Torres Strait Islander sector stakeholders, child protection sector workforce and a public submissions process; and
 - c) A reference group of relevant Aboriginal and Torres Strait Islander stakeholders and experts who will meet no more than four times during the review period. The reference group will provide information and advice to the Chairperson on matters within the terms of reference.
3. The Chairperson will provide an interim report to the Minister on 31st August 2018 and a final report on 31st October 2018:
 - a) The report will include any recommendations about the matters within the terms of reference;
 - b) In making any recommendations, the following matters should be considered:
 - i) Identify the causes of the high and increasing rates of Aboriginal and Torres Strait Islander Children and Young People in Out of Home Care in NSW;
 - ii) An assessment of the effectiveness and application of the statutory Aboriginal and Torres Strait Islander Child and Young People Placement Principles in NSW including a comparative assessment of current policies, practices and learnings relating to the Aboriginal Child Placement Principles in NSW, other Australian jurisdictions and international examples, where relevant; and
 - iii) Recommendations for reform, including practice, based on learnings drawn from the case file review and a plan for implementation within FACS and across government and non-government agencies.

Chairperson's foreword

The Uluru Statement from the Heart, a First Nations articulation of the exigency of national reform in Australia on Indigenous affairs, identifies two public policy areas—primarily the responsibility of the states—as underpinning the logic of Commonwealth structural reforms, child removals and youth detention:

Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are alienated from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.

When I was sounded out by Minister Hazzard to chair this Review, I was co-Commissioner alongside Kathryn McMillan QC on a Queensland statutory inquiry under the *Commissions of Inquiry Act 1950* (Qld) into the treatment of children and young people in Queensland's youth detention centres. One of the things that struck me during that independent review was the apparent link between child protection and youth detention. As a regulatory theorist, a United Nations expert who specialises in Indigenous peoples' rights and a constitutional lawyer, the rights of our children and young people concern me greatly, as they do all Aboriginal and Torres Strait Islander peoples. These two independent reviews, one as a statutory inquiry, and this review as a consultancy, have provided me with invaluable insight into how regulatory systems function to disempower Aboriginal people.

From the outset I want to highlight three issues salient to the work of this Review: (1) the importance of Aboriginal activism, especially Aboriginal grandmothers, as an informal regulator in the child protection system, (2) 'ritualism' in government departments and (3) the use of commissions of inquiries and reviews in the public policy field of Indigenous affairs.

Aboriginal activism

A trajectory of Aboriginal rights since 1901 shows that the catalyst for progress, in so far as the welfare and wellbeing of Aboriginal people is concerned, has mostly originated from Aboriginal political activism for change. This means Aboriginal people have always been active and engaged reformists. This Review is no different. This Review was instigated by the activism of Aboriginal people in New South Wales, in particular Aboriginal grandmothers, who protested the escalating rates of Aboriginal child removals and agitated for reform. This Review has found that the accountability mechanisms in the child protection space are weak and require improvement, including transparency, to restore the faith of Aboriginal families in the system and its decision-making. In any professional space where regulation is weak there are informal regulators that play an important role in accountability. In the child protection space those informal regulators are the media and Aboriginal civil society, and in recent times Aboriginal grandmothers who have organised to advocate for change.



The state has adopted many rituals of listening to Aboriginal peoples’, from government advisory committees, to glossy brochures and policies espousing ‘self-determination’ and Reconciliation Action Plans, but it does not often ‘hear’ what Aboriginal people are saying.

The state has adopted many rituals of listening to Aboriginal peoples’, from government advisory committees, to glossy brochures and policies espousing ‘self-determination’ and Reconciliation Action Plans, but it does not often ‘hear’ what Aboriginal people are saying. The former Minister Brad Hazzard listened and heard the voices of the Aboriginal community, in particular grandmothers, at a forum in 2016, after which he commissioned an independent review into the reasons for the high rates of Aboriginal and Torres Strait Islander children and young people in out-of-home care in New South Wales (NSW).

This Review and the important recommendations contained herein are the result of the courageous advocacy of the Aboriginal men, women, aunties and uncles, grandmothers and grandfathers whose children, relatives and kin have been removed from their families in NSW. This Review is a manifestation of the deep love they hold for the many jarjums they have fought for and continue to fight for, who are at the centre of this review. This love was evidenced by the many Aboriginal family and kin who were recorded on files as ringing FACS and requesting to be assessed to be a carer of a niece, nephew or grannie; and their call not being returned. This was an unexpected finding, as the popular sentiment is that there are not enough Aboriginal people available to be carers. Many of the claims the community have made about the system have been validated by this Review. The anecdotes shared at community meetings and state wide forums are now the subject of recommendations for law and policy reform. I wish to record my deep admiration and gratitude, on behalf of the Review team, for the expertise and knowledge of Aunty Suellyn Tighe, Aunty Deb Swan and Aunty Jen Swan and the quiet leadership and generous advice of Tim Ireland, CEO of the peak organisation in NSW, AbSec.

Ritualism

The Indigenous and non-Indigenous women and men at the frontline of the child protection system, who are employees of the state, are anxious about this review and its findings. The work of child protection, especially casework, is complex and stressful. The impression I formed during the Review was that many caseworkers felt their work and the pressures they face are incomprehensible to anyone outside of the system. Of course, this is not dissimilar to the narrative of the Indigenous community they service who equally feel their life experiences are not able to be understood by caseworkers. The stress of decision making that will incontrovertibly impact a child for their entire life is compounded by the complexities of working in a huge bureaucracy. Bureaucracy is a large beast that, we know from the research, takes on a life of its own, with its own practices, norms and culture. Often this culture can be indifferent or resistant to the intentions of legislators. This means that the regulatory framework—the laws and policies that govern a bureaucracy—often compete with, or are neutralised by, the dominant culture of a department.

Mostly, employees have no choice but to adopt or conform to the culture of a workplace or department. As a caseworker, if the workplace culture is about risk aversion, as many are, then one is likely to minimise those innate skills that invite risk, such as intuition and instinct. Whatever the values of a department, caseworkers—as most employees will—conform.

One of the ways in which workers conform to a culture is through adopting the comfort of rituals or ‘ritualism’. Ritualism is a useful lens to understand the decision-making culture in the Department of Communities and Justice (formerly known as ‘FACS’) as it relates to Aboriginal people. Ritualism is never more valid than when it comes to the implementation of the Aboriginal Child Placement Principle (ACPP). The ACPP was recognised in the primary child protection statute by our democratically elected legislators as a commitment to keeping Aboriginal children with family. Yet this Review has found it is poorly implemented and misunderstood. The commitment, the language, the implementation of the ACPP is replete with ritualism. Ritualism takes the form of *compliance* manifest in endlessly changing policies espousing departmental commitment to ACPP, meetings (where minutes are more important than substance), glossy brochures, tick-a-box forms etc. Despite this, the outward appearance of compliance—formal participation in a system of regulation—shields a culture of non-compliance, as this Review has found.

The findings of the Review suggest that, in so far as the cohort of children and young people relevant to this review, the department has lost focus on achieving the fundamental goal of the ACCP: keeping children and young people connected to family, community, culture and country and, recognising community as a strength for children. This is because the culture of compliance has overwhelmed the other critical skills casework demands: intuition, instinct and judgment. We make recommendations to seek to balance the culture of compliance and risk aversion with the bread and butter work of caseworkers on the ground, building relationships and exercising judgement to improve the lives of families and children on the ground.

Inquiries and reviews

A major challenge faced by my team and I, was the cynicism expressed by many Aboriginal people about the Review. The Review provoked a range of questions about whether the government of the day would listen to voices of Aboriginal people and whether the recommendations would yield any change. For many governments across the federation, commissions of inquiry and reviews have arguably become a can-kicking exercise in Indigenous affairs; a demonstration of reform inertia. In my engagement with Aboriginal stakeholders, it was routinely expressed that the Review would ‘gather dust’ on bookshelves like the many other inquiries and reviews that have come before. It is difficult to hear so many members of the Aboriginal community dismiss the Review as another dust gathering exercise.

As a constitutional lawyer, I know that trust is a fundamental tenet of the relationship between individuals and peoples’ and the state. There is too much evidence today of the disengagement of Aboriginal people from the legal and political processes of the state because they have lost faith in the rule of law. They have lost faith that the system will listen and hear them and respond to their needs. Ensuring this report would be a living document and not gather dust was a primary concern for the Review team.



The spirit of the Review

It is an uncommon practice for a state, a department, or a regulatory system to willingly subject their work and practice to scrutiny by an *outsider*. The *Family is Culture* team and I are, and remain, *outsiders*. We have no skin in the game. We do not come from within the system. We are not caseworkers. None of us were involved with child protection or in out-of-home care. While we had expertise in law reform, domestic violence, administrative law, human rights law and constitutional law or the community sector, none of us were child protection experts.

The learning curve was steep. The language of child protection was, and to some extent still is, alien to us. And certainly, the Review was left with the impression that caseworkers themselves consider their work to be so complex and stressful as to be utterly incomprehensible to outsiders. The outsourced functions of the state complicate the landscape, as do the rapidly changing policies and procedures. We can only imagine what it is like to be an Aboriginal family in contact with the department and navigating the child protection system. It is difficult to understand how the system works. We found that over a two year period, many FACS staffers and caseworkers did not fully understand how the system works. In the process of fact checking for the final report, FACS would often have to seek clarity on policies and processes that at times seem mutable and unwieldy.

The chapter, 'How the system works' is aimed at outsiders, like me, and many Aboriginal families and parents, both in and outside the system, who find the regulatory framework of child protection bewildering, intimidating, adversarial and shape shifting. The knowledge deficit about this complex system is insurmountable for many. This is not the case for the *insiders*. We worked closely with many insiders, Indigenous and non-Indigenous, from FACS to the out-of-home care sector who are intimately involved in the child protection and whose knowledge was expert. The universal view of the insiders was that FACS can do better, NSW can do better. On this, we all agree.

The insider/outsider binary was present throughout the Review, even embedded within the reviewer team based at FACS who assisted in the deep dive of the files of children and young people who were removed between 2015–2016. The team included Indigenous and non-Indigenous ex-caseworkers, non-caseworkers and FACS caseworkers on secondment. The positioning of expertise and professional knowledge apropos outsiders caused tension. We held group meetings routinely to mediate this tension. It is emblematic of the power imbalance that arises when ordinary folk, non-experts, encounter child protection insiders, caseworkers and managers. The tension can be resolved. It is very much about two parties understanding the position of the other.

While this tension can be destructive, as it has been in the past and led to this review, the tension can also be rendered healthy and productive, something the Review report and the recommendations contained herein seek to do. How do we reconcile the tension between the rights of parents to care for their children and the rights of children to be with their parents, siblings and community, with the obligation of the state to ensure children and young people are safe? This is what this Review sets out to do. There are many things the department can do to achieve this. Greater transparency, non-secrecy, yarning, building relationships, more intuition and judgement, less risk aversion and less ritualistic compliance.

It is very clear that the ACPP is not implemented. How do we bridge the divide between the department and Aboriginal communities in this way? Here, the most important person in this space is the street level bureaucrat, the caseworker. How do we resource caseworkers with the skills to improve their casework with Aboriginal families? How do we work to ensure that families are not terrified when a caseworker turns up at their door? How do we educate caseworkers on the complex relationship between Aboriginal people in NSW and the police? The report does make recommendations for the Minister on how we may do this.

There is a cultural gap. I am not sure that the trend of 'cultural competency' is enough to bridge that gulf. How can NSW do that which the Australian nation has not done and that is become as fluent in the Aboriginal history of Australia as we are in the ANZAC legend, from first contact to the frontier wars to the protection era and assimilation? It is ahistorical to decouple the history of Aboriginal people and the state in New South Wales when considering the contemporary child protection and out-of-home care system. This history intersects at various points of the child protection system from entry into care, to out-of-home care, to exit from care. It was not uncommon for FACS staff to not know the name of the former mission/s or reserve/s that were located in their FACS region. How can you understand the local population in NSW if you do not understand the history and geography of the local people and the manifestations of state policies and laws in their daily lives? Such knowledge would assist a caseworker in their conversations with the community and family and in understanding the meaning of 'country' for placement purposes and/or finding family.

When we have power over our destiny our children will flourish. They will walk in two worlds and their culture will be a gift to their country.

We know the child protection system today has resonance with historical practices because Aboriginal people have said so and we must not only listen but hear what they are saying. Their view is supported by research, cited in this report, and voluminous Commonwealth, state and territory commissions of inquiries, parliamentary inquiries and reviews. Often contemporary casework practice reinforces the memory of the authoritarian state that dominated and subjugated Aboriginal lives during the protection era. It animates real fear. Some Aboriginal people fight the system, many give up for fear or exhaustion, defeated. When police are used for removal, especially riot police, this has historical continuity. When babies are removed at hospitals or a pre-natal risk notification is made because the mother is Aboriginal, this has historical continuity. When siblings or twins are separated in care, this has historical continuity. When families reach out to FACS for a carer assessment and are ignored and telephone calls go unreturned, this has historical continuity. When mums and dads are given unrealistic, unachievable goals in order to have their children or grandchildren restored to them, this has historical resonance. Some of the restoration goals are incontrovertibly impossible to be achieved. Some of these practices demonstrate concrete examples of institutional racism. The system is replete with practice that renders our people voiceless and powerless.

On the other hand, there were examples across the cohort of good practice: where caseworkers actively searched for family, where caseworkers returned the telephone calls of prospective Aboriginal family carers and recommended them for assessment, where caseworkers yarned with family, where caseworkers set realistic and achievable restoration goals for Aboriginal



mums and dads. We encountered some delightful and encouraging examples of caseworkers using intuition and good judgement, like the caseworkers who rolled up their sleeves and helped Mum scrub and clean her house for hours one weekend.

At times it seems like there is an irreconcilable tension at play in the system. Many Aboriginal and Torres Strait Islander peoples view the department and its practices as an extension of the state and therefore as imbued with institutional racism and malevolent intent. However, many departmental staffers, from caseworkers to managers, earnestly profess to wanting the best for Aboriginal children and young people. Certainly it is the case that caseworkers feel as misunderstood as the Aboriginal community does; the power imbalance being the unacknowledged distinguishing feature of this. It is my view that this tension can be mediated through the recommendations we present to the Minister. What is needed is more scrutiny and accountability of decision-making that is transparent, better record keeping, proper application of risk assessment tools, a deeper understanding of Aboriginal history and culture to enable a more nuanced comprehension of the ACPP and to enable the confidence of case workers to speak more comfortably with Aboriginal parents, families and community.

A final observation of the Review is that professional scrutiny of decision-making does not exist in this space in the same way it does with lawyers, doctors, teachers, police, or indeed most professions that involve specialist skill and knowledge. If it is the case that caseworkers have knowledge and experience that is incomprehensible to any outsider, then surely that work should be regulated in the same way as other specialist professions? After all we are talking about one of the most important jobs in any society, working with the most vulnerable of our population, children and young people.

Better scrutiny of decision making that ensures there are substantive consequences for lazy or poor practice would inevitably improve practice. It is simply not acceptable to say that the workforce is underfunded and overworked. It may be factual, but it is not an acceptable explanation for poor practice in 2019. The decision to remove a child without a proper risk assessment applied or even recorded, the decision to not find family, the decision to not return the call of anxious, loving and willing Aboriginal family carers, the decision to allocate disempowered and struggling parents restoration goals of Sisyphean proportion; these and many more that we uncovered in our deep dive, have had irreversible impact upon the Aboriginal child or young person.

The Uluru Statement tells us that child removal numbers ‘tell plainly the structural nature of our problem. This is the torment of our powerlessness’. Yet the legislators of NSW saw fit to empower our people *structurally* through the legislating of the ACPP. We have heard from stakeholders time and time again that departmental staff implement only that which they are compelled to do and that is those parts of the ACPP that attract a remedy for non-compliance. The Review has made recommendations on how we can improve legislative recognition and on-the-ground implementation of the ACPP.

The solution to much of the concerns about the rates of Aboriginal children and young people in NSW is, of course, better resourcing and preventative work pre-entry into care. Such resource implications are, of course, the province of the Minister and his department. Yet a less prominent solution, but one that would pay significant dividends, is greater emphasis and resourcing for training of caseworkers, in particular, skills development delivered by the Office of Senior

Practitioner (OSP). Caseworker training must not be solely or mostly about legislation, policy and workplace health and safety legislation and policy. Training must be focused on skills that are needed for casework on the ground; skills that permit caseworkers to elevate their judgement and intuition and other practical skills above the ritual of comfort that compliance culture affords. The work of caseworkers is so incredibly important. The ongoing development of their skills alone will see a radical change in the nature of casework.

Finally, the department must come to understand that the right to self-determination is much more than the ACPP. The NSW report of the Royal Commission into Aboriginal Deaths in Custody states that,

the demand for self-determination is a demand not only to have the management of service delivery to Aboriginal communities, but to have the opportunity to make decisions about policies affecting Aboriginals so that Aboriginals may have some real control over what happens to them. It is a step beyond self-management.

The right to self-determination is not about the state working with our people, in partnership. It is about finding agreed ways that Aboriginal people and their communities can have control over their own lives and have a collective say in the future well being of their children and young people. As the Uluru Statement from the Heart implores:

When we have power over our destiny our children will flourish. They will walk in two worlds and their culture will be a gift to their country.



List of submissions

Submission No	Name
1	Aunty Glendra Stubbs and Elizabeth Rice
2	Barnados Australia
3	The Law Society of New South Wales
4	CREATE Foundation
5	Secretariat of National Aboriginal and Islander Child Care
6	Legal Aid NSW
7	The Benevolent Society
8	Grandmothers Against Removals NSW
9	NSW Council of Social Service
10	Confidential
11	Family Violence Prevention Legal Services Joint Submission
12	National Family Violence Prevention Legal Services Forum
13	Aboriginal Child, Family and Community Care State Secretariat
14	Redfern Legal Centre
15	Glendra Stubbs
16	Northern Rivers Community Legal Centre
17	People with Disability Australia
18	Children's Court of New South Wales
19	Dr Kath McFarlane
20	Women's Legal Service NSW
21	Confidential
22	National Congress of Australia's First Peoples
23	Uniting (NSW.ACT)

List of figures

PAGE

Figure 1	Number and proportion of children and young people entering OOHC between 2011/12 and 2017/18 by Aboriginality, NSW
Figure 2	Number of children and young people with ROSH reports in 2011/12 and the proportion who entered OOHC between 2011/12 and 2016/17 by district of their first ROSH report in 2011/12, NSW
Figure 3	Proportion of children and young people with ROSH reports in 2015/16 by primary reported issue and age groups, NSW
Figure 4	Number and proportion of children and young people in OOHC as at 30 June 2012 to 2018 by Aboriginality, NSW
Figure 5	Number and proportion of children and young people who entered OOHC in 2015/16 by the placement exit reason of their last non-respite placement before 30 June 2018, NSW
Figure 6	Number and proportion of children and young people entering OOHC in 2015/16 by Aboriginality and age, NSW
Figure 7	Number and proportion of children and young people who entered OOHC in 2015/16 by whether the child had been in OOHC previously and Aboriginality, NSW
Figure 8	Number and proportion of children and young people who entered OOHC in 2015/16 by time between their first ROSH report and first entry into OOHC and Aboriginality, NSW
Figure 9	Number and proportion of children and young people who entered OOHC in 2015/16 by the number of ROSH reports in the 2 years prior to entry and Aboriginality, NSW
Figure 10	Statistics for the number of ROSH reports in the 2 years prior to entry into OOHC in 2015/16 by Aboriginality, NSW
Figure 11	Number and percentage of children who entered OOHC during 2015/16 who were reported at ROSH with the specified issues prior to their entry into OOHC by Aboriginality, NSW
Figure 12	Number and proportion of children and young people in the review cohort who had a care application filed by the grounds for care outlined in the care application, NSW
Figure 13	Proportion of children and young people in the review cohort by whether a care application was filed, NSW
Figure 14	Number and proportion of children and young people in the review cohort by the legislative basis of entry into OOHC in 2015/16, NSW

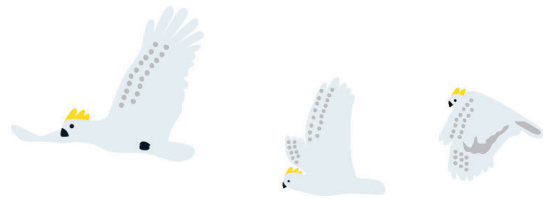


Figure 15 Proportion of children and young people in the review cohort by the legislative basis of entry into OOHC and the authority approving the entry into OOHC in 2015/16, NSW

Figure 16 Number and proportion of children and young people in the review cohort by whether practice issues were identified in the way the children came into OOHC in 2015/16, NSW

Figure 17 Care arrangement at entry into OOHC for children and young people who entered OOHC during 2015/16 by Aboriginality, NSW

Figure 18 Number and proportion of children and young people in the review cohort by sector case managing the child at the time of the review, NSW

Figure 19 Number and proportion of children and young people in the review cohort who were in care by whether the current carer is Aboriginal at the time of the review, NSW

Figure 20 Number and proportion of children and young people in the review cohort who were in care by the current placement type at the time of the review, NSW

Figure 21 Number and proportion of children and young people in the review cohort by the people involved in decision making for the current placement at the time of the review, NSW

Figure 22 Number and proportion of children and young people in the review cohort who had a care application filed by whether the care application identified the child as Aboriginal, NSW

Figure 23 Number and proportion of children and young people in the review cohort who had a care application filed by whether the care application noted that the Aboriginal Child Placement Principle (ACPP) was being considered in the application or placement, NSW

Figure 24 Number and proportion of children and young people who entered OOHC during 2015/16 by their OOHC status at 30 June 2018 and Aboriginality, NSW

Figure 25 Number and proportion of children and young people who entered OOHC in 2015/16 and exited by 30 June 2018 aged less than 17 years by re-entry status at 30 June 2018 and Aboriginality, NSW

Figure 26 Number and proportion of children and young people in the review cohort by the age of the mother at the time of entry into OOHC in 2015/16, NSW

Figure 27 Summary statistics on the age of the mother at the time of entry into OOHC in 2015/16 for the children and young people in the review cohort, NSW

Figure 28	Number and proportion of children and young people in the review cohort by the Aboriginal status of the mother, NSW
Figure 29	Number and proportion of children and young people in the review cohort by whether the child's mother has child protection history in NSW
Figure 30	Number and proportion of children and young people in the review cohort by whether the child's mother has OOHC history in NSW
Figure 31	Number and proportion of children and young people in the review cohort by the age of the father at the time of entry into OOHC in 2015/16, NSW
Figure 32	Summary statistics on the age of the father at the time of entry into OOHC in 2015/16 for the children and young people in the review cohort, NSW
Figure 33	Number and proportion of children and young people in the review cohort by the Aboriginal status of the father, NSW
Figure 34	Number and proportion of children and young people in the review cohort by whether the child's father has child protection history in NSW
Figure 35	Number and proportion of children and young people in the review cohort by whether the child's father has OOHC history in NSW
Figure 36	Number and proportion of children and young people in the review cohort by whether the parents have child protection history in NSW
Figure 37	Children and young people who received Intensive Family Support (IFS) in the 2 years prior to entry into OOHC in 2015/16 by Aboriginality, NSW
Figure 38	Closure status of the program at the time of entry into OOHC for children and young people who received Intensive Family Support (IFS) in the 2 years prior to entry into OOHC in 2015/16 by Aboriginality, NSW
Figure 39	Children and young people who received Brighter Futures (BF) in the 2 years prior to entry into OOHC in 2015/16 by Aboriginality, NSW
Figure 40	Closure status of the program at the time of entry into OOHC for children and young people who received Brighter Futures (BF) in the 2 years prior to entry into OOHC in 2015/16 by Aboriginality, NSW
Figure 41	Number and proportion of children and young people in the review cohort by whether the family was referred to Intensive Family Based Services (IFBS), NSW
Figure 42	Number and proportion of children and young people in the review cohort referred to IFBS by whether the referral was accepted, NSW



- Figure 43** Number and proportion of children and young people in the review cohort by whether the family was referred to Intensive Family Preservation Services (IFPS), NSW
- Figure 44** Number and proportion of children and young people in the review cohort referred to IFPS by whether the referral was accepted, NSW
- Figure 45** Number and proportion of children and young people in the review cohort by type of secondary assessment completed, NSW
- Figure 46** Number and proportion of children and young people in the review cohort who had a SARA assessment by whether a risk assessment was completed, NSW
- Figure 47** Number and proportion of children and young people in the review cohort who had a risk assessment by age group at the time of the risk assessment and whether the child was interviewed for the risk assessment, NSW
- Figure 48** Number and proportion of children and young people in the review cohort who had a risk assessment by whether the child was observed during the risk assessment, NSW
- Figure 49** Number and proportion of children and young people in the review cohort who had a risk assessment by whether a risk re-assessment was completed, NSW
- Figure 50** Number and proportion of children and young people in the review cohort who had a SARA assessment by the safety assessment outcome, NSW
- Figure 51** Number and proportion of children and young people in the review cohort with a safety plan by whether the safety plan addresses the identified dangers, NSW
- Figure 52** How many Aboriginal children in the cohort have experienced substantiated abuse or neglect while in OOHC compared to non-Aboriginal children?
- Figure 53** Who caused harm to the Aboriginal/non Aboriginal child while in OOHC?
- Figure 54** What was the care setting in which the abuse in care against the Aboriginal/non Aboriginal child occurred?
- Figure 55** Did the Aboriginal/non-Aboriginal child remain in the placement where substantiated harm/risk occurred immediately after assessment?
- Figure 56** Number and proportion of children and young people in the review cohort by whether Aboriginal consultation occurred at each key stage of case management, NSW

Figure 57	Proportion of children and young people in the review cohort who had Aboriginal consultation by the Aboriginal people consulted at each key stage of case management, NSW
Figure 58	Number and proportion of children and young people in the review cohort by the people involved in decision making for the first placement in 2015/16, NSW
Figure 59	Proportion of children and young people in the review cohort by the placement type for the first placement in 2015/16, NSW
Figure 60	Number and proportion of children and young people in the review cohort by whether the first placement in 2015/16 was with an Aboriginal carer, NSW
Figure 61	Proportion of children and young people in the review cohort by whether Aboriginal family or kin was assessed or authorised to care for the child, NSW
Figure 62	Number and proportion of children and young people in the review cohort by whether non-Aboriginal family or kin was assessed or authorised to care for the child, NSW
Figure 63	Number and proportion of children and young people in the review cohort who were in care by whether the child has a cultural plan at the time of the review, NSW
Figure 64	Number and proportion of children and young people in the review cohort who were in care and have a cultural plan at the time of the review by whether there is evidence of connection to country in the cultural plan, NSW
Figure 65	Number and proportion of children and young people in the review cohort who were in care and have a cultural plan at the time of the review by whether there is evidence of age appropriate exposure to cultural elements in the cultural plan, NSW
Figure 66	Number and proportion of children and young people in the review cohort who were in care and have a cultural plan at the time of the review by whether there is evidence of engagement with Aboriginal services, NSW
Figure 67	Number and proportion of children and young people in the review cohort who had a care plan filed by whether the care plan identified restoration to parent/s as a possibility, NSW
Figure 68	Number and proportion of children and young people in the review cohort who had a care plan filed by duration between entry into OOH in 2015/16 and filing the care plan, NSW
Figure 69	Number and proportion of children and young people in the review cohort by whether a care plan was filed, NSW



Figure 70 Number and proportion of children and young people in the review cohort who had a care plan filed by whether restoration to the parents was ever considered a possibility after final orders, NSW

Figure 71 Proportion of children and young people in the review cohort who had restoration identified in the care plan by whether the child was restored, NSW

Figure 72 Number and proportion of children and young people in the review cohort who were in care by whether the child has contact with their mother at the time of the review, NSW

Figure 73 Number and proportion of children and young people in the review cohort who were in care and have contact with their mother by whether the frequency of the contact at the time of the review, NSW

Figure 74 Number and proportion of children and young people in the review cohort who were in care and have contact with their mother by whether the contact is supervised at the time of the review, NSW

Figure 75 Number and proportion of children and young people in the review cohort who were in care by whether the child has contact with their father at the time of the review, NSW

Figure 76 Number and proportion of children and young people in the review cohort who were in care and have contact with their father by the frequency of the contact at the time of the review, NSW

Figure 77 Number and proportion of children and young people in the review cohort who were in care and have contact with their father by whether the contact is supervised at the time of the review, NSW

Figure 78 Number and proportion of children and young people in the review cohort by the number of placements the child had during the 24 months since entering OOHC in 2015/16, NSW

Figure 79 Number of children and young people adopted between 2011/12 and 2016/17, NSW

Figure 80 Number and proportion of children and young people entering OOHC in 2015/16 by Aboriginality and age breakdown, NSW

Figure 81 Number and proportion of children and young people in the review cohort who had a risk assessment by age group at the time of the risk assessment and whether the child was interviewed for the risk assessment, NSW

Figure 82 Number of ROSH reports by age and Aboriginality 2016/17

Figure 83 Number of children involved in ROSH reports by age and Aboriginality 2016/17

Acronyms

ABC	Australian Broadcasting Corporation
AbSec	Aboriginal Child, Family and Community Care State Secretariat
ACCO	Aboriginal Community Controlled Organisation
ACPP	Aboriginal Child Placement Principle
ACYFS	Aboriginal Child, Youth and Family Strategy
ADR	Alternative Dispute Resolution
AH&MRC	Australian Health and Medical Research Council
AHO	Aboriginal Housing Office
AIHW	Australian Institute of Health and Welfare
ALRC	Australian Law Reform Commission
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSICPP	Aboriginal and Torres Strait Islander Child Placement Principle
BOCSAR	Bureau of Crime Statistics and Research
COAG	Council of Australian Governments
CSC	Community Service Centre
DCJ	Department of Communities and Justice
DOCS	Department of Community Services
DRC	Dispute Resolution Conference
DVSAT	Domestic Violence Safety Assessment Tool
EIC	Entry Into Care
EIRP	Early Intervention Referral Project
EMRIP	United Nations Expert Mechanism on the Rights of Indigenous Peoples
FACS	Family and Community Services
FACSIAR	Family and Community Services Insights, Analysis and Research
FGC	Family Group Conference
FVPLS	Family Violence Prevention Legal Service
GMAR NSW	Grandmothers Against Removal NSW
HRBA	High Risk Birth Alert
HREOC	Human Rights and Equal Opportunity Commission



IFBS	Aboriginal Intensive Family Based Services
IFPS	Intensive Family Preservation Service
IFS	Intensive Family Support
MOU	Memorandum of Understanding
NCAT	NSW Civil and Administrative Tribunal
NDIS	National Disability Insurance Scheme
NGO	Non-governmental Organisation
NHMRC	National Health and Medical Research Council
OCG	Office of the Children’s Guardian
OCV	Official Community Visitors
OOHC	Out-of-home Care
OSP	Office of the Senior Practitioner
PACT	Protecting Aboriginal Children Together
PCO	Parent Capacity Order
POCLS	Pathways of Care Longitudinal Study
PPPs	Permanent Placement Principles
PRC	Parent Responsibility Contracts
PSP	Permanency Support Program
PWDA	People with Disability Australia
QSR	Quality Service Review
ROSH	Risk of Significant Harm
Royal Commission	Royal Commission into Institutional Responses to Child Sexual Abuse
SAM	Safety Action Meeting
SARA	Safety and Risk Assessment
SDM	Structured Decision Making
SNAICC	Secretariat of National Aboriginal and Islander Child Care
TCA	Temporary Care Arrangement
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
WWCC	Working With Children Check

Definitions

Aboriginal: The term 'Aboriginal' in this report refers to both Aboriginal and Torres Strait Islander peoples. It is used to refer to the numerous nations, language groups and clans in NSW. 'Indigenous' is retained when it is part of the title of a program, report or quotation, or when the context requires it.

Aboriginal Care Review Tool: An online data collection tool which required reviewers to enter data from the case files for analysis. For data resulting from the use of the Aboriginal Care Review Tool, see FACS (Review Tool) data.

Aboriginal Child Placement Principle: The Aboriginal Child Placement Principle, or Aboriginal and Torres Strait Islander Child Placement Principle, is a broad principle that applies to the involvement of Aboriginal children and families in the child protection system, and is made up of the following five elements: (i) prevention; (ii) partnership; (iii) placement; (iv) participation; and (v) connection.

Assessment Tool: A document containing a summary and evaluation of a child's case file, and recommendations for future action in respect of individual cases. Assessment Tools were prepared by the Family is Culture team and Chairperson and sent to FACS to be forwarded to the relevant FACS Districts.

Case file: 'Case files' of the children in the Review cohort comprised information from FACS internal case management systems, KiDS and ChildStory (which contain information relating to child protection, out-of-home care and carer management processes for individual children). In addition, case files occasionally included information from non-government out-of-home care providers.

Caseworker: A caseworker is a Department of Communities and Justice employee who works directly with children and families. Caseworkers must have an undergraduate university degree. In this report, 'caseworker' is often used to describe the individual responsible for making a decision about a particular child's case. However, it should be noted that on occasions other departmental staff may also be involved in decision making about casework practice, such as 'managers casework' or 'managers client services'.

Child: The terms 'child' or 'children' are used in this report to refer to all children under the age of 18. This accords with the definition incorporated into the the United Nations *Convention on the Rights of the Child*. When discussing older children (generally accepted to be those aged 14 to 17) the terms 'young person' or 'young people' may also be used.

Community Service Centre: An office of the Department of Communities and Justice that provides child protection and out-of-home care services.

FACS: The term 'FACS' is used to refer to the Department of Family and Community Services (as it was called for the period of the Review). The Department of Communities and Justice (DCJ), is used when discussing the department responsible for child protection services after 1 July 2019.

FACS (Review Tool) data: FACS (Review Tool) data is the term used to describe data derived from the Aboriginal Care Review Tool.



FACS (Administrative) data: FACS (Administrative) data is the term used to describe data derived from the KiDS/ChildStory dataset.

Guardianship order: An order placing a child in the care of a guardian (who is given parental responsibility for the child) until the child is 18 years of age.

Out-of-home care: Residential care and control of a child by a person other than the child's parent, and at a place other than the child's usual home, for a period of more than 14 days (usually following an order made by the Children's Court). Children who enter out-of-home care in New South Wales are placed into one of the following care arrangements

- **Relative/Kinship care:** 'Relative/kinship care' is care provided through a home-based care arrangement where the carer is a relative (other than a parent), is considered to be family, or is a person to whom the child shares a cultural or community connection. This type of care arrangement is supervised by FACS or a non-government out-of-home care provider. It falls within the definition of statutory out-of-home care when the Minister has parental responsibility for the child.
- **Foster care:** The term 'foster care' is used for the out-of-home care setting where a child is placed with a foster carer and is living with the carer and their family in the family home. Foster carers are authorised, supported and supervised by FACS or a non-government out-of-home care service provider.
- **Residential care:** 'Residential care' is care provided to a child in a residential facility, usually a house with other children, and involves the use of paid staff rather than an individual carer matched with the child.
- **Immediate or crisis care:** An emergency placement of a child, which may occur after hours or on weekends and may involve the child being placed in a motel or other similar emergency accommodation.

Out-of-home care service provider: An organisation that is approved, registered and accredited by the Office of the Children's Guardian to provide out-of-home care services and case management to children in out-of-home care in New South Wales. An out-of-home care service provider may be a government or non-government provider.

Parental responsibility: All of the duties, powers, responsibilities and authority which parents have, by law, in relation to their children.

Quantitative research: The systematic investigation of observable phenomena that utilises statistical and mathematical techniques in the course of analysis.

Qualitative sample data: Qualitative research data derived from a sample of 200 of the 'Assessment Tools' that the Chairperson of the Family is Culture review provided to FACS (see above 'Assessment Tools'). The sample of Assessment Tools was selected randomly and coded using semi-structured and emergent coding techniques, and the results of this process were examined in partnership with the Family is Culture Reference Group.

Review cohort: The group of Aboriginal children who entered out-of-home care in New South Wales between 1 July 2015 and 30 June 2016.

Executive summary

This Review is aimed at examining the high rates of Aboriginal children and young people in out-of-home care (OOHC) in New South Wales (NSW) and the implementation of the Aboriginal Child Placement Principle (ACPP) in this jurisdiction. As required by the Terms of Reference, the Review involved, among other things, an analysis of policies and practices relating to Aboriginal children in OOHC, community consultations and public submissions, and a detailed examination of the circumstances of the 1,144 Aboriginal children who entered OOHC in NSW between 1 July 2015 and 30 June 2016. This case file review process generated a significant amount of qualitative data about ‘on-the-ground’ casework practice in respect to Aboriginal children and families in contact with the child protection system. Examples of this casework practice, and more fulsome case studies, are dispersed throughout this report to provide vivid, real-life illustrations of themes and issues that arose during the Review.

Part A provides an introduction to the Review and comprises four chapters. Chapter 1 begins by providing background to the establishment of this Review, noting the importance of grassroots advocacy by the Aboriginal community, in particular the Grandmothers Against Removals NSW, in harnessing the political will to engage in reform in this area. It then describes why, in a human services system that has been the subject of so many previous inquiries and reviews, this Review is unique. It notes that this is the first review to focus specifically on Aboriginal children and families, and their interaction with the child protection system in NSW. It is also the first review to be led by an Aboriginal chairperson, who has been supported by a largely Aboriginal Reference Group, as well as numerous Aboriginal research and administrative staff. It is also the first review to have been granted permission to access departmental files to review the circumstances of a large cohort of Aboriginal children in OOHC. As such, this is the first review to include a comprehensive evidence-base regarding casework practice—that is, the way that child protection is actually ‘done’ day to day, through casework—and the first to examine this evidence from the perspective of independent ‘outsiders’ who have not previously been a part of this system.

Chapter 1 also provides a brief history of Aboriginal involvement in the child protection system from the late 1800s to today. This history, which has been long overlooked by many Australians is vitally important to understanding the problems in today’s child protection system. This history is so much more than the Stolen Generations—it is a sustained history of oppression, paternalism and cruelty, which included a lengthy period of ‘protection’ or compulsory racial segregation, the consequences of which can still be seen today when, for example, parents are judged for their lack of engagement with FACS caseworkers without the slightest regard for the historical antecedents of Aboriginal peoples’ mistrust of the state.

Chapter 1 also provides an overview of past inquiries and reviews of child protection nationally and in NSW. While this type of overview is standard in many child protection inquiries, this particular section focuses specifically on what each of these past investigations have noted and recommended in relation to Aboriginal children and families in relation to OOHC (usually in a chapter dedicated to Aboriginal children in OOHC). This chapter highlights that child protection is ‘a well-trodden reform landscape that is littered with comprehensive and unimplemented recommendations for reform’.



Finally, Chapter 1 introduces two key concepts which permeate the whole of the Review and are important to discuss from the outset of the report. The first is ‘intergenerational trauma’—a very real concern to Aboriginal families and communities in NSW. Chapter 1 introduces the term and discusses what intergenerational trauma ‘looks like’ for Aboriginal families, including in the child protection context. This chapter also introduces the concept of regulatory ritualism, which is a theory that looks to the functioning of bureaucracy, particular in the human services space. Regulatory ritualism is about workers operating within a regulatory system while losing sight of its substantive goals. In the context of child protection, the Review has looked to the functioning of the large-scale bureaucracy around this human service in NSW. The content of this review demonstrates that it has in many ways, ‘lost sight’ of the actual goal of protecting children in its day-to-day operation.

Chapter 2 outlines the Review’s methodology. It provides an overview of the four main phases of the Review—design and development; information gathering; data analysis; and report writing and delivery. In doing so it expands on the Review’s consultation process, the composition of the Review’s Reference Group, as well as the various sources of quantitative and qualitative data used to inform the Review. After noting issues with the departmental approach to the interpretation of data about Aboriginal people, in particular, the lack of partnership with Aboriginal stakeholders in respect of data interpretation, recommendations are made to improve future approaches to the design, collection and interpretation of data about Aboriginal children and families in contact with the child protection system.

The final chapter in Part A, Chapter 3, introduces the ‘Review cohort’, or the group of Aboriginal children who entered OOHC between mid-2015 and mid-2016. It commences by discussing the overrepresentation and disproportionate ‘systems contact’ of Aboriginal children in OOHC generally, also highlighting that while the raw numbers of children in care have been reducing in recent years, Aboriginal children in NSW are increasingly disproportionately represented in entries into OOHC. This chapter also provides an overview of the demographics of the Review cohort and explores the reasons that children in this group entered OOHC. It concludes by examining data about the recommendations made by the Family is Culture team in respect of individual children’s cases to illuminate some of the areas of practice that were identified to be of concern during the case file review process.

In summary, Chapter 3 concludes that Aboriginal children are over-represented in the care and protection system and are also over-represented in OOHC. It notes that data shows that Aboriginal children are known to this system early, highlighting opportunities for early intervention, prevention and diversion away from care and protection. Once in care, Aboriginal children experience issues with non-compliance with the ACPP. The experiences of the cohort children’s parents—a high proportion of whom had been known to the child protection system in NSW themselves as children—highlight the vulnerability of the cohort families and the need for trauma-informed, dignity driven and culturally appropriate work before children enter care, and where they do enter care, to support restoration. The characteristics of this cohort inform the content and direction of this report. It is the Review’s hope that learning from these children’s and families’ experiences can inform and improve the future directions of child protection practice with Aboriginal children and families in NSW.

While the entire child protection system is incredibly complex and took the Family is Culture team a significant amount of time to understand, it is certainly not incomprehensible, and is in fact understood intimately by those who work within it; although they too struggle to keep

up with the rapidly and constantly changing policy framework. What is lacking, however, is an attempt to break down its complexity for 'outsiders'. It is important for the functioning of the rule of law that parents and families understand how the child protection system works. Part B of the report attempts to go beyond the high level 'factsheet' or 'brochure' approach to explaining the system, to provide genuine knowledge about how and why things happen at various points of the continuum of intervention and the rights and responsibilities of those involved with the system at each particular stage. It is only through this type of real knowledge that Aboriginal children, parents and families can be empowered, and other stakeholders can analyse and attempt to reform parts of the system, with a view to how it operates in its entirety. Chapter 5 outlines the operation of the 'child protection system'. It explains how the system operates, from the first risk of significant harm (ROSH) report that is made about a child, to the removal of the child from his or her family, and the preparation of his or her OOHC case plan. Chapter 6 deals with how the care and protection jurisdiction of the Children's Court of NSW operates, from the point in time in which the department applies for a care order, to the hearing which determines the placement of a child, to any appeal from the Children's Court to the District Court of NSW.

Part C of the report deals with two significant issues that highlight the need for structural change to the child protection system—the issue of self-determination and the issue of public accountability and oversight. The Review has concluded that, if implemented adequately, the reforms proposed in these two chapters alone will go a significant way to addressing the entrenched problem of the over-representation of Aboriginal children in the statutory child protection system.

Chapter 7 discusses the issue of self-determination in the child protection system. It notes that while the term 'self-determination' is used in child protection legislation and policy documents in NSW, it is not defined, nor is it properly understood or implemented in practice. This chapter explores in some detail the concept of self-determination, including its construction in international law, how it can be recognised by states and how it has been recognised by the Commonwealth and NSW governments in Australia. It also analyses how self-determination could operate in the child protection context and examines approaches in other jurisdictions that seek to encourage greater self-determination in this sector. It concludes by recommending that the NSW government and the Aboriginal stakeholders in the child protection sector discuss what they each mean by the right to self-determination and what it may look like in a child protection context. Currently the two parties are misaligned in their approaches.

Those who work in the child protection system have significant statutory powers that often rely on discretionary assessment, for example, the assessment of whether or not a child is at risk of significant harm, who a child should be placed with while in OOHC, and who a child should have contact with while in OOHC. While the exercise of these discretionary powers should ideally be guided by legislation and departmental policies, the Review found there was pervasive non-compliance with these external and internal rules governing worker behaviour. Accordingly, the Review focused on reform designed to rectify this problem and ensure that many of the carefully crafted and researched policies that exist, as well as existing statutory obligations, are actually considered and implemented 'on the ground'.

Chapter 8 discusses public accountability and oversight in the child protection context. It begins by providing an overview of well-known bodies and mechanisms that provide accountability and oversight of the child protection system, such as the complaints-handling system, the Ombudsman and the Office of the Children's Guardian, as well as less well known mechanisms,



such as data collection and publication, and media scrutiny. The chapter then sets out the myriad of concerns about deficiencies in the current regulatory system, focusing, for example, on a pervasive lack of transparency among key players in the accountability and oversight system, and lack of effective monitoring of OOHC providers. It then proposes a flagship reform—namely, the establishment of a new, independent Child Protection Commission which would undertake all the regulatory activities currently performed by other bodies, as well as some additional functions, such as reviewing the circumstances of individual children in OOHC, and conducting regular, random case file reviews. Chapter 8 makes a number of other recommendations for reform designed to enhance transparency in the child protection system and ensure that OOHC services are only provided to children when the provider satisfies the minimum requirements to ensure child safety and wellbeing.

...the current system of prenatal reporting, investigations and newborn removals is flawed and is having a significant impact on the number of Aboriginal children entering OOHC

The remainder of the report is divided up into three parts, each of which addresses a different ‘lever’ of change, or a different area which, if reformed, will reduce the number of Aboriginal children in OOHC. The first of these parts, Part D, examines how to reduce entries into care. Chapter 9 discusses the important issue of early intervention. It begins by providing an overview of existing early intervention services, before outlining barriers to their use, such as a lack of resources, a lack of culturally appropriate services and a lack of casework support. It also sets out the data which demonstrates that there is currently a lack of adequate early intervention support for Aboriginal families. The chapter makes recommendations for legislative reform to mandate the provision of services and the making of active efforts to prevent entry into care prior to a child’s removal. It also makes recommendations aimed at reforming casework practice in relation to Aboriginal families experiencing problems in one or more of the following areas: family and domestic violence, housing and disability.

Chapter 10 discusses an area that was of particular significance during the course of the Review—namely, prenatal reporting and newborn removals. With the data highlighting that a high proportion of Aboriginal children were assumed into care at or shortly after birth and the Review team’s case file analysis uncovering multiple instances of poor and unethical newborn removal practices, this is an area that is in urgent need of reform. Quite simply, the current system of prenatal reporting, investigations and newborn removals is flawed and is having a significant impact on the number of Aboriginal children entering OOHC.

The chapter begins by providing an overview of the existing system of prenatal reporting in NSW and the law and practice surrounding newborn removals. It then makes several recommendations for reform, focusing on the urgent need to devise an Aboriginal prenatal reporting and newborn removal policy, to improve engagement with expectant parents, and to provide post-removal support for the parents of newborn babies assumed into care. This chapter also recommends the repeal of s 106A(1)(a) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*), a provision which stipulates that evidence of a prior removal is *prima facie* evidence that a child is in need of care and protection, in light of the way it has been interpreted by caseworkers as providing a ground of removal and its unfair operation with respect of the Aboriginal community.



...the Review found a substantial level of non-compliance with the requirement to conduct safety and risk assessments

Chapter 11 of the report examines the need for caseworkers to more actively consider alternatives to removal when working with Aboriginal families. These alternatives, such as parental responsibility contracts, parent capacity orders, family group conferences and temporary care arrangements are designed to be used prior to a child being removed. However, the Review has ascertained that these options are underutilised and recommends legislative amendment to mandate the consideration of specific alternatives prior to removal, as well as judicial guidance to Children’s Court magistrates to ensure that the Court plays a more active role in scrutinising the pre entry into care casework of departmental employees.

The next chapter in this part, Chapter 12, considers the need to improve entry into care practice. It focuses on an area that was demonstrated to be in need of scrutiny and reform during the case file review process—namely, the safety and risk assessment process. It is through the safety and risk assessment process that caseworkers decide whether a child is at risk of significant harm, and hence whether or not a child should be removed. However, the Review found a substantial level of non-compliance with the requirement to conduct safety and risk assessments and was also concerned about whether the existing safety and risk assessment tools are culturally appropriate. The Review recommends that the Department of Communities and Justice, commission a detailed, independent review of its screening and assessment tools, and notes that this should be conducted in partnership with Aboriginal stakeholders to ensure these tools are responsive to Aboriginal communities. Chapter 13 also deals with another element of entry into care practice, namely the way children are removed. The Review has significant concerns about the use of police during removals and describes other inappropriate removal practices that were used in relation to children in the Review cohort. It makes recommendations designed to ensure that caseworkers are required to provide a detailed justification of the timing, location and method of proposed removal or assumption, and to ensure that there is further training and internal oversight of caseworkers’ use of police during child removals.

Chapter 14 deals with the need to counter the often implicit assumption made by stakeholders in the child protection system that removal will result in better outcomes for a child. Of course, the safety and wellbeing of Aboriginal children is of paramount importance. The Review acknowledges that in some cases Aboriginal children may need to be removed from their families in order to ensure their safety and wellbeing. However, it is important to recognise that it is also harmful when Aboriginal children are removed from their parents and put into unsafe environments where they may experience ongoing abuse, where their connections to family and culture may not be sustained or respected, and where they may experience considerable trauma and disconnection that has lifelong consequences.

Chapter 14 analyses the harm of removal. It discusses existing ‘safety and abuse in care’ data and recommends that greater effort be made to collect and analyse this data to provide further insights into when and where abuse in care is occurring. It then notes the growing body of literature that demonstrates the myriad of other harms that can be attributed to growing up in OOHC, including poor mental health, poor educational outcomes, substance use problems and homelessness. It concludes that it is time for the NSW Government to formally acknowledge to Aboriginal communities, as well as the broader Australian community that, as an ostensible ‘parent’, it can and does cause harm to children for whom it has parental responsibility. In order



to do this, the NSW Government must increase transparency around safety in care (including by collecting data about abuse in care, and encouraging children to report abuse in care) and encourage the ventilation of issues relating to the harm of children in OOHC during care and protection proceedings. The harm of removal should also be recognised by the judiciary and this chapter recommends legislative amendment to ensure that Children’s Magistrates are required to consider this particular form of harm when making decisions in relation to a child in need of care and protection.

It concludes that it is time for the NSW Government to formally acknowledge to Aboriginal communities, as well as the broader Australian community that, as an ostensible ‘parent’, it can and does cause harm to children for whom it has parental responsibility.

The increased likelihood of involvement in the criminal justice system, which is one of the broader harms of removal experienced by Aboriginal children in OOHC, is dealt with in more detail in Chapter 15. The chapter examines evidence that demonstrates that placing a child in OOHC increases his or her risk of being involved in the juvenile justice system. This risk, known as ‘care-criminalisation’, arises from the fact that children are often charged with offences against carers or residential home staff due to conduct that would not be criminalised if they occurred in the child’s home environment. Care criminalisation also results from placement instability, a lack of cultural connection and a lack of secure accommodation for children in custody and seeking bail. The failure of the child protection and juvenile justice systems to adequately address the issue of the cross-over of children between OOHC and juvenile justice is extremely concerning, as this issue has intergenerational consequences for the Aboriginal community. This ‘drift’ of children from OOHC into the juvenile justice system is of paramount concern to the Aboriginal community, as Aboriginal children are more likely to be affected by this phenomenon due to their gross over-representation in the OOHC system.² Involvement in the juvenile justice system perpetuates a cycle of disadvantage and child removals that must be halted in order to reduce the entry of Aboriginal children into the OOHC system in the longer term. The Review recommends, among other things, greater data collection and research into the cross-over of children in OOHC and the juvenile justice system, as well as the development of further resources to ensure foster carers and residential home staff are trained about appropriate responses to children exhibiting behavioural difficulties in OOHC.

² Note that Aboriginal children are also grossly over-represented in the juvenile justice system, making up approximately 50.1% of the juvenile prison population: NSW Bureau of Crime Statistics and Research, *NSW Custody Statistics: Quarterly Update March 2018* (Report, March 2018) 6.

Part E of the report considers the second ‘lever’ of change necessary to reduce the number of Aboriginal children in OOHC and also improve the experiences of Aboriginal children in care—the implementation of the Aboriginal Child Placement Principle (the ACPP). Chapter 16 provides an overview of the principle, noting that it consists of five elements, prevention, partnership, placement, participation and connection. It recommends that existing legislation in NSW be amended to reflect this fact. This chapter outlines concerns about a lack of compliance with the ACPP, as well as the lack of comprehensive data required to adequately measure compliance and makes recommendations about training and data collection to address these issues.

Chapter 16 also discusses a vitally important foundational issue when it comes to the effective implementation of the ACPP—namely, the identification and ‘de-identification’ of Aboriginal children. It highlights concerns about the way the department is identifying and de-identifying children as being Aboriginal and notes the lack of comprehensive guidance in relation to this practice. In light of the fundamental importance of cultural identity to Aboriginal children, and the ramifications that the failure to identify, or the decision to ‘de-identify’, an Aboriginal child may have for that child’s cultural safety, the Review recommends that regulations be enacted addressing this issue. These regulations, to be devised in partnership with the Aboriginal community, should stipulate appropriate practice with regard to the identification of Aboriginal children, as well as the circumstances in which a child can be ‘de-identified’. In addition, the Review recommends that further judicial guidance be developed to assist judicial officers in all courts in NSW to determine issues relating to the Aboriginality of a child in child protection matters where these issues arise.

This ‘drift’ of children from OOHC into the juvenile justice system is of paramount concern to the Aboriginal community, as Aboriginal children are more likely to be affected by this phenomenon due to their gross over-representation in the OOHC system.

Chapter 17 is the first of four chapters to discuss the elements of the ACPP in detail. This chapter addresses the second element of ‘partnership’ (the first broad element of prevention already being addressed at various points throughout the report). It notes that the concept of partnership is related to, but distinct from, the concept of self-determination. In summary, it requires the NSW Government to partner with Aboriginal community representatives in the design and delivery of child protection policies, strategies and services, as well as in decision-making about individual children (by, for example, providing knowledge about local cultural norms and beliefs, community dynamics or family structures). Evidence derived from the case review process is discussed, including evidence that demonstrates external Aboriginal community stakeholders are rarely approached to be involved in decision-making for Aboriginal children. No specific recommendations are made in this chapter. The recommendations made in the previous chapter are designed to encourage compliance with the ACPP and are sufficient to address problems with the implementation of this element of the ACPP.

The next chapter, Chapter 18, examines the most widely recognised and discussed element of the ACPP—the ‘placement’ element which is reflected in s 13 of the *Care Act*. The chapter notes that data about the physical placement of Aboriginal children needs to be interpreted with caution as it does not demonstrate compliance with the placement element of the ACPP. For example, it does not indicate whether the hierarchy in s 13 was properly applied when placing



the child, or whether the principle was applied for each of the child's previous placements. The chapter then identifies and examines numerous issues that were identified as contributing to non-compliance with the placement principle, including a lack of 'parallel planning' (or early planning for the placement of a child should it become necessary for the child to enter care), poor family finding, and poor casework practices that result in potential carers who volunteer their services being ignored or overlooked. The chapter also analyses significant problems with the Working with Children Check (WWCC) process, including lengthy delays in obtaining working with children check clearances, and the impact of the criminal history and carer checks on the authorisation of potential Aboriginal carers. The Review recommends that the Children's Guardian prioritise applications for WWCC clearances made by potential Aboriginal carers and undertake a review of the way the WWCC scheme operates in respect of Aboriginal applicants. This chapter also discusses carer assessment more generally and recommends the development and use of a culturally appropriate carer assessment tool developed in partnership with the Aboriginal community.

The element of participation is examined in Chapter 19. The chapter divides its discussion of participation into participation of parents and kin and participation of children and highlights the Review's findings that this element of the ACPP was poorly implemented in practice. It looks at Family Group Conferencing, including the mandatory requirement that FACS offer Alternative Dispute Resolution processes to children at risk of significant harm and their families. It notes the lack of data about the operation of Family Group Conferences, concerns about the lack of Aboriginal facilitators and arguments that the current approach is not culturally appropriate or safe for Aboriginal participants. The Review recommends that the Department of Communities and Justice support the development and implementation of a Family Group Conferencing model that is designed, led and delivered by Aboriginal controlled organisations.

The final chapter addressing the ACPP, Chapter 20, examines the element of 'connection'—that is, connection of Aboriginal children in OOHC to family, community, culture, and country. It discusses the importance of children maintaining regular ongoing contact with family and kin, as well as siblings, when in OOHC. It discusses the particular problems that arise when parents are in custody and highlights the Review's findings about the lack of casework to facilitate contact between children in OOHC and parents in custody. It also discusses the lack of coordination between the Department and Corrective Services NSW to ensure that parents in custody have access to programs and services that will enhance their ability to parent their children safely, thereby increasing the possibility of restoration of children upon the parent's release from custody. This chapter also discusses cultural planning and concerns about the lack of effective cultural planning for the cohort of Aboriginal children who entered care between mid-2015 and mid-2016.

Part E of the report examines the third 'lever' to reduce the number of Aboriginal children in OOHC—increasing exits from care. Chapter 21 discusses restoration of Aboriginal children to their families. It outlines the current legal and policy approach to this issue and recommends that the Department of Communities and Justice partner with Aboriginal stakeholders to revise its policies, guidelines and practice relating to restoration for Aboriginal children and families. It discusses practical barriers to restoration, such as a lack of appropriate services, confusion about the restoration process, the imposition of impossible restoration goals and a lack of adequate and appropriate housing, as well as potential legal barriers to families achieving restoration, such as limited access to legal services and abbreviated timeframes for restoration, and makes recommendations to address these barriers.

Chapter 22 discusses an issue related to exits from care—the adoption of Aboriginal children in OOHC. It describes how the concept of legal adoption is not recognised by Aboriginal communities and analyses the increased political interest in the adoption of children in OOHC in the last seven years, culminating in the reforms introduced by the *Children and Young Persons (Care and Protection) Amendment Act 2018* (NSW). The chapter discusses the NSW Government’s continued failure to act upon Aboriginal opposition to the adoption of Aboriginal children and recommends legislative amendment to ensure that adoption is not an option for Aboriginal children in OOHC.

The final chapter of the report, Chapter 23, examines the need to reform certain aspects of care and protection proceedings in the Children’s Court of NSW. This is not the first review in NSW, or indeed the first state review, to raise concerns about the operation of care and protection proceedings. The issue was the subject of scrutiny in Queensland, for example, where reforms have been made to address the problems identified in that jurisdiction. It was also the subject of scrutiny in a NSW parliamentary inquiry into child protection. The Review considers this as an area in need of reform in NSW. This chapter commences by discussing a significant concern uncovered during the Review’s case file analysis process—that is, the extent to which FACS provides misleading and inaccurate evidence to the Children’s Court in care and protection proceedings. After outlining a number of case examples and evidence about the prevalence of this issue, the Review recommends the establishment of a new, independent statutory body to conduct care and protection litigation on behalf of the Secretary of the Department of Communities and Justice in NSW. It also recommends that only specialist magistrates should hear and determine care and protection proceedings and that a pilot Aboriginal court list be established and trialled for care and protection matters involving Aboriginal children.

As noted above, data from numerous sources is dispersed throughout the report. Figures referred to in the main body of the report, or in footnotes, are contained in Appendix A. These figures, which are derived from data collected during the file review (Aboriginal Care Review Tool data), as well as from departmental administrative data, are accompanied by notes which explain their source and limitations. Other notes are included where data is cited in the report.



List of recommendations

Chapter 2 Methodology

Recommendation 1: The Department of Communities and Justice should convene a roundtable with the Aboriginal community and stakeholders to discuss the meaning of data sovereignty and the designing, collecting and interpreting of the department's administrative data relevant to Aboriginal children and young people.

Recommendation 2: After the implementation of Recommendation 1, the Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community, develop a policy which will result in improved partnership being effected in the department's design, collection and interpretation of data relevant to Aboriginal children and families.

Recommendation 3: The Department of Communities and Justice should convene a roundtable with Aboriginal community and stakeholders to discuss the Pathways of Care Longitudinal Study (POCLS) methodology and how this data project may be used to better support Aboriginal community and stakeholders' priorities in respect of supporting Aboriginal children in out-of-home care.

Chapter 3 Introducing the Review Cohort

Recommendation 4: The Department of Communities and Justice should track, monitor and publicly report on the implementation of the recommendations of both the Family is Culture case file review process, and the Family is Culture report, within 12 months of the final report being delivered, with a view to further public reporting on implementation if necessary.

Chapter 4 The need for a new Aboriginal Quality Assurance Unit

Recommendation 5: The Department of Communities and Justice should establish an Aboriginal Quality Assurance Unit to address issues discussed in this report. This unit should:

- a. track, monitor and publicly report on the implementation of the recommendations made in the Review's case file review process and in this report;
- b. ensure that recommendations made by Aboriginal staff or community members in consultative processes are tracked and implemented, and that data about the implementation of these recommendations is made publicly available;
- c. provide ongoing training and practice support to child protection staff about issues relating to Aboriginal children and families in the child protection system; and
- d. collect and analyse data from multiple sources in order to identify systemic issues requiring reform.

Chapter 7 Self-determination

Recommendation 6: The Department of Communities and Justice should engage Aboriginal stakeholders in the child protection sector, including AbSec and other relevant peak bodies, to develop an agreed understanding on the right to ‘self-determination’ for Aboriginal peoples in the NSW statutory child protection system, including any legislative and policy change.

Recommendation 7: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and communities, undertake a systemic review of all policies that refer to self-determination, to consider how they might be revised to be consistent with the right to self-determination.

Recommendation 8: The NSW Government should, in partnership with Aboriginal stakeholders and communities, review the Aboriginal and Torres Strait Islander Principles of the *Children and Young Person (Care and Protection) Act 1998* (currently sections 11-14), with the view to strengthening the provisions consistent with the right to self-determination.

Chapter 8 Public accountability and oversight

Recommendation 9: The NSW Government should establish a new, independent Child Protection Commission. The Commission, which should be required by legislation to operate openly and transparently, should have the following functions:

- a. The handling of complaints about those involved in the operation of the child protection system (including complaints about matters that are before the Children’s Court of NSW where the hearing of the complaint will not interfere with the administration of justice);
- b. The oversight and coordination of the Official Community Visitors Scheme;
- c. The management of the ‘reviewable deaths’ scheme where the death is: a child in OOHC, or a child whose death is or may be due to abuse or neglect;
- d. The accreditation and monitoring of OOHC providers;
- e. The reviewing of the circumstances of an individual child or group of children in OOHC (including the power to apply to the Children’s Court of NSW for the rescission or variation of any order made under the *Children and Young Persons (Care and Protection) Act 1998* (NSW));
- f. The monitoring of the implementation of the *Aboriginal Case Management Policy* and the *Aboriginal Case Management Rules and Practice Guidance*;
- g. The conducting of inquiries into systemic issues in the child protection system, either on its own motion or at the request of the NSW Government;
- h. The conducting of the new qualitative case file review program;
- i. The monitoring of the implementation of the Joint Protocol to reduce the contact of young people in residential out-of-home care with the criminal justice system;



- j. The oversight and monitoring of, and reporting about, the operation of the new mandatory Alternative Dispute Resolution system introduced by the *Children and Young Persons (Care and Protection) Amendment Act 2018* (NSW); and
- k. The provision of information, education and training to stakeholders and the community about the operation of the child protection system.

Recommendation 10: The Department of Communities and Justice should conduct an independent review of its internal complaints handling system, with a view to developing a complaints system that is:

- a. transparent and accessible;
- b. child friendly;
- c. empowered to resolve complaints adequately;
- d. developed in consultation with Aboriginal communities;
- e. supported by a Charter of Rights and Responsibilities for Aboriginal Families.

This system should also employ Aboriginal staff in key roles.

Recommendation 11: The NSW Government should amend clause 45 of the *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) and all other related clauses to ensure that only a charitable or non-profit organisation may apply to the Office of the Children's Guardian for accreditation as a designated agency.

Recommendation 12: The Children's Court of NSW should be appropriately resourced to enable it to publish all of its final judgments online in a de-identified and searchable form.

Recommendation 13: The Children's Court of NSW should prepare and publish annual statistics regarding its operations in the care and protection jurisdiction.

Recommendation 14: The Children's Court of NSW should prepare and publish an Annual Review.

Recommendation 15: The NSW Government should amend s 105 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to include a public interest defence to an offence under s 105(1AA).

Recommendation 16: The NSW Government should, in partnership with Aboriginal communities and stakeholders, introduce a system of qualitative file reviews modelled on the Quality Case Review and Quality Service Review systems that have been implemented in some states of the United States of America, with the introduction of the additional component of an optional Family Group Conference.

Recommendation 17: The NSW Government should amend the *Ombudsman Act 1974* (NSW) to enable the NSW Ombudsman to handle complaints in matters that are (or could be) before a

court, in circumstances where doing so would not interfere with the administration of justice.

Recommendation 18: The Office of the Children’s Guardian should be required to: (i) publish its compliance inspection reports; (ii) provide these reports to the NSW Parliament; and (iii) publish annual summaries of its inspections, as well as its findings from any research and consultation.

Recommendation 19: The NSW Government should amend the *Advocate for Children and Young People Act 2014* (NSW) or otherwise legislate to ensure that a parliamentary committee monitors and oversees the out-of-home care functions of the Office of the Children’s Guardian.

Recommendation 20: The NSW Government should amend the *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) to ensure that the Office of the Children’s Guardian does not have the power to accredit agencies that have not demonstrated compliance with the accreditation criteria.

Chapter 9 Getting early intervention right

Recommendation 21: The NSW Government should increase financial investment in early intervention support as a long-term investment to prevent more Aboriginal children entering the out-of-home care system.

Recommendation 22: The NSW Government should ensure that financial investment in early intervention support is commensurate with the proportion of Aboriginal children in out-of-home care, with a preference for delivery of early intervention and prevention services by Aboriginal Community Controlled Organisations.

Recommendation 23: The Department of Communities and Justice should ensure that its administrative data captures information about referrals made to all relevant early intervention programs, and whether these referrals were accepted or not (and reasons for non-referral and non-acceptance). The Department of Communities and Justice should work with Aboriginal stakeholders and community to design a system for the collection, analysis and reporting of these data.

Recommendation 24: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community members, evaluate existing early intervention and prevention focused programs used by the department and their effectiveness with Aboriginal families based on measures designed in partnership with Aboriginal stakeholders and community.

Recommendation 25: The NSW Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to mandate the provision of support services to Aboriginal families to prevent the entry of Aboriginal children into out-of-home care.

Recommendation 26: The NSW Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to require the Department of Communities and Justice to take active efforts to prevent Aboriginal children from entering into out-of-home care.



Recommendation 27: The NSW Government should establish a Child Protection Advocacy Program to train and support a state-wide network of specialist child protection advocates to give advice to, and advocate for, families who are involved in the child protection system. This program should be akin to the Tenant's Advice and Advocacy Program currently resourced by Fair Trading NSW. This program should be informed also by the advocacy method that GMAR NSW have been performing unofficially.

Recommendation 28: The Department of Communities and Justice establish a notification service, similar to the NSW Custody Notification Service, to notify the Child Protection Advocacy Program or a relevant Aboriginal community body about the removal of an Aboriginal child or young person from their family, providing a timely opportunity for review, oversight and advocacy on behalf of Aboriginal families and communities in the best interests of Aboriginal children and young people.

Recommendation 29: The NSW Government should provide further sustained funding to the Care Partner Program to ensure that more Aboriginal families have access to legal advice to promote early intervention support.

Recommendation 30: The Department of Communities and Justice should mandate the use of the Domestic Violence Safety Assessment Tool by caseworkers where parents are present, or screen-in, in relation to domestic and family violence related issues. This tool should be used to coordinate parents' involvement in the Safer Pathway system. Roll out of this approach needs to be accompanied by further training and education for caseworkers and casework managers around identifying domestic and family violence including coercive and controlling behaviours. Consideration should be given to involving caseworkers in Safety Action Meetings where parents are assessed as being at serious threat and become involved in these meetings.

Recommendation 31: The Department of Communities and Justice should provide targeted and ongoing education about the Dignity Driven practice approach to staff at all levels of the agency, including caseworkers and senior managers. Education should require all staff to complete training developed by and delivered in partnership with Aboriginal domestic and family violence specialists regarding the issues facing Aboriginal women who experience domestic and family violence.

Recommendation 32: The NSW Government should roll out and resource Staying Home Leaving Violence across the whole of NSW.

Recommendation 33: The Department of Communities and Justice should ensure that caseworkers can connect families with the Staying Home Leave Violence service if they present with domestic and family violence issues and housing difficulties.

Recommendation 34: The NSW Government should increase the availability of short-term refuges suitable to the needs of Aboriginal women escaping violence. Increases in the availability of short-term refuges (for temporary housing issues) should be accompanied by a longer term investment in social housing stock in NSW, with a view to increasing the availability of housing for vulnerable Aboriginal women.

Recommendation 35: The Department of Communities and Justice should design, in partnership with Aboriginal stakeholders and community, a new approach to collecting and reporting data around disability prevalence among Aboriginal children in the child protection system, and disability prevalence among their parents.

Recommendation 36: The Department of Communities and Justice should work with the First Peoples Disability Network Australia, People with Disability Australia, the National Disability Insurance Scheme (NDIS) and Aboriginal community and stakeholders to develop a plan of action to improve disability identification, practice competence, and pathways to specialist disability service involvement within the Department of Communities and Justice for children and families at all stages of the child protection system—from early intervention support through to entry into care, restoration and post entry into care casework.

Recommendation 37: The Department of Communities and Justice should, in partnership with the First Peoples Disability Network Australia, People with Disability Australia, Aboriginal community and stakeholders, implement a strategy for early intervention and prevention work specifically targeted towards early identification and responses to the needs of Aboriginal parents and children with disability who come into contact with the child protection system.

Recommendation 38: The Department of Communities and Justice should work closely with relevant agencies and service providers, including Aboriginal Community Controlled Organisations, specialist housing, health, perinatal, alcohol and other drug use, mental health and domestic and family violence services, to develop a plan to co-ordinate integrated service provision in early intervention support efforts for Aboriginal families and children. This plan should focus on providing targeted support for families from an early stage of engagement in the system, focusing on initial contact.

Recommendation 39: The Department of Communities and Justice should commission an independent review of all current child protection policies relating to casework services to ensure the policies (including casework and restoration policies) are in line with current best practice standards in relation to domestic and family violence, alcohol and other drug use, mental health, health issues, disability and intergenerational trauma.

Recommendation 40: The Department of Communities and Justice should provide culturally-competent, trauma-informed training and materials for child protection staff, with reference to the excellent resources already prepared by the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec) and the Secretariat of National Aboriginal and Islander Child Care (SNAICC), around working with Aboriginal community and families. This training should focus on how to appropriately engage Aboriginal families in early intervention and prevention work. This training should also have a component of Aboriginal history in New South Wales to provide child protection staff with some nuanced understanding of the Aboriginal population it works with.

Chapter 10 Prenatal reporting and newborn removals

Recommendation 41: The Department of Communities and Justice should work with Aboriginal stakeholders and community to design a comprehensive system for the collection and reporting of data around assumption into care or removal of Aboriginal children at or shortly after birth, as well as data about the characteristics of parents who are the subject of pre-natal notifications,



numbers and reasons for high risk birth alerts, and pre entry into care casework completed with Aboriginal mothers in the prenatal period.

Recommendation 42: The Department of Communities and Justice should devise, in partnership with Aboriginal community groups and representatives, a comprehensive Prenatal Reporting and Newborn Removal Policy for Aboriginal children that includes, among other things, case studies of good practice intervention with expectant Aboriginal parents and a link to an external, up-to-date list of relevant services and supports for pregnant Aboriginal mothers.

Recommendation 43: The Department of Communities and Justice should publish case studies of good-practice intervention with expectant Aboriginal parents on its website, as well as distributing these case studies to relevant stakeholders, including Aboriginal families in contact with the child protection system, Aboriginal community representatives and organisations, and relevant service providers.

Recommendation 44: The Department of Communities and Justice should expand the Pregnancy Family Conferencing program and monitor and report on its effectiveness in reducing entries into out-of-home care.

Recommendation 45: The Department of Communities and Justice should significantly expand the number of specialised prenatal caseworkers to ensure that expectant Aboriginal parents have access to early, targeted and coordinated intervention services and support.

Recommendation 46: The Department of Communities and Justice should develop, trial and publicly report on a ‘triage’ system for prenatal reports that ensures that the parents of the most frequently report unborn babies are given priority access to early casework support and early intervention services.

Recommendation 47: The Department of Communities and Justice should design and implement, in partnership with Aboriginal community groups and representatives, a system of post-removal support for Aboriginal mothers and fathers who have had newborn or infant children removed from their care. The system should include the mandatory provision of information to parents about their ability to seek post-removal support from the Secretary of the Department of Communities and Justice under s 21 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Recommendation 48: The NSW Government should repeal s 106A(1)(a) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Chapter 11 Considering alternatives to removal

Recommendation 49: The Department of Communities and Justice should record, collect and report data around the consideration of the use of less intrusive options prior to entry-into-care. These data should include whether or not these measures were considered and if they were not used, reasons should be recorded and reported on against each possible measure. This data collection should be designed and interpreted in partnership with Aboriginal stakeholders and community.

Recommendation 50: The Department of Communities and Justice should revise its mandate on Temporary Care Arrangements to ensure that the ability of a parent to terminate a Temporary Care Arrangement is not used to deter its use.

Recommendation 51: The Department of Communities and Justice should ensure that caseworkers receive training on the use of Temporary Care Arrangements in child protection casework. This should include the use of examples of the use of Temporary Care Arrangements with Aboriginal families in practice.

Recommendation 52: The Department of Communities and Justice should ensure that Family Violence Prevention Legal Services and Community Legal Centres are adequately funded to provide legal advice to Aboriginal families to support their engagement with the Department of Communities and Justice and encourage the use of alternatives to removal.

Recommendation 53: The Department of Communities and Justice should update its policies and procedures to ensure that all Aboriginal families receive 'warm' referrals to legal advisors, with a preference for Aboriginal services, before child protection involvement escalates to the point where entry into care is considered a possibility.

Recommendation 54: The NSW Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to require the Department of Communities and Justice to consider specific alternatives prior to removal. Such specific alternatives could include Parent Responsibility Contracts, Parent Capacity Orders, and Temporary Care Arrangements.

Recommendation 55: The Children's Court of NSW should update its internal judicial guidance to ensure Magistrates require the Department of Communities and Justice to provide information to the Court about what prior alternative actions were considered and taken before children entered care.

Chapter 12 Improving entry into care practice

Recommendation 56: The Department of Communities and Justice should commission an independent review of its structured decision making tools and processes to identify how they can be improved to enhance objectivity within child protection assessments. This review should be undertaken in partnership with Aboriginal community and stakeholders to ensure that it examines the cultural adequacy of current risk and safety paradigms and tools.

Recommendation 57: The Department of Communities and Justice should implement internal improvements to chain of command decision-making and safety plan review, to ensure that all safety plans prepared for families respond comprehensively to all identified dangers and include relevant casework responding to all identified risk and safety issues.

Recommendation 58: The Department of Communities and Justice should ensure all staff receive commencement and regular refresher training in how to use the safety and risk assessment tools. The training should be delivered by Aboriginal educators and should incorporate training in cognitive bias and how to undertake safety and risk assessments with Aboriginal families and children.



Chapter 13 Poor removal practices

Recommendation 59: The Department of Communities and Justice should ensure that all caseworkers receive further training in harm minimisation strategies for assumption or removal and in the appropriate use of police to assist with assumptions or removals. This training should be designed to improve cultural knowledge and the knowledge of Aboriginal child protection history, including child removal policies in the protection and assimilation era, with particular focus on the NSW chapter of the Royal Commission into Aboriginal Deaths in Custody.

Recommendation 60: Except for in an unforeseen emergency, caseworkers from the Department of Communities and Justice should be required to seek the authorisation of a team leader before engaging police to assist them to undertake an assumption or removal. In circumstances where caseworkers employ the assistance of police without prior authorisation, caseworkers must be required to justify why they engaged police to their team leader at the earliest opportunity following the assumption or removal. These reasons must be recorded on the child's file and presented to the Children's Court of NSW.

Recommendation 61: Caseworkers from the Department of Communities and Justice should be required to set out a detailed justification for the timing, location and basis for all assumptions and removals that are not conducted on an emergency basis prior to the assumption or removal occurring, and to demonstrate that their proposed method of assumption or removal is the least intrusive method that could be employed.

Chapter 14 Recognising the harm of removal

Recommendation 62: The Department of Communities and Justice should, in partnership with young Aboriginal people and Aboriginal community organisations, develop and implement a child-friendly system to encourage children in out-of-home care to report safety concerns and harm occasioned in out-of-home care placements.

Recommendation 63: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community, design and implement a system for the collection, analysis and reporting of data around the abuse of Aboriginal children in out-of-home care. These data should be disaggregated by the care placement type, who perpetrated the alleged abuse, the department's response to the alleged abuse, whether the alleged abuse was subject to further investigation or action, and the outcome of any investigation or action.

Recommendation 64: The NSW Government amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to require judicial officers to consider the known risks of harm to an Aboriginal child of being removed from the child's parents or carer in child protection matters involving Aboriginal children.

Chapter 15 Care criminalisation

Recommendation 65: The NSW Government should amend s 7 of the *Children (Protection and Parental Responsibility) Act 1998* (NSW) to enable a court exercising criminal jurisdiction, with respect to a child, to require the attendance of a delegate of the Secretary of the Department of Communities and Justice in circumstances where the Secretary has parental responsibility of the child.

Recommendation 66: The Judicial Commission of NSW should prepare and publish information to further guide and inform judicial decision-making involving children in out-of-home care in the criminal jurisdiction.

Recommendation 67: The Department of Communities and Justice and the NSW Police Force should establish and fund an ongoing program of training to ensure that all residential out-of-home care staff, and all NSW police officers, receive training on the *Joint Protocol to Reduce the Contact of Young People in Residential Out-of-Home Care with the Criminal Justice System*, in order to reduce the contact of young Aboriginal people in out-of-home care with the criminal justice system.

Recommendation 68: The new recommended NSW Child Protection Commission should monitor the implementation of the *Joint Protocol to Reduce the Contact of Young People in Residential Out-of-Home Care with the Criminal Justice System* to reduce the contact of young Aboriginal people in OOHC with the criminal justice system. This should include monitoring of the provision of training about the Joint Protocol, as well as the number and nature of calls by out-of-home care staff to the NSW Police Force that relate to the behaviour of children in out-of-home care.

Recommendation 69: The Department of Communities and Justice should design and implement a system for the collection, analysis and reporting of data to ensure that information about children in OOHC who are also in contact with the criminal justice system is recorded and is readily available to inform strategic planning and monitor outcomes for this group of children. This system should identify which children are Aboriginal and which are non-Aboriginal.

Recommendation 70: The Department of Communities and Justice should conduct or commission further research regarding the involvement of Aboriginal children and young people in OOHC in the juvenile justice system to determine, among other things, the:

- a. number of Aboriginal children in OOHC involved in the juvenile justice system;
- b. nature of offences committed by Aboriginal children in out-of-home care (and whether these are influenced by their OOHC status);
- c. nature and level of assistance provided by FACS to Aboriginal children involved in the juvenile justice system; and
- d. outcomes for Aboriginal children involved in the juvenile justice system (and whether these are influenced by OOHC status).



Chapter 16 Introduction to the Aboriginal Placement Principle

Recommendation 71: The New South Wales Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to ensure that its provisions adequately reflect the five different elements of the Aboriginal Child Placement Principle, namely, prevention, partnership, participation, placement and connection.

Recommendation 72: The Department of Communities and Justice should develop guidance for caseworkers on the purpose of the Aboriginal Child Placement Principle (ACPP), the elements of the ACPP, and how to apply these elements during casework. This guide should be developed in partnership with Aboriginal community organisations and after consideration of the existing resources on the ACPP, such as those already developed by the Secretariat of National Aboriginal and Islander Child Care, which the Review regards as best practice.

Recommendation 73: The Department of Communities and Justice should implement an ongoing program of training to test and enhance staff knowledge of the Aboriginal Child Placement Principle. This program should be delivered in partnership with the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec).

Recommendation 74: The Department of Communities and Justice should engage with Aboriginal stakeholders and community members to design and implement a system of data collection and reporting around all elements of the Aboriginal Child Placement Principle (ACPP). In particular, the data should address:

- a. Aboriginal children's contact with their Aboriginal birth parents, siblings (including half-siblings) and extended family, kin and community;
- b. Aboriginal children's placement with siblings (including half-siblings); and
- c. cultural planning for Aboriginal children in care, including information about who participated to develop a child's cultural plan, and what these cultural plans contain in relation to the five domains of the ACPP.

Recommendation 75: The Department of Communities and Justice should publish data on its compliance with all elements of the Aboriginal Child Placement Principle on an annual basis.

Recommendation 76: The New South Wales Government should, in partnership with relevant Aboriginal community groups and members, develop regulations about identifying and 'de-identifying' children in contact with the child protection system as Aboriginal for inclusion in the *Children and Young Persons (Care and Protection) Regulation 2012* (NSW).

Recommendation 77: The Department of Communities and Justice should develop a policy to assist in the implementation of the new regulation about the identification and 'de-identification' of children in contact with the child protection as Aboriginal.

Recommendation 78: The Department of Communities and Justice should ensure that it is mandatory for caseworkers to complete the Aboriginal or Torres Strait Islander status field on ChildStory.

Recommendation 79: The Department of Communities and Justice should collect and publish information about the number of children who are ‘de-identified’ as Aboriginal and the reasons for the de-identification on an annual basis.

Recommendation 80: The Judicial Commission of New South Wales should develop educational materials for all judicial officers about the identification and de-identification of Aboriginal children in judicial proceedings.

Recommendation 81: The Department of Communities and Justice should actively fund and support the implementation of the *Aboriginal Case Management Policy* and the *Aboriginal Case Management Rules and Practice Guidance* and report publicly on its activity in this domain.

Recommendation 82: The Judicial Commission of NSW should, in consultation with the Children’s Court of NSW and the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec), design and implement an ongoing program of judicial education for Magistrates regarding the intent and elements of the Aboriginal Child Placement Principle, as well as how judicial decision making may help to support their implementation.

Chapter 17 Partnership

Recommendation 83: The Department of Communities and Justice should ensure that recommendations made by Aboriginal staff or community members in all consultation processes relating to Aboriginal children are tracked and implemented and that data about the content and implementation of these recommendations is recorded in ChildStory and made publicly available.

Chapter 18 Placement

Recommendation 84: The Department of Communities and Justice should work with Aboriginal stakeholders and community to design a system for the collection and reporting of data about the placement stability of Aboriginal children in out-of-home care.

Recommendation 85: The Department of Communities and Justice should develop a policy and guidelines that incorporate information about good-practice casework regarding the placement of a child immediately post removal and include guidance on parallel planning at the pre-entry into care stage of the child protection system.

Recommendation 86: The Department of Communities and Justice should revise the *FACS Information Guide Assessment and Full Authorisation of Relative and Kinship Carers* to ensure that it reflects evidence-based knowledge about the protective benefits of a child’s placement with family and kin.

Recommendation 87: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community members, develop and implement a policy whereby family or kin who are nominated or nominate themselves as a potential carer for an Aboriginal child entering out-of-home care are subject to formal carer assessment using a culturally appropriate tool. This carer assessment is to occur expediently, before or shortly after the children enter care. If formal carer assessment of a family or kin member is not progressed, the department should record clear reasons for failure to progress this assessment on ChildStory



and provide these reasons in writing to the family or kin member being informally assessed, along with information about ways that family or kin member may challenge this informal assessment.

Recommendation 88: The Department of Communities and Justice should review the formal probity checks required of carers, and the process for obtaining these checks, to ensure that they are not unduly limiting the ability of potential Aboriginal carers to safely care for Aboriginal children in out-of-home care. The review should include consideration of the introduction of a discretion to enable a person to care for a child in out-of-home care despite not satisfying or completing the formal probity checks, when to do so would be in the best interests of the child.

Recommendation 89: The Office of the Children’s Guardian and the Department of Communities and Justice should work together to ensure that data are collected and reported about the number of potential Aboriginal carers who lodge applications for working with children check clearances, the length of time taken to determine the applications, and the outcome of those applications.

Recommendation 90: The Office of the Children’s Guardian should undertake a review of the impact of the Working with Children Check scheme on Aboriginal applicants.

Recommendation 91: The Office of the Children’s Guardian should prioritise the processing of applications for working with children check clearances made by Aboriginal applicants wishing to become authorised carers for Aboriginal children.

Recommendation 92: The Department of Communities and Justice should revise its policy on the provisional authorisation of carers to ensure that provisionally authorised carers do not have children in their care removed solely because of delays in the processing of their application for a working with children check clearance.

Recommendation 93: The Department of Communities and Justice should partner with Aboriginal community organisations and representatives to develop and implement a culturally appropriate carer assessment tool to be used in all carer assessments involving Aboriginal carers.

Recommendation 94: The NSW Government should ensure that the NSW Civil and Administrative Tribunal has jurisdiction to review a decision not to authorise a carer.

Recommendation 95: The NSW Civil and Administrative Tribunal should include training about the Aboriginal Child Placement Principle in its induction and ongoing training program for Tribunal Members. This program should be delivered in partnership with the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec).

Recommendation 96: The Department of Communities and Justice should urgently engage with Aboriginal stakeholders and community to interpret findings from Wave 4 Pathways of Care Longitudinal Study (POCLS) in relation to the support needs of Aboriginal carers and translate these findings into policy and practice.

Chapter 19 Participation

Recommendation 97: The Department of Communities and Justice should develop and provide caseworkers with further training about how to organise and effectively conduct family meetings with Aboriginal families in contact with the child protection system.

Recommendation 98: The Department of Communities and Justice should support the development and implementation of a family group conferencing model that is designed, led and delivered by Aboriginal Community Controlled Organisations.

Recommendation 99: Until Recommendation 98 is implemented, the Department of Communities and Justice should work with relevant Aboriginal organisations to develop guidance as to how to conduct culturally safe and appropriate family group conferences with Aboriginal participants.

Recommendation 100: The Department of Communities and Justice should publish information about how family group conferencing will be monitored and assessed over time.

Recommendation 101: The Department of Communities and Justice should ensure that support persons (such as Aboriginal Community Facilitators) are permitted to be participants in all family group conferences involving Aboriginal families.

Recommendation 102: The new recommended NSW Child Protection Commission should oversee, monitor and report on the operation of the new mandatory Alternative Dispute Resolution system introduced by the *Children and Young Persons (Care and Protection) Amendment Act 2018* (NSW).

Chapter 20 Connection to family, community, culture and country

Recommendation 103: The Department of Communities and Justice should develop policy guidance for caseworkers that addresses the desirability of promoting regular contact between Aboriginal children and their family, kin and community; how to promote this contact in practice; and when supervision is necessary in contact arrangements.

Recommendation 104: The Department of Communities and Justice should develop policy guidance for caseworkers about the issue of contact with parents in custody. This guidance should include a discussion of the types of contact that can be facilitated between children and incarcerated parents, how to arrange the contact in practice, advice about methods of liaison with correctional services and information about facilities to enable contact in individual correctional centres.

Recommendation 105: The Department of Communities and Justice and NSW Corrective Services should consider providing targeted supports and services to parents of Aboriginal children in out-of-home care that are directly related to the department's case plan (for example, a case plan with a goal of restoration).



Chapter 21 Restoration

Recommendation 106: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community, design and implement a system for the collection, analysis and reporting of data about restoration goals and casework provided to support parents of children who enter out-of-home care, including what casework is provided to support parents to achieve restoration goals.

Recommendation 107: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community, develop and implement a specific strategy to promote the restoration of Aboriginal children to their parents. This strategy should take into account findings in this report.

Recommendation 108: To increase restoration rates, the Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community, review its existing policies, guidance and practice relating to restoration to ensure that these all promote best practice in increasing restoration rates. This review should focus on providing sustained and suitable support services for Aboriginal families experiencing complex issues that cannot be solved simply through individual behavioural change.

Recommendation 109: The Department of Communities and Justice should fund an Aboriginal Community Controlled Organisation to design and pilot an Intensive Restoration Program designed specifically for Aboriginal families in NSW. Pilot funding must also include funding for evaluation based on measures designed in partnership with Aboriginal stakeholders and community.

Recommendation 110: The NSW Government should review funding allocations to ensure that these reflect the NSW Government legislative and policy position to prioritise restoration and family preservation. This funding should prioritise the restoration programs that are successfully delivered by Aboriginal Community Controlled Organisations and funding should be commensurate with the over-representation of Aboriginal children in the out-of-home care system.

Recommendation 111: The Department of Communities and Justice should develop a memorandum of understanding (MOU) between Housing and Community Services that allows for the sharing of information held by Community Services when it is required by Housing before parents can access Housing services. This should include information needed to satisfy housing eligibility requirements, to be given 'priority status', or to access programs such as Staying Home, Leaving Violence.

Recommendation 112: The NSW Government should amend s 83 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to allow the Children's Court of NSW a more active role in ensuring restoration is a preferred placement.

Recommendation 113: The NSW Government should amend s 83 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to expressly require the Children's Court of NSW to consider the placement of an Aboriginal child with a relative, member of kin or community, or other suitable person, if it determines that there is no realistic possibility of restoration within a reasonable period.

Recommendation 114: The NSW Judicial Commission should, in partnership with Aboriginal educators, provide opportunities for further education to Children’s Court of NSW Magistrates and staff regarding the research on intergenerational trauma, the effects of colonisation, domestic violence, poverty, substance abuse and mental health issues that may affect Aboriginal parents’ interactions with the Court.

Recommendation 115: The Children’s Court of NSW should develop a practice directive for Magistrates to utilise powers under s 85 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to direct service provision in restoration cases. The Department of Communities and Justice to collect and report data around the use of this section in care and protection proceedings.

Recommendation 116: The Department of Communities and Justice should provide further support to Aboriginal families who seek to progress a s 90 application after final orders have been made. This should be done by way of FACS developing a support strategy in partnership with Aboriginal stakeholders and community, designed specifically for this purpose.

Recommendation 117: The NSW Government should amend s 79(10) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to ensure that it is linked to service provision that would support Aboriginal parents to have their children restored to their care.

Recommendation 118: The Department of Communities and Justice should review and update the restoration information that is publicly available on its website in line with issues raised in this report. The department should also provide online information to improve guidance for parents in relation to restoration practices and processes and further information about what parents can do when restoration is not deemed to be a ‘realistic possibility’.

Recommendation 119: The NSW Government should provide funding to enable a restoration hotline to be established by an Aboriginal organisation in order to provide parents and families of Aboriginal children in out-of-home care more detailed information about the restoration process and what is required to successfully achieve restoration.

Recommendation 120: The Department of Communities and Justice should conduct an internal review examining caseworkers’ non-compliance with existing restoration policy and guidance and use the findings of this Review to improve restoration casework practice and policy in the department.

Chapter 22 Adoption of Aboriginal children in OOHC

Recommendation 121: The NSW Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and the *Adoption Act 2000* (NSW) to ensure that adoption is not an option for Aboriginal children in OOHC.



Chapter 23 Reforming the Children's Court

Recommendation 122: The NSW Government should establish an independent statutory agency to make decisions about the commencement of child protection proceedings (including decisions about what orders are to be sought in the proceedings), and to conduct litigation on behalf of the Secretary of the Department of Communities and Justice in the Children's Court of NSW care and protection jurisdiction.

Recommendation 123: The NSW Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) so that, as in s 4(2) of the Uniform Evidence Acts, the rules of evidence do not apply unless: (i) a party to the proceeding requests that they apply in relation to the proof of a fact and the court is of the view that proof of that fact is or will be significant to the determination of the proceedings; or (ii) the court is of the view that it is in the interests of justice to direct that the laws of evidence apply to the proceedings.

Recommendation 124: The NSW Government should appoint a sufficient number of new Magistrates to ensure that all proceedings under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) are dealt with by specialist Children's Magistrates.

Recommendation 125: The NSW Government should, in consultation with the Children's Court of NSW and other relevant stakeholders, such as the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec) and the Aboriginal Legal Service, design and implement a pilot project establishing a dedicated court list for proceedings under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) involving Aboriginal children.

PART A

Introduction to Review



1. Overview and key concepts

Background to the Review

An independent review is a special examination, conducted by an independent chairperson, of an issue or matter considered to be highly important to government. This independent review was commissioned in response to the political advocacy of Aboriginal grandmothers in New South Wales (NSW). Concerned about the escalating numbers of Aboriginal children in out-of-home care (OOHC), Grandmothers Against Removals (GMAR) campaigned widely and publicly to raise awareness about the ‘ongoing forced removals of Indigenous children, the legacy of trauma, and the steps required to bring about change’.¹

On 27 May 2016, following a forum held by the then Minister for Family and Community Services, the Hon. Brad Hazzard, *Our kids our way: Hearing the voices of Aboriginal people*, the Minister made a commitment to commission an independent review into the high removal rates of Aboriginal children. The review was to examine the circumstances of ‘every Aboriginal child taken into out-of-home care during the past year’.² The file review was limited to this time period to enable a full examination of each child’s circumstances within the set timeframe.

On 19 December 2016, the Minister announced that Professor Megan Davis, a Cobble Cobble woman of the Barrungam nation and a Professor of Law at the University of New South Wales, would be engaged as the Chairperson of the Independent Review. The Review’s Terms of Reference were agreed to by the Minister on or about 15 February 2017.

The draft report of the Review was initially intended to be delivered to the Minister for Family and Community Services on 31 August 2018, with the final report to be delivered on 31 October 2018. It quickly became apparent, however, that the scope and complexity of the Review was much greater than anticipated. The complete suite of file reviews for 1,156 children³ was not completed by the Aboriginal Care Review Team until April 2019. As the case file reviews constituted a key component of the Review, this delay in completion and delivery made it impossible to prepare a report by mid-2018. For this reason, and in anticipation of these delays, Professor Davis sought an extension of the initial due date for the report in May 2018. An extension was granted by the then Minister for Family and Community Services, the Hon. Pru Goward. The delivery date for the final report was revised to 31 July 2019.

1 Paul Gregoir, *The Ongoing Stolen Generations: An Interview with Grandmothers Against Removals*, (3 February 2018) Sydney Criminal Lawyers <<https://www.sydneycriminalawyers.com.au/blog>>; See also Sophie Verass, ‘The Women Fighting Against a Rising Tide of Indigenous Child Removals’, (online, 29 June 2019) *NITV* <<https://www.sbs.com.au/nitiv/feature/women-fighting-against-rising-tide-indigenous-child-removals>>; Camille Nakhid, ‘A Wiradjuri Grandmother’s Sad Story: “The Stolen Generations Have Never Stopped”’, *Asia Pacific Report* (online, 30 July 2016) <<https://asiapacificreport.nz/2016/07/30/a-wiradjuri-grandmothers-sad-story-the-stolen-generations-have-never-stopped>>; Simone Fox Koob, ‘Hundreds of Kids at Risk After Safety Audit’ *The Australian* (Sydney, 17 August 2016); Larissa Behrendt, ‘Indigenous Kids are Still Being Removed From Their Families, More Than Ever Before’ *The Guardian* (online, 13 February 2016) <<https://www.theguardian.com/australia-news/commentisfree/2016/feb/13/eight-years-after-the-apology-indigenous-kids-are-still-being-removed-from-their-families>>.

2 Department of Family and Community Services (NSW), ‘NSW to review cases of Aboriginal kids in care’ (Media Release, 19 December 2016) <https://www.facs.nsw.gov.au/about_us/media_releases/nsw-to-review-cases-of-aboriginal-kids-in-care>.

3 This figure includes the reviews of a number of children who were not later included in the cohort but the case was subject to review for the purposes of developing targeted recommendations. These included a number of cases where children did not enter care during the cohort period (but their carers received supported care allowances during this period) and some other cases that were identified as falling outside the terms of reference for the cohort. The cohort number is 1144 children.



Why this Review is unique

As discussed later in this Part, there have been many attempts to address the existing problems in respect of the OOH system. In particular, over the last 20 years, there have been numerous reviews and inquiries that have examined in detail the operation of the child protection system in NSW and made various recommendations for reform.

This Review, however, is unique for several reasons. First, it is the only review to date to specifically examine the interaction of Aboriginal children and families with the child protection system. Second, it is led by an Aboriginal woman, supported by five Aboriginal female staff members, and advised by a predominantly Aboriginal Reference Group (including three members of GMAR NSW). This composition of Review staff members and the Reference Group has influenced the nature of analysis and the depth of community consultation. Third, it is the first review in NSW that has undertaken a desktop analysis of the case files of a large cohort of children, a process yielding rich and important data which has been used to inform recommendations. Finally, this Review is the first to address the need for significant structural change and accountability mechanisms in this area (in addition to recommending changes to legislation, policy and practice).

The history of child protection in NSW

The following discussion provides a brief overview of the history of the interaction between Aboriginal people and child welfare services since the late 1800s. While this history does not assist in generating recommendations for reform of the modern child protection system in NSW, it places the views of Aboriginal families about the child protection system in an important historical context. It highlights the reasons for Aboriginal peoples' mistrust of the Department of Communities and Justice and other government systems, as well as their concerns about the removal of children for reasons of 'neglect' and their anger at the way in which many present day removals are effected in practice.

Reserves and missions

The history of the involvement of Aboriginal children in the child protection system in NSW is inextricably linked to the story of Australia. NSW was the site of sustained 'first contact' between the British and the Aboriginal peoples of the continent we now know as Australia. After this first contact, 'Aborigines were dispossessed of their land parcel by parcel, to make way for expanding colonial settlement.'⁴ Violent conflicts between Aboriginal people and the British—including the 'Frontier Wars'—took place between the late 1700s and the mid-1800s.⁵ Gradually, as the Aboriginal population dwindled because of the killings and exposure to new diseases, the conflict gave way to a policy of 'protection', proposed by the 1836 recommendation of the Parliamentary Select Committee on Aboriginal Tribes of the British House of Commons,⁶ designed to shield Aboriginal people from 'the worst frontier violence'.⁷

4 *Mabo v Queensland [No 2]* (1992) 175 CLR 1, 69.

5 John Conner, *The Australian Frontier Wars 1788-1838* (UNSW Press, 2005); Peter Dennis et al, *The Oxford Companion to Australian Military History* (Oxford University Press, 2nd ed, 2009).

6 Alan Lester and Fae Dussart, *Colonization and the Origins of Humanitarian Governance Protecting Aborigines across the Nineteenth-Century British Empire* (Cambridge University Press, 2014).

7 Lisa Ford, 'Protecting the Peace on the Edges of Empire: Commissioners of Crown Lands in NSW' in Laura Benton, Adam Clulow and Bain Attwood (eds), *Protection and Empire: A Global History* (Cambridge University Press, 2018), 175.

The history of the involvement of Aboriginal children in the child protection system in NSW is inextricably linked to the story of Australia. NSW was the site of sustained ‘first contact’ between the British and the Aboriginal peoples of the continent we now know as Australia.

This period saw the passage of several statutory frameworks to regulate ‘protection’, including those establishing reserves and missions, aimed at the compulsory racial segregation of Aboriginal people from the wider community. Generally, reserves were run by the state, and missions were run by religious organisations or missionaries. There were many theories of racial superiority that influenced the early colony and eventually the movement for federation. The Darwinian world-view held by many of the British, was that Aboriginal people would die out in the ‘survival of the fittest’— that is, ‘Vulgarized Social Darwinism tinged with Victorian religiosity fuelled the belief that the Aborigine would disappear in the face of the vastly superior civilization that had reached the shores’.⁸ The ‘protection’ approach was intended to ‘smoothe the dying pillow’.⁹

The Aborigines Protection Board starts ‘merging’ the population

The protection era was a lengthy period of non-freedom for Aboriginal people in NSW. The legislation was draconian and restricted every facet of Aboriginal peoples’ lives. However, the protectionist approach slowly fell out of favour. By the late nineteenth century, colonial officials’ anxiety about Aboriginal people was rising. The NSW Aborigines Protection Board was established in 1883 to ‘manage’ the Aboriginal population. It began to implement a new strategy to merge, ‘quadroons and octoroons ... in the white population.’¹⁰

This ‘merging’ was effected by removing Aboriginal children from their families. In 1909, the Board gained a mandate under the *Aborigines Protection Act 1909* (NSW) to remove ‘neglected’ Aboriginal children.¹¹ Removals were framed, in part, as being in the children’s best interests. For example, the Board’s 1912 Annual Report indicated that to allow Aboriginal children to remain on Aboriginal reserves would be ‘an injustice to the children themselves’ as well as a ‘menace to the State’.¹²

Amending legislation passed in 1915 meant that the Board did not even need to prove ‘neglect’ to remove Aboriginal children. After all, the Colonial Secretary lamented that it was

8 Paul McHugh, *Aboriginal Societies and the Common Law* (Oxford University Press, 2004) 189.

9 Charles Darwin, *The Descent of Man and Selection in Relation to Sex* (London: John Murray, 2nd ed, 1882) 181–92. See also Russell McGregor, ‘The Doomed Race: A Scientific Axiom of the Late Nineteenth Century’ (1993) 39(1) *Australian Journal of Politics and History* 14, 16–17.

10 Cited in NSW Government, Submission to Australian Government Human Rights and Equal Opportunity Commission, *Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997), 26 in Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997) 36.

11 *Aborigines Protection Act 1909* (NSW) s 11.

12 NSW Aborigines Protection Board, *Annual Report* (Report, 1912), cited in the Link-Up, Submission 187 to Australian Government Human Rights and Equal Opportunity Commission, *Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997), 47 in Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997), 35.



... very difficult to prove neglect; if the aboriginal child happens to be decently clad or apparently looked after, it is very difficult to show that the half-caste or aboriginal child is actually in a neglected condition, and therefore it is impossible to succeed in the court.¹³

Even though some members of the NSW Parliament objected to the amendment as ‘an act of cruelty’ and ‘the reintroduction of slavery in NSW’, the Bill passed. As a result for many years reasons for child removal included ‘to send to service’, ‘being 14 years’, or simply ‘Aboriginal’.¹⁴ The state now removed Aboriginal children (mostly girls) to institutions with the goal of training them for domestic service.¹⁵ Conditions in the institutions were often horrific, violent and tantamount to slavery.

Assimilation and residential homes

The first national conference on the Aboriginal ‘problem’ was held in 1937. This resulted in a national consensus on an ‘assimilationist’ approach. Assimilation was a formal policy explicitly adopted to rapidly ‘break-up’ Aboriginal groups because they were considered to be ‘socially and culturally deprived’ and ‘a great annoyance to the community’.¹⁶ This policy was action-oriented and explicitly designed to ‘assimilate’ Aboriginal people with the urban white population. According to David Pollard, a former Senior Assistant Secretary of the NSW Ministry of Aboriginal Affairs:

Assimilation was an attempt to force differing cultures together to form a single culture. In the context of Australian culture, given the recognised behaviour patterns of white Australians and their numerical superiority, this meant the extinction of what was distinctive in the Aboriginal subculture under the weight of mainstream values. Aboriginal culture was not to be preserved because it was not worth preserving. Implicit, but not stated, was the further assumption that Aboriginal culture was not worth preserving because Aborigines were themselves marginal and valueless people.¹⁷

To implement the policy in NSW, the Board was renamed the ‘Aborigines Welfare Board’. Its child removal powers were now derived from the *Child Welfare Act 1939* (NSW). This legislation set up a dual system in NSW, where the NSW Child Welfare Department managed non-Aboriginal children and the Board had complete control of Aboriginal children.

Under this new legislation, the Board now needed to prove that children were either ‘neglected’ or ‘uncontrollable’ in order to remove them. In practice, the new criteria provided little protection for Aboriginal families as ‘neglect’ was defined to include ‘destitution’ (extreme poverty). Aboriginal people were dispossessed of their land, underpaid, unable to receive social welfare payments, and often needed to travel to seek employment and avoid having their children removed. As a result of these social factors, poverty and destitution—the criteria for removing children—were inevitable. White officials also interpreted ‘neglect’ in ways that

13 John Conner, *The Australian Frontier Wars 1788-1838* (UNSW Press, 2005); Peter Dennis et al, *The Oxford Companion to Australian Military History* (Oxford University Press, 2nd ed, 2009) 35.

14 Peter Read, *Stolen Generations* (Department of Aboriginal Affairs, 1981), 6. Read examined NSW archival material, now closed, including committal notices, as part of his doctoral research. Read’s 1981 pamphlet was a driver of the *Bringing Them Home* report and key extracts appear in Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997).

15 Heather Goodall, ‘Saving the Children—Gender and the Colonisation of Aboriginal Children in NSW, 1788 to 1990’, (1990) 2 *Aboriginal Law Bulletin* 44, 44.

16 Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997).

17 David Pollard, *Give & Take: The losing partnership in Aboriginal poverty* (Hale & Oremonger, 1988), 31.

correlated with traditional Aboriginal living practices, for example, travelling on lands and rearing children with the support of extended family and kin.

Further, even though the judiciary ostensibly now had oversight powers in relation to Aboriginal children and families, the courts were usually not located within a reasonable distance of Aboriginal communities and poverty-stricken Aboriginal parents did not have legal assistance to appeal unlawful Board decisions. Therefore, in practice, the Board's control continued unchecked by the rule of law.

Once the Aborigines Welfare Board removed an Aboriginal child, he or she became a 'ward' of the Board. At this time, institutions such as the Parramatta Girls' Home were already operational, and through the new child welfare legislation, the Board obtained the formal mandate to establish and maintain further institutional 'homes' for its wards. To effect the assimilation policy, it was now an offence for Aboriginal parents to contact their child once in a home, or for a ward to leave a home (punished by, amongst other things, corporal punishment). As detailed at length in the *Bringing Them Home Report*, these 'homes' were hotbeds of abuse and trauma for the Aboriginal children who had been stolen from their families.¹⁸

By the mid-1940s, the Board had implemented the segregation and assimilation policies with such gusto that the institutional homes were filling up, and the Board did not have the funds available to create new institutions for its wards. This situation resulted in the state establishing the backbone of the modern day OOHC system: foster care.

Foster care and other strategies

In 1950, the Board advertised for foster parents for 150 Aboriginal children, and by 1960, 300 Aboriginal children were living in foster homes in NSW. By the 1960s, the popularity of British psychiatrist John Bowlby's 'attachment theory' supported the case for increasing foster care arrangements (rather than use of homes).¹⁹ This theory suggested that an infant needed to develop a relationship with a primary caregiver for social and emotional development. Given that the assimilation policy was in full effect during this period, foster carers were predominantly non-Aboriginal people.

As the state homes continued to fill and the foster carer supply dwindled, the state pursued additional options to assimilate Aboriginal children including detention and adoption. Under these reforms, Aboriginal children deemed 'uncontrollable' by the NSW Children's Court were placed in state corrective institutions or were adopted by non-Aboriginal families.

Adoption was also a way to effect assimilation at low cost to the state. Evidence presented to the *Bringing Them Home* Inquiry highlighted the ways in which Board workers pressured Aboriginal mothers to give up children at birth, without advising the mothers that they were consenting to permanent removal.²⁰ Also, under the *Adoption of Children Act 1965* (NSW), when a foster carer wished to adopt a child, the Board could apply to the Children's Court to waive the consent requirement. Once a child was adopted, there was virtually no legal recourse for

¹⁸ Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997) 11.

¹⁹ Ibid 28.

²⁰ Ibid 42.



the parents. Understandably, given this historical context, Aboriginal people remain acutely sensitive to adoption laws today.²¹

Abolition of the Board and shift to current arrangements

It was against the backdrop of the 1967 Referendum that the Aborigines Welfare Board was finally abolished in 1969, leaving over a thousand Aboriginal children in OOHC in NSW. When the Board was abolished, control of Aboriginal wards was transferred to the NSW Department of Child Welfare, the precursor to FACS (now the Department of Communities and Justice). Homes such as Kinchela Boys Home and Cootamundra Girls Home closed shortly after the Board was abolished, but other homes continued to operate, with Bomaderry Aboriginal Children's Home not closing until 1980.²² During the Review Professor Megan Davis and members of her staff met with the NSW Government Stolen Generations Advisory Committee, which comprises representatives of Kinchela Boys' Home Aboriginal Corporation, Coota Girls Aboriginal Corporation, Children of the Bomaderry Aboriginal Children's Home Incorporated and the NSW/ACT Stolen Generations Council.

In 1972, the federal policy became one of self-determination, a concept discussed at length in Part C of this report. However, despite the rhetoric of self-determination, Aboriginal children continued to be over-represented in OOHC. By 1980, 15.5% of children in foster care in NSW were Aboriginal, 10.2% of children in non-government children's homes were Aboriginal, and 17.2% of children in corrective institutions were Aboriginal.²³ At this stage, the Aboriginal population in NSW was about 1%. Further, the state continued to place Aboriginal children who had been removed from their families with non-Aboriginal foster carers. For instance, a 1987 survey found that only 51% of the families fostering Aboriginal children were Aboriginal themselves.²⁴ In 1987, the Aboriginal Child Placement Principle (ACPP) was included in the *Children (Care and Protection) Act 1987* (NSW). Like this Review, the ACPP was a result of Indigenous community activism, in particular the political advocacy of Aboriginal and Torres Strait Islander Child Care Agencies (AICCAs). Amongst other things, the ACPP was intended to ensure that when an Aboriginal child was removed, he or she was placed with Aboriginal family and kin. Issues around implementation of the ACPP in NSW are discussed in Part E of this report.

Contemporary out-of-home care: The scope of the current crisis

The latest government statistics, released in January 2016, show that 39% of children in foster care in NSW were Aboriginal, 54% of children in NSW residential homes were Aboriginal and 50% of the average daily detention population of children and young people aged 10–17 years of age in NSW was Aboriginal. The Aboriginal population in NSW in 2016 was 3%.²⁵

21 At the time of writing, the NSW Government is explicitly pursuing a strategy of adoption to reduce the number of children in out-of-home care, as detailed in Chapter 22 of this report. Adoption for Aboriginal children is considered an option of last resort in the Permanent Placement Principles, but an internal flowchart shows the process of adoption for Aboriginal children, and the case file review revealed cases where adoption was being sought or considered for Aboriginal children.

22 See NSW Office of Environment and Heritage, *Heritage Places and Items* (online, 30 June 2019), <<https://www.environment.nsw.gov.au/heritageapp/ViewHeritageltemDetails.aspx?ID=5061330>>.

23 NSW Legislative Assembly, *First report from the Select Committee of the Legislative Assembly upon Aborigines* (1981), 293.

24 Lisa Ford, 'Protecting the Peace on the Edges of Empire: Commissioners of Crown Lands in NSW' in Laura Benton, Adam Clulow and Bain Attwood (eds), *Protection and Empire: A Global History* (Cambridge University Press, 2018), 89.

25 Australian Bureau of Statistics, 'Aboriginal and Torres Strait Islander Population: 2016 Census Data Summary' 2071.0 - *Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016*.

To give concrete numbers: in 1993, there were 829 Aboriginal children and young people in OOHC in NSW.²⁶ In the latest statistics period, there were 6,766 Aboriginal children in OOHC in NSW (there were 10,681 non-Aboriginal children and three with unknown status).²⁷ Of these, 2,641 Indigenous children were in foster care, rather than relative/kinship care (4,925 non-Indigenous children were in foster care and one child had unknown status).²⁸ There were 170 Indigenous children in residential homes (and 355 non-Indigenous children in these homes).²⁹

To be effective, any reform to law, practice and policy must respond to the extent and intergenerational nature of the trauma that has been caused and compounded by the state.

The numbers of Aboriginal children removed from their parents have increased since the end of the assimilation era, including after the Prime Minister Kevin Rudd's Apology in 2008. For example, in 2008–09, there were 4,991 Aboriginal children and young people in OOHC in NSW. In 2010–11, there were 5,737 Aboriginal children and young people in OOHC, and in 2013–14, there were 6,520 Aboriginal children and young people in OOHC.³⁰ Although most recent data suggest that the number of children entering care has reduced (this is discussed further later in this Part), these data also highlight that Aboriginal children continue to be disproportionately represented in the system (Figure 1). The statistical evidence indicates that the situation for Aboriginal children and families is worsening. To be effective, any reform to law, practice and policy must respond to the extent and intergenerational nature of the trauma that has been caused and compounded by the state.

Previous inquiries and reports examining the child protection system

The safety and wellbeing of Australian children is an issue that has generated a substantial amount of political, academic and community interest in the last 30 years. As the Royal Commission into Institutional Responses to Child Sexual Abuse noted in its 2017 report, 'since 1990 there have been no fewer than six national and at least 18 state or territory inquiries into the effectiveness of child protection systems that included a focus on the treatment of children in out-of-home care'.³¹ In recent years, legislative and policy interest in the area has been particularly intense due to the increasing numbers of children coming into contact with child protection systems. Since 2009, there have been 'at least 25 Ombudsman inquiries, Auditor-General inquiries, commissions of inquiry, judicial reviews, parliamentary inquiries and Royal Commissions into various aspects of child protection practice and policy across the eight jurisdictions'.³²

26 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 5.

27 Australian Government Productivity Commission, *Report on Government Services, Vol F Community Services* (2019) Table 16A.19.

28 Ibid.

29 Ibid.

30 Australian Institute of Health and Welfare, *Child Protection Australia 2013–2014*, Table 5.4, 51.

31 Royal Commission into Institutional Responses to Child Sexual Abuse, (December 2017), Vol 12, 32.

32 ACIL Allen Consulting, *Measuring Progress Under the National Framework: Evaluation of Progress under the National Framework for Protecting Australia's Children* (Report, June 2015) 35.



At the state and territory level, most of these inquiries have been initiated ‘in response to critical failings in the statutory system’.³³ Unfortunately, an examination of these reports reveals that ‘departments do not always respond to previous inquiries’ recommendations or suggestions’.³⁴ In some instances, this has led to disillusionment among reformers, especially among the Aboriginal and Torres Strait Islander community. As the ACT Assembly Committee noted in 2003 that:

it is difficult to see where progress has been made and members of the community may legitimately ask how many recommendations, from how many reviews does it take for action to occur? The Committee had no desire to produce yet another report that simply sits on someone’s shelf collecting dust.³⁵

Similarly, in 2005 the Senate Community Affairs References Committee noted that:

at regular intervals over many years, reports on problems and shortcomings of the care and protection of children in out-of-home care have been produced. Unfortunately, it seems that these reports had minimal impact in achieving a system that was responsive, accountable and achieved outcomes in the best interest of children. A spate of more recent reports for a number of States and Territories reveal crisis-ridden child protection systems that are under-resourced, under-funded, understaffed resulting in a high turnover of over-worked (burnt-out) and often inexperienced workers. They have also found that the crisis-ridden systems have resulted in children at risk not being adequately protected.³⁶

This section provides an overview of some of the most comprehensive and influential reports and policy documents relating to Aboriginal children and young people in OOHC. It does not attempt to capture all of the relevant academic and grey literature in this area,³⁷ nor does it cover all of the reform agendas that have an impact on the number of Aboriginal children and young people in OOHC (such a social justice initiatives, crime prevention strategies and health reform projects). However, it does provide essential background to this Review by highlighting that it is conducted against a well-trodden reform landscape that is littered with comprehensive and often unimplemented recommendations for reform.

33 Ibid 26.

34 Senate Community Affairs References Committee, *Protecting Vulnerable Children: A National Challenge* (Report, 2005) [1.71].

35 Cited in Senate Community Affairs References Committee, *Protecting Vulnerable Children: A National Challenge* (Report, 2005) [1.71].

36 Senate Community Affairs References Committee, *Protecting Vulnerable Children: A National Challenge* (Report, 2005) [1.75].

37 For a more complete overview of much of this material, see Myfanwy McDonald et al, *Protecting Australia’s Children Research Audit* (Final Report, 2011).

National inquiries and reports

The Bringing Them Home Report

On 26 May 1997, the Human Rights and Equal Opportunity Commission ('HREOC', as it was then called)³⁸ released the *Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (the *Bringing Them Home Report*). This report was the first to examine in detail the forced removal of Aboriginal and Torres Strait Islander children from their families and communities between the late 1800s and the early 1970s. Over the course of 689 pages, the report exposed the nature and extent of gross violations of human rights perpetrated against Aboriginal and Torres Strait Islander peoples by non-Indigenous people and outlined the 'multiple and disabling effects' of forcible removal.³⁹

The HREOC inquiry was also asked to examine 'current laws, practices and policies with respect to the placement and care of Aboriginal and Torres Strait Islander children and advise on any changes required, taking into account the principle of self-determination by Aboriginal and Torres Strait Islander peoples.'⁴⁰ Part 6 of the *Bringing Them Home Report* analysed 'the extent, nature and causes of contemporary removals of Indigenous children from the families and communities'.⁴¹ It noted that Indigenous children were over-represented in OOHC, particularly in long-term foster care arrangements.⁴² They were also more likely to be 'notified' to a child welfare department on the ground of abuse and neglect⁴³ and, despite agreement among commentators and government departments that Indigenous children who must be removed from their families would be best cared for within an Indigenous cultural environment, were often placed in non-Indigenous environments.⁴⁴

When examining the contemporary context, the report noted that there were multiple reasons for the high rate of removal of Indigenous children from their families, including 'continuing cultural bias against Indigenous modes of parenting, inadequate and inappropriate services for Indigenous families and discriminatory treatment of young Indigenous people before the law'.⁴⁵ It concluded that self-determination for Indigenous people was the most important factor in addressing the over-representation of Indigenous children in the child welfare system⁴⁶ and recommended that national legislation be passed to facilitate the making of agreements to enable Indigenous communities, regions or organisations to take control and

38 In 2008, the Human Rights and Equal Opportunity Commission changed its name to the Australian Human Rights Commission: see Australian Human Rights Commission, 'Frequently Asked Questions about the Australian Human Rights Commission's new name and logo' (online, 5 August 2009), <<https://www.humanrights.gov.au/frequently-asked-questions-about-australian-human-rights-commission-s-new-name-and-logo>>. See also *Disability Discrimination and Other Human Rights Legislation Amendment Act 2009* (Cth) sch 3.

39 Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997) 11.

40 'Terms of reference' in Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997) (online) <<https://www.humanrights.gov.au/our-work/bringing-them-home-preliminary>>.

41 Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997), 15.

42 Ibid 372.

43 Ibid 373.

44 Ibid.

45 Australian Human Rights Commission, 'Bringing them home—Frequently asked questions about the National Inquiry' (2 December 2001) Australian Human Rights Commission, <<https://www.humanrights.gov.au/publications/bringing-them-home-frequently-asked-questions-about-national-inquiry>>.

46 Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997), 15.



responsibility for the wellbeing of Indigenous children in relation to child protection (including the transfer of legal jurisdiction and departmental functions to the relevant community, region or organisation).⁴⁷ Further, the report recommended that national legislation be passed that set out minimum standards for the treatment of all Indigenous children,⁴⁸ including standards that required Indigenous communities to be involved in all care and protection matters ‘from the point of notification and at each stage of decision making thereafter, including whether and if so on what grounds to seek a court order’.⁴⁹

The response to the *Bringing Them Home Report* was ‘sustained and intense’.⁵⁰ It generated widespread public, political and media discussion and debate.⁵¹ However, debate about past removals tended to overshadow that relating to the contemporary removal of Indigenous children. As the 1998 Social Justice Report stated, ‘people find it easier to acknowledge and confront historical wrongs which do not implicate them personally’.⁵²

The *Bringing Them Home Report’s* recommendations regarding national framework legislation and national standards legislation were not implemented. As HREOC noted in 1998:

there is no consensus among Australian governments to pursue such uniform legislative goals ... Indeed, quite the contrary appears to be the case. The current situation is that each jurisdiction is being left to pursue those goals relevant to the issues covered by the recommendations in a way, and to an end, that best suits its particular circumstances.⁵³

The National Sorry Day Committee’s 2015 scorecard on the implementation of the *Bringing Them Home* recommendations⁵⁴ indicated that only two out of the 13 recommendations that had been implemented related to the current generation of Aboriginal and Torres Strait Islander children.⁵⁵

In the aftermath of the *Bringing Them Home Report*, child welfare issues continued to remain the exclusive province of the state and territory governments. In 2000, the Senate Standing Committee on Legal and Constitutional Affairs, when examining the implementation of the *Bringing Them Home* recommendations, noted that ‘there have been limited if any reductions in the separation of Indigenous children within the last few years’.⁵⁶

47 Ibid recs 43A–C.

48 Ibid recs 44–53B.

49 Ibid rec 49.

50 Human Rights and Equal Opportunity Commission, *Social Justice Report 1998* (Report, 1998) 6

51 Ibid ch 2.

52 Ibid 42.

53 Ibid 62.

54 John Rule and Elizabeth Rice, *Bringing them home Scorecard Report 2015* (Report Commissioned by National Sorry Day Committee, 2015).

55 SNAICC, ‘Bringing Them Home Scorecard Report 2015 again highlights startling inaction’ (online, 3 June 2015) <<http://www.snaicc.org.au/bringing-them-home-scorecard-report-2015-again-highlights-startling-inaction/>>.

56 Senate Standing Committee on Legal and Constitutional Affairs, *Healing: A Legacy of Generations* (Report, 30 November 2000) 188.

A Time to Invest report

In 2002, the Child and Family Welfare Association of Australia released a report, *A Time to Invest in Australia's Most Disadvantaged Children, Young People and Their Families*. This report strongly urged all governments in Australia to work together to address the high levels of children in contact with child protection systems.⁵⁷ It contained a number of suggestions for reform to support Aboriginal and Torres Strait Islander children in contact with these systems, including recommending that minimum standards be developed for the protection of Aboriginal and Torres Strait Islander children in need of care, and that child protection responsibilities be transferred to accredited community-based Aboriginal and Torres Strait Islander organisations.⁵⁸

Protecting vulnerable children report

In 2005, the Senate Community Affairs References Committee released a report titled *Protecting vulnerable children: A national challenge*.⁵⁹ This report contained a short reference to the fact that Aboriginal and Torres Strait Islander children were over-represented in OOHC, and noted that 'systems breakdowns' were occurring in NSW. In particular, it noted that the Law Society of NSW's submission indicated that Aboriginal or Torres Strait Islander children 'are not being identified by legislation; indigenous children are not being placed in culturally-appropriate out-of-home care; and no consultations are occurring with the welfare or indigenous community groups that could assist in identifying suitable placements'.⁶⁰

Our Children Our Dreaming

In 2013 the Healing Foundation, in conjunction with other key Aboriginal and Torres Strait Islander bodies, released a discussion paper expressing concern about the continuing rise of Aboriginal and Torres Strait Islander children in contact with child protection services, despite widespread acknowledgment and understanding of the issue.⁶¹ The discussion paper observed that current child protection services were narrow in scope and 'designed to identify and respond to harm rather than prevent harm from occurring in the first place'.⁶² It suggested reforms to address the problem of the over-representation of Aboriginal and Torres Strait Islander children and young people in the child protection system which were grouped under six themes—rights, culture and self-determination; trauma, disadvantage and child abuse and neglect; holistic response; community responsibility and control; partnership; and sustainability.⁶³

57 Ibid 5.

58 Ibid 34.

59 Senate Community Affairs References, *Protecting vulnerable children: A national challenge* (Report, 2005). This report was one of several national reports released in the early 2000s to deal with children in out-of-home care: see, eg, Senate Community Affairs Reference Committee, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children* (Report, 2004).

60 Senate Community Affairs References, *Protecting vulnerable children: A national challenge* (Report, 2005) [3.92].

61 The Healing Foundation, SNAICC and Queensland Aboriginal and Torres Strait Islander Child Protection Peak Ltd, *Our Children, Our Dreaming: A call for a more just approach for Aboriginal and Torres Strait Islander Children and Families*, (Report, June 2013), 2.

62 Ibid 3.

63 Ibid 7.



Out of Home Care Inquiry

In 2015, the Senate Community Affairs References Committee released its report, *Out of Home Care*, which aimed to address problems in Australia's child protection systems 'to ensure they facilitate positive outcomes for all children and families affected by out-of-home care'.⁶⁴ The report noted the disproportionately high number of Indigenous children in OOHC in the states and territories⁶⁵ and noted that this could be attributed in part to the intergenerational trauma caused by past practices of child removal. The Committee highlighted the need for Aboriginal and Torres Strait Islander communities to be engaged and empowered in improving outcomes for their children,⁶⁶ for cultural support for Aboriginal and Torres Strait Islander children and young people in OOHC to be strengthened,⁶⁷ and for the ACPP to be applied consistently.⁶⁸

The report also made numerous recommendations for amendments to the Third Action Plan of the National Framework, several of which related to Aboriginal and Torres Strait Islander children in OOHC.⁶⁹ These included an amendment to include a project 'to develop and implement a nationally consistent approach to building the capacity of Aboriginal community controlled agencies (ACCAs), enabling such agencies to become integrated into all aspects of the child protection system for Aboriginal and Torres Strait Islander children',⁷⁰ and an amendment to mandate cultural competency training for all services working with Aboriginal and Torres Strait Islander children and families.⁷¹

Royal Commission into Institutional Responses to Child Sexual Abuse

On 15 December 2017, the *Royal Commission into Institutional Responses to Child Sexual Abuse* report was released. This report extensively considered child sexual abuse in a wide range of institutional settings—a 'national tragedy, perpetrated over generations within many of our most trusted institutions'.⁷² The Royal Commission noted that child sexual abuse had occurred, and continues to occur, in many institutions, including OOHC.⁷³

Volume 12 of the Royal Commission's report examined child sexual abuse in contemporary (post-1990) OOHC. It noted evidence of

systemic failings that weaken the safety of children in care, including frequent placement changes, poor information sharing, inadequacies in service providers' responses to children's prior abuse and trauma, and significant gaps in the training and support provided to staff and carers, especially kinship carers.⁷⁴

64 Senate Community Affairs References Committee, *Out of Home Care* (Report, 2015), [1.4]

65 Ibid 12–15.

66 Senate Community Affairs References, *Protecting vulnerable children: A national challenge* (Report, 2005) [8.22], [8.109].

67 Senate Community Affairs References Committee, *Out of Home Care* (Report, 2015), [8.78].

68 Ibid [8.79].

69 Ibid recs 31–23, 34, 36.

70 Ibid rec 31.

71 Ibid rec 32.

72 James Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, (November 2008), vol 1, 5.

73 Ibid vol 1, 10.

74 *Royal Commission into Institutional Responses to Child Sexual Abuse*, (December 2017), vol 12, 9.

The Commission made a number of recommendations to reduce the risk of sexual abuse in OOHC, including the following:

- Improved data collection about the identification and reporting of child sexual abuse in OOHC;⁷⁵
- Mandatory accreditation for all OOHC care service providers by an independent agency;⁷⁶
- A more comprehensive national screening system for carers;⁷⁷
- The development of mechanisms for children in OOHC to communicate views, concerns or complaints;⁷⁸
- Training of carers and child protection workers in the principles of trauma-informed care;⁷⁹ and
- That the ACPP be fully implemented.⁸⁰

During its inquiry, the Royal Commission heard from 80 Aboriginal or Torres Strait Islander survivors of child sexual abuse in contemporary OOHC.⁸¹

In respect of Aboriginal and Torres Strait Islander children in OOHC, the Royal Commission observed that ‘insufficient recognition of the role of Aboriginal and Torres Strait Islander culture’ was a risk factor for child sexual abuse that should be addressed to ensure child-safe institutions.⁸²

ALRC report on Indigenous incarceration

In December 2017, the Australian Law Reform Commission (ALRC) completed its report, *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*.⁸³ Noting the link between OOHC and incarceration, the ALRC stated that

the incarceration rate of adult Aboriginal and Torres Strait Islander peoples cannot be fully and satisfactorily addressed without a national review of Aboriginal and Torres Strait Islander children in child protection, and the state and territory laws that see such children placed into out-of-home care.⁸⁴

One of the ALRC’s 35 recommendations was that the Commonwealth Government establish ‘a national inquiry into child protection laws and processes affecting Aboriginal and Torres Strait Islander children’.⁸⁵

75 Ibid recs 12.1–12.3.

76 Ibid recs 12.4–12.5.

77 Ibid rec 12.6.

78 Ibid rec 12.10.

79 Ibid rec 12.11.

80 Ibid rec 12.10.

81 Ibid 58.

82 Ibid 215, 4.5.1.

83 Australian Law Reform Commission, *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report 133, 2018).

84 Australian Law Reform Commission, *Report 133(2018) Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, 15.4.

85 Ibid rec 15-1.



New South Wales inquiries and reports

The Wood Inquiry

In 2007, following the high-profile deaths of two children known to the then NSW Department of Community Services (DOCS), the Special Commission of Inquiry into Child Protection Services in NSW was established.⁸⁶ In 2008, the inquiry released a three-volume report into child protection services in NSW. The report contained 111 recommendations for change of the law, policy and practice relating to child protection in NSW, one of the most significant of which was that only children and young people suspected of being at risk of significant harm should be reported to DOCS.⁸⁷

In respect of OOHC, the report recommended that responsibility for OOHC should be gradually transferred to the non-government sector.⁸⁸ It noted that there were large numbers of Aboriginal and Torres Strait Islander children in OOHC and recommended that priority be given to 'strengthening the capacity for Aboriginal families to undertake foster and kinship caring roles'.⁸⁹ The report also recommended that DOCS develop training guidelines to ensure staff compliance with the ACPP under s 13 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*).⁹⁰

The Wood Report noted that there were not enough culturally appropriate and competent services for Aboriginal children, young people and their families.⁹¹ It also contained recommendations aimed at increasing the self-determination of Aboriginal and Torres Strait Islander peoples within the child protection system. For example, one of the eight principles put forward to guide child protection in NSW was that Aboriginal and Torres Strait Islander peoples should participate in decision making concerning the care and protection of their children and young people 'with as much self-determination as is possible'.⁹² The report also included a longer term recommendation that the NSW Government build capacity in Aboriginal organisations to enable them to be involved in 'all facets of child protection work including assessment, case planning, case meetings, home visits, attending court, placing Aboriginal children and young persons in OOHC and making restoration decisions'.⁹³

Ombudsman reports 2012–2014

Between 2011 and 2014, the NSW Ombudsman released a number of reports examining the child protection system in NSW generally.⁹⁴ These reports consistently highlighted serious concerns about FACS' ability to adequately handle its volume of work, particularly in high-need remote areas with chronic staff shortages. In all of these reports, the Ombudsman recommended the

86 'Child deaths inquiry calls for reporting overhaul', *ABC News*, (ABC News Digital, 18 November 2018), <<http://www.abc.net.au/news/2008-11-24/child-deaths-inquiry-calls-for-reporting-overhaul/216586>>.

87 James Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, (November 2008), vol 1, xiii, rec 6.2.

88 *Ibid* vol 1, xxviii, rec 16.2.

89 *Ibid* vol 1, xxx. Rec 16.12.

90 *Ibid* vol 2, rec 11.5.

91 *Ibid* vol 1, iv.

92 *Ibid* vol 1, 380.

93 *Ibid* vol 2, rec 8.5.

94 New South Wales Ombudsman, *Keep them Safe? Special Report to Parliament August 2011* (2011) <https://www.ombo.nsw.gov.au/data/assets/pdf_file/0014/3344/SR-to-Parliament-keep-them-safe.pdf>; New South Wales Ombudsman, *Addressing Aboriginal Disadvantage; Ombudsman 2010 Inquiry into service provision to the Bourke and Brewarrina Communities*, (August 2010), <https://www.ombo.nsw.gov.au/data/assets/pdf_file/0012/3342/SR_Aboriginal-disadvantage-report.pdf>.

adoption of an intelligence-driven approach to child protection, similar to the evidence-based strategies employed to identify and target high-risk young offenders.⁹⁵ It was noted that among other things, an intelligence-driven approach would enable FACS to readily identify ‘frequently encountered families’⁹⁶ and the most at-risk children, analyse information about these families and children, and translate this analysis into well-informed intervention decisions.⁹⁷

FACS discussion paper: Child Protection Legislative Reforms

In late 2012, FACS released a discussion paper titled *Child Protection Legislative Reforms* and sought feedback on the legislative reforms and changes in practice and procedure that it proposed to improve the child protection system in NSW. Following this, in 2014 FACS released a Consultation Report that outlined the findings of its consultation process, highlighting the differing views of stakeholders to the various proposals and explained the reform pathway that the NSW Government would adopt.

One of the reforms proposed in the discussion paper was of significant concern to Aboriginal and Torres Strait Islander children and young people in OOHC. The Consultation Report noted that the Aboriginal community expressed fear about the proposal to encourage greater adoption of children and young people in OOHC, on the basis that it ‘could result in a new generation of children removed from their families, communities and culture’.⁹⁸ Further, Aboriginal stakeholders were concerned that the idea of ‘permanency and stability’ promoted by FACS did not recognise cultural differences and that Aboriginal children could enjoy permanency and stability when being cared for ‘by a number of relatives and kin at different times’.⁹⁹

In response to these concerns, FACS noted that it was deeply committed to supporting Aboriginal children to live with their families and communities, and recognised that adoption was not a preferred placement option for Aboriginal children who could not live with their parents.¹⁰⁰ Instead, it committed to ensuring that decisions about the placement of these children would continue to be made in accordance with ACPP.¹⁰¹

NSW Auditor-General report on OOHC

In 2015, the NSW Auditor-General released a report on the progress of the NSW Government’s commitment to transfer OOHC services to non-government providers (a process which began in 2012 and is due to be completed by mid-2022).¹⁰² The report concluded that while FACS had made considerable progress towards reaching its goal, it was difficult to assess whether outcomes for children in care had improved due to a lack of clarity about the desired outcomes

95 See, example, New South Wales Ombudsman, *Addressing Aboriginal Disadvantage; Ombudsman 2010 Inquiry into service provision to the Bourke and Brewarrina Communities*, (August 2010), https://www.ombo.nsw.gov.au/data/assets/pdf_file/0012/3342/SR_Aboriginal-disadvantage-report.pdf, 25.

96 Ibid 15.

97 Ibid 46.

98 Department of Family and Community Services (NSW), *A Safe Home for Life, Report on the outcomes of public consultation on the child protection legislative reform discussion paper 2012* (2013), 11.

99 Ibid.

100 Ibid.

101 Ibid 11, 27.

102 NSW Auditor-General, *Transferring out-of-home care to non-government organisations: Performance audit report for the Department of Family and Community Services* (September 2015), 2.



to be achieved.¹⁰³ The report also noted that the number of children returning to their birth families had reduced,¹⁰⁴ and that current funding models provided little incentive for non-governmental organisations (NGOs) to return children to their birth families.

In respect of Aboriginal children and families, the report recommended that FACS develop (in collaboration with the Aboriginal community) a clear strategy for increasing the number of Aboriginal NGOs involved in OOHC.¹⁰⁵ It noted that there were still parts of the state with very few NGOs, and as such, the proportion of Aboriginal children case managed by NGOs varied by district.¹⁰⁶

The ‘Tune Report’

In November 2015, the NSW Government commissioned David Tune AO PSM to conduct an independent review of OOHC in NSW.¹⁰⁷ The review had a number of aims, including to ‘understand the causes and propose options to reduce the over-representation of Aboriginal children in the out-of-home care system and the poorer outcomes for many of these children’.¹⁰⁸ The review was also asked to examine the appropriateness of programs funded by the Keep Them Safe reforms.¹⁰⁹

The ‘Tune Report’ was released to the public in June 2018, almost 18 months after it was delivered to the NSW Government. Prior to its release, the NSW Government claimed that the report was protected by cabinet confidentiality.¹¹⁰

The report found that the child protection system in NSW was ‘ineffective and unsustainable’.¹¹¹ It noted that the cost of OOHC was increasing, in part due to the transfer of OOHC service delivery to the non-government sector.¹¹² It concluded that interventions for vulnerable families were inflexible, poorly targeted and not well evaluated,¹¹³ and that long term outcomes for those in contact with the child protection system remained poor¹¹⁴ (and ‘particularly poor’ for Aboriginal children).¹¹⁵ The report also noted that collaboration among service areas remained ‘ad hoc, driven by relationships and interpersonal negotiation skills’.¹¹⁶

The report recommended far-reaching, systemic reform to address the problems plaguing the NSW child protection system. It recommended shifting the focus from crisis-oriented expenditure to expenditure on effective, evidence-based early intervention services.¹¹⁷ It also

103 Ibid.

104 Ibid 20.

105 Ibid rec 3, 13.

106 Ibid 19.

107 David Tune AO PSM, *Independent Review of Out Of Home Care in New South Wales—Final Report* 10.

108 Ibid

109 Ibid; Lorena Allam, ‘Crisis-driven’: scathing report damns NSW children protection system (online, 12 June 2018) <<https://www.theguardian.com/australia-news/2018/jun/12/crisis-driven-nsw-child-protection-system-is-failing-study-says>>.

110 Anne Davies, ‘NSW Government caves in to pressure and agrees to release key documents’ *The Guardian* (online, 6 June 2018) <<https://www.theguardian.com/australia-news/2018/jun/06/nsw-government-set-for-showdown-after-refusing-to-release-of-documents>>.

111 David Tune AO PSM, *Independent Review of Out Of Home Care in New South Wales—Final Report* 3.

112 Ibid 14.

113 Ibid 23.

114 Ibid 18.

115 Ibid 19.

116 Ibid 21.

117 Ibid 35.

recommended that parents and children receive personalised support packages depending on their needs¹¹⁸ and that a new entity be established to coordinate reform across different areas of government to achieve better outcomes for vulnerable children and families (the NSW Family Investment Commission).¹¹⁹ However, the final report did not contain any in-depth discussion about the unique needs and circumstances of Aboriginal children in OOHC.¹²⁰

Legislative Council report: Reparations for the Stolen Generations

In its 2016 report, *Reparations for the Stolen Generations in New South Wales: Unfinished Business*, the Legislative Council General Purpose Standing Committee No 3 noted that the over-representation of Aboriginal children in OOHC had led many stakeholders to argue that NSW was creating another Stolen Generation.¹²¹ It noted the vital importance of early intervention and support services for Aboriginal parents and families and recommended that FACS, in consultation with Aboriginal organisations and communities, identify strategies to promote early intervention programs that aim to prevent Aboriginal children and young people being removed from their families.¹²² It also discussed the ACPP and recommended that FACS commission ‘an independent audit of adherence to the Aboriginal and Torres Strait Islander Child Placement Principles, with a view to improving compliance and reporting’.¹²³ The Committee also expressed concern that cultural care plans were not being ‘genuinely tailored to each child’¹²⁴ and recommended that FACS review the quality and effectiveness of cultural care planning for Aboriginal children and young people in OOHC.¹²⁵ Finally, the Committee expressed its support for the principle of self-determination and encouraged FACS to continue engaging with Aboriginal organisations and families when making child protection decisions.¹²⁶

Legislative Council report: Child Protection

In 2017, the Legislative Council’s General Purpose Standing Committee No 2 released a report into child protection in NSW.¹²⁷ The report examined a wide range of issues relating to child protection, including the system’s capacity to investigate and assess reports of children and young people at risk of harm, the funding allocated to FACS and NGOs for child protection services, and the support services provided to carers in the child protection system.

The Committee’s terms of reference included an instruction to examine ‘specific initiatives and outcomes for at risk Aboriginal and Torres Strait Islander children and young people’.¹²⁸ The Committee accordingly examined the high and increasing rates of Aboriginal children and young people in OOHC and noted that it was confounded that ‘despite the range of policy initiatives designed to address these trends, there appears to be no evidence that the situation is

118 Ibid 4.

119 Ibid 5.

120 However, it appears that the Interim Report, delivered to the NSW Government in March 2016, contained recommendations relating to Aboriginal children and young people in OOHC: Ibid 10.

121 Legislative Council General Purpose Standing Committee No 3, *Reparations for the Stolen Generations: Unfinished business* (2016), [10.7]–[10.8].

122 Ibid rec 31.

123 Ibid. The ACPP is discussed further in Ch 16.

124 Legislative Council General Purpose Standing Committee No 3, *Reparations for the Stolen Generations: Unfinished business* (2016), [10.80].

125 Ibid rec 33.

126 Ibid [10.92]–[10.94].

127 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017).

128 Legislative Council General Purpose Standing Committee No 2, *Inquiry into child protection—Terms of reference*, [g].



improving'.¹²⁹ The Committee's report identified and discussed a number of key issues affecting Aboriginal children, young people, and families, including that:

- Aboriginal people were not accessing existing early intervention services because of fear that engagement with the services would lead to the removal of their children;¹³⁰
- the ACPP was not being implemented (in whole or in part) in all cases and the statistics collected to assess the application of the principles were inadequate;¹³¹
- children and young peoples' Aboriginality was not being identified at all, including in some cases where FACS had been informed of the child or young person's Aboriginality, or was not being identified in a timely manner;
- cultural planning and support was inadequate and cultural care plans were poor, created without input from the child or young person, and ineffective;¹³²
- consultation with Aboriginal communities under s 12 of the *Care Act* was 'inconsistent or inadequate';¹³³
- inadequate cultural training and cultural bias within the child protection system was leading to Aboriginal children being identified as being neglected on trivial grounds (such as the fact that they were not wearing shoes)¹³⁴ and was hindering the identification of appropriate carers for children and young people;¹³⁵ and
- Aboriginal people were not sufficiently empowered to make decisions for their children, families and communities.¹³⁶

The Committee recommended the NSW Government work with Aboriginal communities and organisations to provide 'a far greater degree of Aboriginal self-determination in decisions on supporting families, child protection and child removals'.¹³⁷

The NSW Government's response to the report was released in September 2017. It accepted the Committee's recommendation to increase Aboriginal self-determination in the child protection area, and outlined a number of initiatives being undertaken to achieve this goal, including the implementation of the *Guiding Principles for Strengthening the Participation of Local Aboriginal Community in Child Protection Decision Making*, which were developed by GMAR, FACS and the NSW Ombudsman.¹³⁸

129 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) [7.90].

130 Ibid [7.27].

131 Ibid [7.32]–[7.44].

132 Ibid [7.52]–[7.61].

133 Ibid [7.62].

134 Ibid [7.18]–[7.23].

135 Ibid [7.69]–[7.70].

136 Ibid [7.71]–[7.82].

137 Ibid rec 18.

138 New South Wales Government, *NSW Government response to Report 26 of the Legislative Council Portfolio Committee No. 2 Health and Community Services – Child protection* (September 2017), 21.

FACS discussion paper: Shaping a Better Child Protection System

In October 2017, the NSW Government released a discussion paper, *Shaping a Better Child Protection System*. The paper outlined proposed amendments to the *Care Act* and the *Adoption Act 2000* (NSW) to support the Their Futures Matter reforms (discussed below). The discussion paper focused on two main areas of reform: (i) earlier family preservation and restoration; and (ii) streamlining court processes and orders.

In October 2018, the NSW Government released a report on the outcome of consultations on the discussion paper.¹³⁹ In relation to the first area of reform, it indicated it would not proceed with some of the reforms suggested in the discussion paper (such as expanding the concept of restoration or mandating time frames for responses to ROSH reports).¹⁴⁰ However, it indicated it would mandate the use of alternative dispute resolution (ADR) for families before care orders were sought from the Children’s Court, unless there were exceptional circumstances¹⁴¹ and strengthen the requirement that other government agencies and funded NGOs deliver services to children and young persons when requested.¹⁴²

In relation to the second area of reform—streamlining court processes and orders—the NSW Government indicated that it would introduce reforms, including reforms designed to:

- enable the Children’s Court to make guardianship orders by consent in certain circumstances;
- enable any party to care proceedings to apply to vary an interim order without filing a s 90 application;
- limit the duration of an order allocating parental responsibility to the Minister to a period of 2 years if the Children’s Court approved a permanency plan involving restoration, guardianship or adoption;
- empower the Children’s Court to relist a matter on receipt of a s 82 report if it was not satisfied that proper arrangements had been made for the care and protection of a child or young person;
- enable the Children’s Court to make contact orders that extended beyond 12 months where it made a guardianship order and enable the parties to the orders to vary them by agreement in writing and register the variation with the Children’s Court; and
- enable the Children’s Court to dismiss a s 90 application for leave to vary or rescind a care order where it had no reasonable prospects of success, or was frivolous, vexatious or an abuse of process.¹⁴³

The report also indicated that the NSW Government would not make a number of the proposed changes with respect to the legislative provisions in NSW relating to adoption.¹⁴⁴ However, it indicated that it would extend the current period of time during which a child may live with his or her parents prior to restoration from 6 to 12 months.¹⁴⁵

139 Department of Family and Community Services (NSW), *Shaping a Better Child Protection System: Report on the outcomes of consultations* (October 2018).

140 Ibid 4–5.

141 Ibid 5.

142 Ibid 6.

143 Ibid 13–15.

144 Ibid 15.

145 Ibid 13–15.



Key concept: Intergenerational trauma

During the Review, the Aboriginal community, the broader child protection and OOHC sector, and FACS caseworkers, all raised the concept of ‘intergenerational trauma’. As such, it is discussed here at the outset of the report.

According to the literature, intergenerational trauma is passed down through generations. Following the work of Judith Herman,¹⁴⁶ in 2004 Wesley-Esquimaux and Smolewski introduced a new model for trauma transmission and healing. They suggested that the presence of complex or endemic post-traumatic stress disorder in Aboriginal cultures originated as a direct result of historic trauma transmission. They described their model of trauma transmission as follows:

trauma memories are passed to next generations through different channels, including biological (in hereditary predispositions to post-traumatic stress disorder), cultural (through story-telling, culturally sanctioned behaviours), social (through inadequate parenting, lateral violence, acting out of abuse), and psychological (through memory processes) channels.¹⁴⁷

The authors argued that while substance abuse, mental health issues, and poverty may exacerbate the effects of intergenerational trauma, the root cause of this trauma was colonisation and its subsequent effects. Currently, law, practice and policy does not address this trauma. This is arguably because the history set out in this chapter is not well known. To say that the root cause of the trauma is colonisation is one thing. To fully understand the history of that colonisation and the phases described above in this chapter is another. In Australia, intergenerational trauma is generally misunderstood. This trauma manifests itself in behaviours that are regularly viewed as a reason to remove children, and not restore those children once they have been removed. A joint submission by four Family Violence Prevention Legal Services noted the knock-on effects of intergenerational trauma:

The loss of parenting skills and knowledge has contributed to an increase in the communities’ vulnerabilities of; mental health, domestic and family violence, substance misuse and homelessness.¹⁴⁸

It is the view of many in the sector, that the recognition of this erosion of community and familial capacity should be considered in reform efforts. Rather than being judgemental about parenting practices (which is repeatedly common in the reviewed case file notes), caseworkers must recognise that many Aboriginal parents who are in contact with the child protection system have had their parenting abilities adversely affected by intergenerational trauma and its compounding effects. For example, they may not have had safe and stable homes themselves because their parents may not have had safe and stable homes.

146 Judith L Herman, *Trauma and Recovery: The Aftermath of Violence, from Domestic Abuse to Political Terror* (Basic Books, 1997).

147 Cynthia C Wesley-Esquimaux and Magdalena Smolewski, *Historic Trauma and Aboriginal Healing* (Report, Aboriginal Healing Foundation, 2004), 76.

148 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 1-2.

Legal Aid NSW note in its submission that, historically, trauma did not cease at the point of removal but that ‘many of these children also went on to experience abuse and neglect in institutions and foster families. The effects of these policies and practices reverberate today’.¹⁴⁹ According to Legal Aid NSW the traumatic effects of OOHC were not only historical, but remained resonant today:

Rather than supporting their recovery and healing, the OOHC system can compound and add to the trauma of Aboriginal children and young people. This inevitably compromises their ability to parent their own children in the future, and therefore results in more Aboriginal children and young people in OOHC.¹⁵⁰

In their submission, Aunty Glendra and Elizabeth Rice noted that intergenerational trauma created the conditions that are often construed as ‘neglect’. The problem is that the historical and structural factors that create these conditions then

become codified as risk factors which are sometimes used to “red flag” families. If “red flags” are not applied with proper, skilled, culturally competent examination of the particular circumstances, the results for children and young people, families and communities are disastrous.¹⁵¹

The data in Chapter 3 of this report demonstrate that a key risk factor for a child being removed is previous experience in the child protection system or having family members or parents in the system. If child protection authorities keep removing children for symptoms of neglect, rather than treating the root causes of that neglect, then numbers in OOHC will keep increasing as those children, in turn, have children who enter OOHC. The SNAICC *Family Matters* report indicated that one in five Aboriginal women, and over one in 10 Aboriginal men who were in OOHC, will have a child in OOHC at some point in the twenty years following their exit from OOHC.¹⁵² Compared with the general population, OOHC leavers are more than 10 times more likely to have their child in OOHC.¹⁵³

Legal Aid NSW noted that this trend was borne out in their casework:

Our Children’s Civil Law Service (CCLS) solicitors act for Aboriginal children and young people in OOHC who are the second, third or fourth generation in their families to have been removed from their families. This can be viewed as a direct legacy of past government policies of protectionism and assimilation. ... Our CCLS solicitors observe that if Aboriginal children and young people in OOHC have children themselves, their children are often removed and placed in OOHC.¹⁵⁴

The following case study from our Review is also indicative of this:

149 Legal Aid, Submission No 6 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 8.

150 Ibid 17-18.

151 Aunty Glendra Stubbs and Elizabeth Rice, Submission No 1 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 11.

152 SNAICC, *The Family Matters Report Measuring Trends to Turn the Tide on the Over-Representation of Aboriginal and Torres Strait Islander Children in Out-of-Home Care in Australia* (2017).

153 Ibid 6.

154 Legal Aid, Submission No 6 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 8.



Case study

J was an Aboriginal child in the cohort who was removed at birth. J’s mother, A, had been removed as a child herself and FACS had been involved with J’s father when he was a child. A’s grandmother was part of the Stolen Generations.

There were issues in J’s home prior to his birth (and removal), including substance abuse and domestic violence. FACS received the first ROSH report for J nearly two months prior to his birth and removal but did not provide any casework before his removal.

A Safety Assessment was done on the day of J’s removal with the outcome ‘Unsafe’. The information in the case file raises questions about the accuracy of this assessment, for example, a danger was identified based on the fact that J’s mother, A, did not give details of her newborn’s ‘lunchtime routine’. At the time of the assessment, A was a first-time mother of a one-day-old baby. ‘A’ had indicated that she planned to feed her baby every three to four hours as she had been advised. The case file also indicates that A had prepared supplies such as bottles and that she had indicated that she would work with Brighter Futures.

Even though there had been generations of trauma in this case, we still see a mother attempting to parent her newborn baby but being prevented from so doing.

When J was removed, he was not placed with his Aboriginal grandmother, who had requested to care for him. He was left in hospital for several days and then placed with a non-Aboriginal foster family for five months, before being placed with his grandmother. In the crucial days and weeks after birth, the stage was set for another generation of trauma.¹⁵⁵

Aunty Glendra submitted to the Review:

We know that the intergenerational issues need to be addressed—family violence, drug and alcohol abuse, poverty and neglect—but we need to address these issues, not just take the kids away. The “rubber stamping of a red flag” approach does nothing to encourage anyone to come forward and say I’m struggling. It does the opposite, it discourages them. And removal without addressing the issues just perpetuates them.¹⁵⁶

The Review agrees that casework must take into account intergenerational trauma. It must understand that, for example, ‘neglect’ is usually a result of intergenerational trauma and that trauma must be addressed first, rather than becoming the reason to remove the child. While this may seem obvious (and reflected in rhetoric), it is simply not born out in practice, a fact which is reflected in the disproportionate numbers of Aboriginal children in OOHC. Grandmothers Against Removal NSW (GMAR NSW) argue that:

despite official rhetoric, FACS sees a “better” child protection system as one that removes increasing numbers of children, rather than one that avoids removal by

155 Family is Culture Case 370.

156 Aunty Glendra, Submission 15 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW* (December 2017), 12.

supporting families. It is a system that does nothing to address the cultural genocide and constantly accumulating trauma and injustice inflicted on First Nations children, families and communities in the past, which is ongoing into the present. ... You only need to look at the Stolen Generations and compare them with current similar removal rates, practices and well-documented system failures to see this.

FACS cannot ... cannot continue to punish Aboriginal people for the effects of the policies that all Australian governments have inflicted on First Nations people. And it cannot expect to continue to carry out technocratic policies that have produced the same horrific outcomes in each generation.¹⁵⁷

How to address intergenerational trauma

Legal Aid NSW recommended a trauma-informed approach to child protection casework:

Trauma-informed care is a framework for service delivery that is based on “knowledge and understanding of how trauma affects people’s lives, their service needs and service usage”. ... it requires an understanding of the intergenerational trauma associated with colonisation, including past child removal policies and practices, as well as the trauma associated with distressing life events, such as exposure to abuse and family violence.¹⁵⁸

The following principles for trauma-informed care have been laid out by Aboriginal scholar Judy Atkinson:

- create environments in which children feel physically and emotionally safe;
- employ culturally competent staff and adopt practices that acknowledge and demonstrate respect for specific cultural backgrounds;
- support victims or survivors of trauma to regain a sense of control over their daily lives and actively involve them in the healing journey share power and governance, including involving community members in the design and evaluation of programs;
- integrate and coordinate care to meet children’s needs holistically; and
- support safe relationship building as a means of promoting healing and recovery.¹⁵⁹

The Review agrees that as a matter of priority, service delivery should take into account trauma-informed principles. Further resources on intergenerational trauma are available through organisations in NSW, such as the Healing Foundation and Winangay.

157 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 1-2.

158 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, January 2018.

159 Judy Atkinson, “Trauma-informed services and trauma-specific care for Indigenous Australian children”, Resource Sheet No 21 produced for the Closing the Gap Clearinghouse (July 2013), 1.



Key concept: Ritualism

The Review consulted much regulatory literature about how bureaucracy functions. We found this literature important because the size and complexity of FACS and its workforce is an important factor in understanding the role of the caseworker, as the street level bureaucrat, interacting with Aboriginal children and families. Sociologist Robert Merton identified five modes of how individuals adapt to a normative order such as FACS: conformity, innovation, ritualism, retreatism and rebellion.

These modes operate equally in bureaucracies, however one particular mode of adaptation seems relevant to the work of the Review and that is ritualism. Ritualism is defined as ‘acceptance of institutionalised means for securing regulatory goals while losing all focus on achieving the goals or outcomes themselves’. This means that in a work environment, like FACS which has a regulatory framework of law and policy that has been, until now, attuned to risk aversion, caseworkers take comfort in the rituals of casework, such as safety assessment and risk assessment while losing focus on the goal of child protection, to reunite children with their families. Similar international studies have been made of other human services such as Aged Care.¹⁶⁰

There are many examples of ‘ritualism’ that have played out over the course of this Review. A stark example is the application of the Aboriginal Child Placement Principle (ACPP). The ACPP is recognised in law and policy yet compliance is poor.

160 John Braithwaite, Toni Makkai and Valerie Braithwaite, *Regulating Aged Care: Ritualism and the New Pyramid* (Edward Elgar Publishing, 2007).

2. Methodology

The work of the Review was undertaken in four main phases, some of which have overlapped. The four phases were as follows:

- Phase One: Design and development
- Phase Two: Information gathering
- Phase Three: Data analysis
- Phase Four: Report writing and delivery

The following sections describe the first three of these phases in more detail.

Design and development

The first phase of the project involved recruitment of staff members and general project design. On 19 December 2016, the then Minister for Family and Community Services, the Hon. Brad Hazzard MP, announced the Chairperson to the Review, Professor Megan Davis. Upon commencement of her role in April 2017, Professor Davis appointed members to the Review Reference Group in consultation with the Minister.

The Reference Group was made up of Aboriginal community members and experts with professional and lived experience of the issues affecting Aboriginal children and young people, and particularly experiences of OOHC. It included three representatives of Grandmothers Against Removals NSW (GMAR NSW) and four youth ambassadors with personal experience of OOHC in NSW. It also included Professor Valerie Braithwaite from the Australian National University, a world-renowned regulatory scholar with extensive experience researching the challenges of regulatory systems (including the undertaking a major study of the regulation of the aged care sectors in the United States of America, England and Australia).¹⁶¹ It also included Tim Ireland, the CEO of the peak Aboriginal organisation, the Aboriginal Child, Family and Community Care State Secretariat (AbSec).

The Reference Group provided their perspectives and advice to the Chair, assisting with decision-making in line with the Terms of Reference and ensuring that broad community views were represented. The members of the Reference Group were as follows:

- Suelleyn Tighe (GMAR NSW)
- Jennifer Swan (GMAR NSW)
- Deb Swan (GMAR NSW)
- Tim Ireland (CEO, AbSec)
- Christine Corby (CEO Aboriginal Medical Service, Walgett)

¹⁶¹ John Braithwaite, Toni Makkai and Valerie Braithwaite, *Regulating Aged Care: Ritualism and the New Pyramid* (Edward Elgar Publishing, 2007).



- Steve Kinmond (the then NSW Deputy Ombudsman, Community and Disability Services Commissioner)
- Julianna Demerius (Assistant Ombudsman, Strategic Projects)
- Valerie Braithwaite (Professor, Regulatory Institutions Network, Australian National University)
- Melinda Mumbler (AbSec Youth Ambassador)
- Cody McGrady (AbSec Youth Ambassador)
- Monak Morris (AbSec Youth Ambassador)
- Isaiah Dawe (AbSec Youth Ambassador)
- Casey Ralph (Chief of Operations, KARI).

Following the appointment of the Reference Group members, Professor Megan Davis appointed the independent Family is Culture team as resources became available. A full-time legal researcher Kobie Mulligan was appointed for a short transitional period until Dr Erin Mackay was appointed in December 2017. Also temporarily on staff at this time was Lucinda Stewart, a Wadi Wadi woman of the Yuin Nation and lawyer. Next, the Family is Culture team was joined by a Barkindji woman and administrative lawyer from UNSW Law, Gemma McKinnon, who was appointed to a part-time position. Wiradjuri woman Bernadette Riley was appointed as project manager and community liaison in December 2017. A part-time executive assistant was appointed on a temporary basis from December 2017 until May 2018. Another legal researcher, Dr Althea Gibson, commenced on a part-time basis in February 2018 and new funding was made available for legal researcher and social scientist Emma Buxton-Namisnyk to commence in July 2018 to undertake case file reviews and qualitative and quantitative data analysis. Finally, Wiradjuri woman and lawyer Prudence Mewburn was engaged in 2019 to assist in research and editing work along with Bridget Cama, a Wiradjuri woman and lawyer. This team is referred to as the 'Independent Review Team'.

In 2017, FACS contracted employment agencies to engage 'reviewers' to conduct qualitative and quantitative reviews of the 'case files' relating to the Aboriginal children removed during the relevant time period. These 'case files' were made up of information from FACS internal case management systems, KiDS and ChildStory (which contain case information relating to child protection, OOHHC and carer management processes). In addition, reviewers occasionally made requests for further information from non-governmental OOHHC providers.

The case file review presented a formidable task. Over 40 reviewers were contracted on a casual basis by FACS from 2017-19. In addition, FACS employees, including staff members from the Office of the Senior Practitioner, acted as managers to conduct 'Quality Assurance' of the reviewers' work and an internal director and several other staff were appointed to oversee their work. This internal team within the Office of the Senior Practitioner is known as the Aboriginal Care Review Team.

The researchers in the small Independent Review Team worked collaboratively with FACS in the initial design stage. The project design involved an initial mapping of the relevant policy and legislative framework, the development of an initial consultation timetable, and the development of a 'narrative template' (required to enable the reviewers to collect qualitative information from

the files in a consistent manner). It also involved the development of a 'Aboriginal Care Review Tool' to capture the collection of quantitative data from the files for later analysis by FACS Insights, Analysis and Research (FACSIAR).

In June 2017, the Aboriginal Care Review Team (FACS) and the then Independent Team (composed of a researcher and the Chair) commenced a process examining the circumstances of 52 Aboriginal children who formed part of the cohort group in order to test the narrative template and the Aboriginal Care Review Tool.

This process helps to illustrate the time-consuming and difficult nature of the task of reviewing FACS case files. The Independent Review Team reviewed the results and identified the need to re-design the initial narrative template to ensure that reviewers were capturing the full breadth of information necessary for the preparation of this report. The Independent Review team completed this re-design in early February 2018 after approval by the Minister. FACS approved the new template in late March 2018. To ensure quality data collection, the reviews already completed were migrated into the new narrative template (the Narrative Review Template) and contemporaneously updated.

This process also revealed that there were numerous outstanding issues requiring a casework response in respect of individual children and families in the cohort. It had always been anticipated that, where issues were identified for an individual child or sibling group (and where immediate benefit would be possible), the Chairperson would recommend steps for consideration and action by the FACS Districts. After the 'pilot study', the Independent Review Team determined that Professor Davis would make recommendations for casework action to be taken in respect of all the children in the cohort.

Accordingly, a further step was included in the project design in February 2018. The Independent Review Team developed an 'Assessment Tool' to ensure that the reviews of all case files were also assessed by Professor Davis. Each Assessment Tool contained a concise summary of the case file review (or 'narrative template') and recommendations for further relevant casework action, which was then reviewed by Professor Davis and returned to FACS for distribution to the relevant FACS District.

At various stages in the Review, minor amendments were made to the Aboriginal Care Review Tool. These are further discussed below in the data methodology.



Information gathering

This phase involved stakeholder engagement (including public consultations and the calling for submissions), data collection and further research.



Consultations

From June 2017 to June 2019, the Independent Review Team held consultations with Aboriginal communities and families, government agencies, lawyers, NGO workers and caseworkers in the child protection system and OOHC sector. These occurred in Sydney and in numerous locations in rural and regional NSW. Consultations took the form of meetings, district forums, yarning circles, barbecues and other informal gatherings and focused on connecting with stakeholders and listening to their stories.

Stakeholders speaking confidentially in consultations raised issues relating to deficiencies in casework practice that the Independent Review Team later observed in the case file reviews. A particular focus of this Review has been community consultations, which is discussed below.

Methodology for Community Consultations

One of the key strengths of this Review is that it is Aboriginal-led and it has always been underpinned by strong community values. The Review was the result of advocacy and tireless work by GMAR NSW, and accordingly, the need for the Review reflected the needs identified in Aboriginal communities for the removals to stop and the government's practices to be questioned and evaluated. As a consequence of this background, the Review prioritised consultations with Aboriginal community members and families who have first-hand, and sadly often intergenerational, experiences of the care and protection system.

In the course of this Review, many Aboriginal individuals, Aboriginal families and Aboriginal communities generously shared their experiences and all stated their hopes for genuine improvement. Hope was the gravitas behind the Review and the Review has valued the hope and faith given to it from the community in doing its work.

Building relationships has been important to getting to the deeper issues relevant to addressing the high number of our children who are in OOHC. Community referral was the key driver for consultations and the methodology preferred by participants and the Review team. This organic approach was built on developing foundations of trust, understanding of cultural protocols, identity and insight.

The Independent Review Team's Project Manager described her approach to consultations as being based on establishing trust, because when people have lost so much and hold so much fear, when you lose your children, it runs deeper than any physical or emotional loss. According to the Project Manager:

The women I have spoken with have had the most hideous life experiences, the system is very punitive when it comes to black women, the stories I have been told have been absolutely heart breaking. I am in genuine awe of all these women who have shared so much with me. They are hard cookies to crack as they didn't know me. It is challenging working off country but I am getting more calls now and these are the women that go to the heart of what we are trying to achieve; better to start with the hardest of experiences to form the most insightful and considered recommendations.

Understanding and bearing witness to women's and community members' stories, including the stories of children who have themselves been in the system, has been central to this Review and has informed it at every stage. This is also a methodology that could not have been executed by any other government or data collection process outside of community and mob; this embedded and genuine approach to understanding and respecting the life stories of our women and kids is something that only an Aboriginal-led Review could have done. Work like this is important. It should be valued. We hope that this genuine work can frame the system's approach to future engagement with Aboriginal community, which at its core should respect and deeply value our peoples' dignity, experience, and wisdom.

Submissions

The Review invited submissions from the public from October 2017 to December 2017. Twenty-three public submissions were received in this process from a range of stakeholders, including peak Aboriginal advocacy bodies, legal practitioners, scholars, OOHC providers, judicial officers and private individuals. A list of public submissions to the Review has been included at the start of this report.



Reference Group

The Review Reference Group met four times throughout the Review period. In Reference Group meetings, members provided input into the issues arising in the Review. Professor Davis and Independent Review team members also liaised separately with members of the Reference Group for guidance on their research and recommendations.

Case file review process

As noted above, the case file review process was resource intensive. For each child and young person in the cohort,¹⁶² the process included the following steps:

- The completion of a Narrative Review Template by a reviewer;
- The completion of the Aboriginal Care Review Tool by a reviewer;
- The completion of a quality assurance, editing and proofreading process by a FACS staff member;
- The delivery of the Narrative Review Template to the Independent Review Team;
- The allocation of the Narrative Review Template to an Independent Review Team member for analysis;
- The drafting of an Assessment Tool for Professor Davis' review, including the drafting of recommendations for actions in relation to that child;
- The triage of the Assessment Tool as a group;
- The review of the Assessment Tool and Narrative Review Template by Professor Davis, who would either endorse the draft recommendations, or formulate additional or different recommendations;
- The inclusion of the qualitative data from the Assessment Tool into a Research Management System for a sample qualitative study (discussed in Chapter 2);
- The return of the Assessment Tool to FACS;
- The return, by FACS, of the Assessment Tool to the relevant District;
- The consideration of the Assessment Tools and its recommendations by the relevant District.
- The provision of an annotated 'Action Plan' prepared by the District (which was then returned to the FACS team working on the Review);
- The return of the Action Report to the Independent Review Team.

¹⁶² Note that sibling groups in the cohort were considered in a single Narrative Review Template and Assessment Tool. This means that there were 616 templates and tools prepared for the review.

Data analysis

The external quantitative data used to inform this Review was primarily composed of three main sources:

- The data report provided by FACS Insights Analysis and Research (FACSIAR) to the OSP in response to FIC requests (FACSIAR report data). This mostly comprises cohort data (derived from ChildStory, KiDS, and also the Aboriginal Care Review Tool) and has been prepared by FACSIAR as an internal report for use by the Review;
- Pathways of Care Longitudinal Study: Outcomes of children and young people in OOHC (POCLS data);¹⁶³ and
- Seeding Success cross-sectoral longitudinal linked data study (Seeding Success data).

In addition to the external data sources, the Review has additionally prepared its own qualitative analysis:

- Qualitative data, prepared by the Family is Culture team, using a representative sample of 200 case reviews of families in the cohort (qualitative sample data).

Specific information about each of these datasets and a brief overview of their methodologies and limitations is outlined below. Specific data gaps identified through these processes and analysis are raised throughout the report.

In addition to these data, the Review unsuccessfully attempted to gain access to existing analyses of the large combined governmental dataset held by Their Futures Matter, particularly analysis relating to data held that combined dataset about children who have contact with Juvenile Justice and enter, have been, or are in, OOHC. Unfortunately these data analyses were unable to be accessed by either the Independent Review Team or FACSIAR.¹⁶⁴ It is important that the combined Their Futures Matter dataset is made available and its implications examined in true partnership with Aboriginal stakeholders and community, in order to inform future policy directions within both FACS and Juvenile Justice to address care criminalisation issues.

FACSIAR report data

The primary source of quantitative data for the Review is the FACSIAR report, which was prepared based on a framework of information negotiated by the Independent Review Team, primarily during data meetings throughout 2018 and 2019. FACSIAR delivered its final report to Professor Megan Davis in May 2019 to inform the Review.

The FACSIAR report comprises FACS administrative data (from KiDS and ChildStory), and Aboriginal Care Review Tool data entered by reviewers during the case file review process. It should be noted that there is a counting disparity between the Aboriginal Care Review Tool data and the FACS administrative data, with the FACS administrative data identifying more children as Aboriginal than is the case in the Aboriginal Care Review Tool. This counting disparity is due

¹⁶³ Most of this data was publicly available at the time of writing. Some data requested for the review was not available in time to inform the review. Other data has not been reviewed by the Reference Group due to embargoes preventing appropriate consultation around this data, discussed further below.

¹⁶⁴ FACSIAR was provided with advice that analysis documents could not be distributed outside of participants in projects. No response was provided to the request to Their Futures Matter made by the Family is Culture Analyst.



to the Aboriginal Care Review Tool data resulting from a manual process where the cohort was considered on a case-by-case basis, rather than being derived from existing KiDS or ChildStory data. The manual review process undertaken by the Review resulted in some children being excluded from the cohort who were not Aboriginal, or who were Aboriginal but did not enter care during the review period.¹⁶⁵ It also resulted in some children being included in the cohort who were not originally identified as Aboriginal.

Throughout this report, FACS (Administrative) data is the term used to describe data derived from the KiDS/ChildStory dataset. FACS (Review Tool) data is the term used to describe data derived from the Aboriginal Care Review Tool. These data have a number of limitations, some of which are outlined below.

The process of engaging with Aboriginal stakeholders around Aboriginal data

A limitation of this Review has been that the Family is Culture team was precluded, by Ministerial direction, from engaging its Aboriginal Reference Group in analysis and interpretation of key data findings contained in the FACSIAR report. The FACSIAR report was also prepared without the involvement of any Aboriginal reference group or Aboriginal stakeholders.¹⁶⁶

There are expected standards for partnership and involvement of Aboriginal people in research in Australia, expressed in and upheld by numerous research ethics organisations including the Aboriginal Health and Medical Research Council in NSW and the National Health and Medical Research Council (NHMRC). According to NHMRC guidelines, conducting research with Aboriginal peoples with merit and integrity requires that research methods and processes provide opportunities to develop equal research partnerships where the research focuses on a topic identified as being of specific concern to Aboriginal and Torres Strait Islander peoples. According to these ethical principles, research should provide a fair opportunity for Aboriginal people to be involved, in meaningful partnership and collaboration, in any research that concerns them.

As an Aboriginal-led Review, Family is Culture sought to reinforce the importance of data processes meeting these standards by involving its Aboriginal Reference Group members in interpretation and discussion of implications of the FACSIAR report data and a number of POCLS data publications (which were embargoed at the time of this report being completed). In response to its request to the Minister to engage its reference group in this process, so to ensure ethical standards of research were met, Professor Davis was advised by the Minister that:

It is important that researchers skilled in data analysis and interpretation undertake the data interpretation. My understanding is that the reference group is made up of diverse stakeholders rather than analysts and researchers. Therefore I request you proceed to finalise your report.

¹⁶⁵ For instance, in several cases a change in status on the FACS systems (such as a carer seeking a carer allowance) triggered that child being considered a 'new' entry into care in the FACS systems. These cases were excluded where children did not enter care during the dates of the review period. Issues such as this may also affect the counting of non-Aboriginal children entering care, although considering this did not form part of this Review process.

¹⁶⁶ Based on the lack of Aboriginal consultation around data interpretation in other FACS publications and due to the interpretive approach taken in early examples of the FACSIAR report provided to the Review, the Family is Culture Review asked that FACSIAR not provide its own (FACS) data interpretation in the FACSIAR data report. This was to enable data interpretation to be led by the Family is Culture team in partnership with Aboriginal Reference Group members. The Minister ultimately prevented this partnership approach taking place. Accordingly, where provided, discussion around the interpretation and significance of FACSIAR report data reflect the views of Family is Culture, and are based on understandings of significance and meaning derived from other partnership in the Review—including submissions, consultations and discussions convened around the Review's own qualitative study (in partnership with the Reference Group).

Professor Davis unsuccessfully sought review of this decision. The Minister indicated that the Family is Culture Reference Group could review the FACSIAR report data only once the draft report had already been furnished.

Aboriginal people are experts in their own experience¹⁶⁷ and this Review cannot more strongly reiterate the importance of government departments engaging in appropriate partnership with Aboriginal people when it comes to issues that concern them¹⁶⁸—including issues that can be quantified or interpreted using administrative data. It is important that measures are developed in response to issues that the community identifies as being of concern to Aboriginal children and families; and it is important that community members and stakeholders are partners in any interpretation of data concerning Aboriginal children and families.

this Review cannot more strongly reiterate the importance of government departments engaging in appropriate partnership with Aboriginal people when it comes to issues that concern them

Any administrative data concerning Aboriginal people and children must be subject to rigorous stakeholder engagement and partnership, governed by frameworks and supported by infrastructure. This is a first step towards effecting Aboriginal data sovereignty. Although FACSIAR has advised the Review of plans to convene an Indigenous data sovereignty roundtable, to inform and guide these anticipated processes of stakeholder engagement and partnership, the Review makes the following recommendations.

Recommendation 1: The Department of Communities and Justice should convene a roundtable with the Aboriginal community and stakeholders to discuss the meaning of data sovereignty and the designing, collecting and interpreting of the department's administrative data relevant to Aboriginal children and young people.

Recommendation 2: After the implementation of Recommendation 1, the Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community, develop a policy which will result in improved partnership being effected in the department's design, collection and interpretation of data relevant to Aboriginal children and families.

¹⁶⁷ See, eg, Pat Dudgeon et al, *We are not the problem, we are part of the solution: Indigenous Lived Experience Project Report*, (Report, Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and the Black Dog Institute, November 2018); NSW Aboriginal Affairs, *Aboriginal identification: the way forward. An Aboriginal peoples' perspective* (Report, 2015).

¹⁶⁸ 'Ethical guidelines for research with Aboriginal and Torres Strait Islander People, *National Health and Medical Research Centre* (Web Page, 2018) <<https://www.nhmrc.gov.au/research-policy/ethics/ethical-guidelines-research-aboriginal-and-torres-strait-islander-peoples>>.



FACS (Review Tool) data limitations

FACS (Review Tool) data (quantitative data derived from the case file review process, coded by reviewers and quality assured by FACS managers) comprises around half of the data contained in the FACSIAR report, and some of this data has been used to inform this Review.

In addition to some specific limitations with these data outlined in the FACSIAR report,¹⁶⁹ the Aboriginal Care Review Tool was not designed or implemented by or in sufficient consultation with skilled quantitative researchers, resulting in the data collection process having some limitations. Design and process limitations include a lack of guidance documents being prepared for reviewers entering data,¹⁷⁰ a lack of independent scrutiny of reviewer coding through robust quality assurance processes,¹⁷¹ some limitations in the framing of questions and variables,¹⁷² and the fact that there was no comprehensive pilot process.¹⁷³

No data analysis position was resourced for the Family is Culture team until mid-2018, and by this time the FACS (Review Tool) data collection design and process had been finalised and was well underway. Some attempts were made to remediate aspects of these data and improve guidance to reviewers from mid-2018 onwards, although limitations continue to impact some categories of data. As a consequence some categories of data were excluded from the FACSIAR report and have been excluded from analysis in this report.

Specific issues and limitations arising with remaining FACS (Review Tool) data are outlined in the report where relevant.

Pathways of Care Longitudinal Study: Outcomes of children and young people in OOHC

This Review has also been informed by the Pathways of Care Longitudinal Study: Outcomes of children and young people in OOHC (POCLS).¹⁷⁴ The POCLS is described by FACS as the first large-scale prospective longitudinal study of children and young people in out-of-home care (OOHC) in Australia and links data on children's child protection backgrounds, OOHC placements, health, education and offending with the first hand accounts of children, caregivers, caseworkers and teachers.

Limitations of the POCLS data for the purposes of informing this Review into Aboriginal children in care include that the data concerning the care experiences of Aboriginal children is largely framed in comparison to non-Aboriginal children (including as presented in the Delfabbro publication

169 Not repeated here.

170 For instance, no data dictionary was prepared to support reviewers coding the Aboriginal Care Review Tool and guidance in the relevant form was limited. This goes to the reliability of some of the data.

171 Quality assurance processes were internal to FACS and did not include blind coding processes; quality assurers checked completed Aboriginal Care Review Tools resulting in potential false positives.

172 For instance, in some areas of the Aboriginal Care Review Tool the sequencing of questions made some the data unable to be used. Some variables were incomplete, impacting the usefulness or reliability of some of the data.

173 The pilot process convened by FACS did not involve reliability piloting or involve coders who were to be working on the project.

174 Due to embargoes and its inability to involve Aboriginal Reference Group members in interpretation, not all POCLS publications sent to the Review have been used in this report.

discussed below);¹⁷⁵ the data is limited to children who entered care; and the methodology does not routinely engage the parents of children who are in care.¹⁷⁶

One particular POCLS publication, the *Aboriginal children in out-of-home care in NSW: Developmental outcomes and cultural and family connections* report by Professor Paul Delfabbro, has been used more extensively to inform this Review than other POCLS publications due to its focus on Aboriginal children.¹⁷⁷ As noted above, the paper is largely comparative and seeks to ‘provide insights into whether the OOHC system is providing an equivalent standard of care and outcomes for all children’ by Aboriginal and non-Aboriginal status.¹⁷⁸

While this publication provides some useful information, it is concerning that the report indicates, as a key finding, that the results of the study suggest that Aboriginal children are faring reasonably well in the NSW care system both in *absolute terms* and relative to their non- Aboriginal peers.¹⁷⁹ This finding is concerning, as this does not reflect the perspectives of the Aboriginal community members consulted for this Review and does not appear to be well supported by the limited domains of inquiry presented in the publication.¹⁸⁰ Further, the comparative methodology of the study does not lend itself to adequately drawing conclusions about the welfare of Aboriginal children in OOHC in absolute terms. Further, Aboriginal stakeholders consulted by the Review raised concern at this approach and with some of the publication’s key findings.¹⁸¹

It is important that FACS’ statistical research projects are designed in partnership with Aboriginal stakeholders and that they adequately involve these stakeholders in the interpretation of the results of any research. FACSIR staff noted, in response to the Review’s concerns in this area, that internal and external stakeholders were consulted during the preparation of this publication, and that the study was subject to Aboriginal Health and Medical Research Council ethical approval. Nevertheless, some stakeholders who were consulted by FACSIR for the purposes

175 While this could be considered a strength of this study, the comparative methodology has been criticised by stakeholders to this Review due to its limited utility when attempting to understand the particular experiences of Aboriginal children in care. See; Paul Delfabbro, ‘Aboriginal children in out-of-home care in NSW: Developmental outcomes and cultural and family connections. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care’ (Research Report Number 11. Sydney. NSW Department of Family and Community Services).

176 Birth parents of children restored are included in the POCLS from Wave 2 of that data collection process. Birth parents are an under researched group and their inclusion was considered in the main study but due to sensitivities of recent removal during the first wave of the study it was determined not to include birth parents of children in OOHC.

177 Paul Delfabbro, ‘Aboriginal children in out-of-home care in NSW: Developmental outcomes and cultural and family connections. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care’ (Research Report Number 11. Sydney. NSW Department of Family and Community Services).

178 Ibid 1.

179 Ibid 7.

180 For instance, cultural and connection measures, although they form part of the study, are not comprehensive in part due to the POCLS methodology—the cultural connections data is based on subjective carer interview data, and teacher interview data, and may not reflect the views of Aboriginal community members or people. Accordingly, a very low bar is set throughout the publication for what constitutes connection (particularly when contact with parents is used as a proxy for connection without disaggregating by the parents’ Aboriginality). Although FACSIR indicated in response to these concerns that the study does not collect information about specific policy measures (but instead focuses on developmental outcomes), it is the perspective of the Review that understanding the developmental outcomes of Aboriginal children requires strong consideration of culture and connection measures. It is noted that some improvements have been made to data collection in Wave 5 of the study, and greater engagement with Aboriginal stakeholders will further improve these components of the study.

181 In response to this statement, FACSIR noted its conclusions could be drawn because the study compared Aboriginal and non-Aboriginal children on final orders (and thus compared children with similar backgrounds). It noted that its findings did not downplay the overwhelming evidence of Aboriginal disadvantage in the broader community, which was reflected in the fact that Aboriginal children were entering care at a higher rate than non-Aboriginal children. The Review notes this explanation, but remains of the view that any conclusions about how Aboriginal children are faring in care need to be informed by meaningful measures relevant to Aboriginal children’s specific experiences as Aboriginal children, without comparisons to non-Aboriginal children (even where those children are subject to comparable final orders).



of this publication questioned the extensiveness of the consultation process and articulated concern that their views were not fully taken into account.

FACSIAR has indicated that it is always looking to improve its practices and processes. The Review notes that FACSIAR must partner further with Aboriginal stakeholders to: (i) enhance the future directions of the POCLS study; (ii) consider the appropriateness of comparative reporting as a means of examining Aboriginal children's experiences in care; and (iii) ensure that the way information is collected and presented meets community expectations as to what is relevant and important to understanding Aboriginal children's wellbeing in OOHC. Although some engagement is currently occurring with Aboriginal stakeholders, further work is necessary to ensure best practice in this area.

Recommendation 3: The Department of Communities and Justice should convene a roundtable with Aboriginal community and stakeholders' to specifically discuss the Pathways of Care, Longitudinal Study (POCLS) methodology and how this data project may be used to better support Aboriginal community and stakeholders priorities in respect of supporting Aboriginal children in out-of-home care.

Seeding Success

The Review has also been informed by the Seeding Success study, with analyses prepared by Dr Kathleen Falster and Dr Mark Hanly from UNSW Big Data being provided to the Independent Review Team in mid-2019 following negotiations with FACS to secure funding for this resource during 2018 and early 2019.¹⁸²

The Seeding Success study is a longitudinal, cross-sectoral data linkage study in NSW. Seeding Success attempts to address information gaps around key drivers of positive and negative early childhood development in Aboriginal children, and the features of local communities and early childhood service provision that make a tangible difference.

According to the report provided by Seeding Success to the Review:

The Seeding Success Study 'joined up' routinely collected, population data from health, community services and education to build a cross-sectoral population data resource to study child health, development and wellbeing, with a focus on inequity. The Seeding Success data resource includes data on NSW Kindergarten children in 2009 and 2012, from the time they were born until they started school. These data offer the opportunity to better understand the health and social circumstances of children and families involved with child protection services, and their outcomes (e.g. development outcomes at age five).

¹⁸² Kathleen Falster and Mark Hanly, 'Childhood child protection services involvement and developmental outcomes among Aboriginal and non-Aboriginal Kindergarten children in New South Wales: Findings from a population-based, cross-sectoral data linkage study (The Seeding Success Study)' (Report for the Family is Culture Review. Sydney: UNSW Sydney Centre for Big Data Research in Health, 2019).

In respect of limitations, the report notes that:

Although the Seeding Success data resource includes many types of health and community services contacts during early childhood, there remain gaps in the types of data available. For example, there is no information available on children's contacts with the Aboriginal Community Controlled Health Service sector, which is an important provider of health services for many Aboriginal children and families. As such, analyses of the Seeding Success data shed light on some – but not all – of the opportunities to strengthen the response to vulnerable children and families.

Seeding Success data provides large scale, population-based statistics, which are based on large administrative datasets. It has proved very useful for scale data and is used throughout this report.

A strength of this data has also been that Seeding Success engages in Aboriginal consultation and participation. The study has an Reference Group who are partners in interpreting and deriving implications from its data. This engagement shapes the data reporting within the study and ensures that the data meets community expectations and views about what information is useful to understanding and improving outcomes for Aboriginal children.

Qualitative sample data

In addition to the data provided in the FACSIAR report, the POCLS study and Seeding Success, the Review has produced its own qualitative research based on information in the Assessment Tools provided to the districts; 200 of these Assessment Tools (selected randomly) were uploaded onto Nvivo10 and an initial pilot process involving 30 tools was undertaken by a single coder to generate a list of codes based on an approach of semi-structured and emergent coding. These codes were then presented to and discussed with the Family is Culture Reference Group during 2018 to ensure the accuracy of this approach, and to finesse language and approach in response to feedback during the pilot phase.

Following this pilot process, a single coder reviewed all 200 Assessment Tools and coded these in Nvivo10, creating a list of data categories from which smaller codes were manually developed. These codes and approaches to data coding were continuously checked with the Family is Culture team and with appropriate Aboriginal stakeholders.

After the initial results were generated, initial findings were presented to the Review's Reference Group for interpretation. Taking this feedback into account, and after the initial results were complete, these findings were presented to members of AbSec (who formed part of the Reference Group) to assist in interpretation and implication discussions. This process was extremely valuable to ensure the appropriateness and meaningful nature of these data to understanding this cohort and the issues facing Aboriginal children in out-of-home care more generally.

A key limitation with these sample data is that Assessment Tools did not always present clear and comparable information, as they were designed to highlight issues and strengths in practice and were prepared by multiple people (namely, members of the Independent Review Team, some reviewers, and the Review Chairperson), for the purpose of informing the districts and supporting recommendations.



Another limitation is that Assessment Tools did not always consistently identify issues in a particular case. This means that all data in this report derived from this sample is likely an underestimation of the true prevalence of a particular issue or phenomena occurring in the cases.¹⁸³

It has been a strength of this process that the sample selection was random and based on a whole year of Aboriginal children who entered care from every district. However, these cases do not necessarily reflect the experience of all children who enter care or have entered care since (or prior to) the cohort period. It should be noted, however, that through stakeholder consultation it has become evident that many of the issues identified as being problematic in respect of the cohort are still occurring in practice. Until now there has been little evidence to support many of the ‘anecdotal’ issues raised by Aboriginal families and community members around the functioning of the system for Aboriginal children who enter care. The data in this Review fills this gap in the literature.

183 While all issues identified will be accurate and quantifiable, not all issues will be consistently identified in all Tools (meaning that the number representing issue prevalence will likely be less than the true number).

3. Introducing the ‘Review cohort’

Background

As indicated previously, Aboriginal children are disproportionately represented in the child protection and out-of-home care (OOHC) systems in New South Wales (NSW). The scale of this issue—at a whole-of-population level in NSW—is most strongly highlighted by the Seeding Success data used to inform this Review. According to these data, almost one in two Aboriginal children who lived in NSW and entered Kindergarten in 2009 and 2012 were screened-in at ROSH by the age of 5 years,¹⁸⁴ with almost one in three of these children experiencing a child protection response beyond a ROSH report before their fifth birthday, including investigations and substantiations of maltreatment allegations by child protection services and placements in OOHC. This highlights a profound and early representation of contact with the child protection system. Almost one in ten Aboriginal children in NSW, who entered Kindergarten in 2012, were subject to a ROSH report before they were born.¹⁸⁵ Multiple child concern reports screened-in as ROSH were common among Aboriginal children, with three in five of the Aboriginal children involved with child protection services having three or more ROSH reports by the age of five years.¹⁸⁶ Compared with their same-aged non-Aboriginal peers, Aboriginal children were almost four times more likely to be screened-in as ROSH at least once by age five (i.e. 45% vs 12%), and approximately eight times more likely to enter care by the age of five years (i.e. ~8% vs ~1%). This highlights a profound and early over-representation of Aboriginal children having contact with the child protection system in NSW.

FACS (Administrative) report data also show that across all FACS districts, of children first reported at ROSH in 2011–12, a higher proportion of Aboriginal children entered OOHC compared to non-Aboriginal children.¹⁸⁷ These differences were found to be significant.¹⁸⁸ These data show that the most common primary reported issues for Aboriginal children screened in at ROSH under the age of five were prenatal (83% of children);¹⁸⁹ domestic violence (49.2% of children); carer mental health (48% of children); and carer drug/alcohol issues (45.4% of children).¹⁹⁰ Seeding Success data show that the most common types of substantiated maltreatment among Aboriginal children before age five years in that study were domestic violence and neglect.¹⁹¹ This highlights the need for earlier, targeted intervention and support for vulnerable Aboriginal families.

184 Kathleen Falster and Mark Hanly, ‘Childhood child protection services involvement and developmental outcomes among Aboriginal and non-Aboriginal Kindergarten children in New South Wales: Findings from a population-based, cross-sectoral data linkage study (The Seeding Success Study)’ (Report for the Family is Culture Review. Sydney: UNSW Sydney Centre for Big Data Research in Health, 2019).

185 Ibid.

186 Ibid.

187 Figure 2, Appendix A.

188 Based on ROSH reports made in 2011/2012 and tracking entries into care until 2016/2017: see Figure 2, Appendix A.

189 A primary reported issue for 83% of Aboriginal children who had a ROSH report in 2015/2016.

190 For older Aboriginal children in the 5 years to 9 years age group the most common primary reported issues were emotional abuse (32.2%); child inappropriate sexual behaviour (31.7%); physical abuse (29.6%); neglect (29.6%) and domestic violence (26.9%). For Aboriginal children in the 10–14 years age group the most common primary reported issue was child/young person drug and alcohol issues (46.5%) followed by child young person being a danger to self/others (44.4%) and suicide risk for child (42.9%). For children aged 15–17 years, the most common primary reported issues were suicide risk for child (27.9%); child/young person drug/alcohol issues (25.8%) and child/young person being a danger to self/others (23%): see Figure 3, Appendix A.

191 Kathleen Falster and Mark Hanly, ‘Childhood child protection services involvement and developmental outcomes among Aboriginal and non-Aboriginal Kindergarten children in New South Wales: Findings from a population-based, cross-sectoral data linkage study (The Seeding Success Study)’ (Report for the Family is Culture Review. Sydney: UNSW Sydney Centre for Big Data Research in Health, 2019).



Aboriginal children are known to the child protection system in NSW early in life and are considerably more likely to become known to this system than non-Aboriginal children of the same age. Once they are known to the system, they are more likely to enter care than non-Aboriginal children. Of the children who entered Kindergarten in 2009 and 2012, it was considerably more common for Aboriginal children to be reported to, and escalated through, child protection services during early childhood compared with non-Aboriginal children.¹⁹²

Aboriginal children are known to the child protection system in NSW early in life and are considerably more likely to become known to this system than non-Aboriginal children of the same age.

Child protection services involvement was also more common among Aboriginal children with multiple indicators of socioeconomic and health vulnerabilities early in life.¹⁹³ Moreover, it was found that Aboriginal children who escalated through child protection services during early childhood had a higher burden of developmental vulnerability and diagnosed health and developmental conditions and impairments than their same-aged peers. As such, Aboriginal children and families with a range of social, economic, health and developmental vulnerabilities are becoming known to, and escalating through, the child protection system before those children start school.

These data highlight the importance of early intervention, including social, economic, health and developmental support services for both children and families who become known to the child protection system, from the antenatal period through early childhood. As this Review shows, however, there is little targeted intervention and prevention work to prevent this escalation and support vulnerable families and children with the services and casework that they need, including from the time of pregnancy. Instead, all too frequently Aboriginal children end up in OOHC, often displaced from their parents, their family, their community and their country.

192 Ibid.

193 Ibid.

Are the numbers of Aboriginal children entering care reducing?

In recent times it has been reported that the number of Aboriginal children entering care (the rate of removals) has significantly reduced in NSW. While it is accurate that the numbers of children in OOHC have reduced in recent years—including Aboriginal and non-Aboriginal children—the data still raises significant concerns around the increasingly disproportionate representation of Aboriginal children in the system.

Data prepared for this Review highlights that in recent times the number of Aboriginal children entering care in NSW peaked in 2014–15, with 1,363 Aboriginal children entering care (Aboriginal children constituting 37.5% of the population entering care).¹⁹⁴ Since the 2014–15 peak, while the overall numbers of Aboriginal and non-Aboriginal children entering care have reduced or deflated (and indeed much has been made of this reduction in raw numbers),¹⁹⁵ data show that Aboriginal children continue to disproportionately enter the OOHC system—constituting 37.9% of all children entering care in 2017–18, which is the highest *proportion* of Aboriginal children entering care across all years presented since 2011–12. While the numbers of children entering care has been on a downward trajectory (which may be in part attributable to administrative changes in counting rules for children in OOHC, although the extent of this effect is not clear on available data),¹⁹⁶ Aboriginal children have been consistently (and indeed increasingly) disproportionately represented in the entry into care population (peaking in the current data year, 2017–18, at 37.9% of all children entering care). Further statistical work, including controlling for changes in the OOHC definition, is required to ascertain whether there has been any statistically significant shift in the representation of Aboriginal children entering OOHC over time. However, based on the available proportion statistics it would appear that particular issues of over-representation continue for Aboriginal children in the out-of-home care system (Figure 1).

While it is accurate that the numbers of children in OOHC have reduced in recent years—including Aboriginal and non-Aboriginal children—the data still raises significant concerns around the increasingly disproportionate representation of Aboriginal children in the system.

194 Figure 1, Appendix A.

195 See Figure 1, Appendix A. See also below footnote.

196 According to the FACSIAR data report, new counting rules for OOHC commenced in 2017/18 with the introduction of ChildStory and these data are not directly comparable with previous years. The decrease in the count of children in OOHC in 2017–18 is mainly due to the exclusion of primary placements with parents and the change in the data source system from KiDS to ChildStory. Under the new counting rules, the following children are now excluded from the count: children on orders placed with other agencies or people other than approved carers i.e. primary placement type/whereabouts 'of: placed with parents (including self-placed with parents); Juvenile Justice; camp; hospital/rehab unit; disability services (that are not special care providers); refuges (including supported community housing); boarding school; absent location unknown; self placed. Children in disability placements that have been identified as OOHC placements under the special care provider provisions of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) are an exception to this rule and included in the OOHC count. Children placed in Disability Hospital care are also included in the OOHC count. Children placed away from their usual carer for less than 14 days are not included. This is in line with the *Children and Young Persons (Care and Protection) Act 1998* (NSW). This change improves the accuracy of restoration counts by removing potential over-counting issues associated with very short periods in placements.



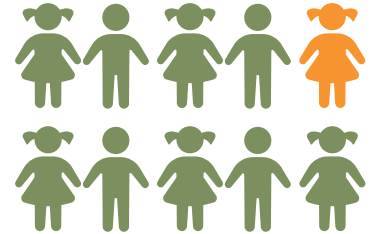
ALMOST 1 in 2

Aboriginal children who lived in NSW and entered Kindergarten in 2009 and 2012 were screened-in at ROSH by the age of 5 years



ALMOST 1 in 3

of these children experiencing a child protection response beyond a ROSH report before their fifth birthday



ALMOST 1 in 10

Aboriginal children in NSW, who entered Kindergarten in 2012, were subject to a ROSH report before they were born

8X MORE LIKELY TO ENTER CARE

Compared with their same-aged non-Aboriginal peers, Aboriginal children were approximately 8 times more likely to enter care by the age of 5 years (i.e. ~8% vs ~1%).

4X MORE LIKELY TO BE SCREENED

Compared with their same-aged non-Aboriginal peers, Aboriginal children were almost four times more likely to be screened-in as ROSH at least once by age five (i.e. 45% vs 12%),

Aboriginal children also continue to be over-represented in the ‘in care’ population. Data prepared for this Review highlights that while there may have been reductions in the raw numbers of all children (including Aboriginal children) entering care in NSW in recent years, it is concerning that as at 30 June 2018, Aboriginal children represented 38.9% of the total population of children in OOHC in NSW. This reflected a steady increase from 30 June 2012, where Aboriginal children accounted for 34.6% of the OOHC population in NSW.¹⁹⁷ Raw numbers of Aboriginal children in care have also been steadily increasing since 2012, peaking in 2017 (with 7152 Aboriginal children in care) and slightly reducing in 2018 to sit at 6766 (Figure 4).¹⁹⁸

data show that Aboriginal children continue to disproportionately enter the OOHC system

These data highlight that despite this Review being called at the apparent ‘height’ of the OOHC crisis for Aboriginal children, the issues at stake during that period continue at the time of this report. While the cohort of children—Aboriginal children who entered care during 2015–16—entered care a number of years ago these data around representation, subsequent policy and practice shifts, and the ongoing testimony of families and workers involved in the system and consulted for this report, highlight the ongoing and urgent need for this Review’s findings and reporting to inform future directions in the department.

Overview of the ‘review cohort’¹⁹⁹

During 2015–16, 1,144 Aboriginal children entered OOHC.²⁰⁰ These 1,144 children represent the cohort for the Family is Culture Review, although the official FACS figure regarding Aboriginal children entering care in this period sits higher at 1,318 (for reasons previously outlined in the methodology section of this report). Of the FACS (Administrative) data figure of 1,318 Aboriginal children, 22.8% (n=261) or less than a quarter of those children were not in care at the time of the Review (which includes children who exited on guardianship orders, children who were restored and children who had ‘aged out’ of the system).²⁰¹ Some children may have re-entered care before or after the date of the Review. Most children who entered OOHC in the cohort period remained in care at the time of the Review.

According to FACS (Administrative) data, around half of the children who entered care during the cohort period did so before they turned five years old (Figure 6) and the qualitative sample analysis highlights that a significant proportion of the cohort entered care at, or shortly after, their birth.²⁰²

197 This is despite OOHC data at 30 June 2015 onwards being not comparable with previous years’ data. NSW Safe Home for Life (SHFL) legislative reforms, effective 29 October 2014, transitioned eligible children to the independent care of their guardian. These children exited and were no longer counted in OOHC. These data are also affected by the new counting rules around OOHC commenced in 2017/2018.

198 The disproportionate representation of Aboriginal children in care may be partially attributable to non-Aboriginal children exiting care through restoration or guardianship orders at a higher rate than Aboriginal children.

199 This section does not purport to provide a comprehensive overview of all characteristics of children in the cohort and should be read in conjunction with the body of the report.

200 This number excludes two Aboriginal children who were identified for inclusion after the dataset was finalised. As previously indicated at the start of the report, this number is less than FACS administrative data indicates for the same period, which nominates that 1,318 Aboriginal children entered care.

201 Figure 18, Appendix A.

202 This is discussed further in Chapter 10.



For most of the Aboriginal children who formed part of this cohort, their 2015–16 entry into care was their first. However, of those children who had previously been in care, most had previously been subject to Parental Responsibility to the Minister or Director-General, the most intrusive care option apart from adoption according to OSP guidelines.²⁰³

Over a third of Aboriginal children who entered care had been known to the child protection system for between one and four years before they entered care.

Over a third of Aboriginal children who entered care had been known to the child protection system for between one and four years before they entered care.²⁰⁴ Aboriginal children in the cohort received an average of 5.5 ROSH reports in the two years before they entered care;²⁰⁵ and children were most frequently reported at ROSH for issues involving carer drug and/or alcohol use (77.9% of the children), neglect (75.8% of the children), physical abuse (71.3% of the children), domestic violence (64.2% of the children) and emotional abuse (52.2% of the children).²⁰⁶

Why did children in the cohort enter care?

It is difficult to ascertain precisely why children entered care from available data sources for the Review, as this is not the way FACS structures its datasets or its entry into care assessment processes. For children who entered care and had a care application filed (83.6% of children),²⁰⁷ the most common ground for a care order nominated in the application was that the child's basic, physical, psychological or educational needs were not being met, or were likely not to be met, by the child's parents or primary care givers (nominated for 88.3% of children who entered care and had a care application) (Figure 12). The second most common ground for a care order nominated in the care application was that the child was suffering or was likely to suffer serious developmental impairment or serious psychological harm as a consequence of the domestic environment in which he or she is living (nominated for 78.5% of the children who entered care and had a care application). The third most common ground for a care order nominated in the care application was that the child had been, or was likely to be, physically or sexually abused or ill-treated (nominated for 46.3% of children who entered care and had a care application).

How did children in the cohort enter care?

According to FACS (Review Tool) data the most common legislative basis according to which the cohort children were entered into care was assumption under s 44 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*) (43.8%).²⁰⁸ Most children's assumptions into care were authorised by managers of casework (71.3%). Removal under s 43 of the *Care Act* was the second most common basis under which children entered into care (27.2%);²⁰⁹ and in almost half of cases these entries were authorised by managers casework

203 Figure 7, Appendix A.

204 That is, since their first ROSH report: see Figure 8, Appendix A.

205 Figure 9 and Figure 10, Appendix A.

206 Figure 11, Appendix A.

207 Figure 13, Appendix A.

208 Under s 44 of the *Care Act*, an 'assumption' occurs when FACS assumes care responsibility without removing the child from the premises under a power of removal (for example, an assumption may occur at a hospital where a child will not be removed, but parental responsibility for the child will pass to the Department).

209 Under s 43 of the *Care Act*, FACS or a police officer may remove a child from a particular premises without a warrant in a number of circumstances, such as when satisfied on reasonable grounds that the child is at immediate risk of serious harm and the making of an apprehended violence order would not be sufficient to protect the child.

(47.3%, with managers client services authorising a further 38.3% of these care entries). 13.2% of the cohort entered care on a Temporary Care Arrangement and these care arrangements were almost always approved by managers casework (91.4%).²¹⁰ These data, as well as the other sections under which children entered care are outlined in Figures 14 and 15 of Appendix A.

For almost half of the children who entered care, reviewers identified practice issues in the way the children came into care (47%).²¹¹ These are concerning findings.

What legal orders or arrangements were children placed under when they entered out-of-home care? Who is case managing children in the cohort?

FACS administrative data show that almost three quarters (73.2%) of Aboriginal children who entered care during the cohort period were subject to a care arrangement of parental responsibility to the Minister or Secretary. The next highest numbers of Aboriginal children were subject to Temporary Care (11.1%) and 'other/relative' kinship care: no order (6.8%).²¹²

FACS (Review Tool) data show that majority of Aboriginal children and young people in the cohort were case managed by FACS at the time of the Review (49.4%), with 10.7% of children being case managed by an Aboriginal OOHC NGO and 10.3% being case managed by a (mainstream) OOHC NGO.²¹³

Who were the children in the cohort's carers?

According to FACS (Review Tool) data, only about half of the children who remained in care at the time of the Review were in a placement with an Aboriginal carer (53.1%).²¹⁴ Of the 29.2% of children who were placed in a foster care placement, over half were placed with non-Aboriginal foster carers.²¹⁵

While Aboriginal families were involved in placement decision-making for almost two thirds of the children's current placements (including the children who had exited care), in few cases were kinship groups, communities, or representative organisations involved.²¹⁶ This is further discussed at Chapter 18.

Were children identified as Aboriginal, and was the ACPP noted as being considered, when Aboriginal children entered care?

As noted previously, most Aboriginal children who entered care had a care application filed with the Children's Court (83.6%) and for the majority of the children (94.8%), the care application identified the child as being Aboriginal (Figure 13, Figure 22). However, it is concerning that for 39 children in the cohort (4.1% of Aboriginal children who had a care application filed), the care application did not identify them as an Aboriginal child. For the children who had a care application filed with the court, the vast majority (90.2%) of those care applications noted that the ACPP was being considered.

210 Figure 14 and Figure 15, Appendix A.

211 Figure 16, Appendix A.

212 Figure 17, Appendix A.

213 While the data variable 'not applicable' in this category may mean that there was no referral, this was not clearly defined and it is not clear whether reviewers have interpreted this consistently: see Figure 18, Appendix A.

214 Figure 19, Appendix A.

215 Figure 20, Appendix A.

216 Figure 21, Appendix A.



However, it is concerning that for 39 children in the cohort (4.1% of Aboriginal children who had a care application filed), the care application did not identify them as an Aboriginal child.

For 8.6% of children—or 82 children, a number higher than the 39 who were not identified as Aboriginal—the care application did not indicate that the ACPP was being considered (Figure 23).

The Review's qualitative data also raise concerns about this and other misleading information presented to the Children's Court during care and protection proceedings (see Chapter 23).

Have children in the cohort exited care?

As noted previously, according to FACS (Administrative) data the majority of Aboriginal children who entered care in the cohort period have remained in OOHC (63.1%) and just over a third (36.9%) have exited care (Figure 24).²¹⁷ Children who exited care may have since re-entered care (see below). The proportion of Aboriginal children who have remained in OOHC is slightly higher than non-Aboriginal children for the same period.

According to FACS administrative data, almost half of Aboriginal children who exited care were restored to their parents (47.3%).²¹⁸

Most Aboriginal children did not re-enter care after exiting care at less than 17 years of age (78.4%) but around a fifth of Aboriginal children did re-enter care (21.6%). A higher proportion of Aboriginal than non-Aboriginal children in this time period re-entered care after exit (Figure 25).

Who were the parents of children in the cohort?

FACS (Review Tool) data highlight that the average age of mothers of children in the cohort was 30.3 years old and most mothers were Aboriginal or Torres Strait Islander (73.7%). Over two thirds of mothers of children in the cohort had a child protection history in NSW (68.3%), which is a substantial and concerning figure.²¹⁹ Further, a quarter of mothers of children in the cohort had previously been in an OOHC arrangement themselves as a child (25.5%).²²⁰

FACS (Review Tool) data highlight that the average age of fathers of children in the cohort was 33.7 years old and most fathers were Aboriginal or Torres Strait Islander (58.1%). The data show that 41.5% of fathers of children in the cohort had a child protection history in NSW.²²¹ Further, 14.6% of fathers of children in the cohort had previously been in an OOHC arrangement themselves as a child.²²²

For almost a third of children in the cohort, 32.4%, both parents had a child protection history in NSW.²²³

217 FACS administrative data, which does not match the cohort numbers due to counting issues outlined in the methodology section to this report.

218 Figure 24 and Figure 5, Appendix A.

219 This figure excludes child protection histories in other states and territories. This includes non-Aboriginal and Aboriginal mothers. There is no comparative statistic available for non-Aboriginal children who entered care during this time period.

220 In NSW or coordinated by Child Protection in NSW. Excludes other states and territories. See Figure 26, Figure 27, Figure 28, Figure 29 and Figure 30, Appendix A.

221 And this figure excludes child protection histories in other states and territories.

222 In NSW or coordinated by Child Protection NSW. Excludes other states and territories. See Figure 31, Figure 32, Figure 33, Figure 34 and Figure 35, Appendix A.

223 See Figure 36, Appendix A.

What recommendations have been made in this Review?

Family is Culture made 3,018 recommendations relating to 616 case files in the course of the Review.²²⁴ On average, the Review made 4.9 recommendations per case file. These recommendations were aimed at the various FACS Districts and outlined specific actions to be taken in respect of particular cases. Some of these recommendations also related to the provision of training and education about specific issues to FACS caseworkers and non-government workers, where these issues were significant in the casework practice in a particular case.

Recommendations were categorised for later analysis. The most commonly made recommendations related to cultural planning, case planning, contact arrangements with family/kin other than siblings, record-keeping, sibling contact arrangements and restoration. These data are outlined below.

Recommendation Category	Total Frequency
Aboriginal consultation	142
Aboriginal identification	89
Aboriginal Child Placement Principle	112
Carer competency/training	61
Case planning	375
Connection to family/culture	250
Cultural planning	412
Entry into care decision-making	0
Evidence to the Court	13
FACS casework development	176
FACS' interaction with the Children's Court	23
Family/kin carer assessment	75
Locating family members	146
No recommendations	20
Other	53
Other contact arrangements (not siblings)	398
Post-entry into care casework	157
Pre-entry into care casework	17
Recognising injustice/restoring dignity (apologies)	54
Record keeping	362
Restoration	247
Sibling contact arrangements	250
Total	3,432

²²⁴ It should be noted that this included a small number of additional files that were not included in the cohort, but the children's cases were completed as part of the Review before the children were excluded from the cohort data number. The Independent Review Team elected to review and in some cases develop recommendations for action in these cases.



Over two thirds of mothers of children in the cohort had a child protection history in NSW (68.3%)



A quarter of mothers of children in the cohort had previously been in an OOHC arrangement themselves as a child

41.5%



41.5% of fathers of children in the cohort had a child protection history in NSW

14.6%



14.6% of fathers of children in the cohort had previously been in an OOHC arrangement themselves as a child

32.4%



For almost a third of children in the cohort, 32.4%, both parents had a child protection history in NSW

In reading the above table, the total number of recommendations made in the categories (3,432) is greater than the number of recommendations actually made by the Review, as many recommendations encompassed two or more categories (for example, a recommendation could have been labelled 'Aboriginal Child Placement Principle/Other'). Further, it is important to note that few recommendations were made about some significant areas of concern to the Review, such as entry into care decision making. There was no action that could be taken to remedy any problems with these issues at the time of the Review. These issues are best explored through reading the analysis and recommendations contained elsewhere in this report. Finally, some larger categories have been separated in the data analysis to maintain their visibility. For example, it would have been possible to include many of the categories, such as 'Aboriginal consultation', 'connection to family/culture' and 'cultural planning', under the rubric of the ACPP (which would significantly increase the number of recommendations made about this broad area). Similarly, it would have been possible to combine the categories of 'sibling contact arrangements' and 'other contact arrangements' into one category. Despite all of these qualifications, the data nonetheless provides a broad indication of the categories in which the most recommendations were made by the Independent Review Team.

In light of the large number of recommendations in respect of individual children's cases and the additional 125 recommendations for reform in this report, the Review has concluded that DCJ should track, monitor and publicly report on the implementation of the Review's recommendations within 12 months of the final report being delivered. By reporting in this manner, the department will keep Aboriginal families and stakeholders informed about the progress of reform arising from this report. After 12 months, the department should consider the need to continue to periodically report on the implementation of recommendations (for instance, at 12 monthly intervals beyond the first public monitoring report).

Recommendation 4: The Department of Communities and Justice should track, monitor and publicly report on the implementation of the recommendations of both the Family is Culture case file review process, and the Family is Culture report, within 12 months of the final report being delivered, with a view to further public reporting on implementation if necessary.

3018
recommendations

Family is Culture made 3,018 recommendations relating to 616 case files in the course of the Review.

4.9
recommendations

On average, the Review made 4.9 recommendations per case file.



4. The need for a new Aboriginal Quality Assurance Unit

In 2013, the Department of Family and Community Services established the Office of the Senior Practitioner (OSP). The OSP is a 'specific unit dedicated to practice leadership', now located within the Department of Communities and Justice. It aims to 'promote good practice, inspire, support and review the work of the frontline'.²²⁵ The establishment of the OSP was an important step in improving the performance of the child protection system in New South Wales (NSW), and was based on a growing recognition of the need to develop strategies for continual practice improvement among frontline child protection staff.

The Review has concluded that there is a need to establish a similar specialist unit to focus on improving casework practice in respect of Aboriginal families specifically. A number of issues that have arisen during this Review only affect Aboriginal children and families (such as the identification and 'de-identification' of Aboriginal children and the application of the ACPP). Others affect Aboriginal children and families disproportionately or in unique ways (such as prenatal reporting and newborn removals and carer assessment processes). It would be of benefit if these issues were examined and addressed in a coordinated manner by a unit with specialised knowledge about Aboriginal children and families in NSW, and the issues affecting their interaction with child protection services.

there is a need to establish a specialist unit to focus on improving casework practice in respect of Aboriginal families

Further, the Review notes that a number of recommendations made in this report relate to the issue of training. A recurrent theme throughout the Review was the disjunct between policy and practice in child protection casework. In other words, in the case files that were reviewed, caseworkers often failed to comply with existing policy and practice guidance issued by FACS. One way to remedy this is to increase caseworker accountability (as discussed in Chapter 7). However, an additional and complementary approach to addressing this problem is to enhance the amount and quality of caseworker training and caseworker support (thereby building internal caseworker knowledge and skills).

The Review has recommended that all caseworkers receive further training in a number of areas, such as in recognising and responding to family and domestic violence, engaging in dignity driven practice, engaging and working with Aboriginal families, conducting safety and risk assessments, employing harm minimisation strategies during child removals, and implementing the ACCP. It is essential that this training is targeted and effective (that is, it should be ongoing, have a 'one-on-one' component and incorporate elements of coaching or mentoring). It is also important that any training is consistent, is rolled out state wide, and is delivered by (or in partnership with) Aboriginal staff members.

²²⁵ Kate Alexander, 'The critical importance of supervision in child protection: Harnessing the energy of teams' *Australian Institute of Family Studies* (26 November 2014) <<https://aifs.gov.au/cfca/events/critical-importance-supervision-child-protection-harnessing-energy-teams>>.

The Review notes that the design and delivery of the training recommended in this report could be coordinated by the new Aboriginal Quality Assurance Unit. The new Aboriginal Quality Assurance Unit could also ensure that all recommendations made by Aboriginal staff or community members in consultative processes are tracked and implemented, and that data about this be made publicly available (as recommended in Chapter 4).

The new Aboriginal Quality Assurance Unit could also include a practice support team that provides advice and support to caseworkers outside of the training program discussed above. For example, the new unit could assist caseworkers with genealogy issues, as well as with specific practice questions about working with Aboriginal families and communities.

As noted above, the Review recommends that the Department of Communities and Justice should track, monitor and publicly report on the implementation of the Review's recommendations within 12 months of the final report being delivered. This task could also be performed by the new Aboriginal Quality Assurance Unit.

Finally, the Review notes that the new Aboriginal Quality Assurance Unit should use data obtained from multiple sources to continue to identify systemic issues requiring further training and policy development in the future. For example, data could be used to identify defunct policies, policies which do not operate as expected in practice, geographical differences in compliance with legislative or policy requirements, deficiencies in record-keeping practices, problems with administrative tasks, or the need for further training resources for staff or general resources for children and families.

In this regard, the Review notes that the Aboriginal Quality Assurance Unit should use data obtained from:

- The qualitative case reviews (recommended in Chapter 7);
- Exit from OOHC interviews with children and families;
- The new complaints handling system (recommended in Chapter 7);
- Focus groups and surveys conducting with children and families;
- Child death review reports;
- Parliamentary, royal commission and other relevant reports, both at the state and federal level;
- Academic or other evaluations of staff activities, attitudes or approaches to their work;
- Other stakeholders in the child protection system; and
- Any other relevant sources.

The Aboriginal Quality Assurance Unit should also be tasked with communicating expectations to staff throughout the agency, for example, through quality assurance reports at the state and local level. The quality assurance reports may flag cases that require further work to ensure compliance with legislative and policy requirements. As O'Brien and Watson note, 'quality assurance efforts ... should ensure that all employees receive regular information about the quality of services. Regular and open communication to all levels about performance helps



engage staff in efforts to improve the quality of services'.²²⁶ There must also be a dedicated system in place to ensure that the observations of the quality assurance reports are translated into on-the-ground practice change and the actions taken in response to the reports should be further evaluated by the staff of the Aboriginal Quality Assurance Unit.

Recommendation 5: The Department of Communities and Justice should establish an Aboriginal Quality Assurance Unit to address issues discussed in this report. This unit should:

- (a) track, monitor and publicly report on the implementation of the recommendations made in the Review's case file review process and in this report;
- (b) ensure that recommendations made by Aboriginal staff or community members in consultative processes are tracked and implemented, and that data about the implementation of these recommendations is made publicly available;
- (c) provide ongoing training and practice support to child protection staff about issues relating to Aboriginal children and families in the child protection system; and
- (d) collect and analyse data from multiple sources in order to identify systemic issues requiring reform.

²²⁶ Mary O'Brien and Peter Watson, 'A Framework for Quality Assurance in Child Welfare' (National Child Welfare Resource Center for Organizational Improvement, March 2002), 24.

PART B

How the System Works



5. How the child protection system works

Introduction

The child protection system in New South Wales (NSW) is incredibly complex. It is based on a mixture of legislation, policies and standard practice procedures, all of which are difficult to understand without relevant training or experience. The system's lack of accessibility is compounded by the endless cycle of reform, with internal FACS policies being constantly reviewed and replaced, and amendments to care and protection legislation occurring at regular intervals.

The Review is concerned that a lack of understanding of how the child protection system works disadvantages those external to the inner workings of the system, such as the families in contact with DCJ. It also confuses children who are removed from their families. For example, in its submission to the Review, CREATE Foundation noted that its research demonstrated that Aboriginal children lacked understanding of the care process and why they were in care, and that caseworkers did not effectively communicate about these issues with young people.¹

The system's lack of accessibility is compounded by the endless cycle of reform, with internal FACS policies being constantly reviewed and replaced, and amendments to care and protection legislation occurring at regular intervals.

This section provides a summary of how the child protection system works, from the first risk of significant harm (ROSH) report to the removal of a child from the child's family. While the complexity of the system makes it difficult to address each and every step in the process, it is hoped that this broad overview will advance public knowledge about the operation of the system. Access to this knowledge may help to alleviate some of the fear of the department that permeates many Aboriginal families and communities. It may also assist Aboriginal families and communities to determine whether the actions of caseworkers are legitimate and appropriate in the circumstances of a case and to plan what response should be taken to child protection intervention. Some of the issues discussed in this section, such as restoration, are dealt with in further detail elsewhere in the report. The flow chart contained in this chapter provides a visual representation of the 'ROSH to removal' stage of the child protection system.

¹ CREATE Foundation, Submission No 4 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 4.



Risk of significant harm (ROSH) reports

Child protection concerns are usually triggered by a report or notification made to the Child Protection Helpline by ‘mandatory reporters’ (that is, people required by legislation to report that a child is at risk of significant harm),² or other people involved in a child’s life (such as family members, professionals or neighbours).³ A report can also be made about an unborn child.⁴ Helpline workers assess the notification using the Screening and Response Priority Tool (the SCRPT) and decide whether the child is at risk of significant harm as defined by s 23 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*). If not, the case is closed (as permitted by s 30(b) of the Act) and written feedback is provided to the mandatory reporter within 24 hours of the screening and assessment process.⁵

If the child is at risk of significant harm, the report is ‘screened in’ and allocated a ‘response priority time’—namely, within 24 hours, three days or 10 days.⁶ The report is then transferred to a Community Service Centre (CSC) for further assessment. If the report discloses evidence of sexual abuse, extreme neglect or serious physical injuries, it will be referred to the Joint Child Protection Response Program (formerly the Joint Investigation Response Team, or JIRT) via the Joint Referral Unit.⁷ The Joint Child Protection Response team is made up of staff from DCJ, NSW Health and the NSW Police Force.

‘Triage’ and allocation of the ROSH report

At the CSC, the ‘screened in’ report is ‘triaged’—that is, it is assessed and more information may be gathered, usually by telephone. This information may be gathered from a range of sources, including from any funded service provider with current or prior case management of the child and their family,⁸ or from any other person who may have information about the safety and wellbeing of the child. At this stage, if DCJ has reason to believe that the child is of Aboriginal or Torres Strait Islander background, it must make ‘such inquiries as are reasonable in the circumstances’ to determine if this is the case.⁹

At the triage stage, no further action will be taken if the available information does not indicate that the matter requires allocation, or if there are insufficient resources to allocate it to a

2 For example, health care professionals, teachers and psychologists: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 27. Note that mandatory reporters use the Mandatory Reporter Guide (MRG) to determine whether to report their concerns to the Child Protection Helpline or to identify alternative supports that should be provided to the child or young person.

3 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 24.

4 An unborn child may be at risk of significant harm if the child was the subject of a prenatal report under s 25 and the mother of the child ‘did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report’: s 23(1)(f).

5 Child Wellbeing & Child Protection, ‘Feedback to mandatory reporters’, *Family and Community Services* (Factsheet), <https://www.facs.nsw.gov.au/data/assets/pdf_file/0020/336305/feedback_reporters_fact.pdf>.

6 Child Wellbeing & Child Protection, ‘Determining a response time for a report of risk of significant harm’, *Family and Community Services* (Factsheet), <https://www.facs.nsw.gov.au/data/assets/pdf_file/0019/336304/Helpline_response_time_fact.pdf>.

7 Department of Family and Community Services (NSW), ‘Work with the Joint Child Protection Response (JCPR) Program’ (10 July 2019) <<https://www.facs.nsw.gov.au/providers/children-families/child-protection-services/joint-child-protection-response>>.

8 FACS Rules and Practice Guidance, ‘Assessing Safety’ *Family and Community Services* (webpage), <<https://www.facs.nsw.gov.au/families/permanency-support-program/permanency-case-management-policy/rules-and-practice-guidance/chapters/assessing-safety>>.

9 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 32.

caseworker.¹⁰ In some cases, DCJ will refer the matter to a service such as Brighter Futures and close the case.

If the matter warrants further investigation and there are sufficient resources to do so, it will be allocated to a caseworker for a field response. The caseworker will then conduct an internal pre-assessment consultation with other DCJ staff and any other relevant persons to formulate an approach to a home visit. It is at this stage that any potential risk to the caseworker is analysed and addressed,¹¹ and any practical issues, such as the need for interpreters, are canvassed.

The initial field response—the safety assessment

The initial field response involves a home visit by a caseworker. At this home visit, a safety assessment is conducted to determine whether the child is in immediate danger of serious harm, and what interventions can be utilised to ensure the child is appropriately protected from any danger.¹² The initial safety assessment examines the dangers that may be faced by the child (such as living conditions that threaten the health or safety of the child or young person or suspected sexual abuse) and the protective abilities of the child and the child's parents (such as the existence of supportive relationships with people who may be willing to participate in safety planning, or parental commitment to meeting the needs of the child). The outcome of the initial safety assessment can be 'safe' (if no dangers are identified), 'safe with plan' (if the dangers identified can be mitigated by safety interventions) or 'unsafe' (if the dangers identified cannot be mitigated by safety interventions).

If the outcome is 'safe', no further tool is used until a risk assessment is completed (the risk assessment, discussed below, looks at the risk of future harm). If the outcome is 'safe with plan', a safety plan must be developed. If the outcome is unsafe, then the child must be removed from the home, either into a temporary care arrangement (ss 151 and 152 of the *Care Act*), or into statutory out-of-home care (OOHC). If the child who is the subject of the ROSH report is unborn, it is at this point that a High Risk Birth Alert can be created.

10 Department of Family and Community Services (NSW), *Triage Assessment* (FACS Casework Practice Mandate, FACS Intranet). Note that an Interagency Case Discussion Meeting may also be held about a case that is to be closed due to a lack of resources. At this discussion, agencies and services involved with the family can discuss actions or services that may be implemented in the future: Department of Family and Community Services (NSW), *Triage Assessment* (FACS Casework Practice Mandate, FACS Intranet).

11 This is conducted by the Manager Case Work using the Client Context Risk Management Tool.

12 The safety assessment is part of the Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012) 28. Note that an initial safety assessment is required in most circumstances, although there are some exceptions, such as when the child or young person is already in the parental responsibility of the Minister and residing with an authorised carer. These cases are 'processed in accordance with existing policies and procedures', and may receive an 'Alternative Assessment': The Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Family and Community Services, 2012) 29–30; 'PSP Rules Practice Guidance', *Family and Community Services* (Web Page) <https://www.facs.nsw.gov.au/providers/children-families/deliver-ppsp/permanency-case-management-policy/rules-and-practice-guidance?merge_chapters=true>.



The safety plan

As noted above, if the outcome of an initial safety assessment is ‘safe with plan’, a safety plan must be developed with the family.¹³ A safety plan is ‘a written, mutually developed arrangement between the child protection service (the caseworker) and the family’.¹⁴ It aims to use the least intrusive interventions possible to address the safety concerns identified in the initial safety assessment.¹⁵ As such, it ‘permits a child/young person to remain home during the course of the investigation/assessment/ongoing work’.¹⁶ A safety plan is developed with the parent or caregiver and other relevant family members.¹⁷ It can include safety interventions such as: planned care arrangements for a child if the parents or carers intend to drink alcohol or use drugs; respite care; in-home health care; or transportation services.¹⁸ Safety interventions should be able to be immediately implemented.¹⁹

A safety plan should not remain in place for more than 72 hours without being reviewed and should not be used to ‘enforce parental restrictions’, such as residence or contact arrangements.²⁰ It should be regularly monitored and may be adjusted or modified as needed.²¹ If the risk assessment (which is conducted within 30 days of the initial safety assessment) results in a risk level of ‘high’ or ‘very high’, a case plan must be developed and ‘any previously identified safety interventions should be incorporated into the case plan’.²²

The risk assessment

A risk assessment examines the likelihood that the child will be abused or neglected in the next 12–18 months.²³ It does not aim to actually predict abuse or neglect, but rather to assess ‘whether a family is more or less likely to have another abuse/neglect incident without intervention by the agency’.²⁴ It must be conducted within 30 days of the initial safety assessment.²⁵

The risk assessment contains two indices—the neglect index and the abuse index. The caseworker gathers information from the child, the child’s parents and other sources, and then completes both indices (this requires the caseworker to select from a number of answers to

13 Safety plans are discussed further in Chapter 12.

14 Office of the Senior Practitioner, *Safety Planning Resource* (Family and Community, October 2016) 5. Note, however, that the safety plan may be developed verbally with a victim of domestic violence if the provision of a written safety plan may increase her risk of being subjected to violence: Office of the Senior Practitioner, *Safety Planning Resource* (Family and Community, October 2016) 22.

15 Safety plans are discussed further in Chapter 12.

16 The Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Family and Community Services, 2012) 34

17 Office of the Senior Practitioner, *Safety Planning Resource* (Family and Community, October 2016) 5.

18 Ibid 14

19 Ibid.

20 Department of Family and Community Services (NSW), *Assessing Safety and Risk* (Casework Practice Mandate, FACS Intranet).

21 Office of the Senior Practitioner, *Safety Planning Resource* (Family and Community, October 2016), 12.

22 Ibid.

23 The Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012), 47.

24 Ibid 47.

25 There are a few exceptions to this rule, including where the child is in the care of the Minister and not residing with an authorised carer (i.e. in a residential care service). These cases are ‘processed in accordance with existing policies and procedures’: Ibid 48.

questions on a form).²⁶ Each answer has a 'score', which is then tallied, to give a 'total neglect risk score' and a 'total abuse risk score'.²⁷ A final risk level is then allocated: low, moderate, high or very high. In some circumstances, such as where the ROSH report relates to non-accidental injury to a child younger than two years old, the final risk level is automatically 'overridden' to very high.²⁸ In other cases, the caseworker has the discretion to override the risk level to one level higher (if a reason is provided and the caseworker's manager approves of the override).²⁹ If the risk level is high or very high, the child is considered 'in need of care and protection' and DCJ may take whatever action necessary to promote the child's safety, welfare and wellbeing.³⁰ If the child with this risk rating remains in the home (i.e. the safety plan showed 'safe' or 'safe with plan'), DCJ will either refer the family to a funded service (such as Brighter Futures) or develop a case plan and commence casework with the family.

The family action plan

When FACS decides to commence casework with a family, it will develop a case plan (this was formerly referred to as a 'child protection case plan' and is now known as a 'family action plan'). A case plan must be developed within 15 days of a risk assessment with an outcome of 'high' or 'very high' risk.³¹ It should be developed in consultation with the child and the child's family, and any other people significant to the family, once all relevant information has been obtained (including information obtained during a Family Group Conference, or after Family Finding).³² When the child is Aboriginal, Aboriginal caseworkers or community members must be included in the development of a case plan.³³ The case plan builds upon information obtained during the safety and risk assessments.³⁴

When the child remains in the home, the case plan goal is 'family preservation'³⁵ and the 'Family Action Plan for Change' template is used as the case plan document. The case plan should set out the actions required of parents and other carers to achieve the case plan goal and the 'permanency support services', or other services that will be provided to help them achieve the child's case plan goal.³⁶

The department's guidance states that permanency case planning should be trauma-informed and should build on a family's strengths and resilience. Case plans are reviewed at regular 'case plan review meetings', although the case plan goal can be changed at any time if there has been a significant change in relevant circumstances for the child, their parents and family or kin, such

26 Ibid 49.

27 Note that if the answer to an item cannot be determined, the item must be scored as '0': Ibid 50.

28 Ibid 37.

29 Ibid.

30 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 34.

31 'PSP Rules Practice Guidance', *Family and Community Services*, (Web Page), <https://www.facs.nsw.gov.au/providers/children-families/deliver-ppsp/permanency-case-management-policy/rules-and-practice-guidance?merge_chapters=true> 3.

32 Ibid 4.

33 Department of Family and Community Services (NSW), *Case Planning for Family Preservation* (Casework Practice Mandate, FACS Intranet).

34 'PSP Rules Practice Guidance', *Family and Community Services*, (Web Page), <https://www.facs.nsw.gov.au/providers/children-families/deliver-ppsp/permanency-case-management-policy/rules-and-practice-guidance?merge_chapters=true> 4.

35 Ibid 5; Department of Family and Community Services (NSW), *Case Planning for Family Preservation* (Casework Practice Mandate, FACS Intranet).

36 'PSP Rules Practice Guidance', *Family and Community Services*, (Web Page), <https://www.facs.nsw.gov.au/providers/children-families/deliver-ppsp/permanency-case-management-policy/rules-and-practice-guidance?merge_chapters=true> 4.



that another case plan goal would be more appropriate.³⁷ The case plan must be reviewed every 90 days and this review will be informed by the risk re-assessment.³⁸

The following table demonstrates the differences between a safety plan and a case plan.³⁹

The safety plan	The case plan
The purpose is to ensure the child/young person's immediate safety.	The purpose is to provide for the child/young persons safety and wellbeing in the long term.
The safety plan is limited to impending danger.	The case plan can address a wide range of family need.
The safety plan is put in place immediately upon identifying impending danger.	The case plan can be put in place following further assessment and when the family is ready (or when policy demands).
Activity and services within the safety plan are dense which means there are frequently a lot of things going on.	Activity and services can be spread out occurring intermittently over a long period of time.
The safety plan must have an immediate effect. This means it must work the day it is set in place.	The case plan is expected to have long term effects achieved over time.
The provider's role and responsibility in the safety plan are exact and focused on dangers.	The provider's role and responsibility vary according to client need.

The risk reassessment

The risk reassessment is conducted when a child who has received a risk assessment in the past remains in the home (or has been returned home). The first risk reassessment is conducted within 90 days of the completion of the initial case plan, when the caseworker meets face-to-face with the family to formally review progress on case plan goals, and every 90 days thereafter (although it may be completed sooner 'if there are new circumstances or new information that would affect risk').⁴⁰

The risk reassessment is a single index that 'guides the decision to keep a case open or close a case'.⁴¹ Again, the caseworker must override the risk level to 'very high' if certain incidents have occurred since the initial risk assessment (again, this includes a small number of conditions

³⁷ Ibid 15.

³⁸ Department of Family and Community Services (NSW), *Case Planning for Family Preservation* (Casework Practice Mandate, FACS Intranet).

³⁹ Table from the Office of the Senior Practitioner, Department of Family and Community Services (NSW), 'Safety Planning Resource' (October 2016), 13.

⁴⁰ The Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012), 58-59.

⁴¹ Ibid 58.

such as non-accidental injury to a child younger than two years old).⁴² The caseworker can also override the risk level of the risk reassessment, and in this case may increase or decrease the risk level by one step (with the approval of the manager casework).

If the final risk level is assessed as low or moderate and the safety assessment outcome is 'safe', the case may be closed. If the risk level is assessed as low or moderate and the safety assessment identified dangers (ie, was 'safe with plan' or 'unsafe'), then a closing safety assessment must be completed before the case is closed. The case remains open if the risk level is 'high' or 'very high'.⁴³

If two risk reassessments return a final risk level of high or very high (indicating there has been little to no progress towards case plan objectives), the caseworker 'should consider stronger casework intervention such as the development of a Parent Responsibility Contract, a Registered Care Plan, or an Application for a Care Order'.⁴⁴

Parent responsibility contracts

A parent responsibility contract is a written agreement between DCJ and one or more of a child's primary care givers that 'contains provisions aimed at improving the parenting skills of the primary care-givers and encouraging them to accept greater responsibility for the child or young person'.⁴⁵ A parent responsibility contract can also be made between DCJ and either or both expectant parents of an unborn child.⁴⁶ The contract may contain provisions requiring the primary care giver to attend treatment for drug or alcohol abuse, undergo drug testing, participate in courses, or attend counselling.⁴⁷ However, it cannot contain provisions relating to the allocation of parental responsibility for a child, or the placement of the child in OOHC.⁴⁸

A parent responsibility contract must be registered with the Children's Court and cannot be for a period of more than 12 months.⁴⁹ It must also 'specify the circumstances in which a breach of a term of the contract by a party to the contract will authorise the Secretary to file a contract breach notice with the Children's Court'.⁵⁰ If the contract is breached, and DCJ files a contract breach notice, the notice is treated as an application for the care order specified in the notice.⁵¹

Like a registered care plan (discussed below), a parent responsibility contract may be used by DCJ as evidence of an attempt to resolve a matter without bringing a care application.⁵² The fact that a primary care-giver refused to enter into a parent responsibility contract may also be used for the same purpose.⁵³

42 Ibid.

43 Ibid.

44 Ibid 60.

45 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 38A(1)(a).

46 Ibid s 38A(1)(b).

47 Ibid s 38A(5).

48 Ibid s 38A(6).

49 Ibid s 38A(2).

50 Ibid s 38A(2)(f).

51 Ibid s 61A.

52 Ibid s 38D(1).

53 Ibid s 38D(2).



Registered care plans

A care plan is a written document that sets out a plan to ‘meet the needs of a child or young person’.⁵⁴ A care plan that is developed in the course of alternative dispute resolution conducted under the Act⁵⁵ can be registered with the Children’s Court by filing it in the registry of the Court.⁵⁶ It is not enforceable, but may be used by FACS as evidence of an attempt to resolve a matter without bringing a care application.⁵⁷ The Court may also take it into account when deciding what orders to make in a matter.⁵⁸

A care plan that allocates some or all parental responsibility to a person other than a parent of the child, can only take effect if the Children’s Court makes orders by consent to the changes in parental responsibility. The Court must be satisfied that the parties to such a care plan understand its provisions and have freely entered into it. It must also be satisfied that a party, other than the department, has received independent advice about the care plan and that the plan will not contravene the principles of the Act.⁵⁹

From 9 January 2017, care plans include a section titled ‘Aboriginal and Torres Strait Islander cultural plan’, which requires FACS to record the following:

- the person or people with whom the child will be placed and which level of the placement hierarchy of the ACPD has been applied in determining the placement;
- whether the child’s placement is outside of country or community of belonging and, if so, how the child will be assisted to return and spend time in their country and community of belonging;
- how the child will maintain contact with family, kin, country and significant places;
- the views of the child in respect of placement;
- the members of the child’s family, kin or community who have been consulted prior to the development of the Cultural Plan; and
- the Aboriginal community-controlled organisations that have been consulted prior to the development of the Cultural Plan.⁶⁰

Temporary care arrangements

As noted above, if a safety assessment indicates that a child is unsafe, the child must be removed. In these circumstances, a child may be placed in a ‘temporary care arrangement’.⁶¹ This is an arrangement by which another person (an authorised carer) looks after a child for a period of up to three months (with an option for the period to be extended by a further three

54 Ibid s 3.

55 Alternative dispute resolution under the Act includes dispute resolution conferences conducted by the Children’s Registrar prior to the hearing of a care application: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 65.

56 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 38, 38F.

57 Ibid s 38(1)

58 ‘Community Services want to talk about my kids: what will happen?’ *Legal Aid NSW*, (Web Page), <<https://www.legalaid.nsw.gov.au/publications/factsheets-and-resources/kids-in-care/1.-community-services-want-to-talk-about-my-kids-what-will-happen>>.

59 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 38(2A), 38(3).

60 Care Plan Template, *Family and Community Services*, (Web Page), <<https://www.facs.nsw.gov.au/download?file=388786>>.

61 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 151.

months).⁶² A temporary care arrangement can generally only be made with the consent of a parent of the child and can only be made when a permanency goal of restoration is being pursued (and as such a permanency plan involving restoration has been prepared).⁶³

Removal of a child

DCJ staff and members of the NSW Police Force are permitted to remove a child without a warrant or a court order in a number of circumstances, namely, if satisfied on reasonable grounds that:

1. the child is at immediate risk of serious harm (and that the making of an apprehended violence order would not negate that risk);
2. the child is not subject to the supervision of a responsible adult, is living or frequenting a public place, and is in need of care and protection; or
3. The child has been on any premises where prostitution occurs or child abuse material is produced.⁶⁴

If a child is removed in these circumstances, DCJ must lodge an application for a court order (either an emergency care and protection order, an assessment order, or a care order) within three working days of removal and must explain to the court why the removal of the child without a warrant was necessary.⁶⁵ If DCJ does not make such an application, it must explain to the Children's Court at the first available opportunity why no care application was made.⁶⁶

The OOHC case plan

An OOHC case plan must be developed within 30 days of the child entering into the care of the Secretary of FACS or statutory OOHC.⁶⁷ A number of people must be given the opportunity to participate in the development of the OOHC case plan, including the child, the child's parents, family members and carers, as well as an Aboriginal caseworker or community member where a child is Aboriginal. The Manager Casework attends all case planning meetings and will usually chair the meeting. A minute taker will be assigned and the case plan and the minutes will be provided to participants in the meeting. At the meeting, a case plan goal will be determined, namely: restoration; guardianship; adoption; parental responsibility to the Minister; or leaving care. DCJ uses the 'OOHC case plan and review template' for this case plan.

An OOHC case plan must be reviewed annually (at a minimum), but must also be reviewed:

- when a significant change in the placement or a change in the child's circumstances occurs;

62 Ibid s 152.

63 Ibid s 151, s 84. Note, however, that a TCA can be made without the consent of the child's parents if the Secretary is of the opinion that the child's parents are incapable of consenting to the arrangements: s 151(3)(b).

64 Ibid s 43.

65 Ibid s 45.

66 Ibid s 45(3).

67 'PSP Rules Practice Guidance', *Family and Community Services*, (Web Page), <https://www.facs.nsw.gov.au/providers/children-families/deliver-ppsp/permanency-case-management-policy/rules-and-practice-guidance?merge_chapters=true>.



- within four months after an interim order is made;
- within two months after a final order is made for a child less than two years of age;
- within four months after a final order is made for a child over two years of age;
- within 21 days before a planned change of placement;
- within 21 days after an unplanned change of placement; and
- within 21 days after the death of the authorised carer.⁶⁸

In addition, a case plan with the goal of guardianship must be reviewed:

- when an application for a guardianship order has been lodged;
- following completion of a guardianship assessment or assessments; and
- when the care plan is finalised.⁶⁹

Restoration

When a child is removed from the child's home (either into a temporary care arrangement or OOHC), DCJ caseworkers are required to assess whether restoration is a realistic possibility.⁷⁰ Restoration is the first preference for permanent placement of a child or young person.⁷¹ A number of factors are taken into account when considering whether restoration is a realistic possibility, including the parents' capacity or willingness to keep their child safe and meet their child's needs, as well as the severity and frequency of the harm suffered by the child, and progress of contact visits between the parents and the child.⁷² Since late 2018 or early 2019, a structured decision making tool, the *Policy and Procedures Manual Restoration Assessment*, has been used to guide decision-making about restoration.⁷³ If the risk to the child's safety prior to removal was primarily due to 'serious and persistent drug use', or drug use now appears to be a problem for the child's parent, FACS must arrange for the parent to undergo drug testing prior to considering whether restoration is an option.⁷⁴

68 Department of Family and Community Services (NSW), *Case Planning in out-of-home care* (Casework Practice Mandate, FACS Intranet).

69 Ibid.

70 Department of Family and Community Services (NSW), *Restoration and assessment planning* (Casework Practice Mandate, FACS Intranet).

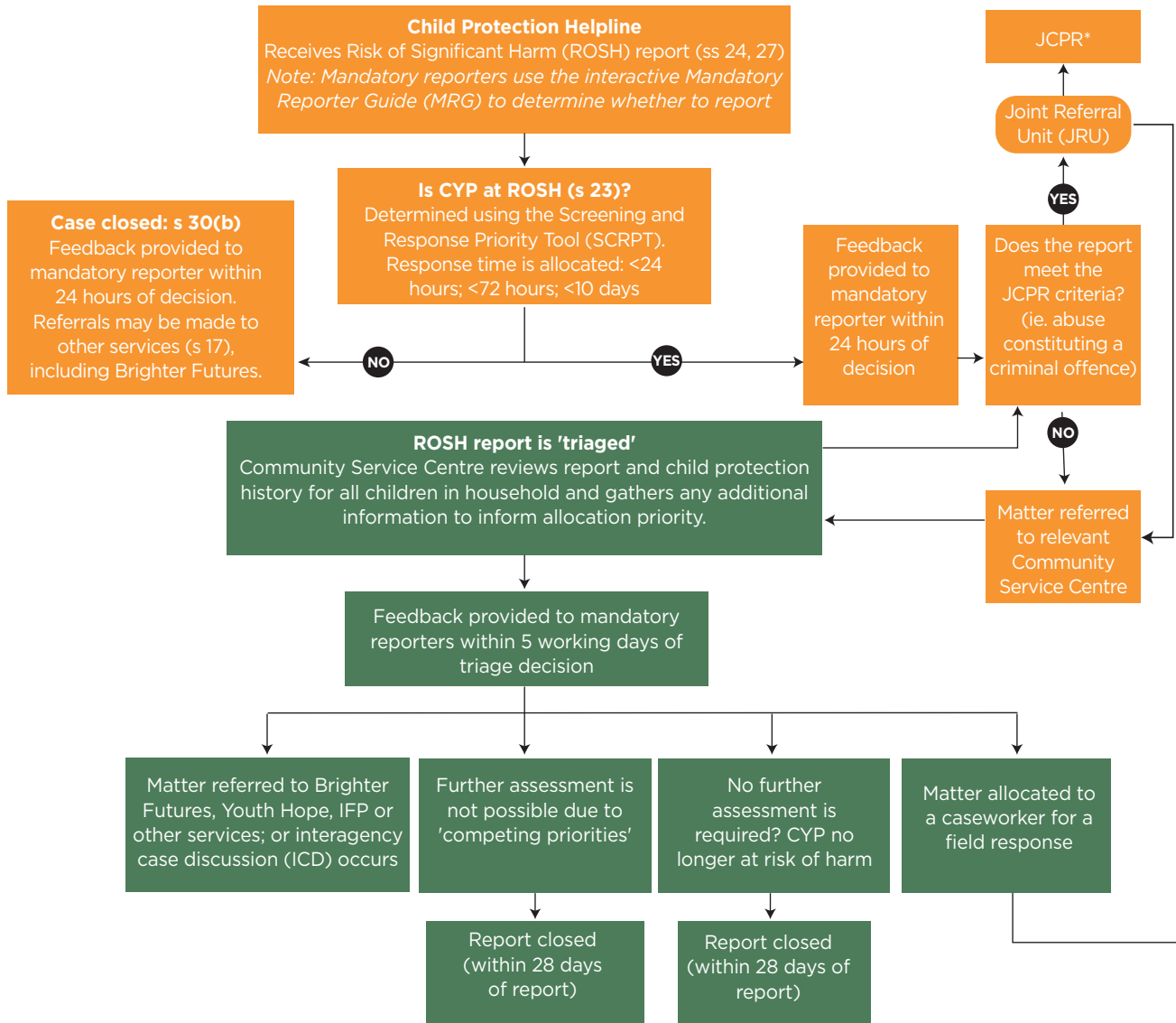
71 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 10A.

72 Department of Family and Community Services (NSW) and Children's Research Centre, *Policy and Procedures Manual Restoration Assessment*, (November 2010, updated July 2018).

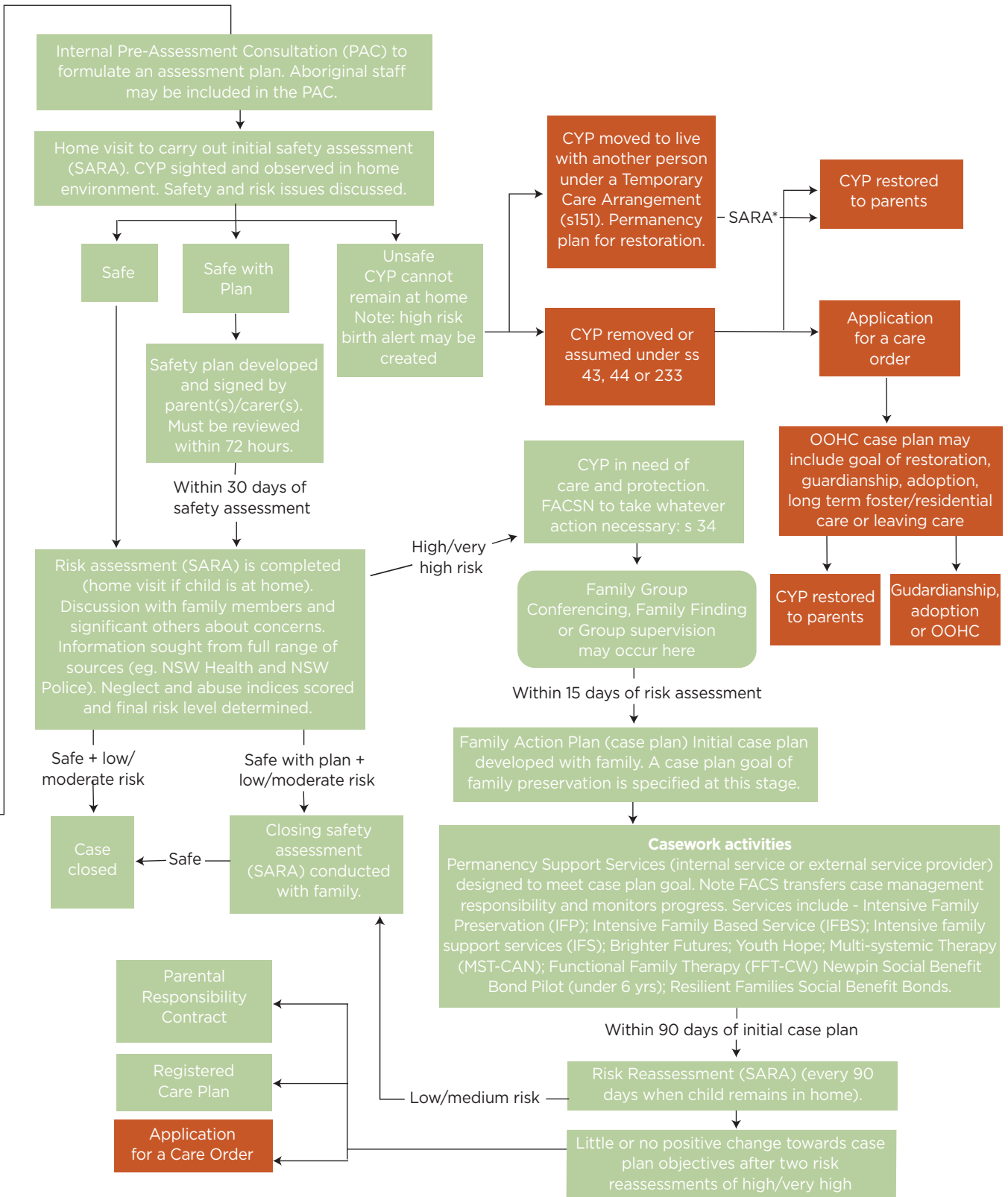
73 Email correspondence from Aboriginal Care Review team to Family is Culture team, 28 August 2019. See Department of Family and Community Services (NSW), *Restoration and assessment planning* (Casework Practice Mandate, FACS Intranet).

74 Department of Family and Community Services (NSW), *Assessing and testing for alcohol and other drug use* (Casework Practice Mandate, FACS Intranet).

CHILD PROTECTION FLOWCHART



- ROSH report stage
- Triage stage
- Casework stage
- OOH stage



* This may include one or more of the following: a risk assessment, a risk reassessment or a closing safety assessment
 * FACS, NSW Health and NSW Police Force

6. How the Children’s Court works

The ‘care and protection’ jurisdiction

In order to remove a child from his or her parents, the Secretary of DCJ must initiate proceedings under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*).⁷⁵ Any person with parental responsibility for a child has a right of appearance in the matter,⁷⁶ while other people can apply to be joined in the proceedings if they have a genuine concern for the ‘safety, welfare and wellbeing’ of the child.⁷⁷ A ‘guardian ad litem’⁷⁸ may also be appointed and the child will be legally represented.⁷⁹

In the Children’s Court, proceedings are conducted with as little formality as possible (for example, practitioners remain seated when addressing the court)⁸⁰ and the rules of evidence do not apply (unless the Court determines otherwise).⁸¹ Proceedings are heard in a closed court⁸² and decisions are made on the balance of probabilities.⁸³

The vast majority of proceedings under the *Care Act* are heard by specialist Children’s Magistrates (usually in a dedicated Children’s Court, although in regional areas other court complexes may be utilised by travelling Children’s Magistrates).⁸⁴ However, care proceedings may be heard by a local court magistrate exercising the jurisdiction of a Children’s Court.⁸⁵

There is little academic literature on the operation of the Children’s Court. Further, as the Court is closed to the public and does not publish court statistics, its operation in practice is difficult to understand. The Review was informed that most Aboriginal parents found participating in court proceedings challenging as they did not understand the court process.⁸⁶ This section provides a simple overview of how a matter would generally proceed through the Court. The flow chart contained in this chapter provides a visual overview of a simple care and protection proceeding in the Children’s Court.

75 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 61. For ease, the Secretary of FACS will simply be referred to as ‘FACS’.

76 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 98.

77 *Ibid* s 98(3). For a discussion of this concept, see *Go v The Secretary Department of Family and Community Services* [2017] NSWDC 198.

78 A ‘guardian ad litem’ is appointed for a party who is not capable of giving proper instructions to a legal representative: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 98.

79 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 99; NSW Judicial Commission, *Local Court Benchbook*, 47-040.

80 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 93.

81 *Ibid* s 93(3).

82 *Ibid* s 104B.

83 *Ibid* s 93(4).

84 Children’s Magistrates hear approximately 90% of cases in NSW: Judge Peter Johnstone, Submission No 19 to NSW Parliamentary Committee on Law and Safety, *Inquiry into the Adequacy of Youth Diversionary Programs in NSW* (8 February), 6.

85 See *Children’s Court Act 1987* (NSW) s 13.

86 Confidential, *Consultation*, FIC 71.



Application for a ‘care order’

An application to remove a child from his or her parents is commenced as an application for a ‘care order’ under s 61 of the Act.⁸⁷ The application must specify the particular care order sought and the grounds on which it is sought.⁸⁸ It must also be accompanied by:

- (1) a written report that succinctly and fairly summarises the information that FACS claims is sufficient to support a determination that a child is in need of care and protection (and any interim orders that are being sought);⁸⁹ and
- (2) evidence of the support and assistance provided for the safety, welfare and wellbeing of the child, and alternatives that were considered before the making of the application and the reason why they were rejected.⁹⁰

The parents of the child must be notified of the application and copies of any documents filed with it (such as the written report and any affidavits) must be served on the parents as soon as possible.⁹¹ Other ‘specified documents’ must also be served on the parents prior to the first return date (although the genogram may be served up to 14 days after the first return date).⁹²

The first return date

When the application first comes before the court (the ‘first return date’), DCJ will generally ask the court to grant parental responsibility of the child on an interim basis. Parental responsibility is ‘all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children’.⁹³ Other interim orders, such as orders for supervision and contact, may also be made at this time.⁹⁴ Before making an interim order allocating parental responsibility, the Court must be satisfied that it is not in the best interests of the child to remain with the child’s parents⁹⁵ and that no other order would be sufficient to protect the child from harm.⁹⁶

At the first return date, directions will also be made about the progression of the matter. Generally, DCJ will be ordered to file and serve a ‘Summary of the Proposed Plan for the Child/ Young Person’ within 14 days and the child’s parents will be ordered to file and serve evidence in reply to the application and report within 24 days.

87 Note that the Secretary can apply for other care orders, such as a contact order or a supervision order: see *Children and Young Persons (Care and Protection) Act 1998* (NSW) pt 2.

88 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 61(2), *Direction-General, Department of Community Services v Dessertaine* [2003] NSWSC 972, 16.

89 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 61(2); Children’s Court of New South Wales, *Practice Note No 2, Initiating Report and Service of the relevant portion of the Community Services file in Care Proceedings* (last amended 1 July 2016).

90 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 63(1).

91 *Ibid* s 64(1), (2).

92 Children’s Court of New South Wales, *Practice Note No 2, Initiating Report and Service of the relevant portion of the Community Services file in Care Proceedings* (last amended 1 July 2016).

93 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 2.

94 *Ibid* s 62.

95 *Ibid* s 69(2).

96 *Ibid* s 9(2)(c).

The second return date

At the second return date, the Court will determine the threshold question of whether or not the child is in need of care and protection (this is the ‘establishment’ phase).⁹⁷ Section 71 of the *Care Act* sets out a non-exhaustive list of reasons that a child may be in need of care and protection, including, for example, if the child has been (or is likely to be) physically or sexually abused or ill-treated,⁹⁸ or if the child’s basic physical, psychological or educational needs are not being met by the child’s parents or primary care-givers.⁹⁹

Parties are required to advise the court if the issue of ‘establishment’ is contested. However, ‘most parents consent to a “*finding on a without admissions basis*” which usually means that the parent accepts that the child is in need of care and protection however they do not necessarily accept the specific facts alleged by [the] Department ...’.¹⁰⁰

If establishment is contested, the matter will be listed for a hearing. The Court will make directions giving the parties an opportunity to file and serve evidence on the issue of whether the child is in need of care and protection. The matter may be referred to a dispute resolution conference to be conducted prior to the hearing. If the Court decides that a child is not in need of care and protection, it may dismiss the application.¹⁰¹ If it decides that a child is in need of care and protection, the matter will move on to the ‘placement stage’ of the proceedings.

Preparation for the placement hearing

Prior to the placement hearing, DCJ is required to file and serve certain documents, such as a final care plan¹⁰² and a permanency plan.¹⁰³ The child’s parents are required to file and serve evidence in reply to these documents.¹⁰⁴

The final care plan must include certain information, such as:

- information about the proposed allocation of parental responsibility between the Minister and the child’s parents for the duration of the child’s removal;
- details of the kind of placement to be sought for the child;
- information about the agency designated to supervise the OOHC placement; and
- details about the arrangements for contact between the child and the child’s family and friends.¹⁰⁵

97 Ibid s 72.

98 Ibid s 71(c).

99 Ibid s 71(d).

100 New South Wales Bar Association, ‘A Reader’s Guide to the Care and Protection Jurisdiction’ (Online) <https://www.nswbar.asn.au/docs/professional/prof_dev/BPC/course_files/Care%20and%20Protection%20-%20Childrens%20Court%20-%20Lawson.pdf>, 7. The Review notes that it was informed in consultations that lawyers attended to advise their clients to concede to ‘establishment’, a fact that made them ‘feel guilty before proven innocent’: Confidential, *Consultation*, FIC 71.

101 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 72(2). Alternatively, it may adjourn the application to permit the Department to bring other relevant evidence before the Court.

102 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 78(1).

103 Ibid s 83, Children’s Court of New South Wales, *Practice Note 5: Case management in care proceedings* 16.6.2 (c).

104 Children’s Court of New South Wales, *Practice Note 5: Case management in care proceedings*, 16.6.2 (d).

105 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 78(2).



It must also contain information about the child concerned, such as the child's family structure, and whether the child is of Aboriginal or Torres Strait Islander descent,¹⁰⁶ as well as information about the responsibilities of each participant in the plan and how long those responsibilities are to be carried out.¹⁰⁷

A care plan is only enforceable to the extent that its provisions are 'embodied in or approved by orders of the Children's Court'.¹⁰⁸ A court cannot make a final order for removal of a child from his or her parents, or allocate parental responsibility in respect of a child, unless it has considered the care plan.¹⁰⁹ A court is not obliged to agree to the proposals in the care plan¹¹⁰ and must scrutinise it carefully to ensure it accurately reflects the department's proposals for the future care and protection of the child. If the care plan does not accurately reflect the department's proposals, the plan may not be valid.¹¹¹

The permanency plan, which is also filed prior to the placement hearing, aims to provide a child with a stable placement that offers long-term security and avoids the child experiencing multiple short term placements.¹¹² Such a placement should normally comply with the 'permanent placement principles' in s 10A of the *Care Act*, which sets out a hierarchy of placement preferences, from restoration to the child's parents to placement with the Minister. When a permanency plan is prepared, DCJ must assess if there is a realistic possibility of restoration to the child's parents.¹¹³ If it assesses that there is a realistic possibility of restoration, the permanency plan must outline how the restoration will occur.¹¹⁴ If it assesses that there is no realistic possibility of restoration, the permanency plan should outline another suitable long-term placement for the child.¹¹⁵ When a permanency plan is prepared for an Aboriginal child, it must show how the plan has complied with 'the ACP' in s 13 of the *Care Act*.¹¹⁶

At this stage of the proceedings, a party to the proceeding may also apply for an assessment order¹¹⁷ (an order that the child receive a psychological or psychiatric assessment by the Children's Court Clinic).¹¹⁸ This may involve an assessment of a person's capacity for parental responsibility (with that person's consent).¹¹⁹ Although an assessment report is an independent

106 *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) Reg 22(2).

107 *Ibid.*

108 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 78(4).

109 *Ibid* s 80.

110 *George v Children's Court of New South Wales & 4 Ors* [2003] 389 NSWCA, 58.

111 *Re Tracey* [2011] 43 NSWCA; Judicial Commission of NSW, *Children's Court of NSW Resource Handbook* (2019), 72-736.

112 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 78A.

113 *Ibid* s 83(1).

114 *Ibid* ss 83(2), 84.

115 *Ibid* s 83(3).

116 These principles are discussed further in Chapter 21.

117 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 53-56. The application for this order is to be made as soon as possible after establishment: Children's Court of New South Wales, *Practice Note 6: Children's Court Clinic assessment applications and attendance of Authorised Clinicians at hearings, dispute resolution conferences and external mediation conferences*, 5.2.

118 Note that while the Act refers to a 'physical, psychological, psychiatric or other medical examination', the Children's Court Clinic is not currently resourced to conduct physical or medical examinations: Children's Court of New South Wales, *Practice Note 6: Children's Court Clinic assessment applications and attendance of Authorised Clinicians at hearings, dispute resolution conferences and external mediation conferences*, 3.1. Further, a child or young person who is able to make an informed decision about the matter may refuse to submit to the assessment: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 53(4). If the Clinic declines to make the assessment, the Court may refer the child or young person to another person for an assessment: *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 53-55, Children's Court of New South Wales, *Practice Note 6: Children's Court Clinic assessment applications and attendance of Authorised Clinicians at hearings, dispute resolution conferences and external mediation conferences*, 5.2.

119 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 54.

report to the Court (and not evidenced tendered by a party),¹²⁰ the author of the report (the Authorised Clinician) may attend the hearing for cross-examination if required.¹²¹

Also at this stage of the proceedings, the parties can be referred to a dispute resolution conference (DRC).¹²² This is conducted by the Children's Registrar to 'provide the parties with an opportunity to agree on action that should be taken in the best interests of the child concerned'.¹²³ The DRC is attended in person by the parties, their legal representatives, the relevant caseworker, as well as a legal representative for DCJ and any guardian ad litem.¹²⁴ Other people, such as a member of a kinship group or an authorised clinician of the Children's Court Clinic, may attend at the discretion of the Children's Registrar.¹²⁵ The child may attend if he or she wishes.¹²⁶ At the conclusion of the DRC, the Children's Registrar will provide a report to the court outlining any agreement or issues remaining in dispute.¹²⁷ A hearing date for a matter will not generally be allocated until after a DRC.¹²⁸

Less commonly, the Court may refer the parties to an external alternative dispute resolution (ADR) process, on its own initiative or on the application of a party to the proceedings.¹²⁹ The participants in an external ADR process are expected to comply with the responsibilities and obligations that apply in a DRC.¹³⁰ At the conclusion of an external process, the convenor will provide a report to the Court outlining any agreement, or identifying issues remaining in dispute.¹³¹ Evidence of anything said, or of any person's conduct in any ADR process conducted under the *Care Act*, is not generally admissible (without the consent of all participants) in any later court proceedings.¹³²

The placement hearing

At the placement stage of proceedings, the Court is required to make final orders for the care and protection of the child. During the placement hearing, the parties may cross-examine witnesses and make submissions to the Court on the issues in dispute. The Court will consider all the evidence (including the evidence of any expert witnesses) and decide whether it agrees with DCJ's assessment of whether or not there is a 'realistic possibility of restoration' to the parents.¹³³

The Court may not make a final care order unless it has given consideration to the 'permanent placement principles' and has expressly found that permanency planning for the child has been

120 Ibid s 59.

121 Children's Court of New South Wales, *Practice Note 6: Children's Court Clinic assessment applications and attendance of Authorised Clinicians at hearings, dispute resolution conferences and external mediation conferences*, 2.2.

122 Note, however, that the parties may be referred to ADR at any stage of the proceedings: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 65 (1).

123 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 65(2).

124 Children's Court of New South Wales, *Practice Note 3, Alternative Dispute Resolution Procedures in the Children's Court*, 4.1.

125 Ibid 4.2.

126 Ibid 6.1. However, note that this is rare in practice.

127 Ibid 15.5.

128 Ibid 12.2.

129 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 65A. Note that the approval of the President of the Children's Court approval is generally needed before such an order is made: Children's Court of New South Wales, *Practice Note 3, Alternative Dispute Resolution Procedures in the Children's Court*, 17.1.

130 Children's Court of New South Wales, *Practice Note 3, Alternative Dispute Resolution Procedures in the Children's Court*, 17.2.

131 Ibid 17.4.

132 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 244B. For exceptions, see *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 244C.

133 Ibid s 83(5). This assessment is provided in the permanency plan filed with the application for care orders: Ibid s 83. Restoration is discussed further in Chapter 21.



appropriately addressed.¹³⁴ A court cannot make a final order for removal of a child from his or her parents, or allocate parental responsibility in respect of a child, unless it has considered the care plan.¹³⁵

There must be no comparison made between a parent and alternative carers in this exercise. Even if it appears that another carer may provide better care, if there is a realistic possibility of restoration, then orders must be made which support restoration to a parent.¹³⁶

At the conclusion of the hearing, the Court may make one or more of the following final orders:

- an order allocating parental responsibility to DCJ, the child's parents or another person. Parental responsibility can be shared between DCJ and the child or young person's parents or another person;¹³⁷
- a guardianship order allocating parental responsibility for a child to a suitable person until the child reaches 18 years of age.¹³⁸ This order must not be made unless the Court is satisfied that there is no realistic possibility of restoration of the child to his or her parents;¹³⁹
- a supervision order placing the child under the supervision of DCJ for a maximum period of 12 months (although the order may be extended to a maximum of 2 years in special circumstances);¹⁴⁰
- a contact order;¹⁴¹
- an order prohibiting certain action;¹⁴²
- an order accepting undertakings (such as an undertaking to accept the advice, guidance and support of DCJ officers in respect of the child);¹⁴³
- an order for the provision of support services to the child person;
- an order requiring a child of less than 14 years of age to attend a therapeutic program relating to sexually abusive behaviours;¹⁴⁴ or
- an order for costs in exceptional circumstances.¹⁴⁵

At the conclusion of the final hearing, the Court retains some scope to monitor the implementation of its orders. For example, if the Court allocates parental responsibility to a non-parent, it may order that a written report be prepared about the suitability of the arrangements for the care and protection of the child within 12 months of the final order.¹⁴⁶ If the Court is

134 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 83(7).

135 *Ibid* s 78.

136 NSW Judicial Commission, *Local Court Benchbook*, 47–340.

137 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 79.

138 *Ibid* s 79A.

139 *Ibid* s 79A(3)a.

140 *Ibid* s 76.

141 *Ibid* s 86, Children's Court of NSW, *Contact Guidelines*.

142 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 90A.

143 *Ibid* s 73.

144 *Ibid* s 75.

145 *Ibid* s 88. Esther Lawson, 'A Reader's Guide to the Care and Protection Jurisdiction', (Bar Practice Course, NSW Bar Association, 12 May 2012) 9.

146 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 82.

not satisfied with the situation outlined in the report, it may conduct a review of progress in implementing the care plan (a progress review) and re-list the matter for that purpose.¹⁴⁷ Similarly, if the Court makes a supervision order, it may require a status report during or before the end of the period of supervision for a limited period of time¹⁴⁸ (after which it may extend the period of supervision or revoke the order).¹⁴⁹

Variation or rescission of a care order

Under s 90 of the *Care Act*, an application can be made to vary or rescind a care order. However, this application may only be made with the leave of the Children's Court. Leave will be granted if there has been 'a significant change in any relevant circumstances since the care order was made or last varied'.¹⁵⁰ Section 90(2B) sets out the primary matters the Court must take into account before it grants leave for an application to vary or rescind the care order (namely, the views of the child, the length and stability of the child's present placement, and the least intrusive option that would be in the best interests of the child). Section 90(2C) sets out additional considerations, such as the age of the child and whether or not the applicant has an arguable case. The Court may dismiss an order if it is frivolous, vexation or an abuse of process.

If the Court grants leave for the s 90 application, it must then determine whether to vary or rescind the order. If it rescinds an order, it may make any order it has the power to make during a care application.¹⁵¹ However, before making or rescinding a care order that gives parental responsibility to the Minister (or the Minister and another person), the Court must take into account a list of facts, such as the age of the child, the wishes of the child and the strength of the child's attachments to his or her birth parents and present caregivers.¹⁵²

Breach of care orders

If the Children's Court is notified of a breach of an undertaking or supervision order it may, after hearing from the parties, make such orders that it could have made at the time of the initial order.¹⁵³ If the Children's Court is notified of a breach of a prohibition order it may, after hearing from the parties, make such orders 'as it considers appropriate in all the circumstances'.¹⁵⁴ The Children's Court does not have any specific power to enforce a contact order and as such, will generally make an order accepting an undertaking to comply with a contact order at the same time as it makes a contact order.¹⁵⁵

147 Ibid s 82(3). If, after considering the report, the Children's Court is not satisfied that proper arrangements have been made for the care and protection of the child or young person concerned, the Court may, on its own motion, conduct a review of progress in implementing the care plan (a progress review) and re-list the matter for that purpose. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 82(3).

148 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 76(4).

149 The supervision order cannot total 24 months in total. See *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 76(6), (7).

150 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 90(2); *JL v Secretary, Department of Family and Community Services* [2015] 88 NSWCA, 200.

151 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 90(7).

152 Ibid s 90(6).

153 Ibid ss 73(5), 77(3).

154 Ibid s 90A (3).

155 NSW Judicial Commission, *Local Court Benchbook*, 47-480.

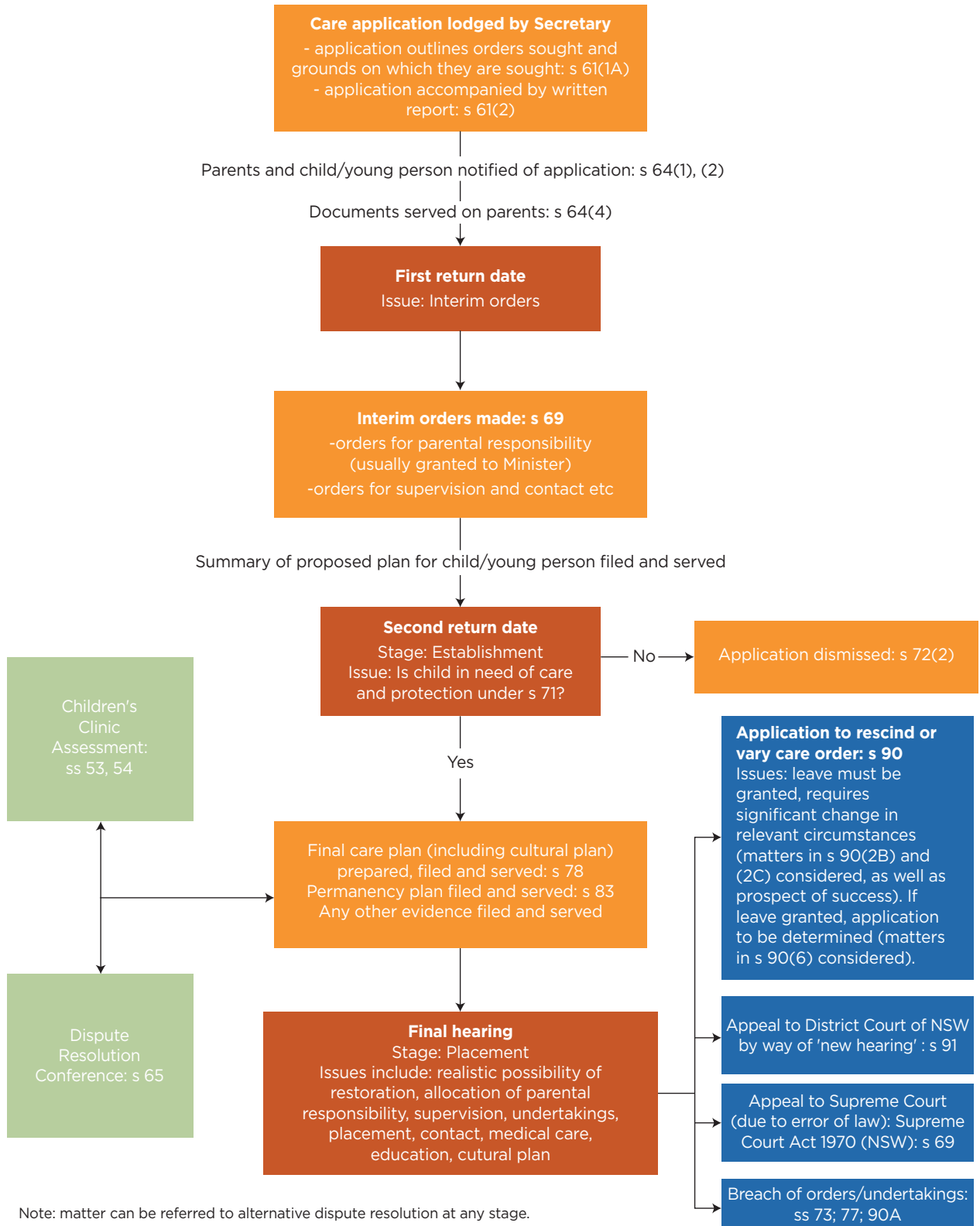


Appeals

An appeal can be lodged to the District Court pursuant to s 91 of the *Care Act*. The appeal is *de novo*, that is, the District Court will hear the matter again and has the power to confirm, vary or set aside the decision of the Children’s Court. There is no right of appeal from an appeal judgment of the District Court. However, an application for judicial review can be made to the Supreme Court under s 69 of the *Supreme Court Act 1970* (NSW) if a party believes the District Court judge committed a jurisdictional error, or if there is an error on the face of the District Court record.¹⁵⁶

156 See, for example, *Re Jeremy (a pseudonym); DM v Secretary, Department of Family and Community Services* [2017] 200 NSWCA.

CARE AND PROTECTION PROCEEDINGS FLOWCHART



PART C

Key areas requiring significant structural change



7. Self-determination

What is self-determination?

The language of self-determination is frequently used in respect of Aboriginal child protection, yet the concept is ill-defined in law and policy at both the state (NSW) and Commonwealth levels. Further, the language employed by multiple stakeholders in the NSW child protection space can be inconsistent, with some stakeholders referring to self-determination as a principle and others referring to it as a right. This creates confusion around what self-determination means and how it should be operationalised.

The international right to self-determination for Indigenous peoples is recognised in the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP),¹ which Australia has endorsed. However, this right is not necessarily what the NSW Government is referring to when it uses the language of self-determination in child protection and other fields. For this reason the state's concept of self-determination may not align with what Aboriginal people regard as the right to self-determination, or the right to self-determination at law. This chapter accordingly examines the right to self-determination in an international context, in an Australian context, and in an NSW child protection and OOHC context (with some comparative analysis to other jurisdictions). It is the Review's perspective that reform in this area, including greater clarity around the concept of self-determination, is necessary to address power imbalances between the state and the Aboriginal community in relation to child protection and OOHC law and policy.

The language of self-determination is frequently used in respect of Aboriginal child protection, yet the concept is ill-defined in law and policy at both the state (NSW) and Commonwealth levels.

The right to self-determination in international law

The right to self-determination is the right of Indigenous peoples to freely determine their political status and economic, social and cultural destiny. Indigenous peoples around the world invoke the right to self-determination as the normative basis of their relationship with the state. Decades of advocacy by Indigenous peoples led to the United Nations General Assembly adopting the UNDRIP in 2007. The UNDRIP's legal framework provides Indigenous peoples with much more than a right of participation or consultation, including the right to develop autonomous arrangements and the power to make decisions. Rights within UNDRIP are internal rights, recognised within the democratic governance of the state, accommodated within the public institutions of the state from the Constitution, or reflected in the creation of any new mechanism or institution that allows Indigenous peoples enhanced participation within the democratic structures of the state. This includes Aboriginal autonomy in the delivery of child and family services and statutory child protection functions.

¹ *Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UN GAOR, 61st sess, UN Doc A/RES/47/1 (2007) (UNDRIP).



The right to self-determination has a long history at international law. Its evolution has been influenced by the development of international human rights law and Indigenous peoples' engagement with the United Nations. For most Indigenous peoples, the right to self-determination involves exercising control over their own communities and participating in decision-making processes, as well as in the design of policies and programs affecting their communities.²

The right to self-determination is the right of Indigenous peoples to freely determine their political status and economic, social and cultural destiny.

The UNDRIP is different to other human rights treaties as it is a collective rights instrument and recognises group rights.³ Collective, or group rights, are also familiar to the Australian legal system. Australia has long interpreted Indigenous rights as collective rights and applied these rights in many ways, from native title to land rights to cultural heritage and, of course, through the right to political participation through the Aboriginal and Torres Strait Islander Commission (ATSIC). The Commonwealth Government has never disputed the collective nature of Indigenous peoples' rights at an international level.

When determining the normative framework of Indigenous peoples right to self-determination, jurist S James Anaya distinguishes between substantive and remedial self-determination.⁴ Anaya notes that substantive self-determination has two components: constitutive and ongoing self-determination.⁵ Constitutive self-determination involves the establishment of governing institutional arrangements and requires that such arrangements reflect the collective will of the people or peoples governed. This constitutive form of self-determination is demonstrated in the proposal AbSec submitted to the Review, seeking to establish a statutory Aboriginal body within the child protection sector. In contrast ongoing self-determination means that those arrangements, independently of the processes that created them, must establish a system of governance enabling individuals and groups to make meaningful choices about their lives.⁶

Remedial self-determination, on the other hand, refers to the actions or measures that must be taken where the substantive elements of self-determination have been violated. The National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families (Bringing Them Home Inquiry) and the National Apology to the Stolen Generations are two Australian examples of remedial self-determination.⁷

2 See for example, Megan Davis, 'Aboriginal Women: The Right to Self-Determination' (2012) 16(1) *Australian Indigenous Law Review* 78; Christine Fletcher (ed), *Aboriginal Self-Determination in Australia* (1994); Larissa Behrendt, *Achieving Social Justice* (2003) 86; Aboriginal and Torres Strait Islander Commission, *Recognition, Rights and Reform: A Report to Government on Native Title Social Justice Measures* (1995).

3 *Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UN GAOR, 61st sess, UN Doc A/RES/47/1 (2007) art 3

4 S James Anaya, *Indigenous Peoples in International Law* (2nd ed, 2004) 57.

5 *Ibid.*

6 *Ibid.*

7 *Ibid.*

The right to self-determination and child protection

For a child protection system to be effective, many Aboriginal people have argued that it must be consistent with Australia's human rights obligations and founded on Indigenous peoples' right to self-determination. This raises important questions about how the right to self-determination should be translated in a domestic context in relation to the child protection and OOHC sector, particularly as it relates to the Aboriginal Child Placement Principle (ACPP), but also other features of the system.

Examining international human rights law on this point yields significant guidance around how United Nations member states, like Australia, who are signatories to the *United Nations Convention on the Rights of the Child*, should implement the right to self-determination in child protection and OOHC systems. In General Comment 11, the United Nations Committee on the Rights of the Child stated that special measures may be needed 'to safeguard the integrity of indigenous families and communities by assisting them in their child rearing responsibilities'.⁸ The Committee has also stated that states should collect data on family situations including on foster care and adoption processes and use this data to design family and alternative care policies in a culturally sensitive way,⁹ noting that:

Maintaining the best interests of the child and the integrity of indigenous families and communities should be primary considerations in development, social families and health and education programmes.¹⁰

The Committee has also noted that member states should take steps to respect and support traditional extended family structures.¹¹ Furthermore the Committee has noted that where Indigenous children are over-represented in OOHC there must be

specially targeted policy measures developed in consultation with indigenous communities in order to reduce the number of indigenous children in alternative care and prevent the loss of cultural identity. Specifically, if an indigenous child is placed in care outside their community, the State party should take special measures to ensure that the child can maintain his or her cultural identity.¹²

Recognition of the right to self-determination

Recognition of the right to self-determination can be viewed on a spectrum from 'strong form' to 'weak form'. Strong form recognition involves autonomous arrangements, which are usually the type of autonomy exercised in countries that recognise Aboriginal sovereignty, such as some Native American tribes (including Salt River in Arizona), who have been empowered to develop a comprehensive early intervention, wraparound service for child welfare and child protection of Native American children. The other end of the spectrum is 'weak' form recognition, which is a form of recognition that does not require the state to act. This weak form of recognition is

8 United Nations Committee on the Rights of the Child, General Comment No 11: Indigenous Children and their Rights under the Convention, UN Doc CRC/ C/ GC/ 11 (12 February 2009) [46].

9 Ibid [47].

10 Ibid.

11 United Nations Committee on the Rights of the Child, Concluding Observations: New Zealand, UN Doc CRC/ C/ 133 (2003), [154].

12 Ibid.



more akin to the concept of ‘self-determination’ recognised in the *Children and Young Persons (Care and Protection Act) 1998 (NSW) (Care Act)*, which in the absence of a definition of self-determination by the NSW Government, reflects a vague and indeterminate rendering of the right. In light of the spectrum of recognition under self-determination, it is important for law and policymakers be specific about its content. Inconsistent uses of the term can create competing expectations of what it can achieve.

The Review notes that any weak form of self-determination is unlikely to achieve substantive change in respect of Aboriginal policy and program design, including in respect of decision-making. This perspective was confirmed through stakeholder engagement related to self-determination as recognised in the *Care Act*. Through these engagements Aboriginal stakeholders raised particular concern around the way the ‘rhetoric’ of self-determination was used by government, and the way the right to self-determination seemed to be conflated with weak participatory rights.

The conflation of the right to self-determination with consultation and participation has concerned the United Nations Expert Mechanism on the Rights of Indigenous Peoples (EMRIP), for some time.

As the 1997 *Bringing Them Home Report* stated when considering self determination in the context of Aboriginal child protection and child removals,

self-determination requires more than consultation because consultation alone does not confer any decision-making authority or control over outcomes. Self-determination also requires more than participation in service delivery because in a participation model the nature of the service and the ways in which the service is provided have not been determined by Indigenous peoples. Inherent in the right of self-determination is Indigenous decision-making carried through into implementation.¹³

The conflation of the right to self-determination with consultation and participation (including free, prior and informed consent) has concerned the United Nations Human Rights Council’s subsidiary body, the United Nations Expert Mechanism on the Rights of Indigenous Peoples (EMRIP), for some time.¹⁴ In response to these concerns, the EMRIP published a study aiming to clarify the relationship between the right to self-determination and concepts of consultation and participation. In this study, EMRIP stated that:

The right to self-determination is the fundamental human right upon which free, prior and informed consent is grounded. It includes internal and external aspects. Historically, the right to self-determination ... was devised to ensure subjected nations and peoples could recover their autonomy, preside over their destinies, make decisions for themselves and control their resources. The right to self-determination was indeed construed as a pillar right, including other rights of peoples and nations to be free from coercion of any sort, to live in dignity and to enjoy all rights equally, including the right to be responsible for their futures, to be fully informed and to be in a position to freely refuse or accept offers, plans, projects, programmes and proposals that affected them or their resources.

¹³ Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, (1997), 276.

¹⁴ The revised mandate of the EMRIP is to provide UN member states with clarity on the meaning of each of the UNDRIP provisions.

The concepts of being free, being fully informed, having the right to say yes or no and having control over their own lands and resources as nations or peoples are not therefore new in international human rights law. These concepts derive from the elements of the right to self-determination, on which the Declaration bases its provisions on free, prior and informed consent, as a way of operationalizing the right to self-determination, taking into account the particular historical, cultural and social situation of indigenous peoples.¹⁵

It should also be noted that in recent years there has been a renewed interest in a ‘treaty’ in Australia, which is an equally ill-defined concept to that of self-determination. A study conducted by United Nations Special Rapporteur Miguel Alfonso Martinez on treaties, agreements and other constructive arrangements sought to move beyond the idea that a ‘treaty’ is the only way in which Indigenous peoples could negotiate arrangements with the state. Martinez wrote about agreements and other constructive arrangements between Indigenous peoples and the state, noting the

widespread desire of indigenous peoples to establish a solid, new and different kind of relationship—quite unlike the almost constantly adversarial, often acrimonious relationship they had always had—with the non-indigenous sector of society in countries where they co-existed.¹⁶

In light of these considerations, it is important that the state and Indigenous peoples have the opportunity to engage in meaningful dialogue about what the right to self-determination means in law and in practice.

The right to self-determination and the Commonwealth

In order to consider how Aboriginal peoples’ right to self-determination may be implemented in the child protection and OOHCC care sector in NSW, it is important to consider how the right to self-determination is currently recognised in Commonwealth law and policy. The Commonwealth leads on the recognition of Indigenous peoples’ rights under Australia’s federal structure and influences the degree to which Australian states are compelled to recognise a strong form of self-determination in terms of autonomous arrangements. This is a consequence of the constitutional status of Indigenous affairs after the 1967 referendum in which an alteration to the Australian Constitution provided the Commonwealth Parliament with the constitutional authority to make laws for Aboriginal and Torres Strait Islander peoples. The 1967 referendum was an important landmark, not least as the states had, until this point, performed so poorly in terms of ensuring the welfare and wellbeing of Indigenous peoples. Currently, however, the contemporary legal and policy environment in Australia, in so far as Commonwealth Indigenous affairs is concerned, has not been amenable to Indigenous peoples’ right to self-determination. Rather,

‘self-determination’ has been eviscerated from the lexicon of Australian politicians, policymakers and Australian journalists and political commentators and inelegantly dismissed as a ‘failed experiment’ and antithetical to Aboriginal economic development.¹⁷

15 Human Rights Council, *Draft study on Free, Prior and Informed Consent: A human rights based approach*, UN Doc A/HRC/EMRIP/2018/CRP.1 (5 July 2018) 8–9.

16 Ibid 3.

17 Megan Davis, ‘Aboriginal Women: The Right to Self-Determination’ (2012) 16(1) *Australian Indigenous Law Review* 78.



This recent approach has not always been the case. From the Whitlam government in 1972¹⁸ to the abolition of the independent statutory Commonwealth commission ATSIC in 2005,¹⁹ successive Commonwealth governments formally supported the right to self-determination for Indigenous peoples. Recognising the right to self-determination in law and policy led to measures aimed at improving the situation of Aboriginal and Torres Strait Islander people including the granting of land rights (for example, through the *Aboriginal Land Rights (Northern Territory) Act 1976* (Cth)) and the establishment of Aboriginal medical and legal services. The Whitlam government also established the first Department of Aboriginal Affairs and appointed a Minister to head the department.

It is important to revisit how the right to self-determination was implemented or translated into domestic law because it did involve the creation of specialist domains that were administered and used by Aboriginal and Torres Strait Islander peoples themselves. This is akin to stronger forms of self-determination previously discussed.

However, the bipartisan policy of self-determination ended with the abolition of ATSIC. Following this, there was a trend toward the ‘mainstreaming’ of Aboriginal services at a Commonwealth level, requiring Aboriginal people to access the same services as other Australians rather than services established by Aboriginal people for Aboriginal communities.

In recent times there has been a resurgence of governments and their bureaucracies employing the language of self-determination and committing to a renewed emphasis on self-determination. It is difficult, however, to assess whether the revival in state governments use of the language of self-determination equates to an endorsement of a strong form of the right to self-determination.

Self-determination in Aboriginal child protection in NSW

The right to self-determination is not currently applied in the Aboriginal child protection system in NSW, despite the fact that it has been 20 years since the publication of the *Bringing Them Home Report*, which advocated for the recognition of a strong form of self-determination in Aboriginal OOHc. It has been argued by some stakeholders to this Review that this lack of self-determination is a core contributor to the Aboriginal child protection crisis in NSW and the importance of the right to self-determination to Aboriginal people and communities was the subject of multiple submissions and consultations in this Review.

For example, AbSec submitted that if true self-determination is not introduced in NSW child protection, any reforms run the risk of

creating a statutory system that is not focused on the values and the rights of children and the principles of justice, dignity and family, but the simplistic permanent transfer of children from marginalised to relatively more advantaged families, akin to practices of the Stolen Generation.²⁰

18 Gough Whitlam, ‘It’s Time for Leadership: 1972 Campaign Launch for the Australian Labor Party’ (Speech delivered at the Blacktown Civic Centre, 13 November 1972) <http://www.whitlam.org/collection/1972/1972_alp_policy_speech/>.

19 *Aboriginal and Torres Strait Islander Commission Act 1989* (Cth).

20 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHc in NSW*, December 2017, 21.

In further unpacking this issue, the *Bringing Them Home Report* remains a useful guide given it was drafted during a stronger self-determination period in Australia. Chapter 26 of the report contains extended consultation of stakeholder views, as well as considerable discussion about the issue of self-determination.²¹ The recommendations made in this chapter were directed towards the transfer of power from the Australian state to Indigenous peoples in the child protection arena.²² Specific recommendations included that the Council of Australian Governments (COAG) negotiate with relevant bodies, including the then-ATISC, to create national legislation establishing a framework for negotiations at community and regional levels in order to implement self-determination in relation to the wellbeing of Indigenous children and young people.²³ That new national framework legislation was intended to bind the Commonwealth and all state and territory governments, and to ensure that Indigenous communities were free to negotiate relevant agreements based on measures best suited to their individual needs. Removal of Aboriginal children was intended to be the option of last resort.²⁴ The national framework legislation was also intended to authorise negotiations with Indigenous communities on the transfer of legal jurisdiction in relation to children's welfare, care and protection, adoption, and juvenile justice to an Indigenous community, region or representative organisation, as well as transferring judicial and departmental functions, relationships relating to police and the court system, and the funding and other resourcing of programs and strategies relating to children and young people.²⁵

These recommendations of the *Bringing Them Home Report* were not implemented. Inquiries conducted since *Bringing Them Home*, including in NSW, have continued to refer to self-determination, although there has not always been in-depth discussion on the real meaning of the term or its implementation in practice. For example, the NSW Legislative Council General Purpose Standing Committee No 2 recommended in their 2017 Child Protection Inquiry that the NSW Government commit to working across NSW with Aboriginal communities, as well as Aboriginal organisations such as Grandmothers Against Removals (GMAR), to provide a far greater degree of Aboriginal self-determination in decisions on supporting families, child protection and child removals.²⁶ This does not reflect a strong form understanding of self-determination or sufficiently comprehend the ambit of the right.

The current child protection framework in NSW uses the language of self-determination. Section 11 of the *Care Act* indicates that Aboriginal and Torres Strait Islander people 'are to participate in the care and protection of their children and young people with as much self-determination as possible'.²⁷ The section also provides that the Minister may 'negotiate and agree with Aboriginal and Torres Strait Islander people to the implementation of programs and strategies that promote self-determination'.²⁸ Self-determination is not defined in the legislation.

Beyond the legislation, there are further references to self-determination in recent policy documents published by FACS. For example, in a factsheet on the child protection system released in December 2018, FACS noted that:

21 Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997) ch 26.

22 Ibid recs 43a-53b.

23 Ibid rec 43a.

24 Ibid rec 43b.

25 Ibid rec 43c.

26 NSW Legislative Council General Purpose Standing Committee No. 2, *Child Protection* (2017), rec 18.

27 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 11(1).

28 Ibid s 11(2).



The NSW Government remains committed to working with Aboriginal communities and Aboriginal organisations across NSW to increase Aboriginal self-determination and Aboriginal participation in child protection decision-making.²⁹

Similarly, the 2019 FACS *Aboriginal Case Management Policy* refers to ‘case management that values community involvement, including self-determination’. This policy defines self-determination as

the collective right of communities to freely pursue their economic, social and cultural development, and to develop and implement their own processes, services, supports and frameworks that sit around Aboriginal children and families.³⁰

Inaccurate use of the term

While it may appear positive that the language of self-determination is used in law and policy in NSW child protection, its use, without the appropriate structural recognition, creates unrealistic expectations about what the state will permit in terms of autonomous arrangements. As outlined above, the right to self-determination is the right to freely determine political status and economic, social and cultural destiny. As the recommendations in the *Bringing Them Home Report* make clear, meaningful self-determination involves the devolution of power from the state to Indigenous peoples (strong form self-determination).

When the department refers to self-determination in practice and policy, it is not with this robust understanding of the term in mind. Self-determination involves more than Aboriginal ‘participation’ in decision-making³¹ and case management that ‘values’ self-determination sets an extremely low bar in which power is retained by the state.³² There has been much concern internationally concerning the way in which United Nations member states have tried to diminish the right to self-determination as recognised in UNDRIP, rendering it a merely procedural right or the right to free, prior and informed consent.³³

Put another way, meaningful self-determination is not about the state granting Aboriginal communities the ‘permission’ to develop and implement support services; it is about recognising that Aboriginal families have the right to be free from unwarranted state interference and the right to respond appropriately to issues within their communities. Meaningful self-determination also recognises that Aboriginal people have been negatively affected by over two centuries of colonisation and require financial and other support to develop and implement services to ameliorate their socioeconomic disadvantage.

In this way, self-determination touches upon the need to recognise ‘intergenerational trauma’. In their submission to our Review, GMAR NSW spoke to the realities of intergenerational trauma and oppression, and its consequences:

The legislative and systemic reforms that have been and continue to be proposed to address the problems of the system—such as those laid out recently in the Shaping a

29 Department of Family and Community Services (NSW), *Factsheet 2* (December 2018).

30 Department of Family and Community Services (NSW), *Aboriginal Case Management Policy 2019* (online, 30 June 2019) <<https://www.facs.nsw.gov.au/families/permanency-support-program/aboriginal-case-management-policy/chapters/principles>>.

31 Department of Family and Community Services (NSW), *Factsheet 2*, (December 2018).

32 Department of Family and Community Services (NSW), *Aboriginal Case Management Policy 2019* <<https://www.facs.nsw.gov.au/families/permanency-support-program/aboriginal-case-management-policy/chapters/principles>>.

33 Human Rights Council, *Draft study on Free, Prior and Informed Consent: A human rights based approach*, UN Doc A/HRC/EMRIP/2018/CRP.1 (5 July 2018).

Better Child Protection System discussion paper—are superficial changes. They will not make a difference to the realities of the NSW child protection system that our communities face every day on the frontlines of service provision—the frontlines of fighting to live and to heal from long-term oppression and suffering. Reforms such as these completely ignore the fact that the injustices of the system are far more deeply embedded in frontline staff and the logic of the system than the proposed changes address.³⁴

Further, and as noted previously, self-determination is not simply about ‘consultation’ and ‘participation’. In its submission to the Review, AbSec highlighted that recent FACS investment in intensive family preservation services fell short of meaningful self-determination. AbSec noted that, as part of that investment, international models were selected and imposed on Aboriginal communities. AbSec critiqued this approach, noting that:

While Aboriginal organisations were invited to participate in service delivery of these models, and many organisations accepted this invitation recognising it as the only opportunity to deliver much-needed family supports to their communities, Bringing Them Home clearly articulated that this approach does not rise to the NSW Government’s statutory obligation to Aboriginal self-determination.³⁵

In its submission to this Review, AbSec described self-determination as ‘the collective right of Aboriginal communities to make decisions, through their own processes, and carry them through to implementation’. It pointed to ‘the fundamental failure of the NSW Government’ to recognise this right—namely, its ‘failure to enshrine genuine Aboriginal self-determination into the child and family system’.³⁶ Similarly, Aunty Glendra Stubbs and Elizabeth Rice highlighted that the real barrier to effective reform in Aboriginal child protection is an incorrect application of self-determination. Specifically, their submission pointed to the unwillingness of Australian governments to ‘share power’ with Aboriginal and Torres Strait Islander peoples and noted the way this precluded any real improvement to the system, emphasising that:

The retention, within FACS or any government agency, of responsibility for the protection and care of Aboriginal and Torres Strait Islander children and young people is a major risk to good outcomes for them’.³⁷

What self-determination means in practice was succinctly summarised in their submission: no improved child protection system can meet the needs of Aboriginal and Torres Strait Islander children unless ‘it is planned, developed, managed, implemented and reviewed by Aboriginal people themselves’.³⁸

34 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 2.

35 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 21.

36 Ibid 5.

37 Aunty Glendra Stubbs and Elizabeth Rice, Submission No 1 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 5.

38 Ibid.



no improved child protection system can meet the needs of Aboriginal and Torres Strait Islander children unless 'it is planned, developed, managed, implemented and reviewed by Aboriginal people themselves'.

Stakeholder views

In submissions to the Review, a number of stakeholders supported a more fulsome vision of self-determination than the current NSW approach, including the National Congress of Australia's First Peoples,³⁹ the Benevolent Society,⁴⁰ the Secretariat of National Aboriginal and Islander Child Care (SNAICC),⁴¹ and AbSec.⁴² SNAICC's submission summarised the core elements of its Family Matters Roadmap⁴³ as 'prevention and early intervention, enabling genuine Aboriginal and Torres Strait Islander participation in decision-making, and pursuing culturally safe and accessible services designed and delivered by community-controlled organisations in a manner aligned with self-determination'.⁴⁴ Specifically, SNAICC supported the vision of self-determination articulated by AbSec.

As noted previously, to translate the principle of Aboriginal self-determination into meaningful practice in the NSW child protection space, AbSec proposed the establishment of a legislative Aboriginal commissioning and oversight body.⁴⁵

AbSec argued that this body should undertake the following:

- Genuine commissioning for outcomes for Aboriginal child and family services through Aboriginal community-controlled mechanisms across government departments. This would facilitate an integrated service response, as well as facilitate investment in areas of need to address child welfare, wellbeing and protection matters;
- Establishing and applying Aboriginal-led standards for services delivered to Aboriginal children, families and communities;
- Investing in and supporting local Aboriginal communities to design Aboriginal child family services in partnership with Aboriginal community-controlled organisations (ACCOs), aligned to those standards; and

39 National Congress of Australia's First Peoples, Submission No 22 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, January 2018, 1.

40 The Benevolent Society, Submission No 7 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 3.

41 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 4.

42 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 16.

43 The Family Matters Roadmap is a SNAICC-led, collaborative initiative of the Family Matters campaign's national steering committee, the Family Matters Champions Group. It outlines evidence-based strategies to meet the *Family Matters: Strong Communities, Strong Culture. Stronger Children* campaign's goal to eliminate Aboriginal over-representation in OOH by 2040: see Family Matters Champions Group, *The Family Matters Roadmap* (August 2016).

44 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 1.

45 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 16.

- Overseeing service system responses to Aboriginal children, their families and communities and reporting outcomes of these responses directly to Aboriginal communities—including the ongoing monitoring, systemic improvement and practice development of the NSW Government in delivering their child protection statutory functions.⁴⁶

AbSec made further specific suggestions for the functions of such a body. It suggested that this body engage with ACCOs in every matter where a child is believed to be Aboriginal, for example, overseeing safety and wellbeing goals and placement decisions. The new statutory body could also provide consistent practice guidance and contribute to the oversight and development of an (international and local) evidence base to drive systems accountability and continual service improvement. The new body could also be involved in decision-making such as assessing the possibility of restoration and endorsing case planning and care planning. It could have the power to appear as *amicus curiae* in Children’s Court matters. It could also be involved in the review and support full compliance with all five elements of the ACPP.⁴⁷

AbSec anticipated that such a body would be established in partnership with Aboriginal communities and would be led by a board of Aboriginal people appointed through an appropriate process, ensuring relevant expertise, experience and authority for community confidence.⁴⁸ AbSec pointed to the proposed Aboriginal Cultural Heritage body as a potential model for the development of a statutory body for the Aboriginal child protection in NSW. The proposed new governance structure for cultural heritage would sit under the strategic oversight of the relevant Minister and receive operational support from agencies. It would have the power to make decisions about Aboriginal cultural heritage, informed by local consultation panels.⁴⁹

AbSec suggested that establishing such a body in the Aboriginal child protection space could be a crucial first step in ensuring self-determination, noting that

by empowering Aboriginal people to make decisions about Aboriginal children through their own processes, genuine self-determination will become a key feature of the NSW statutory child protection system, rather than a promise that lives in a vacuum.⁵⁰

Several stakeholders such as Women’s Legal Services, Barnados and SNAICC, similarly raised the need for greater resourcing of ACCOs as one way to effect self-determination and strongly encouraged the NSW government to work in closer partnership with ACCOs.⁵¹ To this point the NSW Council of Social Services submitted that:

There needs to be a fundamental shift in the current approach to child protection that focuses on crisis and statutory intervention. We need to address the fundamental issue of the well of poverty, disadvantage and intergenerational trauma that disproportionately impacts on the safety, welfare and wellbeing of Aboriginal children and young people, their families and communities. ... Aboriginal families and communities must be

46 Ibid.

47 The ACPP is discussed further in Part E.

48 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 16.

49 Ibid 18.

50 Ibid 19.

51 Women’s Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017; Barnados Australia, Submission No 2 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017; Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.



involved in decision-making about the care and protection of their children. Aboriginal community-controlled agencies are best placed to support Aboriginal children and young people in OOHC, including maintaining their connection to family, community, culture and Country that is central to identity development and wellbeing.⁵²

Any expansion in the role of ACCOs would need to be supported by additional funding, in particular to provide ‘appropriate supports to kinship carers and families providing the day-to-day nurturing care of Aboriginal children and young people’.⁵³

Stakeholders also critiqued FACS’ approach to self-determination in current policy and practice. For example, SNAICC critiqued FACS’ Family Group Conferencing (FGC) model, suggesting that ACCOs could play a greater role within these processes to effect more meaningful self-determination. SNAICC also referenced statistics, which are not publicly available, noting that while the total number of FGCs convened in the year 2016–17 was 351,⁵⁴ and 226 of those referrals were for Aboriginal families, only 16 of the 100 FGC facilitators were Aboriginal.⁵⁵ This is a concerning finding. SNAICC further indicated that Aboriginal models, such as ‘Connecting Voices’, which is run by AbSec, are being

undermined by the Department-controlled approach of FGC, an approach that is not ACCO designed, led, or delivered and so not suited to engaging and enabling Aboriginal and Torres Strait Islander child and family participation. Instead, FGC as set out above, is managed and facilitated by the Department, a key problem and obstacle in effective and culturally safe and accessible participation of children, family, and community in decision-making processes.⁵⁶

In their submission to the Review, Aunty Glendra Stubbs and Elizabeth Rice pointed to the Victorian Government taking the lead in initiating dialogue with Aboriginal and Torres Strait Islander peoples on developing a treaty in that state and suggested that the NSW Government could initiate similar dialogue in the area of child protection.⁵⁷ They suggested that this might be done through the voices of First Nations, or within the COAG framework envisaged by the *Bringing Them Home Report* as playing a role in monitoring recommendations of that report (although no such framework was ultimately implemented). They also suggested that this work build on the work of GMAR NSW.⁵⁸ Aunty Glendra Stubbs and Elizabeth Rice also endorsed the recommendations related to self-determination in the *Bringing Them Home Report*, suggesting that the states and territories should act immediately to implement these recommendations.⁵⁹

Finally, Aunty Glendra Stubbs and Elizabeth Rice noted that the major barrier to achieving self-determination appeared to be ‘the lack of either the will or the capacity of the settler-colonial state to accept’ that the cultures of the First Nations have their own legitimate logic, as well as effective systems and practices that flow from and reinforce that logic. They noted that First

52 NSW Council of Social Service, Submission No 9 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 2.

53 Ibid.

54 Following 527 referrals.

55 Family Group Conferencing is discussed further in Chapter 19.

56 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 15.

57 Aunty Glendra Stubbs and Elizabeth Rice, Submission No 1 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 5.

58 Ibid.

59 Ibid.

Nations have had over 200 years of experience in preserving and adapting their cultures within the evolving framework of Australia today and that Aboriginal people are the experts on how power can be shared so that their cultures can maintain their integrity.⁶⁰

What do other jurisdictions tell us about child protection?

The following section briefly surveys some limited examples of the international experience on child protection, as well as some examples from within Australia. There are always limitations to comparative examples, particularly when it comes to advocating for the replication of international models of self-determination within child protection systems that derive from strong forms of recognition.⁶¹ As Australia does not have any historical treaty or post-colonial treaty agreement, this section regarding the international experience should accordingly be treated with some caution.

Canada

Canada has a history of forced child removals. Like Australia, Canada is a federation and its child protection legislation has historically been administered by its provinces (in an arrangement similar to Australia's state jurisdiction).⁶² In late February 2019, Bill-92 was introduced into the federal House of Commons in Canada.⁶³ This Bill was introduced as part of the Canadian Government's commitment to implement the UNDRIP. If passed into law, this Bill would transfer jurisdiction over child and family services to First Nations, Inuit and Métis Nations people.

The Preamble to this Bill, still before the Canadian Parliament at the time of the Review, explicitly recognises the legacy of residential schools in Canada, and the harm, including intergenerational trauma, caused to Indigenous peoples by colonial policies and practices. It recognises the importance of reuniting Indigenous children with their families and the communities from which they were separated in the context of the provision of child and family services. Crucially, it affirms Indigenous peoples' right to self-determination, including the inherent right of self-government, which is defined in the draft legislation as including jurisdiction in relation to child and family services. This approach goes beyond mere 'participation and consultation' and is an example of a state recognising that Indigenous peoples have an inherent right of self-government at international law.

The Review understands that the proposed Canadian approach is federal and that the NSW Government is constrained by its state powers. However, current developments in Canada illustrate what may be possible in a system of government that is analogous to Australia. The Canadian Bill contains further features of interest to this issue, including incorporating cultural continuity in the meaning of the best interests of the child.

60 Ibid.

61 Such as recognition of tribal sovereignty in the United States of America or child protection mechanisms in Canada, which derives from constitutional recognition in s 35 of the Canadian Constitution.

62 Further information about Canadian history and relevant governance can be found in the recent Canadian Truth and Reconciliation Commission report, *Honouring the Truth, Reconciling for the Future*, which was delivered in 2015. See Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada* (Summary of Final Report, 2015).

63 Canadian Parliament, *Bill-92 An Act respecting First Nations, Inuit, and Métis Children* <Youth and Families <http://www.parl.ca/DocumentViewer/en/42-1/bill/C-92/first-reading>>.



United States

The United States *Indian Child Welfare Act of 1978* (ICWA) is often discussed in the literature as a model reflecting better Indigenous decision-making in child and family services.⁶⁴ The ICWA is national legislation which transfers legislative, administrative and judicial decision-making to Indian groups when children are living on a reserve. Indian children who do not live on a reserve are subject to United States state arrangements, although there are a number of intergovernmental child agreements relevant to this. These arrangements are discussed at length in Chapter 26 of the *Bringing Them Home Report* and this discussion is not replicated here. Australian governance arrangements can be distinguished from the United States as Australia does not recognise tribal courts and treaties.

Australian states

The Victorian government has committed to a fuller expression of self-determination than that currently supported in NSW.⁶⁵ With respect to child protection, Victoria has legislatively delegated certain child protection functions to ACCOs under the *Children, Youth and Families Act 2005* (Vic). Section 18(1) of the Act provides that the Secretary may authorise the principal officer of an Aboriginal agency to perform specified functions and exercises related to protection orders for Aboriginal children. Against the backdrop of the state-wide commitment to self-determination, the Victorian Government has also commenced implementation of the 'Transitioning Aboriginal Children to ACCOs Program'.⁶⁶ The intention behind this program is to gradually transfer the responsibility and case management for Aboriginal children and young people in OOHC from government and non-Aboriginal Community Service Organisations (CSOs), to ACCOs.

Other positive developments include the establishment of a statutory role of an Aboriginal Child Commissioner in Victoria and the intended establishment of such a role in South Australia. This commissioner function sits within the greater system, providing for greater input of Aboriginal voices into state child protection systems, however this remains a very weak version of self-determination and should not be the preferred approach in NSW.

Recommendation 6: The Department of Communities and Justice should engage Aboriginal stakeholders in the child protection sector, including AbSec and other relevant peak bodies, to develop an agreed understanding on the right to 'self-determination' for Aboriginal peoples in the NSW statutory child protection system, including in any legislative and policy change.

Recommendation 7: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and communities, undertake a systemic review of all policies that refer to self-determination to consider how they might be revised to be consistent with the right to self-determination.

64 *Indian Child Welfare Act of 1978* 25 U.S.C §§ 1901-1963 (1978).

65 Victorian Government, *Self-Determination Factsheet* (2015) (online, 30 June 2019) <https://w.www.vic.gov.au/system/user_files/Documents/av/Aboriginal_Self-determination_Fact_Sheet.pdf>.

66 Department of Human Services (Vic), *Changes to the care and case management of Aboriginal children involved with Child Protection: Factsheet for Carers* (2017) <https://www.fcav.org.au/images/carers-resources/articles-publications/TACT_Factsheet_for_carers.pdf>.

Recommendation 8: The NSW Government should, in partnership with Aboriginal stakeholders and communities, review the Aboriginal and Torres Strait Islander Principles of the *Children and Young Person (Care and Protection) Act 1998* (currently sections 11-14), with the view to strengthening the provisions consistent with the right to self-determination.



8. Public accountability and oversight

But there can be no assurance that government is carried out for the people unless the facts are made known, the issues publicly ventilated. Sometimes, inevitably, those involved in the conduct of government, as in any other walk of life, are guilty of error, incompetence, misbehaviour, dereliction of duty, even dishonesty and malpractice. Those concerned may very strongly wish that the facts relating to such matters are not made public. Publicity may reflect discredit on them or their predecessors. It may embarrass the authorities. It may impede the process of administration. Experience however shows, in this country and elsewhere, that publicity is a powerful disinfectant.⁶⁷

Introduction

Child protection workers are responsible for protecting children from harm, abuse and neglect. To assist them in this difficult task, they have been granted legislative powers which enable them to override a number of important human rights, including the right to be protected against arbitrary or unlawful interference with the family⁶⁸ (which includes interference with Aboriginal kin),⁶⁹ and the right of a child not to be separated from his or her parents.⁷⁰ They also possess other significant legislative powers, such as the power to enter any premises where a child may be at immediate risk of serious harm in order to remove the child;⁷¹ to enter and search a premises for a child (with a warrant);⁷² and to use reasonable force when exercising these functions.⁷³ Many of the powers given to child protection workers rely on an element of discretion—that is, they are based on the caseworker’s assessment of whether or not a child is at risk of significant harm (which in turn requires discretionary and subjective assessments of the child’s safety and wellbeing).

one enduring and consistent theme that ties together all the criticisms that have been identified in these different fields—the absence of public accountability among those who hold power to make decisions.

The number of reviews and inquiries into child protection systems in Australia hovers around the half century mark and after no improvements since landmark Royal Commissions into the suffering of children (be they in families, out-of-home care (OOHC), or detention centres). Considering this, this Review seeks to underline one enduring and consistent theme that ties together all the criticisms that have been identified in these different fields—the absence of public accountability among those who hold power to make decisions.

Given the importance of the caseworker’s role, the rights that a caseworker can affect and

67 *R v Shayler* [2003] 1 AC 247, [21].

68 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 17.

69 UN Human Rights Committee definition of ‘family’ see *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 17.

70 *Convention on the Rights of the Child*, 20 November 1989, [1991] ATS 4, (entered into force generally on September 1990) art 9. Note that these legislative powers do not violate these human rights when they are used to protect a child from harm and when they are exercised in the best interests of the child.

71 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 43.

72 *Ibid* s 233.

73 *Ibid* s 240.

the powers the caseworker can exercise, it is injudicious that there are so few accountability mechanisms for DCJ staff. The situation in Australia can be contrasted with that in other similar Western federal jurisdictions. For example, in the United States of America, child protection agencies are subject to oversight by multiple agencies and individuals who are involved in monitoring their work, including Guardians ad Litem (court advocates), the courts (which engage in six monthly reviews of each child in care)⁷⁴ and citizen review panels.⁷⁵

In addition to DCJ staff, employees in the non-governmental OOHC sector also possess many significant powers relating to ‘case management’ of children in OOHC, including the power to determine the carer with whom a child is placed with, how much contact a child will have with their family (including siblings) and, in the case of residential OOHC providers, the conditions in which a child will live. While there are some existing oversight mechanisms in place to oversee the OOHC sector, they are deficient and unsatisfactory. In particular, they lack effectiveness, transparency, independent oversight and coordination.

existing oversight mechanisms in place to oversee the OOHC sector, lack effectiveness, transparency, independent oversight and coordination.

This chapter examines the existing accountability and oversight mechanisms for the NSW child protection system. After providing a brief overview of the nature and importance of public accountability, it outlines the current mechanisms that are in place to provide accountability in the child protection system. It then highlights numerous deficiencies with the existing accountability scheme and recommends several significant reforms that, if implemented, will greatly improve the entire system by reducing secrecy, improving transparency, encouraging compliance with legislation and policy, stimulating discussion and reform, and enhancing access to justice.

What is accountability?

Government accountability has been dubbed the ‘hallmark of modern democratic governance’.⁷⁶ It is the means by which the voting public can assess the ‘fairness, effectiveness and efficiency of governance’⁷⁷ and provides a safeguard against ‘corruption, nepotism, abuse of power, and other forms of inappropriate behaviour’.⁷⁸ Importantly, accountability has been found to help to improve the performance of government (by encouraging open discussion and public participation), and enhance its overall legitimacy. Finally, government accountability has been

74 *Adoption Assistance and Child Welfare Act* 42 USC §§ 672(A)(2)(a)(II), 675(5)(b) and 675(5)(E)(iii).

75 *Adoption Assistance and Child Welfare Act* 42 USC § 5106(A) (1980); Wendy Blome and Sue Steib ‘An Examination of Oversight and Review in the Child Welfare System: the Many Watch the Few Serve the Many’ (2008) 1(3) *Journal of Public Child Welfare* 3; Kathleen G. Noonan, Charles F. Sabel, and William H. Simon, ‘Legal Accountability in the Service-Based Welfare State: Lessons from Child Welfare Reform’ 2009) 34(3) *Law and Social Inquiry*, 523.

76 Mark Bovens, ‘Public Accountability’ in Ewan Ferlie, Laurence E Lynn & Christopher Pollitt (eds) *The Oxford Handbook of Public Management* (Oxford University Press, 2007) 182; Monika Djerf-Pierre, Mats Ekstrom and Bengt Johansson, ‘Policy Failure or Moral Scandal? Political Accountability, Journalism and New Public Management’ (2013) 25(8) *Media, Culture & Society* 960, 961.

77 Jane Davison, ‘Visual Accountability’ in Mark Bovens, Robert E. Goodin, Thomas Schillemans (ed), *The Oxford Handbook of Public Accountability* (OUP, 1st ed, 2014) 193.

78 *Ibid.*



said to provide ‘public catharsis’ in the rare case of a tragedy or other significant failure in governance.⁷⁹

While the importance of accountability is not disputed, the term is notoriously hard to define with any precision.⁸⁰ Nevertheless, it is possible to identify the key aspects of accountability. Open government scholar Jennifer Shkabatr, argues that public accountability has two core components: ‘the explanation and justification of agencies’ activities to the public, and an accompanying mechanism for public sanctions’.⁸¹ In other words, in order for an agency to be accountable to the public, it is essential for it to be transparent so that its performance can be discussed and analysed,⁸² and for there to be sanctions for poor performance.⁸³

Existing oversight bodies and accountability mechanisms

DCJ is, of course, subject to the typical accountability channels of any government department. The Minister for DCJ is accountable to Parliament, while public servants within DCJ are accountable to the Minister (and other external bodies).⁸⁴ DCJ is also subject to the *Government Information (Public Access) Act 2009* (NSW), which imposes obligations on it to proactively release a range of information and respond to applications for access to information. The following section does not address these typical accountability channels in any detail. Instead, it examines the major accountability mechanism that exists specifically for DCJ staff—that is, the existing scheme established for handling complaints from children and families who have contact with child protection workers—before examining some of the bodies set up to oversee the operation of the child protection system as a whole. It then provides a brief overview of three further accountability mechanisms—data collection and publication, judicial oversight and media commentary.

The complaints handling system

Currently, if an Aboriginal parent, extended family member or child has a complaint about the conduct or actions of a DCJ caseworker or manager, the website directs the person to contact the ‘Enquiry, Feedback and Complaints Unit’ by telephone, email or mail (and provides these contact details). It also notes that, alternatively, the person may contact their local Community Services Centre.⁸⁵ If the complaint is about an OOH provider, the complaint may be made to DCJ, which will then refer it to the service provider. The service provider will then ‘manage complaints in accordance with their service agreements with FACS, and in line with relevant legislations, industry practices and standards’.⁸⁶ There is no charge for the complaint and it may

79 Ibid.

80 Monika Djerf-Pierre, Mats Ekstrom and Bengt Johannson, ‘Policy Failure or Moral Scandal? Political Accountability, Journalism and New Public Management’ (2013) 25(8) *Media, Culture & Society* 960, 963.

81 Jennifer Shkabatr, ‘Transparency with(out) accountability: Open Government in the United States’ (2012) 31(1) *Yale Law and Policy Review*, 82.

82 Ibid 83.

83 See Mark Bovens, ‘Public Accountability’ in Ewan Ferlie, Laurence E Lynn & Christopher Pollitt (eds) *The Oxford Handbook of Public Management* (Oxford University Press, 2007) 182, 185.

84 Richard Mulgan, ‘The Processes of Public Accountability’ (1997) 56(1) *Australian Journal of Public Administration* 25, 28

85 Department of Family and Community Services (NSW) *Complaints and Feedback* <<https://www.facs.nsw.gov.au/about/contact/complaints>>.

86 Department of Family and Community Services (NSW), *FACS Complaints and Feedback Management Policy* (2018) 9.

be made anonymously.⁸⁷ Generally a complaint will be dealt with within 20 business days.⁸⁸ In addition, a complaint about an OOHC provider can be made to the NSW Ombudsman.⁸⁹

The information about the department's complaints handling process is scant. The website contains a link to the *FACS Complaints and Feedback Management Policy* (a policy introduced during this Review),⁹⁰ which (once downloaded and read carefully) advises that complaint handling process is a three-step process. First, the complainant is to contact 'the relevant business area', which will review and resolve the complaint 'in accordance with ... [its] own complaints handling policies, procedures, guidelines, timeframes as appropriate; and in accordance with the provisions of this Policy'.⁹¹ If unsatisfied with the decision of the business area, the complainant can request a review of the initial decision from the same business area. Finally, if unsatisfied with the review of the decision, the complainant may refer the matter to the NSW Ombudsman.

The *FACS Complaints and Feedback Management Policy* defines a business area as 'usually a Directorate within a Division/Entity of FACS, headed by a Director or Executive Director'.⁹² However, it is unclear from this policy, or any information on the website, what business units exist within FACS, which of these have their own complaints-handling policies, and what these policies contain. However, as noted above, the website states that complaints about child protection matters are to be made to the Enquiry Feedback and Complaints Unit (EFCU), a unit which 'provides a centralised intake and referral point for feedback relating to child protection services, including FACS-funded NGOs'.⁹³ Thus it may be presumed that the EFCU is the relevant business unit.

The *FACS Complaints and Feedback Management Policy* sets out principles to be applied by all business areas when handling complaints.⁹⁴ These principles mirror the 'commitments' set out in the NSW Government's Complaint Handling Improvement Program.⁹⁵ One principle is the principle of 'respectful treatment', which includes a commitment to ensure 'that the person handling a complaint is different from any staff member whose conduct or service is being complained about', and that 'no unfair treatment comes from making a complaint or providing feedback'.⁹⁶ Another is the principle of 'transparency', which includes a commitment to 'record, review and report on complaints handling data as part of our commitment to continuous improvement'.⁹⁷

Despite the stated commitment to report on complaints handling data, it is very difficult to locate any further information about the department's complaints handling activities. In fact,

87 Ibid 11.

88 Ibid 10.

89 NSW Ombudsman *Complaints about community services* <<https://www.ombo.nsw.gov.au/what-we-do/our-work/community-services/complaints-about-community-and-disability-services>>.

90 Introduced on 30 September 2018. This may have replaced the previous (unpublished) policy set out in the *Enquiry, Feedback and Complaints Unit Procedure Manual*: see Senate Community Affairs References Committee Report: *Out-of-home care*, (August 2015), 8.74.

91 Department of Family and Community Services (NSW), *FACS Complaints and Feedback Management Policy* (2018) 5.

92 Ibid.

93 Department of Family and Community Services (NSW), *Annual Report 2017-18* (Report, 2018) 73.

94 Note, although business units are defined in the policy as 'usually a Directorate within a Division/Entity of FACS, headed by a Director or Executive Director', it is unclear what business unit exist, which of these have their own complaints-handling policies, and what these policies contain.

95 NSW Ombudsman, *Complaint Handling Improvement Program: Commitments Implementation Review* (Report, 31 August 2018) 3, 30.

96 Department of Family and Community Services (NSW), *FACS Complaints and Feedback Management Policy* (2018) [5.1.1].

97 Ibid [5.1.6].



the department publishes extremely limited information about this area of practice. In its 2017–2018 Annual Report, FACS stated that Community Services had received ‘feedback’ 525 times in that reporting year. It is only through a later statement about there being an ‘increase of 51 formal complaints for 2017–18’ that it becomes apparent that the ‘feedback’ is being used synonymously with ‘formal complaint’.⁹⁸ The Annual Report breaks down the type of ‘feedback’ into categories such as ‘behaviour of staff’ and ‘communication’, but does not provide further categories which would shed light on the nature of the complaints. It does not report on how many complaints were resolved internally or how many were escalated to the Ombudsman. Further, it doesn’t provide any information about the breakdown of complaints in different FACS Districts. The department’s failure to interrogate complaints data methodically and critically represents a lost opportunity to promote one of the key requirements of good governance—continuous improvement through critical self-analysis of performance. The department’s Annual Reports should identify specific areas for improvement based on complaints and a plan for how that improvement will be achieved. Reports of progress towards these goals should be contained in the next year’s Annual Report.

The NSW Ombudsman

The NSW Ombudsman also plays an important role in the child protection complaint handling system. An Ombudsman is an independent agency that oversees government agencies (and some NGOs) in order to promote ‘good conduct, fair decision making, the protection of rights, and the provision of quality services’.⁹⁹ The NSW Ombudsman receives complaints about the administrative actions of DCJ staff, as well as non-government agencies funded by DCJ (including foster care and residential OOHc services).¹⁰⁰

In 2017–18, the NSW Ombudsman received 430 formal and 590 informal complaints about child and family services.¹⁰¹ This represented a slight decline in the number of complaints made in the previous financial year (476).¹⁰² The vast majority of the formal complaints were about child protection (50%) and the OOHc sector.¹⁰³ Complaints covered the gamut of child protection activities and included complaints about poor casework, customer service, complaint management, decision-making and case management.¹⁰⁴ In this reporting period, the Ombudsman finalised 450 formal complaints and 582 informal complaints.¹⁰⁵

However, it is important to note that the Ombudsman does not necessarily investigate all complaints that it receives. The Ombudsman can decline to investigate a complaint if the events are more than 12 months old ‘and there are no current issues’, or if the issues have been (or could be) considered by a court.¹⁰⁶ The Ombudsman’s fact sheet on complaints about child protection notes that ‘sometimes, when the problem is not resolved or *we think the problem is very serious*, we can formally investigate or refer the complaint to the agency for

98 Department of Family and Community Services (NSW), *Annual Report 2017–18*, (Report, 2018) 73.

99 NSW Ombudsman, *Annual Report 2007–08* (Report, 2008) 17.

100 NSW Ombudsman, *Complaints About Child Protection and Other Child and Family Services Factsheet* <https://www.ombo.nsw.gov.au/data/assets/pdf_file/0008/64862/Complaints-about-child-protection-and-other-child-and-family-services.pdf>.

101 Department of Family and Community Services (NSW), *Annual Report 2017–18* (Report, 2018) 93.

102 NSW Ombudsman, *Annual Report 2007–08* (Report, 2008) 94.

103 Ibid 93.

104 Ibid 94–95.

105 Ibid 94.

106 NSW Ombudsman, *What Happens When You Complain?* (Web Page) <<https://www.ombo.nsw.gov.au/what-we-do/our-work/community-services/complaints-about-community-and-disability-services>>.

investigation'.¹⁰⁷ In its supplementary statistical data for 2017–2018, the NSW Ombudsman noted that it declined 211 formal complaints about child and family services at the outset (or 47% of all formal complaints finalised for child and family services in 2017–2018). It is unclear on what basis the Ombudsman declined to investigate these complaints.

The NSW Ombudsman also has other functions relating to the oversight of the child protection system. For example, it coordinates the 'reportable conduct' scheme, which requires OOHC agencies to notify the Ombudsman of allegations of sexual, physical or psychological harm caused to children by employees of OOHC agencies.¹⁰⁸ It may publish a special report to Parliament (such as 2018 special report into the JIRT partnership).¹⁰⁹ It also reviews and monitors the deaths of children who die in OOHC.¹¹⁰

The NSW Ombudsman also oversees and coordinates the 'Official Community Visitors' scheme. Official Community Visitors, appointed under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW),¹¹¹ visit children in residential care throughout NSW (as well as people who live in disability supported accommodation and assisted boarding houses).¹¹² They may visit unannounced, and during the visit, they may inspect any documents of the residential OOHC provider and confer with children privately.¹¹³ Official Community Visitors can inform Ministers and the NSW Ombudsman about matters affecting residents, provide information and support to children to access advocacy services, and help resolve matters of concern informally with the OOHC provider. If the matter cannot be informally resolved, Official Community Visitors may refer it to the Ombudsman for investigation. Official Community Visitors may also provide the Children's Guardian with 'direct written reports that raise serious or systemic concerns about an agency's out-of-home care services'.¹¹⁴ The Ombudsman can also communicate with the OCG in this regard and has undertaken to 'provide the Children's Guardian with trend and pattern reports about agencies and service issues from the OCV Online system. These reports may be about the sector or particular agencies'.¹¹⁵

In 2017–2018, there were 297 'visitable OOHC services' which accommodated 740 children and young people in statutory and voluntary OOHC.¹¹⁶ Official Community Visitors made 740 visits to these services and identified 1,272 issues.¹¹⁷ The number of issues identified during visits to OOHC providers was higher than those identified in visits to disability supported accommodation or assisted boarding houses (an average of 4.3 issues per service, compared to 2.2 and 3.9 issues per service respectively for the other accommodation providers).¹¹⁸

107 NSW Ombudsman, *Complaints about community services* (Web Page) <<https://www.ombo.nsw.gov.au/what-we-do/our-work/community-services/complaints-about-community-and-disability-services>>. Emphasis added.

108 See *Ombudsman Act 1974* (NSW) pt 3A. Note the issue of harm to children in OOHC is considered in more detail in Chapter 14.

109 *Ombudsman Act 1974* (NSW) s 31. See NSW Ombudsman, *The JIRT Partnership—20 years on* (Report, 5 October 2018).

110 NSW Ombudsman 'Reviewable deaths' (Web Page) <<https://www.ombo.nsw.gov.au/what-we-do/our-work/community-services/reviewable-deaths>>.

111 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 7.

112 *Ibid* ss 4, 8.

113 *Ibid* s 8.

114 NSW Ombudsman, *Cooperative arrangements between the Children's Guardian, Ombudsman and Official Community Visitors* (Web Page) <https://www.ombo.nsw.gov.au/data/assets/pdf_file/0005/3776/IS_OCV-MoU_Jan11.pdf>.

115 *Ibid*.

116 NSW Ombudsman, *Official Community Visitors Annual Report 2017-2018* (Report, December 2018) 6.

117 *Ibid*.

118 *Ibid* 6, 8.



The Office of the Children's Guardian

The Office of the Children's Guardian is responsible for accrediting and monitoring all statutory OOHC providers.¹¹⁹ An agency is required to be accredited before it can receive funding to provide OOHC services. To be accredited, an OOHC provider must comply with relevant legislative requirements and the *NSW Child Safe Standards for Permanent Care* (2015) (the Standards).¹²⁰ If an agency has not provided OOHC services before, it is first required to apply for provisional accreditation for three years.¹²¹ Provisional accreditation is dependant on the agency demonstrating 'indirect evidence' of compliance (namely, policies and procedures). To achieve 'full accreditation', the agency, including any agency that is already accredited and is seeking re-accreditation, must provide both 'indirect' and 'direct' evidence of compliance with the legislation and Standards.¹²² Direct evidence may be obtained by reviewing the case files and records of children in OOHC, or surveying staff, carers, children and families.¹²³

Currently, there are 83 accredited OOHC providers (known as 'designated agencies').¹²⁴ Sixty of these are accredited for five years; eight for three years; and 10 are provisionally accredited. Five are the subject of a 'deferred decision'.¹²⁵ Two of these have only ever been provisionally accredited, meaning they have never satisfied the accreditation criteria (and yet may have been providing OOHC services for over three years).¹²⁶ It is unclear from the OCG's annual reports or website how many have been accredited on the condition that they satisfy the accreditation criteria in the future. The notion of satisfying accreditation criteria in the future is mystifying when the state is the child's ostensible parent—in other words, the 'state-parent' may retain parental responsibility of the child, if it demonstrates that it can be a 'good parent' in three years time.

As noted above, the OCG is also responsible for monitoring the performance of OOHC providers. Between 2004 and 2013, case file audits were the principle tool used to monitor the performance of agencies and organisations providing statutory OOHC services in NSW.¹²⁷ The OCG's 'Case File Audit Program' was designed to help agencies improve their case practice; identify issues for the whole child protection sector; and expose areas requiring further research.¹²⁸ The OCG's Annual Reports outlined the number of case files audited, the target of the audit (for example, how agencies were meeting the health needs of children); and the overall results of the audit, including areas where compliance was acceptable (that is, over 80%

119 *Children and Young Persons (Care and Protection) Act 1998* s 181 (1)(e).

120 *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) cl 48, 49.

121 *Ibid* cl 49.

122 *Ibid* cl 53. Full accreditation can be for one, three or five years: see NSW Office of the Children's Guardian, *About Designated agencies* (Web Page) <<https://www.kidsguardian.nsw.gov.au/statutory-out-of-home-care-and-adoption/designated-agencies/about-designated-agencies>>.

123 NSW Office of the Children's Guardian, *Statutory Out-of-home Care and Adoption Services: Accreditation Guide* (Report, October 2018) 13.

124 NSW Office of the Children's Guardian, *About designated agencies* (Web Page) <<https://www.kidsguardian.nsw.gov.au/statutory-out-of-home-care-and-adoption/designated-agencies/about-designated-agencies>>.

125 NSW Office of the Children's Guardian, *Designated agencies* (Web Page) <<https://www.kidsguardian.nsw.gov.au/statutory-out-of-home-care-and-adoption/designated-agencies?RefineModule=2967&retain=true&StartTax=87>>.

126 *Ibid*.

127 NSW Office of the Children's Guardian Annual Reports in 2004–05; 2005–06; 2006–07; 2007–08; 2008–09; 2010–11; 2011–12; 2012–13: see NSW Office of the Children's Guardian, *Annual Reports* (Web Page) <<https://www.kidsguardian.nsw.gov.au/about-us/annual-reports>>.

128 See, for example, NSW Office of the Children's Guardian, *Annual Report 2004–05* (Report, 31 October 2005).

compliance with an audit item) or unacceptable.¹²⁹

In 2013, in response to the growth of non-governmental providers of OOHC services, the OCG announced it would develop a new 'risk-based Monitoring Program' that would include agency visits and inspections.¹³⁰ Today, the OCG conducts onsite compliance and monitoring assessments of designated agencies in NSW. Assessments consider outcomes for children and young people in a range of care domains and assess the management and operation of each organisation. Assessments include a broad review of records and discussions with staff.

Data collection and publication

The publication of data relating to the child protection system is of vital importance to ensure the accountability of DCJ and the non-governmental OOHC sector. The provision of information is 'implicit in the literal meaning of accounting, that is, giving an account to those to whom one is responsible and accountable, and whose authority gives them the right to demand such an account'.¹³¹ Without information in the form of data (both quantitative and qualitative), the public has no mechanism to analyse the performance of those entrusted with duties within the child protection system. This lack of data means that scholars, public interest groups and oversight bodies are limited in their capacity to assess the quality of the system and suggest reforms to improve it. Further, other governments cannot compare their performance with their counterparts in other jurisdictions and the media cannot interpret and disseminate the information to the wider public. In short, access to data about the child protection system is vital 'to foster responsible and representative government that is open, accountable, fair and effective'.¹³²

The nature and scope of the data currently collected, published and used by DCJ, is outlined in some detail throughout the report. The Review also makes recommendations to improve data collection and use, which will have several benefits one of which will be enhanced accountability.¹³³ In order to avoid repetition, these recommendations are not reproduced here.

**...access to data about the child protection system is vital
'to foster responsible and representative government that is
open, accountable, fair and effective.'¹³²**

Judicial oversight

An independent judiciary represents an important check on the power of government, particularly when the government is a litigant to proceedings. In NSW, the courts play an important role in ensuring the accountability of departmental staff and those involved in the

129 NSW Office of the Children's Guardian, *Annual Report 2004-05* (Report, 31 October 2005); NSW Office of the Children's Guardian, *Annual Report 2005-06* (Report, 31 October 2006); NSW Office of the Children's Guardian, *Annual Report 2006-07* (Report, 31 October 2007); NSW Office of the Children's Guardian, *Annual Report 2007-08* (Report, 31 October 2008); NSW Office of the Children's Guardian, *Annual Report 2008-09* (Report, 31 October 2009); NSW Office of the Children's Guardian, *Annual Report 2009-10* (Report, 30 October 2012); NSW Office of the Children's Guardian, *Annual Report 2010-11* (Report, 31 October 2011); NSW Office of the Children's Guardian, *Annual Report 2011-12* (Report, 31 October 2012); NSW Office of the Children's Guardian, *Annual Report 2012-13* (Report, 31 October 2013).

130 NSW Office of the Children's Guardian, *Annual Report 2012-13* (Report, 31 October 2013) 21.

131 Richard Mulgan, 'The processes of public accountability' (1997) 56(1) *Australian Journal of Public Administration* 25, 27.

132 Information and Privacy Commission, *Fact Sheet—Open Access Information for Citizens* (Web Page) <<https://www.ipc.nsw.gov.au/fact-sheet-open-access-information-citizens>>.

133 See, eg. Chapters 2 and 16.



OOHC sector.¹³⁴ First, when exercising their care and protection jurisdiction, judicial officers ensure that the department has complied with the legislative scheme governing the child protection system. When making decisions in care proceedings, the court can reverse the decisions of those involved in the child protection sector where it is appropriate (such as a decision about removal, restoration, contact and placement).

Importantly, when arriving at its decision, the court may comment on the actions of individual child protection caseworkers or the approach the Secretary of the Department of Communities and Justice has taken to the matter more generally. In several cases, the court has expressed its condemnation of FACS in very strong terms. For example, in a 2018 case, the Children's Court held that the Secretary's care plans were 'replete with significant factual errors' and noted that the Secretary's assessments of the harm to a child were 'based on a flawed, inadequate and one-sided assessment that did not withstand reasoned scrutiny'.¹³⁵ Similarly, in a 2017 case, the Children's Court held that the Secretary's decision to remove a child from the care of his maternal grandparents after approximately eight years and restore him to the care of his father (contrary to the child's wishes, the views of the expert witnesses and the submissions of the child's Independent Legal Representative), amounted to a 'gross error' and was based on an 'entrenched', 'immoveable' and 'unreasonable' view. Further, the evidence filed by the Secretary in the case was 'deliberately misleading', raised 'baseless allegations' and ventilated 'false issues'; and in the course of the proceedings the Secretary exhibited 'contumelious disregard for s 90 of the Act'.¹³⁶

In exceptional circumstances, such as those in the cases outlined above, the court may also order the department to pay the costs of the other party at the conclusion of litigation.¹³⁷ It does not, however, have the power to order costs against a third party, such as a non-governmental OOHC provider.¹³⁸

At this point, it is interesting to note that the legal system has been utilised to significantly increase the accountability of child protection services in other countries. In Canada, for example, a complaint was made that the Federal Government discriminated against First Nations children in contact with the child protection system (on the grounds of race and national ethnic origin) by not providing them with the same amount of funding as that provided to 'off-reserve' children.¹³⁹ Further, the complaint argued that the Federal Government had failed to ensure that First Nations children could access government services as easily as other children.¹⁴⁰ In January 2016, the Canadian Human Rights Tribunal upheld the complaint and made binding legal orders requiring the government to rectify its discriminatory practices.¹⁴¹ This 'marks the first time in history that a developed country has been held accountable for its

134 See Chapter 5 for an overview of the care and protection jurisdiction.

135 *Alice Mason and Reece Mason (No 2)* Children's Court (Care) 30 July 2018, 19.

136 *The Secretary, Department of Family and Community Services and Tyson Tanner (Costs)* [2017] NSWChC 1.

137 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 88; *Re: A Foster Carer v Department of Family and Community Services [No 2]* (2018) NSWDC 71; *SP v Department of Community Services* (2006) NSWDC 168; *Department of Community Services v SM and MM* (2006) NSWDC 68.

138 *Re: A Foster Carer v Department of Family & Community Services [No 2]* (2018) NSWDC 71; *In the matter of Mr Donaghy (Costs)* (2012) NSWChC 11.

139 This complaint was filed by the First Nations Child and Family Caring Society of Canada and the Assembly of First Nations under the *Canadian Human Rights Act*.

140 Cindy Blackstock, 'Social Movements and the Law: Addressing Engrained Government-based Racial Discrimination against Indigenous Children' (2015/2016) 19(1) *Australian Indigenous Law Report* 6, 9.

141 *First Nations Child and Family Caring Society of Canada v. Attorney General of Canada* (2016) CHRT 2.

discriminatory treatment of a current generation of Indigenous children before a body that can make binding legal orders'.¹⁴²

In the United States, concerns about the inability of oversight bodies and legislatures to effectively monitor and improve the performance of child welfare agencies led to the widespread use of class action litigation to drive reform and operate as an accountability mechanism.¹⁴³ Between 1995 and 2005, for example, child welfare class action litigation was launched by various organisations, such as the non-profit watchdog Children's Rights, in 32 different states.¹⁴⁴ To date, the litigation has been based on arguments about constitutional rights, or has relied on claims for 'injunctive relief to ensure that child welfare systems complied with federal statutory and constitutional law and with state law'.¹⁴⁵ If successful, class actions in the United States almost always result in a court order (generally entered by consent), which requires 'the child welfare agency to take specific actions, commit to specific improvements in system performance, and/or achieve certain outcomes'.¹⁴⁶ The court order is then monitored and reports on progress towards compliance with the order often generate media coverage and help maintain external pressure on the child welfare agency to continue to reform process.¹⁴⁷ If necessary, the plaintiff in class action litigation can return to the court for an enforcement action.¹⁴⁸

While the judiciary can provide an important check on the power of the state, as the following case study from NSW demonstrates, pursuit of legal remedies can be extremely costly, time consuming and stressful for those litigating against FACS.

142 Cindy Blackstock, 'Social Movements and the Law: Addressing Engrained Government-based Racial Discrimination against Indigenous Children' (2015/2016) 19(1) *Australian Indigenous Law Report* 6, 10.

143 Judith Meltzer, Rachel Molly Joseph and Andy Shookhoff, 'Introduction and Overview' in Centre for the Study of Social Policy, *For the Welfare of Children: Lessons Learned from Class Action Litigation* (2012) vi.

144 Child Welfare League of America, *Child Welfare Consent Decrees: Analysis of Thirty-Five Court Actions from 1995 to 2005*, (Report, October 2005) 2.

145 Judith Meltzer, Rachel Molly Joseph and Andy Shookhoff, 'Introduction and Overview', in Centre for the Study of Social Policy, *For the Welfare of Children: Lessons Learned from Class Action Litigation* (2012) vi.

146 Andy Shookhoff, 'Reflections on the Role of the Monitor in Child Welfare Litigation' in Centre for the Study of Social Policy, *For the Welfare of Children: Lessons Learned from Class Action Litigation* (2012) 23, 23.

147 Ibid.

148 Ibid.



Case Study: ‘Kirra’s’ story’¹⁴⁹

Kirra was removed from her birth mother when she was 10 days old and placed with Jane, a foster carer with nine years of experience. Jane was already caring for Kirra’s two older brothers (both of whom had been diagnosed with autism). In February 2010, FACS transferred responsibility for Kirra’s care to a non-governmental OOHC provider.

In late 2015, Jane took a pre-arranged leave of absence for an overseas trip. As part of an agreed respite support plan, Kirra and her brothers were left in the care of Kirra’s father. While Jane was away, her father contacted the police for help after Kirra’s brothers were said to be ‘roaming the streets’. When they were located by the police, Kirra’s brothers made allegations that Jane had mistreated them. The children were removed from Kirra’s father’s care and each placed with separate carers while an investigation was conducted into the allegations. Kirra’s brothers indicated that they did not wish to return to Jane’s care. There was unchallenged evidence that Kirra’s brothers had a history of lying about mistreatment.

Both FACS and the OOHC provider commenced investigations into the allegations. FACS concluded that Kirra would be at risk of harm if returned to Jane and the OOHC agency produced a report that substantiated the allegations made against Jane. The investigation by the OOHC agency was overseen by the NSW Ombudsman. At one point, the Ombudsman wrote a letter to the agency outlining deficiencies in the investigation and suggesting a number of additional lines of inquiry that should be pursued. The OOHC agency rejected these suggestions (for example, it rejected the suggestion that it interviewed the caseworker who had worked with Jane and Kirra for a substantial period of time because the caseworker no longer worked with the agency). The OOHC agency also refused to travel to interview certain witnesses because of the cost involved in that exercise.

At the conclusion of the investigations by FACS and the OOHC agency, Jane was informed that Kirra would not be returned to her care and her authorisation as a foster carer had been cancelled.

Jane filed an application in the Children’s Court seeking that Kirra be returned to her care. The hearing in the Children’s Court occurred over 4 days in late 2016.

On 28 July 2017 (almost 9 months after the conclusion of the hearing), the Children’s Court held that it would not be in Kirra’s best interests to be returned to Jane’s care. Jane then lodged an appeal against this decision in the District Court. After a comprehensive review of the evidence, the District Court held that the investigation report prepared by the OOHC provider was a ‘deeply and materially flawed document’ that should not have been relied upon to make adverse findings against Jane. It also held that the Secondary Assessment report prepared by FACS contained ‘spurious and nebulous statements’ about Jane that were not based on any reliable evidence. This ‘unwarranted and prejudicial speculation’ gave the report ‘an illusion or veneer of authoritativeness’.

¹⁴⁹ This story is derived from the judgments of *Re: A Foster Carer v Department of Family & Community Services* (2017) NSWDC 360 and *Re: A Foster Carer v Department of Family & Community Services [No 2]* (2018) NSWDC 71.

On 15 December 2017, the Court rescinded the Children’s Court orders and ordered that Kirra be returned to Jane’s care, and that Jane be granted parental responsibility for Kirra. After hearing evidence that Jane had incurred over \$100,000 in legal fees (and in doing so had exhausted her personal savings, sold many of her possessions, accumulated credit card debt, borrowed money from family and moved in with a relative to save money), the Court ordered that FACS pay her legal costs of the appeal. In doing so, it noted that it had no power under the Act to make a third party costs order against the OOHC agency.

Media scrutiny and public advocacy

It is widely acknowledged that the traditional media performs a ‘watchdog’ function in society. It is ‘the primary link between citizens and state, governors and governed’.¹⁵⁰ It is essential to ensure government accountability and journalists often take on the ‘role of “ombudsman” of the citizens, asking questions on behalf of the general public’.¹⁵¹ Media reports can expose and critique government actions, thereby acting as an instrument of accountability, or they can ‘trigger’ other formal accountability mechanisms, such as Royal Commissions or investigations by regulatory agencies.¹⁵² They can also ‘amplify’ accountability by, for example, reporting on what was said in parliamentary sittings or independent inquiries.¹⁵³

The media plays an active role in scrutinising the child protection system, and ‘the failures of child protection services in particular have preoccupied the media in Australia for decades’.¹⁵⁴ In some cases, child abuse scandals ‘have only seen the light of day because of the persistence of the media’¹⁵⁵ and media campaigns have at times led to changes in policy such as the media campaign to introduce mandatory reporting in Victoria after the death of Daniel Velerio or the campaign to reform Victoria’s child protection system in 1988.¹⁵⁶ Even the threat of media reporting can cause changes in organisational and individual behaviour, as it is ‘well-known that public sector decision-makers are highly media sensitive and that media coverage triggers anticipatory reactions within organisations’.¹⁵⁷ While media reporting of child abuse scandals can be sensationalist, inaccurate and hostile towards caseworkers, thereby driving the ‘emotional politics of child protection’, there is still no doubt that the responsible media plays an important role in ensuring the accountability of those involved in the child protection system.¹⁵⁸

150 Rodney Tiffin, *The Oxford Companion to Australian Politics*, cited in Soloman, ‘What is the Integrity Branch?’, 70 *AIAL Forum* 31.

151 Monika Djerf-Pierre, Mats Ekstrom and Bengt Johansson, ‘Policy Failure or Moral Scandal? Political Accountability, Journalism and New Public Management’ (2013) 25(8) *Media, Culture & Society* 960, 964.

152 See Sandra Jacobs and Thomas Schillemans, ‘Media and public accountability: typology and exploration’ (2015) *Policy & Politics*, 1.

153 Ibid.

154 Chris Goddard and Bernadette J Saunders, ‘Child Abuse and the Media’ *AIFS*, NCPC Issues No. 14, June 2001 <<https://aifs.gov.au/cfca/publications/child-abuse-and-media>>.

155 Ibid.

156 Ibid.

157 Sandra Jacobs and Thomas Schillemans, ‘Media and public accountability: typology and exploration’ (2015) *Policy & Politics*, 5 (citations omitted).

158 For a further discussion of the emotional politics of child protection, see Jane Warner, *The Emotional Politics of Social Work and Child Protection* (Policy Press, 2015).



Stakeholder views

The need for more accountability—and in particular, the need for there to be consequences or sanctions when DCJ staff do not comply with legislation and policy—emerged as a major theme in submissions to the Review. Women’s Legal Service NSW submitted that there needed to be ‘real accountability’ to ensure compliance with existing laws and requirements, such as the ACPP and the requirement for cultural care plans, as opposed to further legislative change.¹⁵⁹ It noted that the absence of consequences for failure to comply with legislative requirements to take alternative preventative action prior to a child’s removal was of particular concern.¹⁶⁰

GMAR NSW submitted that caseworkers consistently misrepresented facts in order to remove children and that this widespread practice had not been acknowledged by any reforms to date.¹⁶¹ It submitted that the power imbalance in the system between the department and families involved with the child protection system enabled misconduct on the part of departmental workers to flourish unchecked and that it was useless to develop policy documents filled with ‘lofty language and jargon’ without ‘implementing the actual changes necessary to achieve these goals on the ground’.¹⁶²

Four family violence prevention legal services submitted that accountability needed to be built into the child protection system, noting that cultural plans were not adhered to or were prepared in a tokenistic manner. The Benevolent Society’s submission included a statement by a former FACS caseworker that alleged serious misconduct on the behalf of FACS caseworkers:

They steal children, they hide children, they don’t let families know where the children are living, they cancel visits and tell the children their parents don’t want to see them.¹⁶³

Uniting submitted that there was a need for a ‘system of checks and balances, to ensure legislative provisions and principles and FACS policies are being implemented’.¹⁶⁴ In particular, it noted there was a need to ensure compliance with the requirement that FACS consider alternative action before removing a child from his or her family and to ensure the proper implementation of the ACPP.¹⁶⁵ It submitted that families should be provided with information about their ability to complain to the NSW Ombudsman at the point of removal.¹⁶⁶

The Aboriginal Child, Family and Community Care Secretariat (AbSec) submitted that the statutory child protection system in NSW needed structural reform to ensure, among other things, that it was accountable to the Aboriginal community.¹⁶⁷ Without significant structural change, ‘any practice improvements are likely to remain superficial in impact’ and will not

159 Women’s Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 8.

160 Ibid 51.

161 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 2.

162 Ibid 3.

163 The Benevolent Society, Submission No 7 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

164 Uniting (NSW,ACT), Submission No 23 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, March 2018, 8.

165 Ibid 7, 9.

166 Ibid 10.

167 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 4.

address the problem of rising rates of Aboriginal children in OOHC.¹⁶⁸

The Secretariat of National Aboriginal and Islander Child Care (SNAICC) included its *Baseline Analysis of Best Practice Implementation of the Aboriginal and Torres Strait Islander Child Placement Principle in New South Wales* (2017) in its submission. This document notes with concern, ‘the lack of—and need for—Aboriginal and Torres Strait Islander community-controlled oversight and accountability mechanisms to ensure compliance with legislative requirements, policy commitments, program guidelines and process requirements.’¹⁶⁹

a reoccurring theme was the fact that FACS caseworkers and managers were not held accountable.

In consultations, a reoccurring theme was the fact that FACS caseworkers and managers were not held accountable. Stakeholders noted that there was no oversight of caseworker’s assessments and caseworkers were not held accountable for the bad decisions they made.¹⁷⁰ There were no consequences for caseworkers who didn’t attend consultations¹⁷¹ and staff did not comply with the placement requirements of s 13 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*) (this was perceived to be a particular problem in relation to non-Aboriginal FACS staff).¹⁷² The Review was informed that managers were willing to accept what caseworkers told them without question¹⁷³ and that FACS staff generally did not wish to answer any questions.¹⁷⁴

Key finding: Existing bodies and mechanisms are insufficient and ineffective in practice

As is discussed in greater detail in Chapter 2, this Review has conducted an in-depth review of the cases of 1,144 Aboriginal children removed from their families between 2015–2016. In addition, the Independent Review Team has received stakeholder input, examined relevant Australian and international academic literature, reviewed government and non-governmental reports and publications, obtained significant amounts of statistical data, and closely analysed the policies, procedures and internal working culture of the Department of Families and Community Services.

the Review has come to the firm conclusion that the child protection system lacks adequate transparency and effective oversight.

168 Ibid 4.

169 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 4.

170 Confidential, *Consultation*, FIC 63; Confidential, *Consultation*, FIC 5–9; Confidential, *Consultation*, FIC 7; Confidential, *Consultation*, FIC 27.

171 Confidential, *Consultation*, FIC 5–9.

172 Confidential, *Consultation*, FIC 5–9; Confidential, *Consultation*, FIC 65.

173 Confidential, *Consultation*, FIC 64.

174 Confidential, *Consultation*, FIC 12.



As a result of this work, conducted over almost three years, the Review has come to the firm conclusion that the child protection system lacks adequate transparency and effective oversight. There is no effective regulator. It is, quite simply, a 'closed' system where information is shared between a small number of primary actors but not the public at large, where reforms are regularly devised and implemented with little or no genuine consultation with the Aboriginal community, where statistics are not adequately collected and published, where court cases are closed to the public, and where interested stakeholders, such as the media, academics and public advocates, struggle to access relevant information.

This lack of transparency would be of less concern if child protection workers engaged in exemplary casework practice and if the child protection system was properly resourced. However, as discussed throughout the report, the case file review found widespread non-compliance with legislation and policy among FACS caseworkers and managers. For example, the requirement to consult regularly with Aboriginal families and communities was routinely ignored by frontline staff, as was the policy requirement to undertake standardised safety and risk assessments at various points in the child protection process. On many occasions, no attempt was made to take the least intrusive intervention in the life of a child, willing and available Aboriginal family members were routinely ignored and not assessed to care for their kin, and siblings, including twins, were separated unnecessarily. Cultural care plans were often non-existent or tokenistic in nature, and the placement hierarchy in the ACPP was routinely disregarded. In the most egregious cases, children who did not appear to be at risk of harm were removed from their families; the Children's Court was misinformed about vitally important information; and the location of young people under the care and protection of the Minister was unknown.

the case file review found widespread non-compliance with legislation and policy among FACS caseworkers and managers.

The Review is in no doubt that the Aboriginal community, as well as the general Australian public, would be concerned to learn of the actions and attitudes of caseworkers in many of the cases reviewed during the Review, as well as by the evidence of the repeated failure of the service system to adequately support vulnerable families. However, at present, there is no mechanism for this type of information—that is, information about how casework actually occurs 'on the ground'—to be adequately brought to the attention of the Aboriginal community or the voting public at large. The lack of transparency and accountability in the child protection system has allowed significant power imbalances between caseworkers and families to develop unchecked and appears to have led to the development of an unhealthy climate of secrecy within the department. The reforms suggested in this chapter are designed to act as a catalyst for a major and vitally important paradigm shift in the system, a shift that will 'open the system up' to ensure that it is easily accessible, understandable and accountable to the community.

Primary issues and concerns

The following section outlines the primary issues and concerns about the operation of the existing accountability mechanisms and oversight bodies outlined above. It begins by examining the complaint handling process (operated by FACS and the NSW Ombudsman), before looking at a number of issues which have arisen during the Review's research.

Poor internal complaint handling processes

The FACS 'mandate' titled *Case planning in out-of-home care* has a section on children's rights, which includes the following:

Children and young people in care have a right to complain if they are unhappy with a service or a decision. When a child or young person enters care, and as part of case planning and review:

- let them know that they are allowed to complain and that their complaint will be listened to and taken seriously
- encourage them to tell their carer, or you, if they have a complaint
- give them your contact details as well as contact details for the manager casework and the Helpline for after hours assistance
- explain the complaints process.¹⁷⁵

It then states that the caseworker should assist a child to make a complaint if they need help to do so, while the casework manager is to ensure the complaint is responded to in a timely matter and must keep the child informed of its progress. There does not appear to be a standard document that is to be given to children explaining their right to complain or the complaints handling procedure. As such, there is no way of ascertaining whether the information given to children about their right to complain is comprehensive and age appropriate. Further, there does not appear to be a similar requirement for caseworkers to advise families involved with the child protection system of their right to complain if they are unhappy with a service or decision.

The OOHC sector is also required to help children to raise complaints. The *NSW Child Safe Standards for Permanent Care* require OOHC agencies to 'provide children and young people with information regarding processes for raising complaints or concerns'.¹⁷⁶ They also provide that carers 'have a right to raise complaints or request a review of an agency's decisions regarding their caring role'.¹⁷⁷

Despite the existence of these statements of policy and principle, concerns about the complaint handling process in the NSW child protection system persist. To this Review, People with Disability Australia (PWDA) submitted that it was important that the OOHC complaints handling system was transparent and accessible 'so that all children and young people feel comfortable

175 Department of Family and Community Services (NSW) *Case Planning in Out-of-Home Care* (Casework Practice Mandate, FACS Intranet).

176 Department of Family and Community Services (NSW), *Child Safe Standards for Permanent Care*, Standard 6.

177 Ibid Standard 21.



to come forward with complaints where necessary'.¹⁷⁸

In 2017, the Legislative Council's General Purpose Standing Committee No. 2 heard more detail about stakeholders concerns about FACS' internal complaints handling process.¹⁷⁹ In particular, it heard that caseworkers and their managers were often requested to investigate complaints about themselves and their own actions.¹⁸⁰ One participant in the Legislative Council's inquiry noted that this led to 'file tampering' by FACS staff and responses that failed to address the complaint.¹⁸¹

A number of other participants stated that complaints about caseworkers often led to retributive action, such as reduced contact arrangements, threats to remove children, and 'termination of funding for Aboriginal families to attend contact when their children are placed significant distances away from them'.¹⁸² They noted that this type of action was widespread and systemic. Indeed, the taking of retributive action by FACS caseworkers has been recognised by the courts on at least one occasion. In *Re Georgia and Luke* (No 2), the New South Wales Supreme Court held that the decision of DOCS caseworkers (as they were then called) to remove two children from their parents' care 'was motivated by upset at the confrontation which they had had at the parents' home that day'.¹⁸³ The Court held that the case demonstrated a 'gross abuse of power' on the part of the caseworkers that caused great distress and psychological harm to the children involved and 'gravely imperilled' their wellbeing.¹⁸⁴

The Legislative Council also heard that children in residential care

see complaints systems located in departments as biased or compromised ... CREATE found that young people in residential care were the largest group wanting to complain but 54 per cent chose not to raise the issue because of concerns about negative outcomes.¹⁸⁵

Other concerns about the internal complaints handling policy were that it was difficult to access. The Legislative Council's consultation with Aboriginal community members noted that

several participants highlighted the challenges they had encountered when attempting to make a complaint about the Department of Family and Community Services. Two individuals said that they had tried to make a complaint via the Helpline but were told this was not possible. Both were not given any other options or advice about the complaints process.¹⁸⁶

Further, it was submitted that the complaints handling procedure was ineffective, with complainants often receiving no response to their complaint, a response stating that the matter had been heard in court, or 'a letter informing them that they need to work with the caseworkers

178 People with Disability Australia, Submission No 17 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 3.

179 NSW Legislative Council General Purpose Standing Committee No 2, *Child Protection*, (March 2017).

180 Ibid [8.77]-[8.88].

181 Submission 114 to the Legislative Council General Purpose Standing Committee No 2, *Child Protection*, 2017, 3, cited in Legislative Council General Purpose Standing Committee No 2, *Child Protection*, (March 2017), [8.78].

182 Legislative Council General Purpose Standing Committee No 2, *Child Protection*, (March 2017), [8.87].

183 *Re Georgia and Luke* (No 2) [2008] NSWSC 1387 (19 December 2008), 72.

184 Ibid 74-75.

185 Legislative Council General Purpose Standing Committee No 2, *Child Protection*, (March 2017), 8.79.

186 Legislative Council General Purpose Standing Committee No 2, *Inquiry into child protection: Consultation with Indigenous community members* (8 September 2016), 6.

that they are complaining about'.¹⁸⁷ The Legislative Council recommended that the Minister for FACS commission an independent investigation of the department's internal complaint mechanisms.¹⁸⁸

In September 2017, the NSW Government supported this recommendation and noted that it was undertaking the 'FACS Integrated Complaints Management System Project'. As part of this project, it stated it had engaged an external contractor to review existing systems and recommend areas for improvement.¹⁸⁹ It also noted

the Integrated Complaints Management System Project that will improve responses to issues raised by clients in a timely and coordinated manner, and supply information that can be used to deliver quality improvements in our customer services and complaints-handling.¹⁹⁰

The NSW Government's August 2018 progress report on the implementation of the Legislative Council's recommendations again noted the development of the Integrated Complaints Management System Project without advising on the progress made in respect of this project or its timeframe for completion. However, it did not refer again to the engaging of an independent investigator to examine complaint handling by FACS, or the results of the inquiry of that investigator.¹⁹¹

The Legislative Council inquiry also recommended that the NSW Government amend the *Ombudsman Act 1974* (NSW) to enable the NSW Ombudsman to investigate complaints about child protection matters that were before the courts.¹⁹² The NSW Government 'noted' this recommendation and indicated it would investigate whether amendments could be made to allow the Ombudsman to investigate a complaint made in relation to a matter that was before the courts in such a way as to preserve the independence of the judiciary.¹⁹³ In its August 2018 progress report, it indicated that it was 'reviewing existing oversight arrangements relevant to child protection, including the role of the NSW Ombudsman, in the context of its response to the final report of the Royal Commission'.¹⁹⁴

However, in its response to the Royal Commission into Institutional Responses to Child Sexual Abuse, the NSW Government simply stated that NSW had 'strong, independent oversight of the out-of-home care system'.¹⁹⁵ In its response to the Royal Commission's recommendation that institutions have clear, accessible and child-focused complaint handling policies and

187 Alliance for Family Preservation and Restoration, submission to Legislative Council General Purpose Standing Committee No 2, *Child Protection*, (June 2016), [8.86]; Eleanor Hansen, submission to Legislative Council General Purpose Standing Committee No 2, *Child Protection*, (July 2016) [8.88]. See also, Legislative Council General Purpose Standing Committee No 2, *Inquiry into child protection: Consultation with Indigenous community members* (8 September 2016), 6.

188 Legislative Council General Purpose Standing Committee No 2, *Child Protection*, (March 2017), rec 21.

189 NSW Government response to Legislative Council General Purpose Standing Committee No 2, *Inquiry into child protection: Consultation with Indigenous community members*, (18 September 2017), 24

190 NSW Government, *NSW Government Progress Report, Implementation of the Government's response to report 46 of the Legislative Council Portfolio Committee No. 2—Health and Community Services—Child Protection*, (August 2018), 19.

191 Ibid.

192 Legislative Council General Purpose Standing Committee No 2, *Child Protection*, (March 2017), rec 22.

193 NSW Government response to the Legislative Council General Purpose Standing Committee No 2, *Inquiry into child protection: Consultation with Indigenous community members*, (18 September 2017), 24.

194 NSW Government, *NSW Government Progress Report, Implementation of the Government's response to report 46 of the Legislative Council Portfolio Committee No. 2—Health and Community Services—Child Protection*, (August 2018), 19.

195 NSW Government, *NSW Government response to the Royal Commission into Institutional Responses to Child Sexual Abuse*, (June 2018), 2.



procedures,¹⁹⁶ the NSW Government noted that ‘NSW out-of-home care providers are already required to have child-focused complaint handling processes in place’.¹⁹⁷ In its response to the Royal Commission’s recommendation that governments develop resources to assist OOHC providers to implement mechanisms to enable children to communicate their complaints, FACS stated that it already had resources about responding to sexual abuse and that it was ‘exploring options to provide further training, support and resources to improve the skill base of government and non-government workers and carers’.¹⁹⁸

As such, it appears that the recommendations of the Senate Inquiry regarding a need for an independent review of FACS internal complaint handling mechanisms and the need to expand the Ombudsman’s jurisdiction to deal with complaints have still not been adequately addressed, and the NSW Government’s response to the recommendations has been one of delay and inaction. The Review is not aware of any further developments in the area of complaint handling in the child protection sector.

The Review also observes at this point that the complaints process does not appear to be ‘child- friendly’. For instance, it does not address some of the known barriers to children making complaints, such as children’s lack of knowledge of the complaints handling system, lack of confidence in their ability to navigate the system, fear of not being taken seriously and fear of repercussions if they complain.¹⁹⁹ In fact, there is limited information published about the complaints process on the FACS website and no age-appropriate or otherwise child friendly resources about the process such as resources using colour and imagery, and providing simple and age-appropriate textual information.²⁰⁰ Further, children who complain do not have a right to an advocate to assist them with the complaint and it appears there are no services developed specifically for children to enable them to use mobile technology or interactive online sites to lodge complaints.²⁰¹

Finally, the Review notes that if a complaint is about a non-governmental OOHC provider, the complaint is dealt with pursuant to that provider’s complaints-handling process. However, non-government OOHC providers do not tend to publish their complaint-handling procedures. Further they are not standardised among providers. To date, there also appears to have been little consideration of the interaction between FACS and non-government OOHC providers in relation to complaints handling (which is necessary to streamline the process and prevent the duplication of work).

Lack of transparency of the Official Community Visitors Scheme

The Royal Commission into Institutional Responses to Child Sexual Abuse noted that official visitors ‘give children in out-of-home care an alternative channel for raising concerns about their carers or about the out-of-home care service provider’.²⁰² The Review concurs. However, it is of concern that important elements of the scheme are unable to be scrutinised due to a lack of

196 *Royal Commission into Institutional Responses to Child Sexual Abuse* (December 2017), rec 7.7.

197 NSW Government, *NSW Government response to the Royal Commission into Institutional Responses to Child Sexual Abuse*, (June 2018), 15.

198 *Ibid* 30.

199 See, eg, Commissioner for Children and Young People (Western Australia), ‘Are you listening? Guidelines for making complaints systems accessible and responsive to children and young people’ (June 2013); Children’s Commissioner for Wales, ‘Children don’t complain ...’ (2005), <<https://www.childcomwales.org.uk/publication/children-dont-complain/children-dont-complain-2/>>.

200 Commissioner for Children and Young People (Western Australia), ‘Are you listening? Guidelines for making complaints systems accessible and responsive to children and young people’ (June 2013).

201 See *Royal Commission into Institutional Responses to Child Sexual Abuse* (December 2017).

202 *Ibid* vol 12, 281.

publicly available information. For example, the publicly available information does not indicate which OOHC services have been visited and which have not. It does not indicate how frequently each individual service is visited (although it notes that visitors ‘may go to some services every month, but other services are visited less frequently’).²⁰³ Nor does it indicate how many visits are announced and how many are unannounced. Importantly, it also fails to note how many of the Official Community Visitors are Aboriginal and what cultural competency training non-Aboriginal OCV’s receive to ensure that they are able to adequately identify issues relating to the cultural and spiritual wellbeing of Aboriginal children in OOHC.

Non-compliant agencies are permitted to provide OOHC

As ‘outsiders’ to the child protection system, the Independent Review Team was surprised to learn that it is possible for an agency in NSW to provide OOHC without satisfying the relevant legislative requirements or the *NSW Child Safe Standards for Permanent Care*. This means in NSW, an agency is permitted to provide OOHC services for children, despite the fact that it does not comply with the minimum requirements for accreditation—that is, *it does not comply with the standards put in place to ensure that a child is safe, supported and nurtured in the OOHC environment*. However, it appears that those involved with the child protection system may have become acculturated to this system, as agencies have consistently failed to satisfy the minimum requirements for the provision of OOHC since the requirements were first introduced. In particular, FACS has consistently failed to meet the required standards. After three of its districts (providing OOHC for approximately 1,200 children) failed to achieve ‘full’ accreditation by the 2013 ‘cut-off’ date (that is, the date by which all agencies providing OOHC prior to 15 July 2003 were required to obtain accreditation),²⁰⁴ the OCG extended their ‘interim’ accreditation for over three years to enable it to continue providing OOHC services despite its consistent non compliance with the legislation and Standards.²⁰⁵

Non-compliant agencies are allowed to provide OOHC in a number of ways. First, the OCG can ‘defer’ a decision on the renewal of an agency’s accreditation when ‘an agency has not demonstrated minimum compliance with accreditation criteria before its accreditation expires’.²⁰⁶ In these circumstances, the agency can continue providing OOHC until the decision on the accreditation renewal application is finalised.²⁰⁷ If the deferral is for a period greater than six months, the OCG must inform the Minister in writing of the deferral.²⁰⁸ There is no statutory requirement to publish this information more widely. Secondly, the OCG can accredit an agency that does not ‘wholly’ satisfy the accreditation criteria and specify that it must satisfy the criteria within a certain period of time (not exceeding 12 months).²⁰⁹

‘For profit’ OOHC providers

Another issue of concern is that providers of statutory OOHC in NSW are able to operate on a ‘for profit’ basis. This situation stands in contrast to that of providers of adoption services, who must be charitable or not-for profit organisations. The first adoption Act in NSW—the *Adoption of Children*

203 NSW Ombudsman, *Official Community Visitor Fact Sheet No 1*, 1.

204 *Children and Young Persons (Savings and Transitional) Regulation 2000* (NSW), reg 22A. These districts were the Western District, the Mid-North Coast District and the Murrumbidgee District.

205 Office of the Children’s Guardian, Legislative Council General Purpose Standing Committee No 2, *Answers to supplementary questions—Office of the Children’s Guardian*, (September 2016), 9.

206 *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) reg 47.

207 NSW Government, Office of the Children’s Guardian, ‘*About designated agencies*’, (Web Page, July 2017) <<https://www.kidsguardian.nsw.gov.au/statutory-out-of-home-care-and-adoption/designated-agencies/about-designated-agencies>>.

208 *Children and Young Persons (Care and Protection) Regulation 2012* (NSW), reg 47.

209 *Ibid* reg 54.



Act 1965 (NSW)—provided that adoption services could only be provided by charitable or non-profit organisations.²¹⁰ Since this time, the premise that adoption should be a non-profit activity has remained unchallenged. Today, it is still the case that only not-for-profit bodies can provide adoption services in NSW. Section 12(1) of the *Adoption Act 2000* (NSW) states that a ‘charitable or non-profit organisation may apply to the Children’s Guardian for accreditation as an adoption service provider’.

The NSW legislation on adoption reflects the international law on the organisational nature of adoption agencies. For example, the *Hague Convention on Protection of Children and Co-Operation in respect of Intercountry Adoption* (the 1993 Hague Convention) requires state parties to prevent ‘improper financial or other gain in connection to adoption.’²¹¹ In particular, art 11(a) provides that an accredited adoption body shall ‘pursue only non-profit objectives’. This safeguard was adopted into the Convention along with other safeguards to ensure that adoption agencies achieved ‘high standards of ethical practice’²¹² and reflected the widely accepted view that ‘the profit motive should not be part of any decision making’.²¹³

As noted above, however, the situation is different for OOHC providers. There is no prohibition on OOHC services being provided by ‘for profit’ companies. While there is very little publicly available information about ‘for profit’ OOHC providers, this Review has determined from an analysis of the Australian Business Numbers of the designated agencies on the Office of the Children’s Guardian’s website, that at least five accredited OOHC providers are ‘Australian private companies’ that operate on a for-profit basis.²¹⁴ Two of these—Interactive Community Care and Treehouse Innovative—were provisionally accredited recently (in 2018).²¹⁵

In 2016, serious concerns were raised about the operation of one of the for-profit OOHC providers, Premier Youthworks (which also operates OOHC services in Canberra). The ABC television program *Four Corners* ‘aired several allegations by former residential care workers that government funding was not reaching the children, houses were unhygienic and dirty, and staff were not trained or supported.’²¹⁶ In 2017, the Canberra Times reported that a whistleblower had alleged that young staff were ‘being left to care for vulnerable children inside residential group homes without adequate support’.²¹⁷ It also stated that a source had observed that ‘the drive for revenue was having a “profound negative impact on the care and experiences that the young people get”’.²¹⁸

In response to these concerns, a CEO of a former residential care provider in the Australian Capital Territory stated that ‘the difficulty with having profit driven companies run the services

210 *Adoption of Children Act 1965* (Qld), ss 10, 11.

211 NSW Law Reform Commission, *Review of the Adoption of Children Act 1965 (NSW)* (Report 81, 1997) [10.177].

212 Hague Conference on Private International Law, *Accreditation and Adoption Accredited Bodies: General Principles and Guide to Good Practice. Guide No 2 under the Hague Convention of 29 May 1993 on Protection of Children and Co-operation in Respect of Intercountry Adoption*, 2012, 50.

213 *Ibid* 64.

214 Interactive Community Care Pty Ltd (residential care); Impact Youth Services Pty Ltd (residential care), Phoenix Rising for Children Pty Ltd (foster care), Premier Youthworks Pty Ltd (residential care); Treehouse Innovative Families (residential care).

215 Office of the Children’s Guardian, ‘*Designated agencies*’, (Web Page, July 2017) < <https://www.kidsguardian.nsw.gov.au/statutory-out-of-home-care-and-adoption/designated-agencies?RefineModule=2967&retain=true&StartTax=8>>.

216 Elise Scott, ‘Four Corners: Concerns raised over housing for vulnerable children in Canberra’, *ABC News*, (ABC News Digital, 15 November 2016), <https://www.abc.net.au/news/2016-11-15/four-corners-concerns-raised-over-housing-children-canberra/8027742>.

217 Steven Trask and Carrie Fellner, ‘Staff fear safety at Premier Youthworks after meat cleaver incident’, *The Canberra Times*, (The Canberra Times News Digital, 13 December 2017), <<https://www.canberratimes.com.au/national/act/staff-fear-safety-at-premier-youthworks-after-meat-cleaver-incident-20171211-h02t59.html>>.

218 Steven Trask and Carrie Fellner, ‘Embattled Premier Youthworks poised to snag millions in government funding’, *The Canberra Times*, (The Canberra Times News Digital, 13 December 2017), < <https://www.canberratimes.com.au/story/6024963/embattled-premier-youthworks-poised-to-snap-millions-in-government-funding/>>.

was their need to make money'.²¹⁹ He stated that to gain such profits 'you have to pull back on staffing issues and possible training'.²²⁰

While it is unclear what the annual turnover of any of the for-profit OOHC providers is, the Newcastle Herald stated that in the past the annual revenue of Premier Youthworks 'has reportedly been estimated at \$20 million'.²²¹ At the end of 2017, the Newcastle Herald reported that Premier Youthworks was seeking 'not-for-profit' status.²²² However, to date, it still operates on a 'for profit' basis.

Lack of transparency about activities of the Office of the Children's Guardian

Another issue of concern to the Review is the lack of transparency about the OCG's regulatory activities with respect to the OOHC sector. First, the Review observed that the OCG publishes limited information about its monitoring activities. As stated above, the OCG's website contains a broad description of its oversight role, stating that

the Office of the Children's Guardian conducts onsite compliance and monitoring assessments of designated agencies in NSW. Assessments consider outcomes for children and young people in a range of care domains and assess the management and operation of each organisation. Assessments include a broad review of records and discussions with staff.

There is no further information about what 'care domains' are assessed, or how the 'management and operation' of the organisation is reviewed. While it is possible to obtain some further information about the OCG's activities through its Annual Reports, many of these contain similarly superficial accounts of the OCG's monitoring of the OOHC sector. For example, in its 2017–2018 Annual Report, the OCG reported that it had visited nine out of 83 designated agencies, and that 'most agencies visited were meeting the requirements of the standards to a satisfactory level. Of the nine agencies visited, only two required further action by the OCG to ensure the matters identified had been adequately addressed'.²²³ The OCG did not indicate which agencies had been visited, which were not meeting the standards to a 'satisfactory level', which standards were not being met, how egregious the failure to meet the standards was considered to be, what action the OCG required the designated agency to remedy the non-compliance, and whether or not that action was taken. Similarly, in the OCG's review of children in residential care as at 30 November 2016, the OCG did not indicate which residential providers were reviewed, which performed well, and which required further monitoring to ensure compliance with the standards.²²⁴

Second, the Review is concerned that the OCG appears to collect, collate and disseminate relevant information about the performance to OOHC agencies to certain actors within the OOHC sector, yet not to the general public. For example, in 2015–16 the OCG reported that its compliance monitoring program had identified 'similar practice issues' across the sector, and

219 Elise Scott, 'Four Corners: Concerns raised over housing for vulnerable children in Canberra', *ABC News*, (ABC News Digital, 15 November 2016), <https://www.abc.net.au/news/2016-11-15/four-corners-concerns-raised-over-housing-children-canberra/8027742>.

220 Ibid.

221 Carrie Fellner and Steven Trask, 'Premier Youthworks investigation part three: provider seeks not-for-profit status', *Newcastle Herald*, (Newcastle Herald News Digital, 15 November 2016), <https://www.theherald.com.au/story/5118503/premier-youthworks-seeks-not-for-profit-status/>.

222 Ibid.

223 Office of the Children's Guardian, *Annual Report 2017–18* (Report, 2018) 25.

224 Office of the Children's Guardian, *Review of Residential Care 2017–18*, 6.



as a result, it ‘prepared a snapshot of the trends identified’ which was provided to the Minister and the designated agencies.²²⁵ Similarly, in 2016–2017, the OCG reported that its compliance monitoring program of all designated agencies had been completed and that individualised reports had been prepared for all agencies, as well as ‘an overview of trends across the sector’, which was provided to agencies as well as ‘key stakeholders’ such as FACS, the Association of Children’s Welfare Agencies and AbSec.²²⁶ These snapshots, individualised reports, and reports about trends across the sector, are not available to the public.

Third, the OCG has commissioned several reports since its inception that do not appear to have been released publicly. For example, in 2011 the Social Policy Research Centre at UNSW delivered a literature review on ‘quality assurance and continuous improvement in the child welfare sector’.²²⁷ This report does not appear to have been publicly released and is not available on the OCG’s website. In 2017, the OCG engaged scholar Kath McFarlane to produce a report reviewing the regulatory processes and safety of children in OOHC, ‘with a particular focus on the needs of children and young people in specific forms of OOHC, including residential care and children placed in motel, caravan parks and other forms of temporary accommodation’.²²⁸ This report was not made public.

Finally, the Review is concerned that the OCG does not more proactively reassure the public about steps that have been taken to rectify failures by OOHC agencies to ensure the safety and wellbeing of children. For example, in December 2010, the *Sydney Morning Herald* published an article alleging that a large OOHC provider, Life Without Barriers, had placed children at risk by failing to properly assess their foster carers.²²⁹ It was alleged that a child was placed with a carer who had a history of sexual assault offences and that another was placed with a carer whose four children had been removed from his care by FACS.²³⁰ As a result of this media report, the NSW Ombudsman conducted an investigation into the provider. It found that Life Without Barriers had ‘very poor practice with respect to carer assessment, carer approval processes, and placement matching’ which had exposed 12 children at ‘significant risk’.²³¹ The Ombudsman made recommendations to address the problems identified with the practices of Life Without Barriers.²³² Despite significant media interest in the matter, and an Ombudsman’s report, the OCG provided virtually no information on what ongoing monitoring would occur in order to ensure that the recommendations made by the Ombudsman were implemented. In its 2011–2012 Annual Report, it simply stated that it had reviewed the OOHC services provided by Life Without Barriers and ‘developed a Quality Action Plan to improve service delivery’.²³³ No information was provided as to what was contained in this plan or how it was to be monitored in the future.

225 Office of the Children’s Guardian, *Annual Report 2015–16* (Report, 2016).

226 Office of the Children’s Guardian, *Annual Report 2017–18* (Report, 2018) 26.

227 Office of the Children’s Guardian, *Annual Report 2010–11* (Report, 2011).

228 Dr Kath McFarlane, Submission No 19 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

229 Adele Horin, ‘Foster Carer Linked to Sex Abuse Slipped Past the Barriers’ *Sydney Morning Herald* (online, 13 December 2010) <<https://www.smh.com.au/national/nsw/foster-carer-linked-to-sex-abuse-slipped-past-the-barriers-20101212-18u1w.html>>.

230 Adele Horin, ‘CEO Goes as Foster Care Under Scrutiny’ *Sydney Morning Herald* (online, 4 April 2011) <<https://www.smh.com.au/national/ceo-goes-as-foster-care-under-scrutiny-20110403-1ctay.html>>.

231 Trent Dalton, ‘Little Girl Lost’ *The Australian* (online, 1 February 2013) <<https://www.theaustralian.com.au/life/weekend-australian-magazine/little-girl-lost/news-story/4f27fe2229072c0c0ff82eb6c0b1c8b3>>.

232 NSW Ombudsman, *Annual Report 2011–12* (Report, 2012) 85.

233 Ibid 11.

Lack of effective regulation by the Office of Children’s Guardian

This Review notes that the paucity of publicly available information from the OCG about its monitoring activities makes it difficult to accurately assess its effectiveness as a regulator in the sector. However, there are several clear indications that the OCG is not engaging in effective oversight of the child protection sector.

Lack of focus on OOHC sector

The first Children’s Guardian was appointed in January 2001 in response to recommendations made in two inquiries to the effect that there should be a special guardian for children in NSW.²³⁴ Initially, the Children’s Guardian was tasked with achieving a relatively small number of objectives—namely, promoting the rights and safeguarding the interests of children in OOHC, accrediting agencies to provide OOHC and monitoring the responsibilities of these agencies under the *Care Act*.²³⁵ Over time, however, the roles and responsibilities of the OCG have expanded dramatically. In 2003, for example, the Children’s Guardian was also given the responsibility of regulating the employment of children under 15 years of age in certain industries in NSW.²³⁶ In 2005, she was also given the responsibility for accrediting adoption service providers²³⁷ and in 2008 she was tasked with also regulating voluntary OOHC.²³⁸

The biggest changes, however, have occurred in the last six years, during which time the OCG’s functions have expanded exponentially. In 2013, the OCG was given the responsibility of administering the Working with Children Check, for encouraging organisations to be safe for children, for administering the Child Sex Offender Counsellor Accreditation Scheme and for establishing the Carer’s Register (these functions were previously performed by the Commission for Children and Young People).²³⁹ At this time, the OCG staff numbers rose from 18.1 equivalent full time employees to 113 staff against a staff establishment of 127 positions (101 permanent, 25 temporary, 1 SES).²⁴⁰ In 2018, the NSW Government accepted the recommendation of the Royal Commission into Institutional Responses to Child Sexual Abuse about regulating child safe standards in NSW and the OCG is involved in consulting on how this is best achieved.²⁴¹

Perhaps as a result of its greatly expanded functions, the OCGs compliance monitoring activities have reduced in scope and intensity in recent years. For example, in 2017–18 the OCG conducted only nine monitoring visits to agencies (two of which required further action to ensure that they were satisfactorily complying with the Standards).²⁴² As such, 74 agencies did not receive a visit. The OCG has not indicated which agencies were visited, so it is difficult to assess whether they were agencies that have had their accreditation ‘deferred’ or whether they were fully accredited agencies. In addition, the last three editions of OCG’s Accreditation and Monitoring e-newsletter,

234 *Review of the Children (Care and Protection) Act 1987* (NSW), *Wood Royal Commission into the NSW Police Service* (1997): see Office of the Children’s Guardian, *Annual Report 2006–2007* (Report, 2007) 92.

235 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 181(1)(b), (c), (e). Note that the provisions relating to accrediting and monitoring designated agencies were proclaimed in 2003. The Children’s Guardian was also given other powers that were never proclaimed—namely, the power to exercise parental responsibilities of the Minister for the child, and the power to examine copies of the case plans for each child in OOHC: see *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 181(a), (d).

236 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ch 13; *Children and Young Persons (Care and Protection) (Child Employment) Regulation 2010*.

237 Office of the Children’s Guardian, *Annual Report 2005–06* (Report, 2006) 7. See *Adoption Act 2000* (NSW) s 10(1) and 206(2).

238 Office of the Children’s Guardian, *Annual Report 2007–08* (Report, 2008) 6.

239 Office of the Children’s Guardian, *Annual Report 2012–13* (Report, 2013) 7.

240 Office of the Children’s Guardian, *Annual Report 2013–14* (Report, 2014).

241 Office of the Children’s Guardian, *Regulating Child Safe Organisations* (Discussion paper for consultation, 2018).

242 Office of the Children’s Guardian, *Annual Report 2017–2018* (Report, 2018) 25.



which was first published in September 2015, have not contained any information on the OCGs monitoring activities. Finally, the regulation of statutory OOHC and adoption received only three pages in the OCG's 2017–18 Annual Report.

The provision of notice for inspections of OOHC providers

Under the *Children and Young Persons (Care and Protection) Regulation 2012*, the Children's Guardian must give a designated agency 'reasonable notice' that it will require entry to a premises unless it 'has certified by notice in writing, that giving notice before requiring entry would frustrate the purpose of requiring entry'.²⁴³ In practice, to date, the OCG has indicated that designated agencies will receive information about the content of the assessment and the dates of their visits approximately three months in advance. If an organisation has been provisionally accredited, staged site visits are planned in advance and the agency is informed of the evidence to be assessed during each visit to assist it 'in preparing direct evidence (evidence of practice) for assessment'.²⁴⁴

In mid-April 2019, the OCG released a factsheet that indicated that every accredited agency would be visited at least once in every 12–18 month period. It also indicated that monitoring visits would be prioritised and would now occur at short notice in response to identified or reported risk, or in some circumstances would occur with no prior notice to the agency.²⁴⁵ This was accompanied by a fact sheet explaining the assessment process for accreditation in more detail, including the steps in the process and the types of evidence the OCG will assess during this process.²⁴⁶

Concerns have been raised about the practice of giving advance notice of inspections to designated agencies. For example, the media report *Broken Homes: On the Frontline of Australia's Child Protection Crisis*, contains the following account of the effect of the OCG's provision of notice to a designated agency:

Amid these heightened concerns for the safety of this child, inside Life Without Barriers there was much fuss being made about a very different matter — an upcoming audit by the Office of the Children's Guardian. For months (because that's how much time the watchdog gave them to prepare) paperwork and the houses themselves were tidied up. One document demanded that a "file note to be created" to show that house rules had been discussed with the resi kids, even though this was meant to have occurred at their point of entry into the home.

It was the "biggest, fakest" thing Natalie Ottini says she'd ever been involved in. While much of the documentation had been done, there were elements missing, and senior managers wanted everything in order. ...

What really stuck in her craw though was suddenly being given an unlimited budget to fill the pantry and fridge, when usually such spending was parsed as though by forensic accountants. "Then I was asked by another staff member there if I knew how to cook curried sausages in a slow cooker because they want the aroma of nice food going

243 *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) sch 3, cl 11(3)(a).

244 Office of the Children's Guardian, *Statutory out-of-home care and adoption services: Accreditation Guide* (October 2018) 10.

245 Office of the Children's Guardian, 'Fact Sheet: Monitoring Accredited Agencies' (January 2019) <<https://www.kidsguardian.nsw.gov.au/statutory-out-of-home-care-and-adoption/fact-sheets>>.

246 Office of the Children's Guardian, 'Fact Sheet: Assessment by the Office of the Children's Guardian' (July 2018) <<https://www.kidsguardian.nsw.gov.au/statutory-out-of-home-care-and-adoption/fact-sheets>>.

through the house,” she remembers. “And they came, some of the people from the office came and put a nice tablecloth and some flowers around on the table. I felt like I was in a cartoon.”²⁴⁷

The approach to inspections of designated agencies is dramatically different to the approach taken to inspecting the employment conditions of children in the entertainment industry. In its 2017–2018 Annual Report, the OCG noted that to ensure compliance with the requirements of employing children and young people it conducted monthly compliance checks which ‘saw employers selected at random for unannounced inspections of work conditions’.²⁴⁸ A total of 68 employers were inspected, a 23% increase from the year before.²⁴⁹ It is difficult to understand why these compliance approaches are different, especially in light of the fact that children in OOHC are more in need of protection from harm than children engaged in employment in the entertainment industry.

Limited use of capacity to make special reports to Parliament

Under s 188 of the *Care Act*, the Children’s Guardian may, at any time, make a special report on ‘any particular issue or general matter relating to the functions of the Children’s Guardian’ and furnish this report to the Presiding Officer of each house of Parliament. This power is similar to that of other statutory oversight bodies, such as the Ombudsman and the Information Commissioner.²⁵⁰ As the NSW Ombudsman has noted, ‘it is demonstrably in the public interest that the Parliament should be fully informed by statutory oversight bodies about their work’.²⁵¹

However, the Children’s Guardian has not utilised this provision to make any special reports to Parliament regarding any systemic concerns relating to its monitoring and oversight of OOHC. The Ombudsman, on the other hand, has ‘made a substantial number of special reports to the Parliament on a great range of topics and with as many recommendations’.²⁵² Some of these reports relate to OOHC, such as the *Review of the NSW Child Protection System—Are things Improving?* and *Keep Them Safe? Special Report to Parliament August 2011*.²⁵³

widespread lack of compliance with OOHC standards and legislative requirements has long been an issue of the OOHC sector.

Lack of enforcement action

As discussed above, widespread lack of compliance with OOHC standards and legislative requirements has long been an issue of the OOHC sector. Quite simply, designated agencies do not always comply with the standards set out to ensure that children in OOHC are provided with a nurturing, safe and secure childhood. This lack of compliance can be seen when examining the past file audits conducted by the OCG. For example, in its comprehensive OOHC file audit in 2006–07, the OCG noted that many agencies failed to meet the ‘80% compliance threshold’

247 Linton Besser, ‘Broken Homes: On the Frontline of Australia’s Child Protection Crisis’ (Four Corners and ABC News Digital, 2016).

248 Office of the Children’s Guardian, *Annual Report 2017–18* (Report, 2018) 37.

249 Ibid.

250 See, eg, *Ombudsman Act 1974* (NSW) s 31; *Government Information (Information Commissioner) Act 2009* s 38; *Advocate for Children and Young People Act 2014* (NSW) s33 (2); *Modern Slavery Act 2018* (NSW) s 19(4).

251 NSW Ombudsman, *Operation Prospect Special Report to Parliament under s 31 of Ombudsman Act 1974* (May 2017) 28.

252 Ibid.

253 NSW Ombudsman, *Review of the NSW Child Protection System—Are things Improving?* (Report, April 2014); NSW Ombudsman, *Keep Them Safe? Special Report to Parliament* (Report, August 2011).



for audit items. In particular only 71% of files of children on final orders contained a current case plan or review, while only 69% showed that a case conference was convened to develop or review the case plan. Only 55% of case plans documented the review of consent arrangements for the use of psychotropic medication and only 74% documented placement decisions based on the ACPP.²⁵⁴

Similar patterns can be seen in later case file audits of practice related to health and education between 2008 and 2013. More recently, the OCG has noted continuing problems with the practice and procedures of OOHC agencies. In its 2016 review of the care records for 1,924 children and young people, the OCG noted that only 33% of children and young people had a permanency planning assessment to guide casework, only 69% of children with behaviour support needs had a behavioural support plan, and only 55% of files showing that the necessary consent of the principal officer had been obtained when children were prescribed psychotropic medication.²⁵⁵

The lengthy and widespread nature of non-compliance among the OOHC raises the question of the effectiveness of the OCG's approach to regulation of the OOHC sector. The OCG has stated that 'enforcement options are always the last resort' and that the Office prefers to work collaboratively and cooperatively with the organisations it monitors.²⁵⁶ This indicates that the OCG has adopted a 'responsive regulation' approach—that is, an approach that sees the regulator being 'responsive to the culture, conduct and context of those they seek to regulate when deciding whether a more or less interventionist response is needed'.²⁵⁷ In other words, the regulator engages in a dynamic process of using only as much regulation as is necessary to achieve compliance (and has a range of regulatory options at its disposal), only moving to more severe or intrusive options when early interventions have proven to be ineffective. As the 'regulatory pyramid' in the figure below shows, most of the responsive regulator's activities are focused on encouraging compliance through informal means, while more severe sanctions are only used when absolutely necessary.²⁵⁸

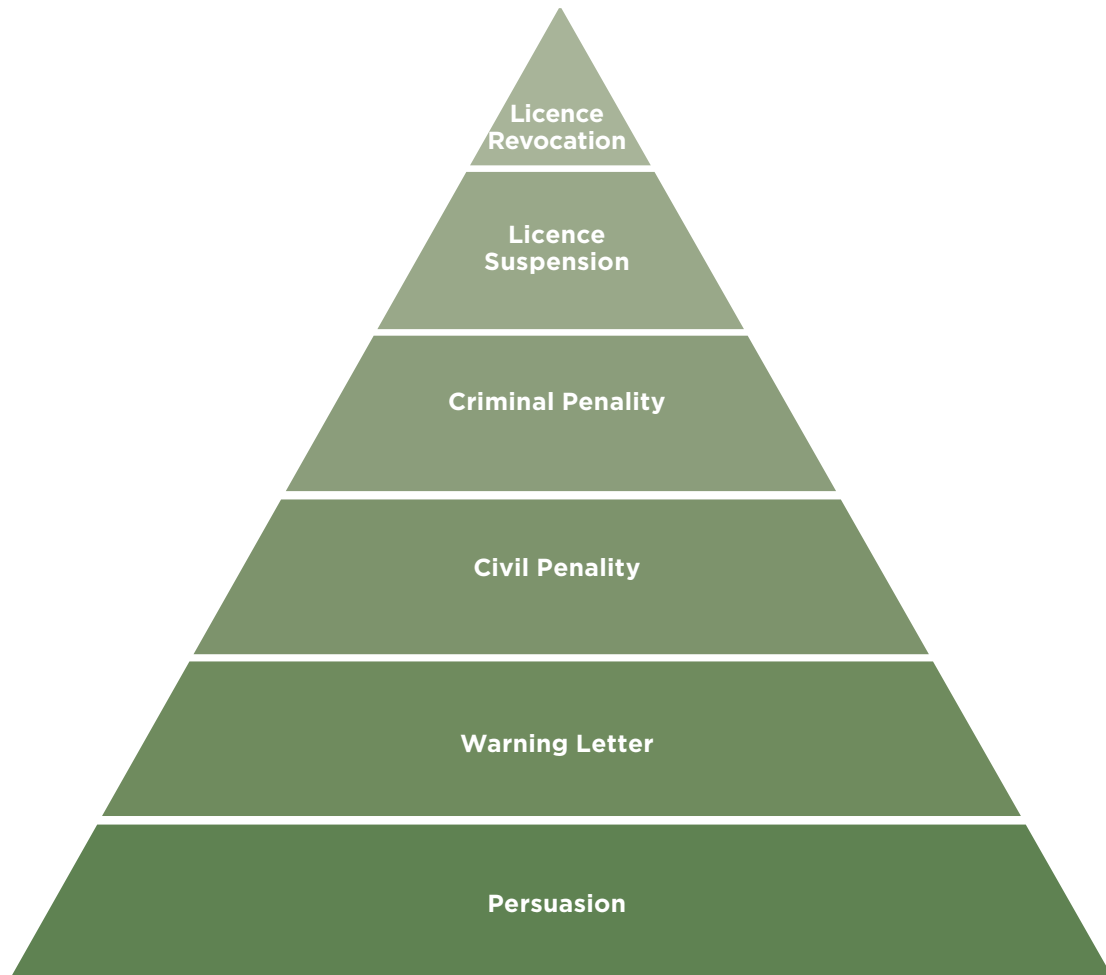
254 Office of the Children's Guardian, *Annual Report 2006–2007* (Report, 2007) 104.

255 Ibid.

256 Office of the Children's Guardian, *Regulating Child Safe Organisations* (Discussion Paper for Consultation, 2018) 3.

257 Charlotte Wood, Mary Ivec, Jenny Job & Valeria Braithwaite, *Applications of Responsive Regulatory Theory in Australia and Overseas, Occasional Paper 15* (Regulatory Institutions Network, June 2010) 3.

258 Ibid.



Source: Ayres and Braithwaite (1992)

The difficulty is, however, that the OCG does not have the ‘credible enforcement peak’²⁵⁹ required to ensure its approach to regulation is effective. There are very few penalty provisions in the *Care Act* or the *Children and Young Persons (Care and Protection) Regulation 2012* (NSW). In addition, the OCG does not utilise its power to suspend or cancel accreditation but has rather adopted an approach whereby an agency who does not satisfy the requirements for accreditation is allowed to continue providing OOH services while working towards satisfying accreditation criteria. The Review is not aware of any instance in which the OCG has refused to accredit an agency for lack of compliance with the OOH Standards or a condition of accreditation. Further, as noted in the discussion of the lack of transparency in the OCG’s activities, the OCG does not ‘name and shame’ organisations who are failing to comply with the OOH Standards. While the OCG publicly states that ‘it may also publish details of failure to comply with conditions of accreditation in the OCG’s Annual Report to Parliament’, it has been extremely circumspect in mentioning any individual agency in any of its Annual Reports to date. It has also been surprisingly silent in the face of media reports about OOH scandals.

259 Ibid.



For example, the OCG did not comment on the concerns expressed in the media about the operation of Wundarra Services, an Aboriginal residential care home that was the centre of allegations of sexual assault of children in OOHC.²⁶⁰ The OCG investigated the OOHC provider, and stated only that it met the required standards for accreditation. Nevertheless, the then Minister for Family and Community Services, the Hon Brad Hazzard MP, disagreed with this conclusion and refused to continue funding the agency, which was then required to close.²⁶¹

No oversight of the Office of the Children’s Guardian

A further concern about the monitoring of the OOHC sector is the fact that the OCG is not accountable to any other body in relation to the exercise of its OOHC functions. The OCG is one of many independent statutory agencies that has been established in NSW and around Australia as ‘governmental and quasi-governmental activity has become more varied and complex’.²⁶² These independent statutory agencies are part of the ‘integrity branch’ of government, ‘equivalent to the legislative, executive and judicial branches’,²⁶³ and are established to ensure that government institutions exercise their powers correctly and for the right purpose.²⁶⁴ As the number of independent statutory agencies has grown, so has recognition of the need to ensure that they are directly accountable to Parliament.²⁶⁵ For this reason, it is common for independent statutory agencies to be supervised and overseen by a Parliamentary Committee.²⁶⁶ The role of these committees is to ‘review and report upon the powers, processes and structures of the integrity agencies, to guard against abuses and to encourage best practice—to guard the guardians’.²⁶⁷

In NSW, most independent statutory authorities are monitored by parliamentary committees, including those involved in the regulation and oversight of the child protection system. For example, the NSW Ombudsman is overseen by the Committee on the Ombudsman, the Law Enforcement Conduct Commission and the Crime Commission,²⁶⁸ while the Office of the Advocate for Children and Young People is overseen by the Parliamentary Joint Committee for Children and Young People.²⁶⁹ The types of functions of these parliamentary committees can be seen in s 31B of the *Ombudsman Act 1974* (NSW), which provides that the Joint Committee overseeing the Ombudsman is required

- (a) to monitor and to review the exercise by the Ombudsman of the Ombudsman’s functions under this or any other Act;
- (b) to report to both Houses of Parliament, with such comments as it thinks fit, on

260 Rachael Hocking, ‘Why is one of the only Aboriginal residential care homes in NSW being defunded?’ (online, 18 October 2016) <<https://www.sbs.com.au/nitv/the-point-with-stan-grant/explainer/why-one-only-aboriginal-residential-care-homes-nsw-being-defunded>>.

261 Ibid.

262 Gareth Griffith, *Parliament and Accountability: The Role of Parliamentary Oversight Committees* by Gareth Griffith, (NSW Parliamentary Library Research Service, Briefing Paper No 12/05, 2005) 8.

263 JJ Spigelman, ‘The Integrity Branch of Government’, *First Lecture in the 2004 National Lecture Series of the Australian Institute of Administrative Law* <http://www.lawlink.nsw.gov.au/sc%5Csc.nsf/pages/spigelman_290404>, cited in Gareth Griffith, *Parliament and Accountability: The Role of Parliamentary Oversight Committees* by Gareth Griffith, (NSW Parliamentary Library Research Service, Briefing Paper No 12/05, 2005) 9.

264 David Solomon, ‘What is the Integrity Branch’ (Speech, AIAL Forum No 70) 26.

265 Gareth Griffith, *Parliament and Accountability: The Role of Parliamentary Oversight Committees* by Gareth Griffith, (NSW Parliamentary Library Research Service, Briefing Paper No 12/05, 2005) 9.

266 Ibid.

267 Ibid.

268 *Ombudsman Act 1974* (NSW) s 31A(1).

269 *Advocate for Children and Young People Act 2014* (NSW) s 36.

any matter appertaining to the Ombudsman or connected with the exercise of the Ombudsman's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed:

- (c) to examine each annual and other report made by the Ombudsman, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report;
- (d) to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Office of the Ombudsman; and
- (e) to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

It is unsettling to note that the OCG's functions relating to the monitoring and oversight of the OOHC sector are not overseen by any Parliamentary Committee. Confusingly, however, its functions under the *Child Protection (Working with Children) Act 2012* (NSW) are overseen by the Parliamentary Joint Committee for Children and Young People.²⁷⁰

Lack of transparency of the Children's Court of NSW

For a number of years, concerns have been raised about the operation of the care and protection jurisdiction of the NSW Children's Court. For example, the NSW Legislative Council General Purpose Standing Committee No 2's inquiry into child protection cited the concerns of a number of stakeholders who expressed that the Court acted as a 'rubber stamp' for the Department of Family and Community Services²⁷¹ (a concern echoed by stakeholders to this Review).²⁷² It also noted that statistics provided by the President of the Children's Court indicated that parental responsibility was initially granted to FACS in approximately 99% of cases, and that this number was reduced to 90% at the 'establishment phase'.²⁷³

The President of the Children's Court has denied, however, that the Court acts as a rubber stamp, emphasising that the Court is staffed by experienced magistrates who independently adjudicate the facts of each case.²⁷⁴ He has noted that in the large majority of his cases, the removal had been justified on the basis of the material provided to the Court.²⁷⁵ In addition, a study in 2000 into parents with a disability and the Children's Court of NSW found that the 'rubber stamp' hypothesis did 'not hold up under scrutiny'.²⁷⁶

Another issue relates to the lack of statistical or operational information about the the care and protection jurisdiction. In NSW, statistics on the operation of criminal courts are published annually by the Bureau of Crime Statistics and Research (BOCSAR). These include statistics about the

270 Ibid s 37(b).

271 General Purpose Standing Committee No 2 *Child Protection* 2017 [4.38]-[4.39].

272 Aunty Glendra Stubbs and Elizabeth Rice, Submission No 1 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 3.

273 See Chapter 1 for a discussion of these terms.

274 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) [4.46]-[4.49].

275 Ibid [4.44].

276 David McConnell, Gwynnyth Llewellyn and Luisa Ferronato, *Parents with a disability and the NSW Children's Court* (The Family Support & Services Project, the University of Sydney, August 2000).



number of criminal matters finalised in the Children's Court of NSW, as well as the demographics of defendants (including their Aboriginal status) and the time taken to finalise the matter (from arrest to finalisation).²⁷⁷ While some statistics regarding the care and protection jurisdiction are published in the annual *Report on Government Services*, these are limited to high-level information, such as the efficacy of case processing and court expenditure, and do not provide comprehensive insight into the work of the Children's Court. They do not, for example, provide information about the nature of the orders sought and granted, whether or not all of the parties were legally represented, or the demographics of the parties to the proceedings.

The Review is of the opinion that it is impossible to adequately review anecdotal concerns about the operation of the Children's Court without further evidence or data about its operations. As discussed in Chapter 6, Children's Court proceedings are closed to the public, and while members of the media can apply to observe proceedings, there are restrictions on the way in which the media can report about them.²⁷⁸ As such, there are limited sources of information about the way in which Children's Court cases are handled and determined. The Review notes, however, that evidence collected from the Review's file analysis, indicates that in many cases, misleading evidence appears to be presented to the Children's Court in care and protection proceedings. This issue is discussed in Chapter 23 (along with suggested remedies for reform).

Restriction on media publication of names and identifying information

In 2018, the *Care Act* was amended to further restrict the publication of information identifying a child or young person in the child protection system. The amendment was passed in response to the judgment of *Secretary, Department of Family and Community Services v Smith*.²⁷⁹ In this case, the Secretary of FACS sought a permanent injunction to prevent an advocacy group from publishing the fact that a missing child had been in the care of the Minister at the time of his disappearance. A media outlet also claimed that FACS had 'threatened journalists with criminal convictions if they revealed he was in state care and living with foster parents when he vanished'.²⁸⁰ One of the arguments advanced by the Secretary was that the publication was prohibited pursuant to the existing s 105 of the *Care Act*. It appears that FACS had long interpreted this provision, which prevented the publication of the name of a child or young person who is or was likely to be a witness or otherwise involved in any Children's Court or non-court proceedings, as imposing a blanket ban on the disclosure of the fact that any named child was under the parental responsibility of the Minister.²⁸¹

While the primary judge accepted that publication of his 'in-care' status would impinge adversely on 'Julian's' welfare, it noted:

That Julian disappeared while he was in the parental responsibility of the Minister, and in the care of departmentally approved carers, is a matter of legitimate public interest. Moreover, the truth has to date been obscured: the public has admittedly been given to think that Julian's carers are his parents.

277 For example, see: BOCSAR NSW. 'Criminal Court Statistics 2017', *Bureau of Crime statistics and Research* (Web Page) 28 May 2018 <https://www.bocsar.nsw.gov.au/Pages/bocsar_media_releases/2018/mr-NSW-Criminal-Courts-Statistics-2017.aspx>.

278 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 104B, 104C, 105.

279 *Secretary, Department of Family and Community Services v Smith* [2017] NSWSC 6.

280 Christopher Harris, 'William Tyrrell court bombshell: Little boy lost was in foster care', *The Daily Telegraph* (online, 25 August 2017) <<https://www.dailytelegraph.com.au/news/nsw/william-tyrrell-court-bombshell-missing-little-boy-lost-was-in-foster-care/news-story/2c7909c0e1fe408a0807fc97c14d21c5>>.

281 Note, however, that Counsel for the Secretary accepted in writing that 'it was not clear that the publication by the respondents in the terms proposed would amount to the commission of a criminal offence': *Secretary, Department of Family and Community Services v Smith* [2017] NSWCA 206 (23 August 2017), [51].

There is a substantial public interest in accountability and scrutiny of the out-of-home care system, and in accuracy of reportage of the circumstances of Julian's disappearance.²⁸²

The Court of Appeal did not find any error in the primary judge's reasoning and dismissed the Secretary's summons seeking leave to appeal.²⁸³

In response to this judgment, FACS proposed an amendment to the *Care Act* to 'explicitly prohibit publishing information identifying a child or young person as being under the parental responsibility of the Minister or in OOHC'.²⁸⁴ It noted that some stakeholders had opposed the change on the basis that it would reduce transparency of the OOHC system.²⁸⁵ However, it noted that 'most written submissions support the proposal'.²⁸⁶ The submissions referred to are not publicly available, so it is difficult to determine how many addressed the issue and which stakeholders explicitly agreed with the proposal. Importantly, however, the proposal was opposed by the peak Aboriginal child and family representative body. AbSec submitted that the amendment could 'significantly constrain reasonable scrutiny of Family and Community Services' and noted that the provision could communicate to children that their 'in-care' status was in some way shameful.²⁸⁷ It suggested that there be a 'process for assessing when the publication of such information might be warranted, to be determined by an appropriate judicial officer'.²⁸⁸

The proposed amendment to the *Care Act* was passed in 2018²⁸⁹ and the new s 105 (1AA) provides that

(1AA) The name of a child or young person who is or has been under the parental responsibility of the Minister or in out-of-home care must not be published or broadcast in any form that may be accessible by a person in New South Wales, in any way that identifies the child or young person as being or having been under the parental responsibility of the Minister or in out-of-home care (however expressed).

Note : Identifying the child or young person as being or having been a foster child or a ward of the State, or as being or having been in foster care or under the parental responsibility of the Minister, or in the care of an authorised carer, are all examples of identifying the child or young person as being or having been in out-of-home care.

The 'name of a child or young person' is defined to include a reference to any information, picture or other material that identifies, or is likely to identify, a child or young person.²⁹⁰

282 *Secretary, Department of Family and Community Services v Smith* [2017] NSWSC 6, [83].

283 *Secretary, Department of Family and Community Services v Smith* [2017] NSWCA 206.

284 Department of Family and Community Services (NSW), *Shaping a Better Child Protection System* (Discussion Paper, 2017) 37.

285 Department of Family and Community Services (NSW), *Shaping a Better Child Protection System: Report on the outcomes of consultations*, October 2018, 16.

286 *Ibid*, 16.

287 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission to *Shaping a Better Child Protection System* (November 2017) 8.

288 *Ibid*.

289 *Children and Young Persons (Care and Protection) Amendment Act 2018* (NSW) cl [35].

290 *Children and Young Person (Care and Protection) Act* (NSW) s 105(4).



There are several exceptions to the provision, including for the publication of a report of the Coroner's Court findings in an inquest concerning the suspected death of a child or young person, publication with the consent of the Children's Court, or in the case of a young person (aged between 16 and 18), with the consent of the young person. The Secretary may also consent to the publication if the child or young person is under the Secretary's parental responsibility and the Secretary is of the opinion that the publication 'may be seen to be to the benefit of the child or young person'. The provision also does not apply if the child has died or if the child or young person reaches 25 years of age.

A person who breaches s 105(1AA) is guilty of an offence with a maximum penalty of 200 penalty units or 2 years' imprisonment (or both) for an individual, or 2,000 penalty units for a corporation.

Key recommendations for reform

The Review's comprehensive file review, submissions, consultations and own research, clearly indicates that there is an urgent need to build much greater transparency and oversight into the child protection system. This section discusses how this should occur. It begins with the key recommendation that a new, independent body be established to (i) handle complaints about child protection workers and the OOHC staff; and (ii) monitor and oversee the child protection system (among other functions, discussed elsewhere in this report). However, the Review notes that until this recommendation is implemented, it is important to resolve a number of the identified problems above. For this reason, this cornerstone or key recommendation is followed by a number of interim recommendations designed to remedy deficiencies in the existing system (deficiencies that will no longer exist after the establishment of the recommended oversight body).

A new, independent oversight body

As the above discussion demonstrates, the current oversight mechanisms in the child protection system are fragmented and complex. The department accepts and handles complaints about its own caseworkers, while it appears to divert complaints about non-government OOHC providers to those providers for resolution. The Ombudsman also accepts complaints about the actions of those involved in the child protection system, although in practice it does not appear to deal with a large proportion of these complaints. The Ombudsman also prepares reports about the OOHC system for parliament, coordinates the 'reportable conduct' scheme and coordinates the Official Community Visitors Scheme. Meanwhile, the Office of the Children's Guardian is responsible for accrediting and monitoring OOHC agencies (including non-government OOHC agencies that are also overseen to some degree by FACS) and maintaining the Carers Register.

This division of responsibilities between DCJ, the non-government OOHC sector, the Ombudsman and the Office of the Children’s Guardian, has necessitated the passing of several provisions to enable the sharing of information between the bodies and to prevent the duplication of work.²⁹¹ It has also led to the development of MOUs, such as the MOU titled *Cooperative arrangements between the Children’s Guardian, Ombudsman and Official Community Visitors*.

The division of functions between the Ombudsman and the OCG has grown increasingly undesirable over the years, as the size of the OOHC population has expanded and the complexity of the system has grown exponentially. As noted on multiple occasions in this report, the child protection system is in a constant state of flux as the NSW Government introduces wave after wave of reform, generally without clearly articulating how each new framework or policy developed interacts with those that already exist. The introduction of Their Futures Matter, and the outsourcing of OOHC to the non-government sector, have added extra layers of complexity to the system. Roles and responsibilities have been blended and divided, while contract management, procurement and monitoring has taken on an increased level of importance.

It is not just the increasing size and complexity of the OOHC system that justifies the introduction of a new independent body. As this discussion has demonstrated, the Ombudsman and the Office of the Children’s Guardian have a number of functions in addition to those relating to oversight of the child protection sector. This has, perhaps inevitably, led to a reduction in the volume and scope of work conducted by these bodies in relation to the child protection system and a lack of sustained focus on the operation of the system. In addition, the outsourcing of OOHC to the non-government sector raises questions about whether the Ombudsman—a body traditionally tasked with overseeing the public sector—should continue to handle complaints about the behaviour of actors in the private sector.

For all of these reasons, the Review is of the view that it is desirable for the system to be governed by a single, specialist body that can focus exclusively on ensuring that it operates fairly and efficiently. The Review notes that it is vital that this body is independent of FACS. The consolidation of oversight and monitoring functions into one body will require additional expenditure. However, the advantages to be gained from effective oversight and monitoring of the entire child protection system leading to improvements in the way in which the system operates and a reduction of the number of children in care are likely to outweigh these costs. In addition, the creation of an independent and transparent statutory body will enhance public confidence in the system, particularly among Aboriginal communities. It will also serve as symbolic recognition of the importance of the current child protection crisis, and a convenient and easily accessible point of contact for children and young people in the OOHC system to raise concerns and seek assistance.

As the above discussion illustrates, there are a number of existing concerns about the effectiveness of the oversight of both the Ombudsman and the OCG. These concerns, combined with the evidence gathered during this Review about widespread non-compliance with legislation and policy among FACS and the non-government OOHC sectors, reinforces the Review’s view that significant change is needed.

291 See for example: *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 8A; *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 180.



For these reasons, the Review recommends that the NSW Government establish and appropriately resource a new independent statutory body, tentatively named the NSW Child Protection Commission. This body should be a ‘one-stop shop’ for the oversight and monitoring of the child protection system in NSW. It should have at least one Aboriginal Commissioner and an Aboriginal Advisory Body (appointed in consultation with the Aboriginal community). The independent NSW Child Protection Commission should have the following functions and should be explicitly required to perform them openly and transparently:

- The handling of complaints about those involved in the operation of the child protection system (including complaints about matters that are before the NSW Children’s Court where the hearing of the complaint will not interfere with the administration of justice);
- The oversight and coordination of the Official Community Visitors Scheme;
- The conduct of the ‘reviewable deaths’ scheme where the death is: a child in OOHC care or a child whose death is or may be due to abuse or neglect;
- The accreditation and monitoring of OOHC providers;
- The monitoring of overall system performance with a view to making recommendations for reform as needed;
- The reviewing of the circumstances of an individual child or group of children in OOHC (including the power to apply to the Children’s Court or the rescission or variation of any order made under the *Care Act*);
- The monitoring of the implementation of the *Aboriginal Case Management Policy* and the *Aboriginal Case Management Rules and Practice Guidance* (see Chapter 16);²⁹²
- The conducting of inquiries into systemic issues in the child protection system, either on its own motion or at the request of government;
- The conducting of the new qualitative case file review program (discussed below);
- The monitoring of the implementation of the Joint Protocol to reduce the contact of young people in residential out-of-home care with the criminal justice system (see Chapter 15);
- The oversight, monitoring and reporting on the operation of the new mandatory Alternative Dispute Resolution system introduced by the *Children and Young Persons (Care and Protection) Amendment Act 2018* (NSW) (see Chapter 19); and
- The provision of information, education and training to stakeholders and the community about the operation of the child protection system.

The ‘reportable conduct’ scheme, which requires the reporting of sexual, physical and psychological abuse of a child by employees of designated government and non-government agencies, should remain with the NSW Ombudsman or the Office of the Children’s Guardian. While this scheme includes children in OOHC, its remit is much broader, making it unsuitable for inclusion in its entirety in the functions of the new Child Protection Commission. In addition, the component of the scheme relating to children in OOHC is not easily divisible for the rest of the scheme (as is the case with the monitoring of deaths of children in OOHC or deaths caused by abuse or neglect), making the NSW Ombudsman the most appropriate body to be tasked with functions under the scheme.

292 These are discussed further in Chapter 16.

Recommendation 9: The NSW Government should establish a new, independent Child Protection Commission. The Commission, which should be required by legislation to operate openly and transparently, should have the following functions:

- (a) The handling of complaints about those involved in the operation of the child protection system (including complaints about matters that are before the Children’s Court of NSW where the hearing of the complaint will not interfere with the administration of justice);
- (b) The oversight and coordination of the Official Community Visitors Scheme;
- (c) The management of the ‘reviewable deaths’ scheme where the death is: a child in OOHC, or a child whose death is or may be due to abuse or neglect;
- (d) The accreditation and monitoring of OOHC providers;
- (e) The reviewing of the circumstances of an individual child or group of children in OOHC (including the power to apply to the Children’s Court of NSW for the rescission or variation of any order made under the *Children and Young Persons (Care and Protection) Act 1998* (NSW));
- (f) The monitoring of the implementation of the *Aboriginal Case Management Policy* and the *Aboriginal Case Management Rules and Practice Guidance*;
- (g) The conducting of inquiries into systemic issues in the child protection system, either on its own motion or at the request of the NSW Government;
- (h) The conducting of the new qualitative case file review program;
- (i) The monitoring of the implementation of the Joint Protocol to reduce the contact of young people in residential out-of-home care with the criminal justice system;
- (j) The oversight and monitoring of, and reporting about, the operation of the new mandatory Alternative Dispute Resolution system introduced by the *Children and Young Persons (Care and Protection) Amendment Act 2018* (NSW); and
- (k) The provision of information, education and training to stakeholders and the community about the operation of the child protection system.



A new internal complaints handling system

It is difficult, without further evidence, to draw many firm conclusions about the nature of complaints received in the child protection sector, the way in which these complaints are resolved, and whether complainants are satisfied with the process and outcomes of their complaints. This evidence, while it may exist, is not publicly available. However, like the Legislative Council inquiry, this Review is concerned about submissions that indicate that departmental staff are not investigating complaints efficiently and professionally, and take retributive action against complainants. As the Legislative Council inquiry noted, it is an offence, punishable by 50 penalty units or imprisonment for 12 months (or both), for any person to take detrimental action against another person because of a complaint about the provision of a service by DCJ.²⁹³ The taking of retributive action, such as the reduction in contact hours with a child, grossly violates the child and parent's human rights, and serves to discourage complaints (and thus reduce accountability of caseworkers and OOHC staff). It also stymies the ability of FACS and OOHC providers to learn from their mistakes and to improve relationships with Aboriginal families and communities.

In light of the existing mistrust surrounding the department's complaint handling and the concerns that have been raised about it, the Review recommends that DCJ engage an independent review of its internal complaints system, with a view to developing a complaints system that: (a) is transparent and accessible; (b) is child friendly; (c) is empowered to resolve complaints adequately; (d) is developed in collaboration with Aboriginal communities; and (e) employs Aboriginal staff in key roles. Undertaking such a review would help to encourage practice change around complaints handling within the department, and is consistent with the Practice First principle that 'critique leads to improved practice'.²⁹⁴ The review of the complaints system should also consider the appropriateness of sanctions for poor performance and any overlap between these sanctions and existing internal disciplinary and management processes.

The Review believes that any new complaints handling system would be complimented by the adoption of a 'Charter of Rights and Responsibilities' for Aboriginal parents and families involved in the child protection system. We recommend the charter developed by regulatory scholars Sharynne Hamilton and Valerie Braithwaite, in consultation with parents, family members and community members.²⁹⁵ This Charter would help to explain the rights and responsibilities of Aboriginal family members to guide their decision-making with respect to the making of complaints about child protection services.

293 *Community Services (Complaints, Review and Monitoring) Act 1993* (NSW) s 47.

294 Department of Family and Community Services, 'NSW Practice Framework' < <https://www.facs.nsw.gov.au/providers/children-families/child-protection-services/practice-framework>>.

295 Sharynne Hamilton and Valerie Braithwaite, 'Parents and Family Members Matter: A Charter of Rights and Responsibilities for Parents and Family Members with Children in the Care of Child Protection Services in Australia' (RegNet Occasional Paper 22, September 2014).

Recommendation 10: The Department of Communities and Justice should conduct an independent review of its internal complaints handling system, with a view to developing a complaints system that is:

- (a) transparent and accessible;
- (b) child friendly;
- (c) empowered to resolve complaints adequately;
- (d) developed in consultation with Aboriginal communities; and
- (e) supported by a Charter of Rights and Responsibilities for Aboriginal Families.

This system should also employ Aboriginal staff in key roles.

No 'for profit' OOHC providers

The Review is concerned about the fact that OOHC providers are able to profit from the services they provide to one of the most vulnerable groups in society—children in need of care and protection. While 'for-profit' entities are engaged in the provision of services for governments in a number of fields, it is questionable whether it is desirable or ethical to permit these types of entities to operate in the child protection space. The transfer of responsibility for OOHC case management services to the non-government sector in NSW was not accompanied by public consultation or in-depth analysis of this issue.

Privately owned, profit oriented companies have an explicit financial interest in maintaining and expanding OOHC services (and thus in appearing to be performing well), and in reducing the costs associated with providing OOHC services. As noted in the discussion above, cost reductions may be realised in many areas, such as staff wages or training, or in the provision of clothing, furniture or other goods required by children in care.²⁹⁶ In other words, there is 'a serious risk of perverse financial incentives (direct or indirect) that could potentially distort decisions in individual cases'.²⁹⁷ The Review is further concerned by the fact that four of the five 'for-profit' OOHC operators provide residential care to children and young people. This is a concern because it has long been recognised that children in residential care are the most vulnerable and are most likely to suffer further harm and abuse. Further, it is concerned that the 'for-profit' OOHC sector may continue to expand, as two of the for-profit providers received provisional approval to operate OOHC services from the Office of the Children's Guardian in 2018. It appears that this expansion may also be occurring largely unnoticed, as it is not clear from the OCG's website which OOHC providers are for-profit entities and which operate on a not-for-profit basis. The OCG has not mentioned any of these designated agencies in any of its annual reports or other publications. For example, the OCG's *Review of Residential Care 2017-18* contained no mention of the fact that four of the residential OOHC providers operated for a profit. It is also unclear how much profit these companies are making, as their financial records are not readily available for scrutiny.

296 Linton Besser, 'Broken Homes: On the Frontline of Australia's Child Protection Crisis' (Four Corners and ABC News Digital, 2016).

297 Association of Directors of Children's Services, cited in R Jones, 'The End Game: The Marketisation and Privatisation of Children's Social Work and Child Protection' (2015) 35(4) *Critical Social Policy* 447, 454.



There is no reason in principle why the providers of adoption services in NSW are required to be non-profit organisations, while the providers of OOHC services are permitted to make a profit. At a fundamental level, adoption service providers are involved in the same work as OOHC providers—that is, they are tasked with finding safe, stable and permanent homes for children who are unable to live with their birth families. The underlying rationale for restricting adoption service provision to not-for-profit organisations—to ensure the highest quality service and to ensure that decisions are not tainted by profit-oriented motives—appears to be just as applicable to the OOHC system. This, combined with concerns about the lack of effective regulation of OOHC providers, that ‘for profit’ companies are providing services to the most vulnerable children in the sector and that media reports indicate that monetary incentives are affecting the standard of care provided to children, have led the Review to conclude that the legislation should be amended to ensure that OOHC services can only be provided by charitable or non-profit organisations.

Recommendation 11: The NSW Government should amend clause 45 of the *Children and Young Persons (Care and Protection) Regulation 2012 (NSW)* and all other related clauses to ensure that only a charitable or non-profit organisation may apply to the Office of the Children’s Guardian for accreditation as a designated agency.

A more transparent Children’s Court

The principle of open justice is a ‘fundamental rule of the common law’.²⁹⁸ The principle, which requires the administration of justice to occur in open court, is designed to maintain confidence ‘in the integrity and independence of the courts’.²⁹⁹ However, the principle is not absolute, and in the case of proceedings in the Children’s Court of NSW, it has been determined that there is a greater public interest in conducting the proceedings in a closed court.³⁰⁰ This approach is taken in most Australian states and territories, although the the Children’s Court in Victoria is open to the public unless the magistrate excludes particular people from attending.³⁰¹

This does not, however, mean that all information about proceedings in the Court should be kept confidential. The public interest that is protected by the provisions requiring the court to be closed is the public interest in protecting a child’s privacy.³⁰² This public interest can be maintained if judgments published by courts are properly anonymised so that they do not reveal any information about the identity of the child who was the subject of the proceedings.

Currently, the Children’s Court of NSW publishes a small number of its decisions each year. At the time of writing, there were 47 civil Children’s Court cases published on Caselaw (spanning the period from 2011 to 2018).³⁰³ Of these, approximately half have been published by the President of the Children’s Court.³⁰⁴ In addition, approximately 100 additional Children’s Court care and protection cases have been published in the Children’s Law News, a ‘regular online publication to alert legal practitioners and other interested persons to important cases and

298 *John Fairfax & Sons Limited v Police Tribunal of NSW* (1986) 5 NSWLR 456, 476– 477.

299 *Russell v Russell* (1976) 134 CLR 495.

300 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 104b.

301 *Children Youth and Families Act 2005* (Vic) s 523.

302 Elizabeth Fernandez et al, ‘A Study of the Children’s Court of New South Wales’ (Part of a National Assessment of Australia’s Children’s Courts’ 2014).

303 As at 30 April 2019.

304 Eighteen have been published by the current President of the Children’s Court, Judge Peter Johnstone, while a further four were published by the former President of the Children’s Court, Judge Mark Marien.

papers considered to be relevant to the Children’s Court jurisdiction’.³⁰⁵ These date back to 2001, when the Children’s Court News was first published. There is no publicly available policy that outlines the criteria necessary to consider a decision suitable for publication, and no publicly available description of the process by which decisions are anonymised and published. The judgments published through the Children’s Court News are not searchable, and to locate them reference must be made to the *Children’s Law News Cumulative Case Index*.³⁰⁶

The Review is of the view that the Children’s Court should publish all of its final judgments online as a matter of standard practice. This approach is taken by most of the other courts that deal with matters involving children. For example, the Chief Justice of the Family Court of Australia introduced a policy requiring almost all of the Family Court’s judgments to be published online and developed a Judgments Publication Office ‘to develop, manage and undertake the publication process’.³⁰⁷ The Family Court’s publication policy ‘has enabled the Court to better respond to community interest and concerns about particular cases highlighted in the media’.³⁰⁸

In 2012, a similar recommendation was made in *Protecting Victoria’s Vulnerable Children* report, which recommended that the Children’s Court of Victoria be appropriately resourced to publish decisions relating to ‘points of principle’ on the Children’s Court’s website (in de-identified form).³⁰⁹ It also recommended that the Children’s Court make transcripts of all its decisions available to the public in de-identified form.³¹⁰

It is important to make all final judgments of the Children’s Court available for several reasons (as opposed to only judgments on points of law or principle being available). First, the publication of all final judgments will help ensure confidence in the independence and integrity of the Children’s Court. It will provide members of the public, the media, scholars, policy makers and any other interested stakeholders with the ability to access information about the way in which proceedings are conducted and determined in the Children’s Court. It will also promote access to justice by providing precedential information to parties and legal practitioners, which is particularly important to promote access to justice for unrepresented litigants.

The publication of judgments will also act as an important mechanism of accountability for DCJ. One barrister has noted when discussing secrecy within the ACT child protection system, ‘if there isn’t a judgment published, the welfare agencies can just dust it off and nobody gets to see or hear about it when they’ve got a case completely wrong’.³¹¹ In cases involving adverse comment about DCJ caseworkers, or the way in which DCJ has conducted litigation, there is a clear public interest in the publication of the judgment. As the Court held in *Re F; F v Lambeth London Borough Council*

305 NSW Children’s Court, ‘Children’s Law News’, *NSW Children’s Court* (Web Page) <<http://www.childrenscourt.justice.nsw.gov.au/Pages/publications/lawnews/lawnews.aspx>>.

306 ‘Children’s Law News Cumulative Case Index’, *NSW Children’s Court* (Web Page) <<http://www.childrenscourt.justice.nsw.gov.au/Documents/CLN%20Case%20Index%20as%20at%20May%202018.pdf>>.

307 Lyn Newlands, ‘Publishing Family Court judgments: problems and solutions’ (2016) 24(2) *Journal of Law, Information and Science*, 3.

308 ‘Finding out about judgments’, *Family Court of Australia* (Web Page, 3 May 2016) <<http://www.familycourt.gov.au/wps/wcm/connect/fcoaweb/judgments/finding-out-about-judgments/>>.

309 Philip Cummins, Dorothy Scott, Bill Scales, *Report of the Protecting Victoria’s Vulnerable Children Inquiry* (2012), rec 65, 407.

310 Ibid.

311 Kimberley Le Lievre, ‘ACT child protection secrecy the ‘most restrictive in the country’, *The Canberra Times* (online, 17 February 2019) <<https://www.canberratimes.com.au/story/5995220/act-child-protection-secrecy-the-most-restrictive-in-the-country/>>.



where the judicial process reveals failings by the State as egregious and damaging as those which I have had to consider in the present case, the argument for public disclosure becomes almost overwhelming. Not merely does the public have a right to be told what is being done; there is ... a clear public interest in these matters being brought to the attention of the public. The public, including the tax-paying, rate paying and council-tax-paying public should be forced to confront what the State is doing or leaving undone even if, left to themselves, some members of the public would rather not know what is happening.

In the final analysis, the only safeguard and guarantee for proper performance of their functions by public authorities is public awareness and the force of informed public opinion and an informed electorate. The public needs to be told what it does. The public needs to be told what it has done to this family.³¹²

The Review has also concluded that the Children’s Court should prepare and publish a stand-alone Annual Review. Similar to an annual report—which is ‘the key medium by which NSW Public Sector entities discharge their accountability to the Parliament, the Government and the public’³¹³—the annual review would provide valuable information about day-to-day operation the Court, such as information about workload, resources (including resources provided to the Children’s Court Clinic), facilities, staff and training. Annual Reviews are already published by other courts in NSW and as the Chief Justice of NSW has noted, the publication of the Annual Review is ‘one of the ways the Court remains transparent and accountable to the public, and in doing so maintains that trust and confidence’.³¹⁴ While the Local Court of NSW already prepares an Annual Review, it contains scant reference to the operation of the Children’s Court care and protection jurisdiction. Although a part of the Local Court, the Children’s Court has a jurisdiction that is sufficiently distinct and specialised to warrant its own Annual Review.

Recommendation 12: The Children’s Court of NSW should be appropriately resourced to enable it to publish all of its final judgments online in a de-identified and searchable form.

Recommendation 13: The Children’s Court of NSW should prepare and publish annual statistics regarding its operations in the care and protection jurisdiction.

Recommendation 14: The Children’s Court of NSW should prepare and publish an Annual Review.

312 *Re F; F v Lambeth London Borough Council* [2002] 1 FLR 217, [83]–[84].

313 NSW Treasury, ‘Annual Reporting’ (Web Page) <<https://www.treasury.nsw.gov.au/information-public-entities/annual-reporting>>.

314 Supreme Court of NSW *Annual Review* (2017).

Media reporting subject to a ‘public interest test’

The rationale behind the introduction of s 105(1AA) of the *Care Act* is that children ‘can suffer stigma and stress when it becomes known that they are in OOHC³¹⁵ and as such are entitled to keep this information private. The Review agrees that children have a right to retain control over private information such as their OOHC status and is of the view that intrusive and sensationalist media reporting of individual child protection matters is highly undesirable. Nevertheless, as *Secretary, Department of Family and Community Services v Smith*³¹⁶ demonstrates, there may be occasions when there is an overriding competing public interest such as ensuring accountability of those involved in the child protection system. While there are exceptions to the s 105(1AA) offence provision,³¹⁷ they are insufficiently broad to cover a number of situations where it may legitimately be in the public interest to publish the fact that a child or young person is or has been under the parental responsibility of the Minister or in OOHC. In particular, the provision may prevent the publication of the following (without the consent of the Secretary, the Children’s Court or a young person over 16 years of age):

- Media reports that identify parents who allege that their children have been wrongfully removed (this identification may occur by way of photograph or voice recognition);
- Media reports and police media releases that state that a named missing child was in OOHC at the time of the child’s disappearance;
- Media reports that criticise the way in which DCJ investigated or handled the fact that a child had gone missing from OOHC;
- Photographs of the condition of the outside of houses in which children and young people in OOHC have been placed;
- Media reports about compensation provided to identified individuals under the age of 25 for harm suffered when under the parental responsibility of the Minister;
- Media reports that identify authorised carers who may wish to criticise the child protection system;
- Media or other reports recognising the contribution and commitment of individual authorised carers;
- Interviews by authorised carers that aim to promote greater public understanding of the role of foster carers in the child protection system;
- Media reports that identify parents or authorised carers who are charged with causing harm to children in their care;
- Social media posts by children disclosing their OOHC status;
- Social media posts by parents or authorised carers about their experiences with the child protection system; and

315 Department of Family and Community Services (NSW), *Shaping a Better Child Protection System* (Discussion Paper, 2017) 37

316 *Secretary, Department of Family and Community Services v Smith* [2017] NSWSC 6.

317 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 105(3).



- Media interviews with children under the age of 16 about their experiences in OOHC if these interviews show or name the children;
 - Speeches, stories or other written work by children under the age of 16 that disclose the child in question's OOHC status; and
 - Speeches at political rallies, conferences and other public forums by parents that refer to the fact that their children are in OOHC.³¹⁸

The great breadth of information that may be suppressed by the new s 105(1AA) of the *Care Act* is clearly undesirable and unwarranted. For example, the provision as drafted would likely have prevented the production and screening of the acclaimed documentary film *Beyond the Apology*, which featured members of the Grandmother's Against Removals (GMAR) talking about the removal of their grandchildren. It is in the public interest that the child protection system be openly scrutinised, analysed and discussed by those involved in or affected by the system, including children, as well as by academics, public interest groups and journalists. The new s 105(1AA) of the *Care Act* was opposed by the Labor Party and the Greens in NSW and is also opposed by several children's welfare groups.³¹⁹

Although consent can be granted for the publication of material that may breach s 105(1AA) of the *Care Act*, it is undesirable that the power to grant such consent be vested in the Secretary of DCJ, who may consciously or unconsciously desire to minimise the political consequences of any perceived failure by DCJ. It also undermines public confidence in the accountability of the child protection system. Further, while consent may also be granted by the Children's Court, the time and expense involved in obtaining a court order may deter potential applicants.

For these reasons, the Review recommends that s 105 of the *Care Act* be amended to include a 'public interest' defence to an offence under s 105(1AA). Whether or not it was in the public interest to publish the fact that a child or young person is or has been under the parental responsibility of the Minister or in OOHC would be determined objectively on the facts of each case. Such a provision, which is not unusual in Australian law, would enable the defendant to any prosecution for a breach of the provision to avoid criminality by establishing that the public interest in the disclosure outweighed the public interest in keeping the information secret. A public interest defence would provide an adequate deterrent to sensationalist or unnecessary violations of a child's privacy, whilst maintaining a channel for transparency and accountability in relation to matters of legitimate public concern.

Recommendation 15: The NSW Government should amend s 105 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to include a public interest defence to an offence under s 105(1AA).

318 For a further discussion of some of these issues see: 'Restrictions on media coverage of child protection and family court matters', *The Law Report* (ABC Radio National, 21 April 2009) <<https://www.abc.net.au/radionational/programs/lawreport/restrictions-on-media-coverage-of-child-protection/3148830#transcript>>.

319 Patrick Begley, "Hiding behind invisible children": welfare groups oppose new laws', *The Sydney Morning Herald* (online, 15 December 2018) <https://www.smh.com.au/national/nsw/hiding-behind-invisible-children-welfare-groups-oppose-new-laws-20181214-p50mcu.html?fbclid=IwAR3eTjM7X6DY24HWPZkVbXErMp_xsc_r2QxmF6_jKwi5_M8r_-DyjszmCyk>.

The introduction of comprehensive qualitative file audits

The Review's case file review revealed that lack of compliance with legislation and policy was disturbingly common among child protection workers and the OOHC sector. For this reason, there is a pressing need for an additional layer of monitoring of the 'front-line practice delivery'³²⁰ of all involved in the child protection system, in particular the decision making and behaviour of caseworkers and OOHC staff. However, it is important to ensure that this quality control process does not unduly burden caseworkers and members of the non-government OOHC sector by adding to their already extensive administrative tasks, or by being too complex or time consuming. Further, it is important that the monitoring does not negatively affect caseworker morale or detract from the department's ability to attract and retain qualified staff. Finally, any additional accountability system must co-exist with those that have been established, without overlapping in terms of function or outcomes, and must be shown to add value by increasing transparency, enhancing individual practice knowledge, encouraging best-practice and effecting system change.

After reviewing a variety of accountability options, the Review has concluded that the NSW Government should introduce a form of diagnostic monitoring of the child protection system and that this should take the form of random, periodic reviews of the files of Aboriginal children in OOHC, combined with a family group conference model of resolving issues of concern.³²¹ This system of qualitative case reviews should be based upon the successful Quality Case Review and Quality Service Review (QSR) systems originally implemented in Utah and Alabama respectively, and now in use in over 10 US States.³²²

While there are some differences in the QSR approach in different US states, it is possible to provide a general overview of the process. First, a random sample of cases are selected for review. These samples 'are adjusted so that each office has at least one review and no worker has more than one, and so that there is a balance of in-home and out-of-home interventions, older and younger children, and boys and girls'.³²³ When a case is selected for review, the relevant caseworkers prepare the file and send it to the reviewers.³²⁴ The reviewers (who generally work in pairs) then read the file and interview the stakeholders, commencing with the caseworker and then moving on to the child in question, as well as the child's family members, service providers and supervisors.³²⁵ It is the caseworker's responsibility to approach the families and ask if they wish to be involved in the review process.³²⁶ Case reviews take approximately two days to complete.³²⁷

After the review, the case is scored numerically on a number of indicators. For example, the Alabama QSR scores the case on 14 indicators relating to the child's current status (such as safety, stability, family connections, physical and emotional wellbeing, cultural accommodation, and child and family satisfaction), as well as 12 indicators relating to the operation of the child protection

320 Bethany G. Womack, 'Qualitative Service Review as a Learning Strategy for Child Welfare Practice Improvement' (PhD Thesis, University of Alabama 2017), 17.

321 Note that Family Group Conferences are discussed further in Chapter 19.

322 Alabama, California (Los Angeles County), Florida, Indiana, Iowa, Michigan, New Jersey, Oklahoma, Pennsylvania, Tennessee, Utah and Virginia: Bethany G. Womack, 'Qualitative Service Review as a Learning Strategy for Child Welfare Practice Improvement' (PhD Thesis, University of Alabama 2017); The Annie E. Casey Foundation, 'Counting is not enough' (1 January 2011), 9.

323 Kathleen G. Noonan, 'Legal Accountability in the Service-Based Welfare State: Lessons from Child Welfare Reform' (2009) 34(3) *Journal of the American Bar Foundation*, 543.

324 Bethany G. Womack, 'Qualitative Service Review as a Learning Strategy for Child Welfare Practice Improvement' (PhD Thesis, University of Alabama 2017) 61.

325 Ibid 64, 666; The Annie E. Casey Foundation, 'Counting is not enough' (1 January 2011), 4

326 Bethany G. Womack, 'Qualitative Service Review as a Learning Strategy for Child Welfare Practice Improvement' (PhD Thesis, University of Alabama 2017) 65.

327 Kathleen G. Noonan, 'Legal Accountability in the Service-Based Welfare State: Lessons from Child Welfare Reform' (2009) 34(3) *Journal of the American Bar Foundation*, 543.



system (including the efforts made to engage the child and family, the level of service coordination and the quality of the child's case plan).³²⁸ Some indicators receive more weight than others³²⁹ and in some states, a case can 'fail' if a majority of indicators, or the indicator of safety, is scored as the 'below acceptable practice' range.³³⁰

At this point, the reviewers provide face-to-face, case-specific feedback to child protection staff.³³¹ This feedback is strengths-based and highlights which aspects of casework are 'working' and which need improvement.³³² The feedback may also contain recommendations on the next steps to be taken in the case.³³³ In some states, there are systems in place to ensure that the QSR feedback is acted upon. The reviewers also prepare written narrative reports on each case and from this, whole regions can receive a score on casework performance.³³⁴ In this way, the QSR process allows reviewers to 'identify common trends across case practice or systemic issues that are facilitating or hindering implementation of best practice'.³³⁵ The results of the QSR process are shared agency-wide and with the community.³³⁶

Qualitative methods such as the QSR process are 'particularly useful' if the purpose of the review is to 'make sense of complex situations, multi-context data and changing and shifting phenomena'.³³⁷ The QSR process has been described as an 'indirect' practice intervention or 'clinical training' for caseworkers as it encourages child protection stakeholders to reflect upon 'on-the-ground' casework while preparing for the review, during the review and upon the receipt of feedback from the reviewers.³³⁸ The QSR process is also educative for the reviewers and enables them to understand existing differences between approaches to casework and how child protection best-practice 'plays out' in the field,³³⁹ which in turn enabled them to revise their own practices in the child protection field. Further, the QSR process helps to 'operationalise' vague, high-level practice principles, such as 'engagement with the family' into frontline case practice.³⁴⁰ Or as Kathleen Noonan et al put it, the QSR 'is a form of norm elaboration through peer review that engages all levels of the system, as well as outside experts'.³⁴¹ The process of the QSR mirrors, and may help, to train staff in collaborative, strengths-based and family-centred approaches to practice.³⁴²

328 Human Systems and Outcomes, Inc, *Quality Service Review: Protocol for Review of the Current Status of Children and Families and Performance of Key Service System Functions (Field Use Version 2.0)* (Produced for use by Alabama Department of Human Resources Family Services Division, 2005).

329 Ibid; Kathleen G. Noonan, 'Legal Accountability in the Service-Based Welfare State: Lessons from Child Welfare Reform' (2009) 34(3) *Journal of the American Bar Foundation*, 544.

330 Bethany G. Womack, 'Qualitative Service Review as a Learning Strategy for Child Welfare Practice Improvement' (PhD Thesis, University of Alabama 2017) 85.

331 Ibid 69.

332 Ibid 70.

333 Ibid 74.

334 Ibid 85.

335 Ibid 69.

336 The Annie E. Casey Foundation, 'Counting is not enough' (1 January 2011),24.

337 Norman Denzin, Yvonne Lincoln, *Handbook Of Qualitative Research* (Sage Publications 2d ed. 2000), cited in Kathleen G Noonan, 'Qualitative Case Review in a Child Welfare Lawsuit', in Centre for the Study of Social Policy, *For the Welfare of Children: Lessons Learned from Class Action Litigation* (2012) 49.

338 Kathleen G. Noonan, 'Legal Accountability in the Service-Based Welfare State: Lessons from Child Welfare Reform' (2009) 34(3) *Journal of the American Bar Foundation*, 545; Bethany G. Womack, 'Qualitative Service Review as a Learning Strategy for Child Welfare Practice Improvement' (PhD Thesis, University of Alabama 2017) 70.

339 Bethany G. Womack, 'Qualitative Service Review as a Learning Strategy for Child Welfare Practice Improvement' (PhD Thesis, University of Alabama 2017) 72.

340 Ibid 87.

341 Kathleen G. Noonan, 'Legal Accountability in the Service-Based Welfare State: Lessons from Child Welfare Reform' (2009) 34(3) *Journal of the American Bar Foundation*, 545.

342 Bethany G. Womack, 'Qualitative Service Review as a Learning Strategy for Child Welfare Practice Improvement' (PhD Thesis, University of Alabama 2017) 73.

Finally, the process of review helps to identify widespread or localised systemic problems and direct training and resource allocation to addressing these problems.³⁴³

The research into the QSR process is somewhat limited.³⁴⁴ However, one study of caseworker perceptions of the QSR process in the USA found that caseworkers found the QSR process to be helpful and validating when the caseworker had implemented effective casework strategies and this was recognised by the QSR process. Further, caseworkers implemented the knowledge and feedback gained from the reviews in later casework.³⁴⁵ Caseworkers found positive feedback, especially from families, particularly meaningful.³⁴⁶ In another qualitative study of 24 state or local jurisdictions with experience implementing QSR system in the US, there was widespread agreement about the value and importance of the process as a means of quality assurance—‘getting behind the numbers’—and as a method to direct meaningful system reform.³⁴⁷ In jurisdictions with a long history of using the QSR process, it was possible to ‘produce tangible evidence of system reform’.³⁴⁸

The Review has concluded that a QSR system is a vital adjunct to the other reforms suggested in this chapter.³⁴⁹ As it is jurisdiction-specific, it could be developed to accommodate the unique child protection legislation, practices, procedures and priorities in NSW. However, the model used in the United States requires modification for local application. For example, the Review does not consider that there should be the same degree of focus on ‘scoring’ and ‘ranking’ caseworkers and FACS districts which may stymie effective dialogue during the file review process. Instead, the principle of the ACP in NSW requires that there be a greater focus on a collaborative and restorative approach to resolving issues identified by the QSR process. Accordingly, the Review recommends that the process of interviews conducted by QSR reviewers should be followed by an optional Family Group Conference, where any issues relating to casework practice, or the safety and wellbeing of the child, can be discussed and resolved by all relevant stakeholders (including Aboriginal Elders or support persons, where requested). As with any new initiative, the QSR process should be developed in partnership with Aboriginal communities to ensure that its content and manner of implementation are culturally appropriate. While the system will require appropriate resourcing to function effectively, it will provide a valuable diagnostic tool that can be used to align caseworker practice to the practice model and in this way drive much needed reform.

Recommendation 16: The NSW Government should, in partnership with Aboriginal communities and stakeholders, introduce a system of qualitative file reviews modelled on the Quality Case Review and Quality Service Review systems that have been implemented in some states of the United States of America, with the introduction of the additional component of an optional Family Group Conference.

343 Kathleen G. Noonan, ‘Legal Accountability in the Service-Based Welfare State: Lessons from Child Welfare Reform’ (2009) 34(3) *Journal of the American Bar Foundation*, 545.

344 The Annie E. Casey Foundation, ‘Counting is not enough’ (1 January 2011), 3, fn 2.

345 Bethany G. Womack, ‘Qualitative Service Review as a Learning Strategy for Child Welfare Practice Improvement’ (PhD Thesis, University of Alabama 2017) 75.

346 Ibid 75.

347 The Annie E. Casey Foundation, ‘Counting is not enough’ (1 January 2011), 5.

348 Ibid 12.

349 Kathleen G Noonan, ‘Qualitative Case Review in a Child Welfare Lawsuit’, in Centre for the Study of Social Policy, *For the Welfare of Children: Lessons Learned from Class Action Litigation* (2012) 53.



Additional interim recommendations for reform

The Review acknowledges that the new independent Child Protection Commission may take some time to establish. For this reason, it makes additional, interim recommendations that can be implemented immediately to address some of the deficiencies in approach of the existing regulatory bodies discussed in this chapter.

Expansion of the NSW Ombudsman's jurisdiction to investigate complaints

The Review is concerned that the Ombudsman declines to investigate numerous complaints and cannot investigate complaints more than 12 months old or issues that have (or could be) considered by a court. There appear to be many cases where complaints about casework could run parallel to court processes without interfering with the administration of justice. It appears that this jurisdictional limitation severely hampers the ability of the Ombudsman to oversee the child protection sector, as in almost every case in which a child is removed from his or her family, court proceedings are commenced. In these cases, it appears that no complaint may be made about the pre-entry into care casework of the child protection caseworkers, even though this casework may not have a bearing on the issues to be decided by the court.

Recommendation 17: The NSW Government should amend the *Ombudsman Act 1974* (NSW) to enable the NSW Ombudsman to handle complaints in matters that are (or could be) before a court, in circumstances where doing so would not interfere with the administration of justice.

A more transparent Children’s Guardian

The Review is also of the perspective that it is imperative that the OCG achieves far greater levels of transparency. It is vitally important that the public is able to access information about the regulator’s activities and the performance of the designated agencies that it monitors in order to: raise public confidence in the performance of OOHC providers and the OCG; encourage public debate about relevant issues in the OOHC sector; encourage best practice from OOHC providers (through the provision of information about the performance of other OOHC agencies and the possibility of public and media scrutiny); enable comparisons between OOHC providers to be made with a view to improving the performance of the entire sector by targeting compliance work to particular issues, areas or clients; and provide information to parents, siblings, kin and community members of children who are in OOHC.

For this reason, the Review recommends that the OCG make its compliance inspection reports public. This approach has been taken in England, where the Office for Standards in Education, Children’s Services and Skills has published reports of its inspections of ‘local authority services, adoption and fostering agencies, residential homes, and other children’s social care services’³⁵⁰ since 2007. Further, as in England, the OCG should be required to provide these reports to Parliament.³⁵¹ It should also produce ‘annual summary reports on the basis of its inspections as well as the findings from research and consultation’.³⁵²

Recommendation 18: The Office of the Children’s Guardian should be required to: (i) publish its compliance inspection reports; (ii) provide these reports to the NSW Parliament; and (iii) publish annual summaries of its inspections, as well as its findings from any research and consultation.

The NSW Parliament to oversee the Children’s Guardian

As outlined in the discussion above, the Review has several concerns about the lack of transparency surrounding the OCG’s activities and about the effectiveness and vigor of its regulatory approach to the OOHC sector. These concerns are compounded by the fact that, unlike most independent statutory authorities, the OCG’s activities in respect of the OOHC sector are not overseen by any parliamentary committee. In contrast, its other activities are subject to scrutiny by the Joint Committee on Children and Young People. There is no reason in principle why the OCG’s OOHC activities should not be subject to parliamentary oversight. Indeed, in light of the identified concerns about the OCG’s performance and the public interest in ensuring that children and young people in OOHC are in safe, stable and secure placements, it is imperative that there is a mechanism to ‘watch the watcher’. Other independent statutory authorities involved in the regulation of the OOHC sector, such as the Ombudsman, are overseen by one or more parliamentary committees.³⁵³ Ensuring that the OCG’s OOHC activities are subject to oversight by the NSW Parliament creates a much needed line of accountability—the OCG is accountable to the Parliamentary Committee, the Committee to the Parliament, and

350 Rick Hood, David Nilsson and Ruth Habibi, ‘An analysis of Ofsted inspection reports for children’s social care services in England’ (2018) 1 (11) *Child and Family Social Work* 1.

351 Ibid.

352 Ibid.

353 Note the Ombudsman is overseen by the Ombudsman Committee.



the Parliament to the citizens of NSW.³⁵⁴ The Review recommends that the OCG's OOHC functions be overseen by a parliamentary committee (the most appropriate being the NSW Parliamentary Joint Committee on Children and Young People).

Recommendation 19: The NSW Government should amend the *Advocate for Children and Young People Act 2014* (NSW) or otherwise legislate to ensure that a parliamentary committee monitors and oversees the out-of-home care functions of the Office of the Children's Guardian.

Only 'compliant' agencies permitted to provide OOHC services

The new independent Child Protection Commission, recommended above, should ensure that only agencies that comply with the relevant legislation and standards should be permitted to provide OOHC services. Until this Commission is established, however, the Review recommends that the *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) should be amended to remove the ability of the Children's Guardian to defer a decision about whether or not to accredit an agency and to accredit agencies who do not 'wholly' satisfy the accreditation criteria. These powers, while perhaps historically useful during the transition to a new oversight system involving the Children's Guardian, are now legislative relics that should no longer be utilised to excuse or overlook non-compliance in the OOHC sector.

Recommendation 20: The NSW Government should amend the *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) to ensure that the Office of the Children's Guardian does not have the power to accredit agencies that have not demonstrated compliance with the accreditation criteria.

³⁵⁴ See Gareth Griffith, *Parliament and Accountability: The Role of Parliamentary Oversight Committees* by Gareth Griffith, (NSW Parliamentary Library Research Service, Briefing Paper No 12/05, 2005) 20.

Concluding remarks

The child protection system is a ‘closed’ system, or a system that operates largely in private, beyond the scrutiny of the general public. It is vitally important that this longstanding and culturally embedded approach to practice and procedure is not permitted to continue. In establishing this Review, the NSW Government and the Minister for Family and Community Services demonstrated a commendable commitment to opening up the ‘on the ground’ practice of caseworkers to scrutiny and the results of that scrutiny indicate that the current system is broken. In particular, the often well-researched and designed policies of the department are quite simply not adhered to by front-line staff.

There is no single reform that will solve the many problems with the lack of accountability and oversight of the child protection system. As such, this chapter has proposed a multifaceted approach, recommending the introduction of a number of new regulatory and accountability mechanisms that will each work at different points in time and will, in combination, ensure enhanced transparency and accountability of the child protection system.³⁵⁵

often well-researched and designed policies of the department are quite simply not adhered to by front-line staff.

³⁵⁵ See John Braithwaite, Toni Makkai, Valerie Braithwaite, *Regulating aged care: Ritualism and the new pyramid* (Edward Elgar Publishing, Cheltenham, UK Northampton, MA, 2007) 313.

PART D

Reducing entries into care



9. Getting early intervention right

Why early intervention?

The history of state intervention in the lives of Aboriginal people in NSW has resulted, among other things, in entrenched poverty for many Aboriginal people. This poverty is exacerbated by secondary factors such as domestic and family violence, substance abuse, lack of safety and security in housing, as well as mental, emotional, spiritual, and physical health issues. Poverty and its secondary factors are compounded by what the sector refers to as ‘intergenerational trauma’. These intersections may lead parents who love and care for their children, to face persistent social and emotional problems which impact both on their ability to be healthy individuals, as well as parents. They may affect parenting ability and hamper parental problem-solving leading to neglect and other issues for children in the home. We cannot assume parents will be able to address issues affecting them and their children without comprehensive, targeted and culturally informed support. To assume parents can turn their lives around without resources and support runs counter to the states’ recognition of its role in the protection era, stolen wages, stolen generations and even dispossession as manifested in the statutory Aboriginal land rights regime in NSW. The logic of NSW recognition of each of these historical events is that repair through law, policy and resources can create the social and economic conditions required to improve the well being of Aboriginal people. The modern child protection system is no different.

There are three primary levers to reduce the number of Aboriginal children in the out-of-home care (OOHC) system. The first is to guard against Aboriginal children entering the system in the first instance. The second lever is to enhance compliance with the Aboriginal Child Placement Principle (ACPP), and the third is to increase the number of exits from the system. This chapter examines the first lever—ways to decrease the numbers of children entering care in the first instance through ‘early intervention’ work.

‘Early’ intervention means intervening early in a child’s life—from birth to school age. The literature is clear that it is crucial to provide intervention support early, when a child’s brain is still developing, to avoid issues later in life. It is well documented that children’s early years are a critical time in which the foundations for healthy development are laid. It is emphasised throughout the literature that positive stimulation early in life affects subsequent health, wellbeing, coping skills and competence across the lifespan. Abundant research also demonstrates that experiences from conception to age three have the most important influence on connecting and sculpting the neurons in children’s brains.¹

More specifically a child’s brain grows from approximately 25 per cent to 80–90 per cent of adult size during the first three years of life. Important connections between the brain’s nerve cells are developed and there is rapid growth in cognitive, language and social emotional development.² Brain development during these early years is strongly subject to environmental experiences and influences. While these early years provide a significant opportunity for

1 See, for example, Australian Institute of Family Studies, *The Efficacy of Early Childhood Interventions: A Report Prepared for the Australian Department of Family Services* (Report, 2005); Irish Department of Children and Youth Affairs, *Right from the Start: Report of the Expert Advisory Group on the Early Years Strategy* (2013).

2 See, eg, Michael C Nagel, ‘The Brain, Early Development and Learning’ (Research Conference 2013), 62, <www.research.acer.edu.au>.



development, negative experiences during this critical period can impact upon outcomes throughout life.³

Child protection services involvement is more common among Aboriginal children with multiple indicators of socioeconomic and health vulnerabilities early in life,⁴ and Aboriginal children who escalate through child protection services during early childhood have a higher burden of developmental vulnerability and diagnosed health and developmental conditions or impairments than their same-aged peers. As data outlined in Chapter 3 show almost one in two Aboriginal children in NSW are known to the department before they are five years old, almost one in ten are known before they are born, and Aboriginal children known to the system early are more likely to escalate through the higher levels of the child protection system.⁵

These data decisively highlight the need for earlier, targeted and specialised work with vulnerable families and pregnant women when they become involved with the child protection system. Investing resources earlier in the system is the key to diverting children away from care and ensuring better outcomes for children and families. The best way to prevent Aboriginal children entering the OOHC system is through providing appropriate support to Aboriginal families prior to children entering care, particularly when children first come into contact with the child protection system. Increasing early intervention and secondary prevention support for vulnerable families is a way to change the system focus from reactive to proactive support, which is needed to move beyond the current crisis-driven, tertiary intervention focused approach.

The NSW Council of Social Service (NCOSS) reinforced the need to address the ‘well of poverty, disadvantage and intergenerational trauma that disproportionately impacts on the safety, welfare and wellbeing of Aboriginal children and young people, their families and communities’.⁶ Further NCOSS submitted that there needs to be ‘a fundamental shift’ in the current crisis-driven approach to child protection. Rather than increasing removals, Aboriginal families need to be supported early in the community to reduce contact with the system.⁷ The findings of the Review support this position.

A refocusing of reform efforts to prioritise early intervention within the child protection system has been advocated for by Aboriginal peak bodies for decades. For example, through its *Family Matters Strategy*, the national Indigenous peak body on Indigenous child protection, the Secretariat of National Aboriginal and Islander Child Care (SNAICC), argues for a refocusing on prevention and early intervention family support efforts, together with Aboriginal and Torres Strait Islander participation in decision-making and culturally safe and accessible services designed and delivered by Aboriginal community controlled organisations (ACCOs).⁸

3 Stacey Fox et al, *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention* (Report, 2015) 17–18. See also Australian Institute of Family Studies, *The Efficacy of Early Childhood Interventions: A Report Prepared for the Australian Department of Family Services* (Report, 2005).

4 Kathleen Falster and Mark Hanly, ‘Childhood child protection services involvement and developmental outcomes among Aboriginal and non-Aboriginal Kindergarten children in New South Wales: Findings from a population-based, cross-sectoral data linkage study (The Seeding Success Study)’ (Report for the Family is Culture Review. Sydney: UNSW Sydney Centre for Big Data Research in Health, 2019).

5 Ibid.

6 NSW Council of Social Service, Submission No 9 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 4.

7 Ibid.

8 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 1.

The critical need for a renewed emphasis on early support for Aboriginal children and families has been echoed in government inquiry after government inquiry. The 2008 Special Commission of Inquiry into Child Protection Services in NSW (Wood Inquiry) found that the key to reducing risk to children is ‘sufficiently resourcing flexible prevention and early intervention services so as to reduce the numbers of children and young people who require the state to step in to keep them safe’.⁹ The 2017 Legislative Council report on child protection found that FACS ‘should be working more effectively with these families to identify whether support services can be provided to address child protection concerns after they have been identified’.¹⁰

The department has made some positive efforts to respond to such recommendations, for example, through the Targeted Earlier Intervention Program (discussed below). However, as in other areas in this Review, law and policy has still not been implemented in the spirit it was intended by these inquiries and commissions.

A promising framework

Legislation and policy

The Australian Government’s *National Framework for Protecting Australia’s Children 2009–2020* (the National Framework) makes clear that all governments and relevant non-government institutions in Australia must work together to protect Australia’s children. According to the framework, the OOH system is regarded as the last resort after all other early intervention options and support have been exhausted.¹¹ NSW law and policy is aligned with the National Framework position. NSW legislation clearly emphasises the primacy of the family. Section 8(c) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*) requires that appropriate assistance be provided to parents and caretakers in order to promote a safe and nurturing environment for the child. Further, s 9(2)(c) requires the ‘least intrusive intervention’ in the life of the child and family, consistent with a child’s best interests.

As in other areas, the Review has found that the core problem for early intervention lies primarily in the implementation of relevant law and policy in practice. While FACS’ position is accordingly supportive of early intervention and prevention work on paper, in practice the situation appears considerably different.

The *FACS Strategic Direction 2017–2021* proposes a strong emphasis on family preservation. Amongst the key areas of strategic direction are that more children are safe at home with their families and that Aboriginal children, families and communities are provided with ‘culturally appropriate support’ so that they can thrive.¹² Further, FACS is involved in a number of specific reform strategies, policies and directions which are outlined in the next section.

9 James Wood, *Report of the Special Commission of Inquiry into Child Protection* (November 2008) Executive Summary i.

10 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) 63.

11 Australian Government Department of Social Services, *Protecting Children is Everyone’s Business: National Framework for Protecting Australia’s Children 2009–2020* (Report, 2009). See also *Royal Commission into Institutional Responses to Child Sexual Abuse* (Final Report, December 2017) vol 12, 64.

12 Department of Family and Community Services (NSW), *Annual Report 2017–18: Performance and Activities Report* (Report, 2018) vol 1, 8.



Early intervention strategies, policies, and services funded by the department

Their Futures Matter

Their Futures Matter is a cross-government reform delivering whole-of-system changes to better support vulnerable children and families. The guiding vision of Their Futures Matter, as stated by the NSW Government, is to significantly improve life outcomes for current and future generations of children and families, and to ensure that every child has a safe, permanent and loving home.¹³ The department has indicated that it uses an investment approach to achieve large-scale benefits for individuals and the system.¹⁴ One of the objectives of the Their Futures Matter reforms is that, by 2020 (next year), children in or at risk of entering OOHC and their families, will be receiving a coordinated package of supports based on their needs.¹⁵

Targeted Earlier Intervention Program Reform

DCJ is also currently implementing the Targeted Earlier Intervention Program Reform program. It states that it is doing so because ‘despite our best endeavours, the number of children reported at risk of significant harm continues to grow and we need to intervene earlier’.¹⁶ The department notes that it is working with clients, service providers, other government departments and related organisations to redesign the service system. According to its policy position, the intention of this reform program is to ensure that the service system is flexible, locally responsive, evidence based, adaptive and client centered.¹⁷

In its submission to the Review, SNAICC noted with approval that the department has stated that 30% of the Targeted Earlier Intervention Reform Program funding will go to Aboriginal and Torres Strait Islander children and families with a preference for delivery by ACCOs.¹⁸ Unfortunately, however, this is not commensurate with the over-representation of Aboriginal children in the child protection system.

The Permanency Support Program

The Permanency Support Program (PSP) is another policy reform which FACS (now DCJ) has been rolling out since October 2017. FACS stated that one of its objectives with the PSP is to have fewer entries into care, while another is to ensure shorter times in care. Among other elements, the PSP involves intensive work with parents and families, and builds permanency and early intervention into casework.¹⁹

13 Department of Family and Community Services (NSW), *Their Futures Matter* (Online) <<https://www.theirfuturesmatter.nsw.gov.au/about-their-futures-matter/reform-overview>>.

14 Ibid.

15 Ibid.

16 Department of Family and Community Services (NSW), *Early Intervention* (Online) <<https://www.facs.nsw.gov.au/providers/children-families/early-intervention/reform>>.

17 Department of Family and Community Services (NSW), *Targeted Earlier Intervention Program Outcomes Framework* (Report, July 2018).

18 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 15.

19 Department of Family and Community Services (NSW), *Permanency Support Program* (Online) <https://www.facs.nsw.gov.au/families/permanency-support-program/about>.

Aboriginal Child, Youth and Family Strategy

Services specific to Aboriginal children are also funded through the Aboriginal Child, Youth and Family Strategy (ACYFS), which is a departmental prevention and early intervention strategy. FACS has indicated that the objective of the ACYFS is to provide Aboriginal families with children the best start in life. The ACYFS focuses on supporting Aboriginal families expecting a baby or with children aged up to five years on the basis that there is strong evidence about the long term effectiveness of supporting parents and children during these early years of development.²⁰ The ACYFS Guidelines indicate that the ACYFS is implemented in close partnership with the department, Families NSW and the NSW Aboriginal Maternal and Infant Health Strategy.²¹

Specific services funded for Aboriginal people by the department

Aboriginal Child, Youth and Family Strategy

The FACS website indicates that the department currently funds these services under the ACYFS:

1. Aboriginal supported playgroups, where parents can share experiences of parenting and children can socialise, play and learn in a structured and positive environment;
2. Parenting programs, which provide parents with effective activities, information and coaching to assist them to build positive parenting skills;
3. Aboriginal family workers, who work to improve the outcomes and wellbeing of Aboriginal families with children aged 0–5 by providing support for parenting, facilitating informal support groups and access to appropriate services;
4. Community capacity building, which are community-based projects aiming to strengthen community connections through local services; and
5. Partnership and network projects, which help service providers work collaboratively to improve conditions in the local community. These projects also improve prevention and early intervention approaches by making local connections between services. This helps with access and engagement with services and achieving results for clients.²²

Alongside the ACYFS, the department funds nine Aboriginal Child and Family Centres (ACFCs) which provide support services for children aged 0–8 years and their families. The ACFCs are located in the following NSW locations: Brewarrina, Lightning Ridge, Gunnedah, Mount Druitt, Nowra, Toronto, Minto, Doonside and Ballina.²³

20 Department of Family and Community Services (NSW), *Program Guidelines for Aboriginal Child, Youth and Family Strategy* (Online) <<https://www.facs.nsw.gov.au/providers/funded/programs/atsi/child-youth-and-family-strategy>>.

21 Ibid.

22 Ibid.

23 Department of Family and Community Services (NSW), *Aboriginal Child and Family Centres* (Online) <<https://www.facs.nsw.gov.au/families/support-programs/aboriginal-families/aboriginal-child-and-family-centres>>.



Aboriginal Intensive Family Based Services

The department also provides Aboriginal Intensive Family Based Services (IFBS), which is a home-based program to support families where children are at risk of being removed or where intensive intervention is required to achieve safe restoration. It funds four IFBS services delivered by Aboriginal NGOs in Kempsey, Wyong, Wagga Wagga and Grafton.²⁴ The department also delivers an Intensive Family Preservation Service (IFPS), a three month intensive program, to Aboriginal and non-Aboriginal families.²⁵

Brighter Futures

Brighter Futures is an early intervention program to support families with children under the age of nine, providing support with such elements as child care and linkage to other relevant services such as drug and alcohol services and financial management services.²⁶

Their Futures Matter

The latest progress report for *Their Futures Matter*, released in December 2018, indicates a range of further early intervention services that are currently being implemented by FACS. Evidence-based family intensive family preservation and restoration therapeutic models such as *Multisystemic Therapy for Child Abuse and Neglect* and *Family Functioning Therapy* have been delivered to 'more than' 1000 families in NSW.²⁷ The initial funding was for 900 places, with half of the 900 places allocated for Aboriginal families.²⁸

While the implementation of Aboriginal early intervention efforts is positive, it is important to note that the Multisystemic Therapy for Child Abuse and Neglect and Family Functioning Therapy interventions were imported from the United States and not trialled with Aboriginal children or families. Accordingly, their effectiveness in relation to Aboriginal clients is uncertain. Further, SNAICC notes that:

it is concerning that the Department acts as the gatekeeper to these services rather than empowering families and communities to engage and access supports if needed.²⁹

Thriving Aboriginal Families

Another program that is being co-designed by the department and Aboriginal communities is *Thriving Aboriginal Families*, which aims to work with Aboriginal communities to enhance local service systems supporting families experiencing vulnerability.³⁰

24 NSW Department of Family and Community Services (NSW), *Intensive Family Based Services* (Online) <<https://www.absec.org.au/intensive-family-based-services.html>>.

25 Department of Family and Community Services (NSW), *Intensive Family Preservation* (Online) <<https://www.facs.nsw.gov.au/families/support-programs/all-families/intensive-family-preservation>>.

26 Department of Family and Community Services (NSW), *Brighter Futures* (Online) <<https://www.facs.nsw.gov.au/families/support-programs/aboriginal-families/brighter-futures>>.

27 Department of Family and Community Services (NSW), *Working Together to Improve Outcomes for Children, Young People and Families—Their Futures Matter Progress Report* (Report, December 2018) 10.

28 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 10.

29 Ibid 40.

30 Department of Family and Community Services (NSW), *Working Together to Improve Outcomes for Children, Young People and Families—Their Futures Matter Progress Report* (Report, December 2018) 9.

Aboriginal Evidence Building in Partnership

The *Aboriginal Evidence Building in Partnership* (AEBP) project is another new initiative to support outcomes data collection and evaluation processes for five promising Aboriginal projects in NSW.³¹

The Review notes that the trend in Australian public policy at a Commonwealth and state level for the language of ‘co-design’ which is notoriously indeterminate in definition, conveys a sense of equality in process but may not necessarily breach the massive power imbalance that exists between Aboriginal people and the state. Even so, the Review welcomes the emphasis on co-design noting that this is very early in the process. The Review agrees with SNAICC that the department should not act as gatekeeper for these services and they should be accessible to families outside of the child protection pathway. The Review also notes that SNAICC and other stakeholders were concerned that there was little evidence-based literature about which programs and approaches are effective with Aboriginal clients. SNAICC further submitted that existing programs may not be effective with Aboriginal families as these do not address intergenerational trauma and are provided over short term periods whereas a longer period is generally needed to build trust and effectively engage with Aboriginal families.³²

In line with the recommendations related to self-determination made in Chapter 7 of this report, funding should be directed towards ACCOs to ensure the most effective program design and delivery. This will ensure the best outcomes, that is, fewer entries into care and better outcomes for Aboriginal children and families. This is explored below in the section addressing adequate service delivery funding of ACCOs.

The Review notes that a very positive recent development in this regard is *The Aboriginal Case Management Rules and Practice Guidance: Strengthening Aboriginal families* developed by FACS in partnership with AbSec in 2018.³³ The Rules and Practice Guidance addresses the expectations, roles and responsibilities for practitioners across the continuum of support, including services, family preservation, restoration, OOHC and after care, in relation to Aboriginal Community Response, Aboriginal Family Strengthening, and Aboriginal Child Safety. The Rules and Practice Guidance is available in full on the DCJ website. The Review believes, as recommended in Part E of the report, that these rules and practice guidelines should be implemented as a matter of priority, and it is positive that they have been developed in partnership with an Aboriginal peak body.

31 Ibid 11.

32 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 17.

33 Department of Family and Community Services (NSW), *Aboriginal Case Management Rules and Practice Guidance* (Online, 30 June 2019) <<https://www.facs.nsw.gov.au/providers/children-families/deliver- psp/aboriginal-case-management-policy/rules-and-practice-guidance>>.



Issues in practice

Financial investment

The Review notes the reinvestment approach the department has indicated that it is undertaking as part of the Forever Family reforms. NSW spending on intervention services increased 25% from 2015–16 to 2017–18. NSW spending on OOHHC services increased 14% from 2015–16 to 2017–18.³⁴ On the other hand, NSW spending on family support decreased 1.7% in the same time period. NSW spending on intensive family support decreased 1% from 2015–16 to 2017–18.³⁵ This means that the proportion of NSW spending on family support services in relation to total child protection spending has declined from 16.6% of the total child protection spend in 2015–16 to just 14.3% of the total child protection spend in NSW in 2017–18.³⁶

It is the position of the Review that DCJ's spending allocations must be revised to reflect the priorities and policies of the NSW Government, and specifically, the proportion of spending in relation to early intervention must be increased as a matter of urgency. Early intervention spending must be significantly increased from 14% of child protection spending. Without adequate funding, program development and delivery will be seriously impaired.

The department has previously stated that 30% of the Targeted Earlier Intervention Reform Program funding would go to Aboriginal and Torres Strait Islander children and families with a preference for delivery by ACCOs.³⁷ The Review welcomes future financial investment that is more commensurate with the proportion of Aboriginal children in OOHHC. For the reasons noted above, the Review is of the opinion that financial investment in early intervention support should have a preference for delivery by ACCOs.

Recommendation 21: The NSW Government should increase financial investment in early intervention support as a long-term investment to prevent more Aboriginal children entering the out-of-home care system.

Recommendation 22: The NSW Government should ensure that financial investment in early intervention support is commensurate with the proportion of Aboriginal children in out-of-home care, with a preference for delivery of early intervention and prevention services by Aboriginal Community Controlled Organisations.

34 Australian Government Productivity Commission, *Report on Government Services, Vol F Community Services* (Report, 2019), Table 16A.7.

35 Ibid.

36 Ibid.

37 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHHC in NSW*, December 2017, 15.

Stakeholder views

The notion that the child protection system was reactive rather than proactive was emphasised throughout the Review's consultations. Stakeholders noted that families required more assistance to prevent child removals and should be provided with relevant services and support before the family situation got to the point of risk, crisis or removal.³⁸ Some stakeholders informed the Review that resources for early intervention were limited,³⁹ whilst others were of the view that the resources were available, but that preventative work did not attract the same interest as removal work⁴⁰ and was not viewed as an investment.⁴¹

In submissions to the Review, stakeholders routinely raised concerns around the lack of early intervention support provided by FACS. For example, Women's Legal Service NSW submitted that:

It has been the experience of several of our clients that FACS did not contact them to offer early support and the opportunity to address issues of concern prior to the sudden removal of their child. It is particularly traumatic when babies are removed from their mother's care in hospital immediately after birth.⁴²

Uniting submitted that the early intervention services in NSW were inadequate, particularly in rural and remote areas, and that there was an urgent need for additional funding for early intervention services for Aboriginal families in NSW.⁴³

A number of stakeholders advocated for more early intervention⁴⁴ and for more money to be invested in the 'front end' of the system (that is, into working with families),⁴⁵ including 'targeted early intervention services'.⁴⁶ Stakeholders also recommended that FACS engage with a family as soon as there is a risk of a child being removed to arrange for the child to be placed with kin, if necessary.⁴⁷ Further, stakeholders argued that Intensive Family Based Services (IFBS) and psychologists needed to be utilised at the 'front end' and not the 'tail end' of working with families.⁴⁸

The Review was informed that there is a lack of support for Aboriginal families to enable them to keep their children,⁴⁹ and that this is the case even when they reach out to the department for help. One mother informed the Review that she requested help and support from FACS because her son was psychotic. However, the department indicated that hers was not a strong enough case to warrant child protection involvement. Later, however, after the police were involved with the family, the mother's child was removed.⁵⁰

38 Confidential, *Consultation*, FIC 5-9; Confidential, *Consultation*, FIC 14-15; Confidential, *Consultation*, FIC 71; Confidential, *Consultation*, FIC 23; Confidential, *Consultation*, FIC 34.

39 Confidential, *Consultation*, FIC 84.

40 Confidential, *Consultation*, FIC 63.

41 Confidential, *Consultation*, FIC 63.

42 Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 12.

43 Uniting, Submission No 23 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 16.

44 Confidential, *Consultation*, FIC 84.

45 Confidential, *Consultation*, FIC 53; Confidential, *Consultation*, FIC 85.

46 Confidential, *Consultation*, FIC 26.

47 Confidential, *Consultation*, FIC 5-9.

48 Confidential, *Consultation*, FIC 53; Confidential, *Consultation*, FIC 23.

49 Confidential, *Consultation*, FIC 86.

50 Confidential, *Consultation*, FIC 12.



Case studies

The following case studies reveal the human face of the lack of effective and consistent early support to Aboriginal children and families.

- In Case 172, S was removed at birth because of concerns about her parents' drug use, homelessness and concerns that her father was violent towards her mother. However, prior to S's birth and subsequent removal, FACS did not attempt any early intervention work with S's parents, despite concerns being reported about the unborn baby and FACS being aware that S had two older siblings who were already in long term care. Although the file was allocated to a caseworker for a short period of time, it was closed on the basis that S's parents could not be located (although there are limited records of the efforts that were made to locate them). Approximately one week before her birth, S's parents obtained stable housing. Further, S's paternal grandmother and aunt both indicated that they were willing to help obtain provisions for the baby and S's mother reported that she wished to attend a drug and alcohol residential rehabilitation program. Despite this, S was removed at birth. FACS did not complete any Aboriginal consultation prior to her removal and did not involve her family in planning for her future placement. S spent approximately six months in the care of an Aboriginal foster carer while efforts were made to identify an appropriate family placement for her.
- In Case 82, FACS did not undertake any prenatal casework with the child's mother, K, despite being aware of her pregnancy and drug use. FACS made few attempts to engage with K before the birth of her child, despite having many opportunities to do so, for instance, when K was having contact with her other children in OOHC. At the point of assumption, risk assessment processes were limited, and the risks identified were primarily based on probable and historical information. The file suggests that FACS had already pre-determined that K's child would be assumed at birth, based on the prior removal of all three of K's older children. FACS did not attempt to identify the child's father at any stage prior to, or after, the child's removal at birth. There was no Aboriginal consultation or any attempts to connect the family with early intervention services prior to the child's removal.
- In Case 300, there were many issues in the home of the M children, including very serious domestic violence and reported sexual abuse. On one occasion, the children's mother was beaten so badly by her partner that her unborn child was killed. A total of 57 ROSH reports were received about the children between 2004 and 2016. However, FACS conducted little casework with the family in this twelve year period. The case file indicates that at one stage a referral to Brighter Futures was refused by the service on the basis that the M children's case was high risk and complex. The case file also notes that at another time the case was closed on the basis there were other high-risk cases with more vulnerable children. Given the serious issues outlined in the case file, it is troubling that the family did not receive early intervention casework.
- In Case 350, several ROSH reports were made about P in the two years prior to her removal. These reports indicated that P was subjected to violence by her parents. However, FACS did not engage in any preventative casework prior to P's removal. The care application indicated that P's parents did not engage with FACS. However, this was inaccurate as P's mother returned phone calls and both parents attended a FACS office after the decision was made to remove P from her home. P's mother indicated she wanted to work with an Aboriginal caseworker 'who is able to demonstrate cultural sensitivities'. She was not provided with an Aboriginal caseworker.

Review data showing limited early intervention support

The following section discusses data obtained by the Review that highlight deficiencies in the referrals and intake of Aboriginal children (and families) into casework prior to entry into care. These data suggest that further work must be done within DCJ to increase appropriate referrals, particularly 'warm' referrals into Aboriginal controlled services (data around Aboriginal controlled services are not currently collected by the department). It is a limitation that no Aboriginal stakeholders have been involved in the interpretation of these data and this remains an urgent priority.

Casework prior to entry into care

In mapping pre-entry into care casework for the cohort, FACS data examined involvement in Intensive Family Support (IFS), Brighter Futures, IFBS and IFPS only, using a combination of FACS (Administrative) data and FACS (Review Tool) data. These data may not reflect the entirety of program involvement for families in the cohort. Further data around pre-entry into care casework and early intervention and prevention work with families (including specifically around Aboriginal controlled services), is required to increase transparency around this important area of the ACP.

These data, presented below, highlighted that the number of referrals into intensive support and casework programs, and the number of Aboriginal families accepted into programs during the cohort period, were low. These data also highlighted that approaches to early intervention and prevention work during the cohort period were ad hoc, with either limited referrals being made or limited availability of services positioned to work with vulnerable families.⁵¹

Intensive Family Support Program

FACS (Administrative) data highlights that the vast majority of Aboriginal children who entered care in the cohort year were not accepted into the Intensive Family Support Program (IFS) in the two years prior to entering care (93.5% of children). This program accepted only 6.5% of Aboriginal children. There is no information available about how many of the children or families in the cohort period were referred to this program due to limitations in the data, so the issue of how many children were being referred compared to how many children were being accepted into the program is not clear. It should be noted that this program may not have been available in some areas, and that access to the program in other areas may have been limited due to a lack of program capacity.

Of the Aboriginal children who were accepted into IFS, for half (50%) of these children the program was ongoing when they entered into care. This is concerning, as there is little transparency around why Aboriginal children were entering care while currently involved with pre-entry into care casework services designed to support the family with presenting issues. The data highlight that more Aboriginal children than non-Aboriginal children had their IFS closed on the basis of eligibility criteria no longer being met and that fewer Aboriginal children than non-Aboriginal children had their case closed on the basis of 'family withdrawal/decline/not located/relocated/not engaging in services'. This data category (family withdrawal/decline/

⁵¹ It should be noted that no comparative data are presented about referral or programs involvement for children (including Aboriginal children) who did not enter care.



not located/relocated/not engaging in services) is problematic, as it is inappropriate to conflate failure to locate family (a system response issue), with other actions which could be more properly construed as actions by the family (for instance, declining to be involved with the service).⁵²

Brighter Futures

FACS (Administrative) data highlights that more Aboriginal children in the cohort were accepted into the Brighter Futures in the two years prior to entering out-of-home care (20% of Aboriginal children in the cohort year) than IFS, however this figure still remains extremely low—with 80% of Aboriginal children in the cohort year not having received this service during this period.

The data highlight that for 25% of the children who received the service, this engagement was ongoing at the time of the child's entry into care. These data highlight that more Aboriginal children than non-Aboriginal children had their engagement closed on the basis of eligibility criteria no longer being met, and a high proportion (43.9%) of Aboriginal children who received the service had their case closed on the basis of family withdrawal/decline/not located/relocated/not engaging in services.⁵³ More Aboriginal children (23.5%) than non-Aboriginal children (16.6%) who received the service were described as no longer meeting the eligibility criteria in relation to Brighter Futures.

Again, no referral information is available about this service from FACS (Administrative) data so it is not clear how many referrals were made (compared with how many families received or were accepted into the program). The data notes that the Brighter Futures program is not universally available and access to the program in some communities may have been limited or a waiting list may have been in place.⁵⁴

Intensive Family Based Services

FACS (Review Tool) data around Intensive Family Based Services (IFBS) highlight the majority of Aboriginal children in the cohort (78.3%) were not referred to IFBS in the two years prior to entry into care. Only 16.2% of children received a referral for this service in the two years before entry into care, and 5.4% of children received a referral during the SARA assessment period prior to entry into care. These are low referral rates which are particularly concerning given that IFBS is a service intended for Aboriginal families.

Of the Aboriginal children and young people referred, most had the IFBS referral accepted by the service (80.2%). Reasons why the referral was not accepted included that for 7.7% of these children the family chose not to engage with the service and that in 4.4% of cases the risk was deemed to be too high—apparently by the service. For 5.6% of Aboriginal children who were referred, the N/A variable was selected. While this may mean that there was no referral, the N/A variable was not clearly defined and it is not clear whether reviewers interpreted it consistently. The file review process also did not provide an option for reviewers to nominate if the service was unable to accept the family due to capacity issues and it is unclear where this data would be reflected.⁵⁵

52 See Figure 37 and Figure 38, Appendix A.

53 As above, this data category (family withdrawal/decline/not located/relocated/not engaging in services) is problematic as it is inappropriate to conflate failure to locate family (a system response issue), with other actions which could be more properly construed as actions by the family (for instance, declining to be involved with the service).

54 Figure 39 and Figure 40, Appendix A.

55 In response to this concern, FACS noted that IFBS referrals are usually only made where the service has capacity.

Data notes highlight that the IFBS program is not universally available and access to the program in some communities may have been limited or a waiting list may have been in place. It is unclear to what extent this may have impacted referral or acceptance into the service.⁵⁶

Intensive Family Preservation Services

FACS (Review Tool) data on IFPS highlights that the majority of Aboriginal children in the cohort (92.6%) were not referred to IFPS in the two years prior to entry into care. Only 5% of the cohort received a referral in the two years to entry into care, and an additional 2.4% of the cohort received a referral during the SARA assessment period prior to entry into care.

Of the Aboriginal children and young people referred, most had the IFPS referral accepted by the service (76.5%). Reasons why the referral was not accepted included that for 12.9% of children the family chose not to engage with the service and that for 5.9% of children the risk was deemed to be too high (apparently by the service). Again, the option of N/A was provided, and it is unclear what this variable would mean in the context of children being referred to IFPS.

Access to the IFPS program is not universally available and access to the program in some communities may have been limited or a waiting list may have been in place. It is unclear to what extent this may have impacted referral or acceptance into the service.⁵⁷

Qualitative sample data

While quantitative report data focus on acceptance into programs as a proxy for early intervention and prevention work and pre-entry into care casework, the qualitative sample data suggest that the problems with these casework areas are not limited to issues around referral, acceptance into and participation in programs.

In most of the cases in the qualitative sample (169 cases out of 200, 84.5% of the sample), issues were specifically identified in the Assessment Tool around the quality of casework prior to children entering care or early intervention and prevention work with families of children in the cohort (or both).

It was common for reviewers to identify that FACS had missed opportunities for early intervention and prevention casework with the families of Aboriginal children in the cohort. In many cases it was identified that no early intervention or prevention work had taken place despite families becoming known to the system early—often many years before the children entered care. Providing earlier and more targeted casework in response to early ROSH reports was often identified as a factor that may have improved the likelihood of the risk not escalating to the point where the children needed to enter care.

In other cases, reviewers identified that there were issues with the quality of early intervention and prevention casework provided to families. In some cases, reviewers identified that no Aboriginal services were involved with the family, or that capacity issues within services meant that families were not able to participate in early intervention programs. In other cases, reviewers noted that family were not involved early enough and that the cultural identities or connections of families and children were not factored in when working with the family (missing opportunities to support families to access culturally appropriate services). In many cases,

⁵⁶ Figure 41 and Figure 42, Appendix A.

⁵⁷ Figure 43 and Figure 44, Appendix A.



reviewers identified that culturally appropriate services should have been engaged to work with families with complex trauma histories and issues engaging with FACS.

It was often identified that early intervention and pre-entry into care casework was not holistic and did not address the complex issues facing many families. In many cases the approach to casework was limited to 'cold' referrals which was seen as inappropriate and unsupportive for families.⁵⁸ In several cases, concerns were raised that there were unnecessary delays in either early intervention and prevention work or in pre-entry into care casework.

The need for trauma-informed, culturally informed, sustained and targeted early intervention work with families is highlighted by the qualitative sample data. These data also highlight that such work has not been occurring for many Aboriginal families and that the department urgently needs to ensure that resources are channelled into this important means to keeping Aboriginal children safe and preventing their entries into care.

Recommendation 23: The Department of Communities and Justice should ensure that its administrative data captures information about referrals made to all relevant early intervention programs, and whether these referrals were accepted or not (and reasons for non-referral and non-acceptance). The Department of Communities and Justice should work with Aboriginal stakeholders and community to design a system for the collection, analysis and reporting of these data.

Recommendation 24: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community members, evaluate existing early intervention and prevention focused programs used by the department and their effectiveness with Aboriginal families based on measures designed in partnership with Aboriginal stakeholders and community.

Addressing barriers to early intervention support

There are several reasons why adequate early intervention support is not being provided to Aboriginal families. A key barrier, noted above, is the lack of adequate resourcing and the related lack of service availability. This is particularly the case in relation to Aboriginal-designed and led service delivery.

SNAICC highlighted the consequences of not properly funding ACCOs:

while there is a legislative and policy position allowing, encouraging, and in some cases requiring community participation in decision-making, there is no resourced role for ACCOs to do this except in two locations according to a limited Department funded program. The trial and subsequent de-funding of ACCO-delivered Aboriginal and Torres Strait Islander Family-Led Decision-Making as a means for family and community participation is another example of a lack of

⁵⁸ A 'cold' referral describes the situation where a person is provided with a name and a number of a service or program to contact. This can be contrasted with 'active' or 'warm' referrals where a caseworker contacts a service or program on the behalf of a client and co-ordinates the client's entry into, or access to, the service or program.

resourced ACCO-led programming. These examples – and the limited resourcing of ACCO-operated prevention and early intervention services, with ACCOs operating only four of the ten Intensive Family Based Services (Aboriginal) funded through the Department – demonstrate New South Wales’ over-reliance on trials, un-sustained approaches, and lack of comprehensive state-wide strategy.⁵⁹

Legal Aid NSW identified further barriers to service provision as remoteness, practical issues such as literacy and cost, and a lack of effective casework to bridge the gap between families and communities and services. It also supported the view of Aboriginal stakeholders in submitting that:

Aboriginal community-based culturally competent prevention and early intervention services are critical in order to effectively assist Aboriginal families and children.⁶⁰

A number of stakeholders also indicated that little effort is made to help families to engage in support services. Women’s Legal Service NSW identified barriers in this regard as including shame on the part of parents, the attitudes of caseworkers, and the development of early support plans in a context of power imbalance, with a fear that such plans will result in the removal of children. Women’s Legal Service NSW also identified that the lack of access to services is exacerbated for women in regional, rural and remote areas.⁶¹ The importance of effective and meaningful—Aboriginal led or partnered—evaluation processes around these programs is also noted by the Review.

Further, Women’s Legal Service NSW noted that Aboriginal communities have an intergenerational fear of having their children removed,⁶² however, that they have had positive engagement with prenatal programs developed by FACS in three districts in NSW.⁶³ It also noted that there are a number of specific programs, such as those under the Aboriginal Child, Youth and Family Strategy, and under the Aboriginal Maternal and Infant Health Strategy and Aboriginal Child and Family Centres. The Review notes that it is important that parents and primary caregivers who reach out for support receive culturally safe, trauma-informed and strengths based services, and that removal is not the first response.

Some possible responses to these barriers to early intervention support are outlined in the following sections.

A requirement to provide early intervention support

Four Family Violence Prevention Legal Services observed that:

From the coal face the system appears skewed towards judgement and punishment (removal of children) and needs to be skewed back towards non-judgemental support and self-empowerment.⁶⁴

59 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 3.

60 Legal Aid NSW, Submission No 6 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 6.

61 Women’s Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 15.

62 Ibid 11.

63 These are discussed further in Chapter 10.

64 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 10.



The Review agrees that, to be effective, the child protection system needs to prioritise non-judgemental support earlier in families' engagements with the system. The Review notes that this is aligned with the aims of the *Care Act*. As noted above, s 8(c) of the *Care Act* states that one of the key objects of the Act is to provide parents with 'appropriate assistance in the performance of their child-rearing responsibilities to promote a safe and nurturing environment'.

However, there is no legislative obligation to actually provide this support. Government departments and agencies, and non-government child protection services in receipt of government funding, are only required to use 'best endeavours' to comply with a request for support, pursuant to s 18(1) of the *Care Act*. This is despite the fact that inquiry after inquiry has recommended the provision of early support. The literature makes clear why early support is necessary, including research commissioned by FACS as part of the early intervention reforms that guide the *Targeted Earlier Intervention Reforms and Their Futures Matter*.⁶⁵

The Review notes that the need to provide early intervention support appears in relevant law and policy, but that there remains a significant gap between law and practice. Given the difficulty that the department appears to experience in translating law and policy into practical application, one way to ensure this culture change is through legislative amendment that *requires* the provision of services. Women's Legal Service NSW recommended that parents and primary caregivers have an enforceable right to services in legislation. These services should be meaningful, available, accessible and low or no cost.⁶⁶

Given that the right services can prevent entry into care, the Review recommends that the NSW Government amend the *Care Act* to require the provision of support services. Such support services should be adequately and appropriately funded, with a preference for design and delivery by ACCOs. The Review notes that there may be a shortage of appropriate support services for Aboriginal families living in rural or remote areas. As a matter of principle, however, the Review is of the perspective that appropriate support services should be offered to all Aboriginal families in contact with the child protection system. Further, a legislative requirement to support Aboriginal families prior to the removal of their children would help to ensure that these services are provided where they are required. Finally, the Review notes that participation in many early intervention services is voluntary. However, this does not alter to fact that the services should be provided (although in some individual cases they may not be utilised if the family chooses not to participate in or engage with the service).

Recommendation 25: The NSW Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to mandate the provision of support services to Aboriginal families to prevent the entry of Aboriginal children into out-of-home care.

A duty to make 'active efforts'

Finally, in the U.S., there is a requirement for the State to take 'active efforts' to support a child

65 Stacey Fox et al, *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention* (Report, 2015) 17-18.

66 Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OHC in NSW*, December 2017, 3.

before removing that child.⁶⁷ The regulations that sit under the *Indian Child Welfare Act of 1978* define the ‘active efforts’ that must be taken by the State prior to removal. They note that family preservation is the preferable choice, unless there is a ‘risk of imminent physical damage or harm’, and that:

- the state has a duty to make active efforts to promote family preservation through the delivery of remedial and rehabilitative services; and
- the State has a duty to demonstrate to the court that active efforts have been provided but were unsuccessful prior to seeking an order for removal of the child.⁶⁸

‘Active efforts’ must be tailored to the individual child and family’s circumstances.⁶⁹ While the *Indian Child Welfare Act of 1978* does not define ‘active efforts’, regulation 23.3 of the guidelines states that active efforts are ‘affirmative, active, thorough and timely efforts intended primarily to maintain or reunite’ a child with the child’s family.⁷⁰

The guidelines note that the ‘active efforts’ requirement was included in the Act in recognition of the historical treatment of Indian children and families, with particular regard to the fact that many Indian children ‘were removed from their homes because of poverty, joblessness, substandard housing, and other situations that could be remediated through the provision of social services’.⁷¹ They also note that the requirement for ‘active efforts’ is regarded by many child welfare organisations as the ‘gold standard’ of services that should be provided to all children in contact with the child protection system.⁷² Further, they note that active efforts should be provided in a culturally appropriate way and should be undertaken in partnership with the child’s Indian parents, family members, custodians and Tribe.⁷³

The majority of US courts and commentators have concluded that ‘active efforts’ require more attention and effort than ‘reasonable efforts’ (another term used in US child protection legislation), and require more than, for example, referring a parent to services, or drawing up a case plan for the family to follow.⁷⁴ To demonstrate that it has made active efforts to prevent the removal of an Indian child, the child protection service must provide the Court with information about: (i) the issues the family is facing; (ii) the active efforts that would best address these issues, and the reasons why they have been chosen; (iii) the dates, people contacted and other details that demonstrate that the caseworker made the active efforts; and (iv) the results of the active efforts, results that ‘were less than satisfactory, and whether the State agency adjusted the active efforts to better address the issues’.⁷⁵

In the opinion of the Review, the concept of ‘active efforts’ makes it clear that the onus is on the state to prevent the removal of the child. While the above recommendations already

67 *Indian Child Welfare Act of 1978* 25 U.S.C §§ 1901–1963 (1978), s 1912(d).

68 US Department of the Interior, Bureau of Indian Affairs, *Guidelines for Implementing the Indian Child Welfare Act* (December 2016), 39–43.

69 US Department of the Interior, Bureau of Indian Affairs, ‘Active Efforts’, <<https://www.bia.gov/sites/bia.gov/files/assets/bia/ois/ois/pdf/idc2-041405.pdf>>.

70 US Department of the Interior, Bureau of Indian Affairs, *Guidelines for Implementing the Indian Child Welfare Act* (December 2016), 39–40.

71 Ibid 39.

72 Ibid.

73 Ibid 40.

74 Leonard Edwards, ‘Defining Active Efforts in the Indian Child Welfare Act’ (Jan/Fec 2019) 41(1) *The Guardian* (National Association of Counsel for Children), 2–4, 7.

75 Ibid 5.



move in this direction, given the disproportionate numbers of Aboriginal children in OOHC, the Review encourages the NSW Government to amend the *Care Act* to make clear that it is the responsibility of FACS to ensure that active efforts are taken prior to removing Aboriginal children from their families.

Recommendation 26: The NSW Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to require the Department of Communities and Justice to take active efforts to prevent Aboriginal children from entering into out-of-home care.

What type of support should be provided?

Funding ACCOs for early intervention service delivery

AbSec welcomed the recent shift in emphasis toward prevention and early intervention in Their Futures Matter. However, it noted that there needed to be better funding of ACCOs for this to result in measurable improvement in outcomes. AbSec stated that, to genuinely improve the child protection system, the government must:

invest at least as much in early intervention, prevention, preservation and restoration services as in tertiary responses including child protection and out-of-home care (including guardianship and adoption).⁷⁶

Women's Legal Service NSW also welcomed the focus on Aboriginal family preservation in Their Futures Matter, given that the work is resource and time intensive. However, it noted that:

if family preservation and restoration are to be genuinely prioritised this should be reflected in funding allocations above guardianship and adoption.⁷⁷

The Review agrees that genuine improvement in this area requires an increase in specific, targeted funding. To be effective, greater financial investment must be accompanied by a commitment to self-determination.⁷⁸ AbSec noted that the adoption of international models in Their Futures Matter was from a top-down, one-size-fits-all approach,

rather than empowering communities to engage with the evidence, and their own knowledge and expertise of their families and communities, to implement those solutions that are most likely to meet their needs, approaches continue to be externally imposed. The approach continues to try to fit communities to models, rather than build models for, and indeed from, communities. In this way, the approach reflects the lower bar of 'participation' rather than self-determination for Aboriginal communities.⁷⁹

⁷⁶ Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW, December 2017, 20.

⁷⁷ Women's Legal Service NSW, Submission No 20 to Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW, December 2017, 19.

⁷⁸ Self-determination is discussed in Chapter 7.

⁷⁹ Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW, December 2017, 9.

And further:

Existing approaches whereby FACS select intervention programs and then invite Aboriginal organisations to participate in service delivery is not an appropriate strategy for the development of targeted services and does not reflect a genuine commissioning for outcomes model.⁸⁰

The Review agrees that to be effective there must be a significant increase in investment in Aboriginal communities to design, deliver and monitor the effectiveness of community-led, evidence-informed approaches. The Review agrees with AbSec that:

As these approaches demonstrate their effectiveness, a reinvestment strategy could be used to further invest in prevention and early intervention, accelerating their impact.⁸¹

The Benevolent Society noted that ACCOs in Victoria are supported by the commitment to self-determination. It noted that the prevention and restoration programs that have been evaluated and shown to have long-running success include: Cradle to Kinder, Stronger Families, Integrated Family Services, Aboriginal Family Led Decision Making, Family Mental Health Support Services and Family Violence programs. The Benevolent Society encouraged NSW to look towards this as a model.⁸²

The NSW Council of Social Services noted that Aboriginal families and communities are best placed to support Aboriginal children in OOHC, including ‘maintaining their connection to family, community, culture and Country that is central to identity development and wellbeing’⁸³. It agreed that greater investment in ACCOs is necessary to meet this need, particularly through providing appropriate supports to kinship carers and families providing the day-to-day nurturing care of Aboriginal children.

AbSec highlighted as an example of good practice the partnership

between AbSec, Bamba Baa Aboriginal Children’s Service and FACS to establish an expanded Aboriginal intensive family support service, drawing on the expertise of Aboriginal intensive family based services and Protecting Aboriginal Children Together practitioners. If supported, this model represents a significant opportunity to reshape the Aboriginal child and family service system in Moree and surrounding areas.⁸⁴

Women’s Legal Service NSW referred to the ‘Health Family Circle’ program developed by Mudgin-Gal Aboriginal Corporation in partnership with Relationships Australia. One component of this program was to encourage young Aboriginal women to participate in the Playgroup Facilitators Training Course, which helped to build women’s parenting skills and provided ‘positive behavioural modelling for parenting and childcare’ that could be implemented in the

80 Ibid 21.

81 Ibid 9.

82 The Benevolent Society, Submission No 7 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 18.

83 NSW Council of Social Service, Submission No 9 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 2.

84 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 9.



women's families and communities. It suggested that in addition to this type of program, early prevention work could take the form of:

for example, coffee mornings where Aboriginal mothers could gather together in their local community to yarn about a range of issues in a supportive environment, such as getting their children to preschool and where they can go in the community for help. Such programs would support Recommendation 36 of the *Bringing them Home* report that the Council of Australian Governments provide adequate funding to relevant Indigenous organisations in each region to establish parenting and family wellbeing programs.⁸⁵

As noted above, the Review agrees that, to align with the right to self-determination, ACCOs must be properly resourced to provide targeted early intervention support to Aboriginal families.

An advocacy and support service for Aboriginal families

It is widely accepted that many Aboriginal and Torres Strait Islander people are highly disadvantaged compared to non-Indigenous people.⁸⁶ Indeed, the Review found that the parents of many of the Aboriginal children who entered OOHC between mid-2015 to mid-2016 had experienced significant childhood adversity themselves, with many being removed from their families as children. The Review found that 68.3% of mothers of children in the cohort had a child protection history and 25.5% had been in OOHC themselves during their childhood. Similarly, 41.5% of fathers of children in the cohort had child protection history and 14.5% had been in OOHC themselves during their children. In almost one third of cases, both of the parents of the child in OOHC had a child protection history. The Review also found that the most frequently reported concerns about the safety and wellbeing of the children in the cohort reflected this disadvantage, namely, parental drug or alcohol abuse, neglect, physical abuse, domestic violence and emotional abuse.⁸⁷

In addition to significant socioeconomic and health disadvantage, parents of Aboriginal children in NSW may also be affected by intergenerational trauma⁸⁸ and have a profound fear of child protection intervention. Further, like all parents, they lack 'insider' or intimate knowledge of the operation of the child protection system (which, as discussed in Chapter 4, is extremely complex) and are forced to interact with child protection workers and the legal system at a time of acute emotional distress and vulnerability.⁸⁹ They also have a different cultural background to the majority of child protection caseworkers.

In light of all of the above, it is no surprise that the Review found that there was often a considerable power imbalance between the parents of Aboriginal children who were involved in the child protection system in NSW and staff employed by FACS or non-government OOHC providers. For example, the Review was informed during consultations that parents who had their children removed were often confused by the process. Families articulated that they often

85 Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 10.

86 See, eg, Australian Government Productivity Commission, *Overcoming Indigenous Disadvantage: Key Indicators 2016* (Report, 2016), 1.4.

87 See Chapter 3 for further discussion of the characteristics of parents and children in the review cohort.

88 Intergenerational trauma is discussed further in Chapter 1.

89 Tamara Walsh and Heather Douglas, 'Lawyers, Advocacy and Child Protection' (2011) *Melbourne University Law Review* 622, 623.

felt as though they did not have the knowledge they needed to engage with FACS effectively.⁹⁰ Families were acutely aware of the power imbalance in their relationship with FACS.⁹¹ One stakeholder informed the Review that ‘people don’t fight FACS because it’s too hard’, while another noted that carers and families were concerned that if they did not follow FACS’ rules they would lose their children.⁹² Many of these conversations were framed in light of the history of Aboriginal child removals set out in Chapter 1. The ‘protection era’ and the removal of Aboriginal children during this period and the assimilation period manifests as a lack of trust and faith in the current day system.

These sentiments were reflected in Uniting’s submission to the Review, which noted that families were often unsure of what they were entitled to expect from FACS ‘in terms of engagement and input to decision making with respect to child placements’.⁹³ Consultations also revealed that families were hesitant to respond to or challenge FACS’ decisions, or otherwise advocate for themselves, for fear they would be ‘blacklisted’⁹⁴ or that FACS caseworkers would report feeling ‘intimidated, threatened and ambushed’, which in turn would result in the family being viewed negatively by FACS staff.⁹⁵ Consultations noted the need for advocacy for Aboriginal families, including the need for more service providers to be trained to assist Aboriginal families in the court process when children were removed.⁹⁶

The Review was also informed that that departmental staff and lawyers did not always explain the child protection process to Aboriginal families.⁹⁷ Stakeholders emphasised the significant need for advocacy and for service providers to be trained in how to assist families in court and legal processes where children are removed, a service which stakeholders believed would assist in keeping FACS accountable.⁹⁸

A number of domestic and international scholars have raised concerns about the support available to parents in contact with child protection systems to address pre-existing power imbalances.⁹⁹ A common suggestion to remedy this problem is the introduction of parental advocacy services. As Collings et al note, advocacy ‘is an established mechanism for ensuring that vulnerable groups have equal access to justice’.¹⁰⁰ Walsh and Douglas argue that advocacy for parents can help to address issues contributing to the power imbalance between parents and child protection authorities, such as significant parental distress (which may inhibit the parent’s ability to communicate during meetings), feelings of disempowerment (which are more prevalent among Aboriginal parents) and a lack of the requisite skills (including literacy skills) to

90 Confidential, *Consultation*, FIC 63.

91 Confidential, *Consultation*, FIC 23.

92 Confidential, *Consultation*, FIC 56; Confidential, *Consultation*, FIC 12.

93 Uniting (NSW.ACT), Submission No 23 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, March 2018.

94 Confidential, *Consultation*, FIC 65.

95 Confidential, *Consultation*, FIC 89.

96 Confidential, *Consultation*, FIC 76; Confidential, *Consultation*, FIC 63.

97 Confidential, *Consultation*, FIC 58; Confidential, *Consultation*, FIC 71.

98 Confidential, *Consultation*, FIC 63; Confidential, *Consultation*, FIC 23; Confidential, *Consultation*, FIC 61; Confidential, *Consultation*, FIC 76.

99 See, eg, B Featherston et al, ‘Advocacy for parents and carers involved with children’s service: making a difference to working in partnership?’ (2011) 16(3) *Child and Family Social Work* 266; Brid Featherston and Claire Fraise, ‘I’m just a mother, I’m nothing special, they’re all professionals’: parental advocacy as an aid to parental engagement’ (2012) 17(2) *Child & Family Social Work* 244; Beth Tarleton, ‘Expanding the engagement model: The role of the specialise advocate in supporting parents with learning disabilities in child protection proceedings’ (2013) 7(5) *Journal of Public Child Welfare* 675; Marina Lalayants, ‘Partnership between child protective services and parent representatives’ (2017) 22 *Child and Family Social Work* 40; Susan Collings et al, ‘“She was there if I needed to talk or to try to get my point across”: specialist advocacy for parents with intellectual disability in the Australian child protection system’ (2018) *Australian Journal of Human Rights* < <https://doi.org/10.1080/1323238X.2018.1478595>>.

100 Susan Collings et al, ‘“She was there if I needed to talk or to try to get my point across”: specialist advocacy for parents with intellectual disability in the Australian child protection system’ (2018) *Australian Journal of Human Rights* < <https://doi.org/10.1080/1323238X.2018.1478595>>, 4.



negotiate with the child protection authority.¹⁰¹ Parental advocacy can also help to ensure that parents are not unduly pressured into consenting to care arrangements for their children, and that parents are able to negotiate case plans (such as those for restoration) that are ‘realistic and achievable’.¹⁰² Further, an advocate can help parents access relevant services to assist them to address any issues that affect the safety of their children and can also be of assistance to parents with disability.¹⁰³

The issue of community-based advocacy was discussed in the 2015 Senate Inquiry into OOH. The Inquiry noted that such services, where they had been established by community-based organisations, helped to assist families to build better relationships with child protection authorities and to address the ‘imbalance of power between families and statutory authorities which by its very nature, is adversarial and does not allow for a collegial working relationship’.¹⁰⁴ The Inquiry noted that the NYP Women’s Council Advocacy Service in Alice Springs had piloted a child advocacy service for families in the central Australian region with the aim of helping parents and families access services, negotiate the child protection system, and to help with the identification of kinship carers.¹⁰⁵ The Inquiry recommended that COAG consider a nationally consistent approach to funding advocacy and support groups for parents with children in or at risk of entering OOH.¹⁰⁶ The Commonwealth Government noted this recommendation and stated it would bring the report ‘to the attention of state and territory governments through the Children and Families Secretaries group’.¹⁰⁷

The Review is concerned about the power imbalance between Aboriginal families and child protection workers. Accordingly, the Review recommends that an Aboriginal Child Protection Advocacy Program be established in NSW. This service would enable ‘advocates’ to assist families ‘at all stages of the process—at the notification and investigation stage, in court proceedings and in family group meetings’.¹⁰⁸ The Review notes that GMAR NSW have been performing these type of advocacy functions unofficially for a number of years in the absence of any resources or formal support.

A similar advocacy service exists in respect to housing for Aboriginal people in NSW. Funded by the Fair Trading NSW, the Aboriginal Tenant’s Service provides advice and advocacy services to Aboriginal clients who have any issues with their tenancy in a number of different locations in NSW. It aims to provide a ‘pro-active service that is both professional and culturally sensitive’ and assist Aboriginal people to ‘access support, representation, advice, information, conciliation and education’.¹⁰⁹ In particular, it helps Aboriginal tenants navigate the housing system by writing letters of support for the tenant, attending hearings or mediation sessions at the NSW Civil and Administrative Tribunal (NCAT) with the tenant, and helping the tenant find services and negotiate with landlords.¹¹⁰

101 Tamara Walsh and Heather Douglas, ‘Lawyers, Advocacy and Child Protection’ (2011) *Melbourne University Law Review* 622, 629.

102 Ibid 634.

103 See, eg, Beth Tarleton, ‘Expanding the engagement model: The role of the specialised advocate in supporting parents with learning disabilities in child protection proceedings’ (2013) 7(5) *Journal of Public Child Welfare* 675.

104 Family Inclusions Networks, cited in Senate Community Affairs References Committee, *Out of Home Care* (Report, 2015) [5.86].

105 Senate Community Affairs References Committee, *Out of Home Care* (Report, 2015) [8.46], Box 8.2.

106 Senate Community Affairs References Committee, *Out of Home Care* (Report, 2015) rec 24.

107 Australian Government, *Commonwealth Government Response to the Senate Community Affairs References Committee Report: Out-of-Home Care* (12 September 2017).

108 Tamara Walsh and Heather Douglas, ‘Lawyers, Advocacy and Child Protection’ (2011) *Melbourne University Law Review* 622, 628.

109 NSWATS, ‘Who we are’, <<https://nswats.com.au/>>.

110 NSWATS, ‘Who we are’, <<https://nswats.com.au/>>.

The Review notes that advocates of the new Aboriginal Child Protection Advocacy Program need to be properly resourced to perform their role and should be Aboriginal (or highly skilled in partnering with Aboriginal clients). It also notes that it is essential that advocates in the new Child Protection Advocacy Program are informed early of a family's involvement in the child protection service in order to assist the family to navigate the child protection system effectively.

Recommendation 27: The NSW Government should establish a Child Protection Advocacy Program to train and support a state-wide network of specialist child protection advocates to give advice to, and advocate for, families who are involved in the child protection system. This program should be akin to the Tenant's Advice and Advocacy Program currently resourced by Fair Trading NSW. This program should be informed by the advocacy function that GMAR NSW have been performing unofficially.

Recommendation 28: The Department of Communities and Justice establish a notification service, similar to the NSW Custody Notification Service, to notify the Child Protection Advocacy Program or a relevant Aboriginal community body about the removal of an Aboriginal child or young person from their family, providing a timely opportunity for review, oversight and advocacy on behalf of Aboriginal families and communities in the best interests of Aboriginal children and young people.

Provision of legal advice to correct the power imbalance

Another aspect of support (and another way to reduce the current power imbalance between Aboriginal families and the state) is the provision of legal advice to Aboriginal families. Northern Rivers Community Legal Centre submitted that resourcing early intervention child protection legal services is necessary to prevent Aboriginal children entering and remaining in OOHC. It emphasised that:

Access to culturally appropriate legal advice and advocacy at the outset of FACS child protection intervention facilitates greater transparency in FACS decision making and can successfully support parents to address child protection concerns and prevent children being removed.¹¹¹

Redfern Legal Centre submitted that:

We also support the continued development of the early intervention Care and Protection solicitors, 'Care Partners'. The process of child protection is extremely disempowering and creates a significant power imbalance between FACS and the parent(s). Having a solicitor involved from the beginning is important; they can advocate for the client when required, assist in negotiations with FACS and ultimately provide a 'voice' for the client in a difficult and emotional time.¹¹²

111 Northern Rivers Community Legal Centre, Submission No 16 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 3.

112 Redfern Legal Centre, Submission No 14 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 10.



The Review agrees that the continued development of the Care Partner program is important and necessary for righting the power imbalance in an area where Aboriginal parents routinely are put in a position of disempowerment by the state. Early legal advice can support parents to navigate the system, understand what their rights are, and to request that their caseworker support them with alternatives to removal, or less intrusive options prior to moving directly towards child removal. It is the opinion of the Review that the use of less intrusive measures is best for all parties. This means children receive support at a critical earlier time, parents receive support to keep their children, and the NSW government is better able to work towards its identified policy objectives of family preservation.

Four Family Violence Prevention Legal Services (FVPLS) submitted that they should be adequately resourced to deliver targeted early intervention and prevention solutions:

FVPLS are established effective holistic legal services that are perfectly placed within the communities to be able to provide targeted help for families to navigate the system, to advocate and work with them before children are placed in OOHC.¹¹³

Northern Rivers Community Legal Centre submitted that it had partnered with a range of community services to create an Early Intervention Referral Project (EIRP). The project was intended to address child protection, family law and tenancy advice for Aboriginal women experiencing family violence:

The project produced referral cards with the contact details of local child protection early intervention legal and family and domestic violence services and a map that details each stage of the child protection intervention process and information as to why it is important at each stage to refer families to legal and domestic and family violence services. The aim of the project is to stem the tide of child removals by providing early access to legal advice so that families have legal advocacy in their dealings with FACS, including encouraging FACS to utilise early intervention tools such as family group conferencing.¹¹⁴

Women's Legal Service NSW noted the work of its Indigenous Women's Legal Program in community development and community legal education. A key component of this is focused on raising awareness within the Aboriginal community about early access to legal advice.¹¹⁵

The Review notes the excellent work undertaken by community legal centres, on very limited budgets, to provide legal advice and also conduct community legal education in this area. The Review agrees that it is vital that service providers be resourced to continue to provide this valuable support.

Recommendation 29: The NSW Government should provide further sustained funding to the Care Partner Program to ensure that more Aboriginal families have access to legal advice to promote early intervention support.

113 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 10.

114 Northern Rivers Community Legal Centre, Submission No 16 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 1.

115 Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 11.

Specific area of concern: Domestic and family violence

The Review has identified a number of areas of specific concern in relation to early intervention and prevention work within FACS. These issues are all identified in this section, but the case reviews have highlighted that FACS' practice limitations in respect of discrete areas of practice—such as domestic and family violence, disability and housing—are reflected throughout the different components of the care system, from early intervention, through OOHC casework and restoration. These issues are accordingly discussed here, as well as at other different points of this report.

Domestic and family violence is a significant issue affecting families in the cohort. It is the Review's perspective that any early intervention support provided by FACS must be informed by a comprehensive understanding of the dynamics of domestic and family violence. Current data collated for this Review and stakeholder submissions suggest that this is not currently the case. Instead, data highlighted considerable deficiencies in the department's response to domestic and family violence within both the child protection system, for children in care, and in respect of restoration goals and goal-setting.¹¹⁶

The joint submission of four FVPLS notes that perpetrators of domestic violence isolate women by cutting them off from family and support networks, putting children at risk and setting up the pathway to children entering OOHC. The key to interrupting this pathway is early intervention and prevention work targeted towards domestic and family violence, followed by ongoing long-term support for vulnerable families.¹¹⁷

Women's Legal Service NSW submitted to our Review that:

In the context of domestic violence, it is often the case that rather than holding the perpetrator (often the father) to account, the mother is punished for not acting in a so-called 'protective manner' ... [and it is] the mother who is unfairly seen as responsible for dealing with the consequences of violence in a child protection context.¹¹⁸

It also noted FACS caseworkers' consistent inability to appreciate that:

when a woman leaves a relationship, it is one of the most dangerous times of the relationship and requires planning and support. This view also fails to acknowledge that some women remain with a violent partner in order to protect their children as they fear what will happen if their children are left unsupervised with the alleged perpetrator.¹¹⁹

The department's limited understanding of the dynamics of domestic and family violence was also reflected in the qualitative and quantitative data for this Review. In 58 cases in the 200 sample (29%), it was identified that there were issues in the way FACS responded to domestic and family violence affecting families in the cohort. Although the data does not indicate how many cases in the cohort involved domestic and family violence issues altogether, this figure and the relevant cases appear to highlight a significant practice issue within the department. In

116 Restoration is discussed in Chapter 21.

117 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 10.

118 Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 15.

119 Ibid 16.



a number of cases before children entered care, domestic and family violence issues attracted no appropriate or early response from FACS, ad hoc (or unsustainable responses), or in some cases FACS inappropriately closed families' cases despite domestic and family violence issues remaining ongoing. In one case, for instance, FACS was aware that the father had threatened to kill the mother and the family was living isolated on a remote property. Nonetheless, FACS did not respond to two ROSH reports around the children's exposure to violence by the father against the mother.¹²⁰ In this case, the entry into care could have been avoided with earlier preventive focused work responding to domestic and family violence issues.

A number of cases also raised concerns about FACS caseworkers not treating mothers who were also victims of violence with compassion or understanding. This responsibility matrix—holding victims (usually mothers) responsible for the violence used against them or experienced by the children due to the male partner's abuse—was common across a number of cases. This was also reflected in a number of cases in FACS' language to the court and in safety assessments. In a number of safety assessments, the mother's protective actions—such as taking her children somewhere safe when she expected violence was coming, contacting FACS for help, or seeking domestic violence orders for the children to protect them from their abusive father—were also not recognised or were minimised as protective actions by FACS.

In a number of cases FACS caseworkers also demonstrated little knowledge of civil legal orders around domestic and family violence. The Review viewed files where the mother's violence victimisation was conflated with their failure to meet FACS' gendered expectations around their responsibility as mothers. For instance, in Case 33, FACS removed a child due to the mother (the party protected under the apprehended domestic violence order) 'allowing her partner (the defendant) to breach his [domestic violence order] and be in the house'. This amounts to a misconstruction of the legal responsibility under domestic violence orders in NSW (which protect victims and bind defendants). Similarly, in Case 35, FACS continually held the mother responsible for the father's violence (including his breaches of domestic violence orders protecting her) but did not provide any response to the father's use of violence (for instance, by referring him to a men's behaviour change program). In other cases, FACS did not discuss ADVOs with victims despite it being identifiable from the facts that it was appropriate, and often necessary, to do so. These cases suggested that FACS required further training and knowledge around domestic violence laws in NSW, as well as knowledge of, and active referral through, pathways into specialist domestic and family violence services.

Despite the NSW Safer Pathway system being in place, cases highlighted that FACS records revealed little knowledge of, or outreach to, this domestic and family violence system. There is also no evidence of families becoming involved in the multi-agency Safety Action Meetings (SAMs), despite in at least one case it being suggested that FACS actively refer a family into this meeting, and in one case the family being assessed as meeting the Domestic Violence Safety Assessment Tool (DVSAT) threshold for SAM entry (high risk of serious domestic violence). It should also be noted that the recent evaluation of the NSW Safer Pathway has also highlighted that FACS and FACS Housing were the agencies most often not represented at the SAMs, limiting the insight that these agencies could bring to the triage process of serious domestic and family violence cases in NSW and also limiting these agencies' ability to improve knowledge and practice around domestic and family violence.¹²¹

120 Exposure, in itself, representing a form of victimisation.

121 Women NSW (ARTD), *Safer Pathway Evaluation Report* (Report, 2019).

The lack of outreach, or involvement in specialist programs and services appears to be an organisational weakness of practice within FACS. It is hoped that the recent restructure of FACS and Justice (becoming the Department of Communities and Justice) will result in further coordination in respect of the child protection system and the NSW Safer Pathway. This should also be considered when giving effect to Recommendation 3 of the Safer Pathway evaluation, supported by the NSW Government, which recommended that Victims Services continue to expand referral pathways to facilitate referrals to Safer Pathway from other agencies, funded services, and community and self-referral.¹²² Given the issues outlined in this section, more integration between FACS and Safer Pathway is likely necessary to support effective and specialised casework practice around domestic and family violence within FACS.

Another issue evident in the sample was that FACS caseworkers did not appear to understand the dynamics of coercion and control central to domestic and family violence. In a number of cases caseworkers inappropriately referred parents to ‘relationship counselling’ or ‘couples counselling’ either during pre-entry into care casework or nominated this as a restoration goal to address issues of domestic and family violence. In one case the caseworker even suggested that the parents ‘spend some time talking together’ despite an evident context of coercion and control. In this same case, the caseworker attempted to mediate violence episodes between the couple over the phone. These examples demonstrated little understanding of the power imbalance characteristic of intimate partner violence, highlighted inappropriate responses to domestic violence that are supported and used within FACS’ casework, and effectively promoted actions that exposed the victim to further risk of violence and abuse.

The lack of knowledge around the dynamics of coercion and control was particularly clear in one of the sample cases. In Case 40, FACS supported the children being placed with their father despite his significant history of violence against the children’s mother. In this case FACS also sought to work with the parents together during case planning despite the father’s coercive and controlling behaviours towards the mother. In the current care arrangement, the father remains responsible for facilitating contact between the mother and her children. ROSH reports have been received (but closed with referral) regarding concerns that the father is using contact with the children to control the mother. The father has also continued to use physical violence against the mother at contact visits and all ROSH reports around this have been closed without response. For this case, the Review made several recommendations relevant to assessing the children’s safety in the care arrangement with their father, as well as recommending further action be taken to ensure the mother’s safety from the father.

Across cases there were few strengths identified in FACS’ current casework practice around domestic and family violence. Although FACS has advised the Review that it has sought to rectify some of these limitations through its Dignity Driven practice under the new Practice Framework —underpinned by some of the work of Allan Wade and the Centre for Response Based Practice—this shift to victim-centred thinking and understandings of victim resistance was not reflected in casework practice for the case review cohort.¹²³ While the Dignity Driven practice approach is promising and appears to address issues of gendered responsibility and resistance identified in the Review, the Review remains concerned that insufficient embedding of this approach is occurring. It considers that more work needs to be undertaken to ensure that effective training about this approach is rolled out to all departmental staff in contact with victims or perpetrators of domestic and family violence.

122 Women NSW (ARTD), *Safer Pathway Evaluation Report* (Report, 2019).

123 Centre for Response-Based Practice, ‘Publications’, *Centre for Response-Based Practice* (2019) <<https://www.responsebasedpractice.com/publications/>>.



Overall, FACS' response to domestic and family violence at all levels of casework practice during the cohort review period demonstrated a lack of knowledge and sensitivity to issues of gender, power and control, as well as a lack of knowledge around contemporary understandings of domestic and family violence. It displayed limited knowledge of, and recourse to, civil protection orders and a lack of outreach into contemporary specialist systems in NSW established to address and respond to violence. Aside from the Dignity Driven practice framework's implementation, there is little to suggest that these other practice issues have been addressed. The lack of specialisation around this issue within FACS is troubling given the number of families experiencing domestic and family violence issues who become involved with the department. Accordingly, the Review's recommendations are aimed at improving specialist outreach and knowledge building from within the department, embedding of the Dignity Driven practice approach, improving understandings of coercive and controlling behaviour, and improving knowledge around the specific barriers faced by Aboriginal women who experience domestic and family violence.

Recommendation 30: The Department of Communities and Justice should mandate the use of the Domestic Violence Safety Assessment Tool by caseworkers where parents are present, or screen-in, in relation to domestic and family violence related issues. This tool should be used to coordinate parents' involvement in the Safer Pathway system. Roll out of this approach needs to be accompanied by further training and education for caseworkers and casework managers around identifying domestic and family violence including coercive and controlling behaviours. Consideration should be given to involving caseworkers in Safety Action Meetings where parents are assessed as being at serious threat and become involved in these meetings.

Recommendation 31: The Department of Communities and Justice should provide targeted and ongoing education about the Dignity Driven practice approach to staff at all levels of the agency, including caseworkers and senior managers. Education should require all staff to complete training developed by and delivered in partnership with Aboriginal domestic and family violence specialists regarding the issues facing Aboriginal women who experience domestic and family violence.

Specific area of concern: Housing

Women's Legal Service NSW noted that families involved in the child protection system may be unable to access to safe and affordable housing. This issue often intersects with domestic and family violence because a child is often removed when a woman remains with an abusive partner and is deemed by the department as being non-protective or 'unable to keep her child safe'. However, a reason why women cannot leave an abusive partner may be because the woman does not have anywhere safe to go should she leave. The child is then at risk of removal for reason of homelessness should she leave or if she stays the child is at risk of removal due to exposure to violence.

Further, it is well documented that the point at which a woman leaves a relationship is an extremely dangerous period for the safety of her and her children. Many homicides of women occur when a domestic violence victim leaves her abusive partner.¹²⁴ In the absence of safe

124 Australian Domestic and Family Violence Death Review Network, 2018 Data Report (Report, 2018).

alternative housing where a woman can protect her children, the logical decision may be to stay with an abuser. Unfortunately, the decision to stay is often used against the mother, in that this is used firstly as a reason to remove the child and then used as a reason not to restore the child.

In recognition of some of these challenges, the NSW Government (FACS) implemented the Staying Home Leaving Violence (SHLV) reforms, where SHLV caseworkers work in cooperation with NSW Police to remove the violent partner from the family home so that the domestic and family violence victim and their children can remain safe. The program prioritises women who are separated from a violent partner but continue to experience ongoing violence and abuse. The program also prioritises Aboriginal and Torres Strait Islander women. The program currently operates in 33 locations around NSW but has not been implemented across the whole state. Another limitation of this program is that it is separation focused and is also located in mainstream services in most areas. This may make the program difficult for some Aboriginal women to access, in contrast to if the program was mostly located within or run by a culturally appropriate or Aboriginal controlled service.

Women's Legal Service NSW wrote that:

The current FACS Housing Pathways policy is that a parent may be considered for priority access to social housing if she/he can provide evidence which demonstrates that 'the lack of appropriate accommodation is impacting their ability to have children restored'. However, we have heard from community members that assessments of social housing applications appear to be based on the parent's current circumstances, such as whether a child is in their care at the time.¹²⁵

Women's Legal Service NSW also noted that the policies of the Aboriginal Housing Office (AHO) around providing priority housing to victims of domestic violence are not clear, nor are these policies clearly implemented (the AHO sits under the auspices of FACS). The Review notes that this type of interaction is consistent across the case file reviews. The focus on the mother's 'failure to protect' children from violence is evident in the reviews of Aboriginal children in OOHC care examined for this Review. Legal Aid NSW also specifically noted that housing should be addressed as a key early intervention strategy:

many Aboriginal children are at risk due to inadequate housing, over-crowding, and poor building maintenance. We therefore recommend that the difficulties experienced by Aboriginal families in finding and maintaining suitable housing should be addressed as a priority early intervention strategy to promote child protection.¹²⁶

The Review agrees that housing is a key issue that continues to act as a driver for removal, as well as a barrier to restoration.

Recommendation 32: The NSW Government should roll out and resource Staying Home Leaving Violence across the whole of NSW.

125 Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 17.

126 Legal Aid NSW, Submission No 6 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 18.



Recommendation 33: The Department of Communities and Justice should ensure that caseworkers can connect families with the Staying Home Leave Violence service if they present with domestic and family violence issues and housing difficulties.

Recommendation 34: The NSW Government should increase the availability of short-term refuges suitable to the needs of Aboriginal women escaping violence. Increases in the availability of short-term refuges (for temporary housing issues) should be accompanied by a longer term investment in social housing stock in NSW, with a view to increasing the availability of housing for vulnerable Aboriginal women.

Specific area of concern: Disability

Disability amongst children who become involved in the care and protection system and disability amongst parents of children who become known to the system is another issue that has been identified in this Review. Data cited earlier in this chapter show that Aboriginal children with complex health and developmental needs are more likely to become known to, and escalate through, the child protection system. This highlights the need for targeted and appropriate early intervention and prevention work to address multi-stratum health and disability issues. What is not so clear from available data is the extent of 'systems contact' with parents who have disability and the approach to early intervention and prevention work with these vulnerable parents. Data from the Review highlight considerable issues both for children with disability and parents with disability who become involved in the child protection system.

People with Disability Australia noted that children and young people with disability were disproportionately represented in OOHC.¹²⁷ In this regard, some stakeholders noted that FACS caseworkers often perceived disability as a risk and placed the burden on parents with disability to prove that they were capable of caring for their children.¹²⁸ The Review was informed of one case where a mother with a mild intellectual disability had her child removed after a ROSH report was made about the child, despite having family support and services set up for when the baby was born.¹²⁹ The Review was also informed that the language used by FACS caseworkers regarding disability was not always appropriate¹³⁰ and that disability support services were not adequate.¹³¹ In one example provided to the Review, a FACS caseworker refused to provide an interpreter for a mother with a hearing impairment to enable her to participate in a meeting about the removal of her children.¹³²

People with Disability Australia also noted that there was a high rate of unrecognised disability in children involved in the child protection system and that placement instability contributed to this problem.¹³³ Further, it expressed its support for Recommendation 12.21 of the Royal Commission into Institutional Responses to Child Sexual Abuse, which states that state and

127 People with Disability Australia, Submission No 17 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 2.

128 Confidential, *Consultation*, FIC 20–21.

129 Confidential, *Consultation*, FIC 14–15.

130 Confidential, *Consultation*, FIC 20–21; Confidential, *Consultation*, FIC 63.

131 Confidential, *Consultation*, FIC 41; Confidential, *Consultation*, FIC 42.

132 Confidential, *Consultation*, FIC 63.

133 People with Disability Australia, Submission No 17 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 2.

territory governments should ensure the adequate assessment of all children with disability entering OOHC and provide support and risk management strategies to these children.¹³⁴ It also submitted that OOHC workers needed to receive more training with regards to Aboriginal children with disability¹³⁵ and that ‘nationally consistent data regarding disability must be collected through OOHC reporting’ so that evidence-based approaches to assisting children in OOHC could be developed.¹³⁶ The Review agrees with these submissions and has taken these into account in guiding its research and developing its recommendations.

Uniting also expressed its concern about the transition of disability services to the National Disability Insurance Scheme (NDIS).¹³⁷ It submitted that the ‘individualised funding model of the NDIS is inadequate to support the continued delivery of holistic, family-centred supports’ for Aboriginal children with a disability.¹³⁸ It submitted that, if support services specific for Aboriginal families with disability closed, there would likely be an increase in Aboriginal children with a disability being relinquished into OOHC.¹³⁹

The concerns of both People with Disability Australia and Uniting have been reflected within cases in the cohort, and limitations around OOHC disability reporting and transparency have also been reflected in the Review’s data.

There is a significant data gap in respect of the identification of children with disability who encounter the child protection system in NSW. Similar limitations around data have been identified for parents with disability who become involved with the child protection system. Although it is acknowledged that definitional challenges exist around disability, these data are necessary to inform the system response to both parents and children who become involved in the child protection system.

FACS was unable to provide comprehensive systems data to this Review about these populations of children¹⁴⁰ and parents who had disability. The data collected by the Aboriginal Care Review Tool did not adequately distinguish between disability or other health issues for children in the cohort including to provide adequate definitional specifications or guidance to reviewers around the meaning of ‘health issue’ including whether this amounted to a long or short term health issue.

Although FACS (Administrative) data has limitations in respect of disability (and does not capture disability prevalence for parents), the FACSIAR data report contained a brief analysis of disability prevalence for children in OOHC based on a ‘disability flag identifier’ that was created where a child was identified as having disability via the disability flag in KiDS, where the child was an Ageing, Disability and Home Care (ADHC) client, or where the child was identified as having a disability in a Housing NSW application. This analysis of FACS (Administrative) data illustrated that 18.4% of children in OOHC on 30 June 2016 (Aboriginal and non-Aboriginal) had a disability, with the prevalence of disability among Aboriginal children being fractionally

134 Ibid 2-3.

135 Ibid 4.

136 Ibid.

137 Uniting (NSW.ACT), Submission No 23 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, March 2018, 18.

138 Ibid.

139 Ibid.

140 FACSIAR, *Family is Culture Framework Data Report Review of Aboriginal Children and Young People in Care in NSW* (Report, 2019) notes that the disability information captured in FACS administrative data and the Review tool has not been presented as it is considered unreliable.



lower than the prevalence among non-Aboriginal children. The analysis noted that the lower prevalence of identified disability in Aboriginal children was attributed to the under-representation of Aboriginal children in NGO care and a higher prevalence rate of disability identification of children in NGO care. For children in statutory care, Aboriginal children made up 37% of children in OOHC, but just 31% of children are in NGO care. Meanwhile, 24% of children in NGO care were identified as having a disability, as compared with 19% in FACS care.¹⁴¹

Although this data has not had the benefit of interpretation by Aboriginal stakeholders, it appears to reflect an under-representation of the true prevalence of disability for children in the system, as census data reported by AbSec indicates, that Aboriginal and Torres Strait Islander people have higher rates of disability across all age groups, with children under 14 being more than twice as likely, compared to non-Aboriginal children of the same age, to have a disability. The under-reporting of disability appears to reflect issues identified in People With Disability Australia's submission to the Review (discussed above).

It should be noted that additional Wave 4 data tables from the POCLS provided to the Review were relevant to the issue of disability. However, the small sample,¹⁴² the methodology and the preclusion on Aboriginal consultation around this data have led to a decision not to include the data in this report.

In the qualitative analysis, disability amongst children and parents was identified for 35 of the families in the sample (17.5%). Most of the cases involved one or both parents having a diagnosed or suspected intellectual disability (n=24, 12% of cases in the sample), and in 16 cases (8% of sample), children were identified as having an intellectual or, in one case physical disability, and in one case other unspecified, disability. For the child who had an unspecified disability, it is concerning that FACS' records did not reflect the nature of this disability nor appear to take this into account at any stage, despite the child with disability being a vulnerable older Aboriginal child in OOHC. It is similarly concerning that while many parents were identified as having a diagnosed intellectual disability, in other cases FACS 'suspected' that one or both parents had intellectual disability issues, however no steps were ever taken to assess the parents' abilities, or develop appropriate casework strategies which would ensure effective and appropriate approaches and engagement.

In five of the cases, one or both parents were identified as having an actual or suspected intellectual disability and their child in the cohort also had an intellectual disability.

In 23 of the 24 cases in which one or both parents of the children in the cohort had a disability, FACS was involved with the family prior to the children in the cohort entering care. In all (n=24) of these cases, reviewers identified deficiencies in the casework provided by FACS before the child entered care. A common issue was that FACS did not provide sufficient support to parents to enable them to participate in pre entry into care casework or work effectively with FACS to address identified safety issues. In the majority of cases, there was no evidence that FACS engaged specialist support such as disability support to promote the rights, interests, and wellbeing of these parents, and in some cases the processes that FACS required parents to participate in were specifically identified by reviewers as not being appropriate for the parents given their disability.

141 FACSIAAR, *Family is Culture Framework Data Report Review of Aboriginal Children and Young People in Care in NSW* (Report, 2019), 31.

142 The Wave 4 sample comprised 961 caregivers and 382 Aboriginal children (including 51 who identified as both Aboriginal and culturally and linguistically diverse).

These cases also highlight an apparent lack of casework strategies to support parents with disability to care for their children both before and after children enter care. In a number of cases, including cases where children were assumed at birth, options for parents with disability to safely care for their children—such as supported accommodation arrangements—were not explored. In one case where supported accommodation was explored, it was not progressed due to unavailability at one service, and availability through other services were not investigated. As a consequence the child entered care.

It was concerning that across cases, a routine lack of specialist consultation and assessment appeared to result in children being removed from their parents due to reasons that, at least in part, appeared to be based on assumptions about (rather than assessments of) the parents' intellectual capacity. For instance, in Case 114 involving a mother with disability, FACS presented vague evidence to the Children's Court about the mother's parenting capacity, while withholding evidence of any actual examples of her parenting which had been used to substantiate the safety assessment and justify removal. In this case, FACS did not present the mother's strengths to the court, nor did it provide enough evidence of the practical impact her disability had on her parenting. The Review is of the perspective that FACS should have conducted a formal assessment of her parenting capacity rather than justifying removal based on vague assumptions based on her disability.

It is concerning that assessment processes, where they did occur (including in some cases during restoration discussions), were identified as not being appropriate to the parents' disability and not culturally appropriate. In Case 16, for example, a parenting capacity assessment was completed with the parents, both of whom had a mild intellectual disability. The parents were identified by the assessor as struggling to participate in the assessment. It does not appear that disability support was provided to either parent to assist their participation. In this case, the assessor specifically recommended that an Aboriginal consultation be engaged to interpret the results, as measures on the assessment had not been validated for Aboriginal people. There is no indication that this occurred.

These findings highlight the importance of working effectively with parents with disability and engaging support organisations to ensure effective casework and practice with families including at the early intervention support stage. For Aboriginal parents with disability, these findings also highlight the importance of supportive approaches and casework being culturally safe. These findings also highlight the importance of the department collecting readily available and comprehensive data around the representation of parents and children with disability in the child protection system.

While there were few identifiable strengths in practice, it should be noted that in Case 164 the mother sought disability advocacy after having her children removed. This followed FACS providing the mother with a phone number to call. Assistance from the disability advocacy organisation is credited with helping the mother to achieve restoration goals and making significant progress around issues impacting her parenting. The mother's achievements contributed to the Review recommending that restoration of the children be considered in consultation with the mother and her disability advocacy worker.

These data and submissions highlight deficiencies in the way FACS records, works with and treats Aboriginal families experiencing disability who become involved in the child protection system. Further work is urgently needed to address these practice deficiencies from early intervention, through to entry into care, OOHC work and restoration. In Chapter 10, the Review recommends the



development of a new Aboriginal prenatal reporting and newborn removal policy. It notes that this policy should highlight the importance of identifying expectant parents with disability early in the intervention process. The following recommendations aim to further improve policy and practice in this area.

Recommendation 35: The Department of Communities and Justice should design, in partnership with Aboriginal stakeholders and community, a new approach to collecting and reporting data around disability prevalence among Aboriginal children in the child protection system, and disability prevalence among their parents.

Recommendation 36: The Department of Communities and Justice should work with the First Peoples Disability Network Australia, People with Disability Australia, the National Disability Insurance Scheme (NDIS) and Aboriginal community and stakeholders to develop a plan of action to improve disability identification, practice competence, and pathways to specialist disability service involvement within the Department of Communities and Justice for children and families at all stages of the child protection system—from early intervention support through to entry into care, restoration and post entry into care casework.

Recommendation 37: The Department of Communities and Justice should, in partnership with the First Peoples Disability Network Australia, People with Disability Australia, Aboriginal community and stakeholders, implement a strategy for early intervention and prevention work specifically targeted towards early identification and responses to the needs of Aboriginal parents and children with disability who come into contact with the child protection system.

Interagency service provision

Although this report has identified a number of areas of specific concern, ROSH report data for this Review cohort highlight that parents often present to child protection services with multi-stratum and complex issues.¹⁴³

The success of early intervention and prevention work is about access to quality and available services across the range of issues relevant to parents and children in the care and protection system. Northern Rivers Community Legal Centre provided the Review with a client case study of how a lack of access to services impacted the ability of parents to meet child protection goals in practice:

Recently [our] child protection early intervention solicitor service gave advice to a client who had experienced long term abuse and violence by her partner. The client had three children and FACS were involved with the family. The mother reported that the intervention of FACS was invasive and replicated the dynamics of power and control in her relationship with the perpetrator. The mother felt as though she was being punished for being the victim of trauma. There were significant

¹⁴³ See Chapter 3, which maps ROSH concerns for the Review Cohort.

barriers which prevented the mother from receiving assistance, including lengthy waiting lists for counselling and other support services and the lack of crisis accommodation or other affordable housing options.¹⁴⁴

Improving interagency service provision is important. The Review agrees with SNAICC that:

solutions should include increasing the availability of non-stigmatising service entry points, including integrated early years targeted family supports, such as those provided by the Aboriginal and Torres Strait Islander Child and Family Centres ... the literature strongly identifies integrated services that provide holistic responses to child and family needs as critical to support Aboriginal and Torres Strait Islander families.¹⁴⁵

In *The First 1000 Days: Catalysing Equity Outcomes for Aboriginal and Torres Strait Islander Children*, Kerry Arabena underscores that:

Coordinated interventions that properly engage parents and vulnerable children with interrelated issues - such as maternal mental health, parental incarceration, racism and familial stress - and also engage with the child protection and welfare systems have the best chance of being effective.¹⁴⁶

Northern Rivers Community Legal Centre also suggested that there be better coordination between FACS and NSW Health. For example, FACS should provide adequate support to Aboriginal families upon receiving a NSW Health notification of a child rather than move to removal of that child.¹⁴⁷

Given the high rates of Aboriginal incarceration, Women's Legal Service NSW also noted that early support is particularly necessary for pregnant Aboriginal women and Aboriginal women in custody with children, to address their trauma, mental health and drug or alcohol issues. It recommended that FACS should 'increase the provision of appropriate referrals prior to a mother's release from custody to ensure she and her children have access to safe and affordable housing and other supports'¹⁴⁸

Recommendation 38: The Department of Communities and Justice should work closely with relevant agencies and service providers, including Aboriginal Community Controlled Organisations, specialist housing, health, perinatal, alcohol and other drug use, mental health and domestic and family violence services, to develop a plan to co-ordinate integrated service provision in early intervention support efforts for Aboriginal families and children. This plan should focus on providing targeted support for families from an early stage of engagement in the system, focusing on initial contact.

144 Northern Rivers Community Legal Centre, Submission No 16 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 5.

145 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 10.

146 Kerry Arabena, 'The First 1000 Days: Catalysing Equity Outcomes for Aboriginal and Torres Strait Islander Children' (2014) 200(8) *Medical Journal of Australia* 442.

147 Northern Rivers Community Legal Centre, Submission No 16 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 9.

148 Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 4.



Recommendation 39: The Department of Communities and Justice should commission an independent review of all current child protection policies relating to casework services to ensure the policies (including casework and restoration policies) are in line with current best practice standards in relation to domestic and family violence, alcohol and other drug use, mental health, health issues, disability and intergenerational trauma.

Caseworker training

Regardless of whether the legislative amendments are made, it is essential that caseworkers receive better training to effect early intervention support. The National Congress of Australia's First Peoples was one of many stakeholders who submitted to our Review that there was a need for greater training to ensure that child protection workers properly recognise and understand the cyclical nature of involvement in the child protection system, and the complexity of intergenerational trauma that can impact parenting capacity of Aboriginal and Torres Strait Islander people.¹⁴⁹

The Review agrees that caseworker training should be improved to ensure that it covers such areas. The Review notes that there are plenty of existing resources in this area and the Review encourages reference to the *The Aboriginal Case Management Rules and Practice Guidance: Strengthening Aboriginal families*, developed in partnership with AbSec, and *The Aboriginal and Torres Strait Islander Child Placement Principle: A Guide to Support Implementation*, released by SNAICC in December 2018.

During consultations, the Review was informed on a number of occasions that departmental caseworkers often lacked cultural awareness and capability. Stakeholders expressed the view that the cultural capability of caseworkers should be an extremely high priority in light of the high percentage of Aboriginal children in OOHC¹⁵⁰ and that existing cultural capability training was inadequate, both in terms of its content, and the amount of time invested in the training.¹⁵¹ Some stakeholders attributed the number of Aboriginal children in OOHC to the fact that caseworkers didn't know how to work in and with Aboriginal communities.¹⁵²

Some stakeholders also raised the issue of racism. Some noted that racism existed in health, education and policing, and that racism influenced FACS to remove Aboriginal children from their homes.¹⁵³ The Review was informed that an example of racism in practice could be seen in a matter where a caseworker wrote that an Aboriginal mother was 'highly under the influence of the Aboriginal community' when attempting to provide evidence about the need to remove a child.¹⁵⁴ In another case, a stakeholder witnessed a police officer ejecting an Aboriginal girl from an interview, stating 'I don't believe her'. An interview was later done in the presence of

149 National Congress of Australia's First Peoples, Submission No 22 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 1.

150 Confidential, *Consultation*, FIC 23.

151 Confidential, *Consultation*, FIC 5–9.

152 Confidential, *Consultation*, FIC 5–9.

153 Confidential, *Consultation*, FIC 27.

154 Confidential, *Consultation*, FIC 63.

an Aboriginal worker and the offender was ultimately found guilty of the offences the child had alleged.¹⁵⁵

To address the lack of cultural competency, stakeholders suggested managers should be encouraged to lead by example,¹⁵⁶ that caseworkers should undergo annual cultural training,¹⁵⁷ and that cultural capability should be tested on recruitment.¹⁵⁸

The Review agrees that staff working in the child protection system should receive initial as well as ongoing training to provide them with the skills and knowledge required to enable them to engage in culturally competent and trauma informed casework with Aboriginal children, families and communities. Most important is that caseworkers and managers are educated in the history of Aboriginal people in NSW. This history, a brief survey is provided in the Introduction to this report, is a fundamental requirement for professionals working in the child protection regulatory space in order to effectively understand and service the Aboriginal population in NSW.

Recommendation 40: The Department of Communities and Justice should provide culturally-competent, trauma-informed training and materials for child protection staff, with reference to the excellent resources already prepared by the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec) and the Secretariat of National Aboriginal and Islander Child Care (SNAICC), around working with Aboriginal community and families. This training should focus on how to appropriately engage Aboriginal families in early intervention and prevention work. This training should also have a component of Aboriginal history in New South Wales to provide child protection staff with some nuanced understanding of the Aboriginal population it works with.

Caseworker support

In addition to further training, it is also important that caseworkers are adequately resourced and supported to perform their role. Further training, which is recommended here and in a number of other sections in the report, will quite simply be ineffective if caseworkers are unable, due to a lack of time, resources or support, to implement their knowledge of the best way to work with an support Aboriginal families (during the early intervention stage, or at any other stage of the child protection system). The issue of caseworker workloads and welfare concerns was discussed in the 2017 Legislative Council report on child protection in NSW, where it was noted that a number of stakeholders held concerns about the volume of work allocated to caseworkers and recommended that FACS set caseload targets for caseworkers.¹⁵⁹

The Review did not obtain any statistical evidence about caseworker workloads. However, in consultations, a number of stakeholders noted that there were not enough caseworkers in the department and that there was a high turnover rate of staff employed to engage in casework with families.¹⁶⁰ Stakeholders discussed the fact that caseworkers were often under-resourced,

155 Confidential, *Consultation*, FIC 73.

156 Confidential, *Consultation*, FIC 27.

157 Confidential, *Consultation*, FIC 31.

158 Confidential, *Consultation*, FIC 53; Confidential, *Consultation*, FIC 5–9.

159 Legislative Council report ch 8, rec 19.

160 Confidential, *Consultation*, FIC 2; Confidential, *Consultation*, FIC 87; Confidential, *Consultation*, FIC 53.



overloaded with cases and generally ‘run down’. It was noted that a caseworker could have between 10 and 17 cases allocated to them, and it was then left to the caseworker to prioritise the work in order of urgency. This high workload often resulted in caseworkers not conducting face-to-face visits with families, or only calling families once a week.¹⁶¹ There was consistent feedback that FACS workers, both caseworkers and middle management, were required to spend considerable amounts of time completing administrative tasks and were often ‘consumed with preparing documents for court’, preparing care plans or calling people, to the point that these tasks become ‘crippling’.¹⁶²

Several stakeholders expressed dissatisfaction with the level of contact they had with their caseworkers, noting that caseworkers only got in contact when visitations were going to occur,¹⁶³ or ‘a few days before court hearings and things’.¹⁶⁴ However, despite a lack of contact, caseworkers would still remove children based on an incident that had happened months previously, without knowing about or taking into consideration the work the family had done in the meantime with services.¹⁶⁵ Parents reported that it was hard to get in contact with caseworkers as they went on leave without advising their clients there would be no contact for that period of time,¹⁶⁶ mostly used emails, and did not engage in a lot of face-to-face contact.¹⁶⁷ The high turnover of caseworkers was also noted, with one parent having four caseworkers in a five year period.¹⁶⁸

Being under-resourced and not having time to engage in proper casework was reported to have a detrimental impact on caseworkers, who noted feeling a sense of guilt about their limited intervention with families.¹⁶⁹ Other notable effects of under-resourcing included that children determined to be a low priority for caseworkers were often ‘the ones that slip through the cracks’ because they did not receive any services or support.¹⁷⁰ A lack of time and resources can also affect the quality of casework services actually provided. For example, one stakeholder recounted supervising a visit between a stepfather and a child without being briefed that it had been alleged that the stepfather had sexually abused the child.¹⁷¹

It was suggested that having a manageable number of cases would enable caseworkers to do a much better job.¹⁷² Positive feedback was given on the United States Home Builders model which involves very intensive casework and requires face-to-face work for up to 10 hours per week, with each caseworker being allocated only two cases. The model was seen as an example of a way to encourage and produce effective casework.¹⁷³

A number of other suggestions were made to improve the ability of caseworkers to work with Aboriginal families. For example, one stakeholder submitted that there should be a

161 Confidential, *Consultation*, FIC 2.

162 Confidential, *Consultation*, FIC 2; Confidential, *Consultation*, FIC 27; Confidential, *Consultation*, FIC 87; Confidential, *Consultation*, FIC 84.

163 Confidential, *Consultation*, FIC 12.

164 Confidential, *Consultation*, FIC 57.

165 Confidential, *Consultation*, FIC 63.

166 Confidential, *Consultation*, FIC 84.

167 Confidential, *Consultation*, FIC 93.

168 Confidential, *Consultation*, FIC 93.

169 Confidential, *Consultation*, FIC 2.

170 Confidential, *Consultation*, FIC 2; Confidential, *Consultation*, FIC 62.

171 Confidential, *Consultation*, FIC 62.

172 Confidential, *Consultation*, FIC 88.

173 Confidential, *Consultation*, FIC 2.

specialised Aboriginal worker in each team to support caseworkers and help them to be ‘culturally prepared to do the work’.¹⁷⁴ Another stated that caseworkers needed to be better equipped to work effectively during high stress and high conflict situations,¹⁷⁵ while another noted that caseworkers were not provided with any guidance about having conversations with people about Aboriginality.¹⁷⁶ Further, it was suggested that caseworkers needed to adopt a strengths-based approach to their casework practice,¹⁷⁷ as well as actually listen to the advice of Aboriginal organisations, and implement the advice in practice.¹⁷⁸

The Review notes that caseworker support and resourcing is vitally important and recommends in Chapter 1 that the new Aboriginal Quality Assurance Unit be tasked with improving caseworker support for caseworkers engaged with Aboriginal families.

The need for more Aboriginal staff

In addition to greater training and support, the Review notes that casework with Aboriginal children and families, at the early intervention stage, as well as at all other stages of the intervention continuum, would be improved by an increase in the number of Aboriginal staff in the Department of Communities and Justice. Participants in the consultations said that having Aboriginal workers was important because they understand Aboriginal families, culture, and community.¹⁷⁹ It was noted that increasing Aboriginal staff levels would result in more effective and accountable casework practice.¹⁸⁰ However, it was also important that Aboriginal workers had the necessary connection to culture and the required skills to work with community.¹⁸¹ One kinship carer consulted by the Review stated that having an Aboriginal support worker helped her have a better experience with the child protection system and to feel more supported.¹⁸²

In consultations, there was an overarching sense that there were not enough Aboriginal workers in FACS¹⁸³ in all positions, including caseworkers, ‘middle managers’¹⁸⁴ and ‘assessors’.¹⁸⁵ It was also noted that Aboriginal youth workers who were strong in their cultural identity were an important resource.¹⁸⁶ Stakeholders gave the following reasons when asked why there were so few Aboriginal workers in FACS:

- There is a stigma associated with working for the department and the application process is long and includes having to go to an assessment centre;¹⁸⁷
- The department does not provide adequate support to Aboriginal workers;¹⁸⁸

174 Confidential, *Consultation*, FIC 11.

175 Confidential, *Consultation*, FIC 27.

176 Confidential, *Consultation*, FIC 98.

177 Confidential, *Consultation*, FIC 63.

178 Confidential, *Consultation*, FIC 65.

179 Confidential, *Consultation*, FIC 69; Confidential, *Consultation*, FIC 76.

180 Confidential, *Consultation*, FIC 11.

181 Confidential, *Consultation*, FIC 89; Confidential, *Consultation*, FIC 27; Confidential, *Consultation*, FIC 62.

182 Confidential, *Consultation*, FIC 68; Confidential, *Consultation*, FIC 11.

183 Confidential, *Consultation*, FIC 5–9.

184 Confidential, *Consultation*, FIC 27.

185 Confidential, *Consultation*, FIC 27.

186 Confidential, *Consultation*, FIC 62.

187 Confidential, *Consultation*, FIC 11.

188 Confidential, *Consultation*, FIC 87; Confidential, *Consultation*, FIC 27; Confidential, *Consultation*, FIC 88.



- It was difficult to be an Aboriginal working at the ‘middle management’ level due to the requirement to ‘climb the ladder’ and Aboriginal staff often felt as though they were ‘living two worlds’,¹⁸⁹
- Senior Aboriginal caseworkers were overlooked for management positions;¹⁹⁰
- Other staff members had issues about the fact that Aboriginal staff were not required to have degrees;¹⁹¹
- Aboriginal positions with the department felt tokenistic;¹⁹²
- Lateral violence is inflicted on Aboriginal caseworkers;¹⁹³
- Aboriginal workers can be ostracised by their family for their actions when working in a small town;¹⁹⁴ and
- Aboriginal staff faced bullying in the workplace.¹⁹⁵

The Review consulted with several Aboriginal employees at FACS and in doing so, encountered a reoccurring theme of lack of recognition. The Review was informed that FACS often dismissed advice or feedback from Aboriginal staff, or avoided consulting with them completely.¹⁹⁶ It was also informed that the existing work culture provided little incentive for management to engage or consult with ‘lower level’ Aboriginal workers.¹⁹⁷ Further, the Review was informed that there was no process for reporting back to management about what did and did not work with Aboriginal families.¹⁹⁸ Other observations were that the skills of Aboriginal workers were undervalued;¹⁹⁹ FACS did not draw on the experience of local Aboriginal people;²⁰⁰ and that FACS did not consult effectively with Aboriginal organisations.²⁰¹ Stakeholders were of the view that that the skills and connections of Aboriginal workers should be more highly valued.²⁰²

189 Confidential, *Consultation*, FIC 53.

190 Confidential, *Consultation*, FIC 90.

191 Confidential, *Consultation*, FIC 88.

192 Confidential, *Consultation*, FIC 88.

193 Confidential, *Consultation*, FIC 27.

194 Confidential, *Consultation*, FIC 88.

195 Confidential, *Consultation*, FIC 73.

196 Confidential, *Consultation*, FIC 88; Confidential, *Consultation*, FIC 89.

197 Confidential, *Consultation*, FIC 88.

198 Confidential, *Consultation*, FIC 88.

199 Confidential, *Consultation*, FIC 88.

200 Confidential, *Consultation*, FIC 89.

201 Confidential, *Consultation*, FIC 63.

202 Confidential, *Consultation*, FIC 56.

10. Prenatal reporting and newborn removals

Introduction

The removal of a newborn child from his or her birth parents is a particularly vexed issue.²⁰³ On the one hand, a newborn child has a right, as far as possible, ‘to know and be cared for by his or her parents’²⁰⁴ and there are numerous and significant health benefits to a child being cared for by his or her birth mother, including those associated with receiving skin-to-skin contact and breastfeeding.²⁰⁵ A newborn child’s parents also have the right to raise their child. The removal of a child has damaging and long-lasting psychological and health consequences for the child’s birth parents, and for Aboriginal parents, may exacerbate and perpetuate a vicious cycle of intergenerational trauma. On the other hand, a newborn child is extremely vulnerable and has the right to receive special safeguards and care to ensure his or her safety and wellbeing. The failure to adequately protect a newborn child from harm occasioned by his or her birth parents can have devastating consequences, with newborn children being particularly vulnerable to suffocation and asphyxia caused by unsafe sleeping environments, and children under one year of age being particularly vulnerable to intentional injury causing death, or death from child abuse and neglect.²⁰⁶

The following chapter discusses the removal of newborn Aboriginal children in New South Wales (NSW). It begins by examining the practice of prenatal reporting and child protection intervention with expectant parents. It then discusses newborn removals, highlighting significant gaps in policy surrounding the issue, demonstrating the lengthy and perhaps unexpected consequences of the removals, and discussing examples of unethical casework from both literature and the Review’s case file reviews. It concludes by making a number of recommendations to improve the policy and practice of DCJ caseworkers in this area.

Prenatal reporting

A ‘risk of significant harm’ (ROSH) report can be made about an unborn child. Under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*), this report (referred to as a pre-natal report) can be made by any person who has reasonable grounds to suspect that a child may be at risk of significant harm after his or her birth.²⁰⁷ Unlike ROSH reports about children, pre-natal reports are not mandatory under the *Care Act*. However, if there are sufficient grounds for making the report, a mandatory reporter may seek assistance

203 Note that for the purposes of this discussion a newborn child is a child under 31 days of age.

204 *Convention on the Rights of the Child*, 20 November 1989, [1991] ATS 4, (entered into force generally on September 1990), art 7.

205 The benefits of skin-to-skin contact include the reduction of infant mortality in low birthweight infants, improving cardiorespiratory stability, as well as preventing pneumonia, sepsis and jaundice. The benefits of breastfeeding include ‘reductions in infectious disease mortality, diarrhea, and lower respiratory infections’, as well as improving cognitive development: Tyler Vaivada et al, ‘Promoting Early Child Development with Interventions in Health and Nutrition: A Systematic Review’ (2017) 140(2) *Pediatrics* 1, 7. See also Conde- Agudelo A, Diaz-Rossello JL, ‘Kangaroo mother care to reduce morbidity and mortality in low birthweight infants’ (2016) 8 *Cochrane Database Systematic Review* 1; Lawn JE et al, ‘“Kangaroo mother care” to prevent neonatal deaths due to preterm birth complications’ (2010) 39 (suppl 1) *International Journal of Epidemiology*, i144; L Kristoffersen et al, ‘Early skin-to-skin contact or incubator for very preterm infants: study protocol for a randomized controlled trial,’ (2016) 17 *BioMedCentral Trials* 593; R English et al, ‘“First 1000 days” health interventions in low- and middle-income countries: Alignment of South African policies with high-quality evidence’ (2017) 10(1) *Global Health Action* 1.

206 See, for example, C Jenny and R Isaac, ‘The relation between child death and child maltreatment’ (2006) 91(3) *Archives of Disease in Childhood* 265.

207 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 25.



from the Mandatory Reporter Guide, which will prompt the reporter to make the report.²⁰⁸ The following table gives an indication of the grounds that may give rise to a pre-natal report.²⁰⁹

SUSPECTED ROSH TO UNBORN CHILD AFTER BIRTH

High Risk Indicators (From Community Services Unborn Child HRBA Form):

- A pregnant child or young person who is under the parental responsibility of the Minister
- History of abuse or neglect of siblings of the unborn child
- A sibling of the unborn child has been removed or has died in circumstances reviewable by the Ombudsman
- Serious and persistent substance abuse by pregnant woman
- Unmanaged mental illness of pregnant woman
- Pregnant woman is at risk of suicide (either threatened or attempted)
- Pregnant woman is the victim of domestic violence involving serious injury to her, or injury requiring hospitalisation/treatment or involving use of a weapon

Other Risk Factors (From MRG Unborn Child Decision Tree)

Other circumstances that suggest that either parent/carer will be unable to care for the baby upon birth due to:

- suicidal tendencies
- serious and persistent substance abuse
- unmanaged mental illness
- domestic violence
- unmanaged intellectual disability
- unmanaged medical condition/physical disability
- homelessness
- inadequate preparations for birth

Note:

In all cases the Health worker should continue to provide Health services to the pregnant woman and unborn child and refer to the other services as appropriate.

208 NSW Health, *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (2013), [9.8.3].

209 Ibid 66.

In many cases, health professionals are the first to identify potential harm to an unborn child. Research conducted in the Australian Capital Territory (ACT) demonstrated that 42.6% of all prenatal reports were made by health service providers.²¹⁰ In their study of 171 mothers in opioid pharmacological treatment in Sydney (one-fifth of whom were Aboriginal), Taplin and Mattick noted that 38.5% of women reported that their last child protection report had been made by a health service.²¹¹ The primary reason for the prenatal report in 65.1% of cases was substance abuse (including alcohol abuse), while domestic violence and neglect accounted for 29.3% and 18.3% of reports respectively.²¹² The *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* encourages prenatal reporting, noting that it can be a ‘valuable process for the provision of early assistance to mothers and their babies’, and that notifying the department of potential risks to the unborn child enables NSW Health and the department to ‘work collaboratively to ensure that all available preventative and early intervention strategies are in place to reduce the risk of harm to a child when born’.²¹³

The need to engage pregnant mothers and engender their trust through ethical and respectful casework is indisputable. It has been observed that in the absence of appropriate services in the child protection system, ‘surveillance leading to removal is more likely than family support’.²¹⁴ Further, the fear of removal may lead pregnant women to avoid health services (including drug treatment services), thereby placing the health of the woman and the unborn child at risk and reducing the period of time in which intervention can occur (that is, after health services are ultimately engaged late in the pregnancy).²¹⁵ Currently, it has been shown that pregnant Aboriginal women attend their first antenatal visit later than non-Aboriginal women and also attend visits less frequently.²¹⁶ The consequences of avoiding health care services due to the fear of attracting the attention of child protection services may be more severe for Aboriginal mothers, who are more likely to have pre-existing diabetes or hypertension than non-Indigenous mothers.²¹⁷

The department’s policy relating to prenatal reports is complex. It provides that a pre-natal report that satisfies the ROSH threshold will be referred to a community service centre (CSC). If it contains the ‘high risk indicators’ set out in the diagram above, it will be assigned a ‘high risk’ level by the Child Protection Helpline (and as such it requires a response time of 72 hours or less).²¹⁸ After receiving the prenatal report, the CSC may: (i) close the report; (ii) refer the expectant parent(s) to appropriate services, including Brighter Futures; or (iii) allocate the case to a child protection caseworker for ongoing intervention, the recording of birth alerts and the planning of post-birth intervention actions.²¹⁹

210 Stephanie Taplin, ‘Prenatal Reporting to Child Protection: Characteristics and Services Responses in One Australian Jurisdiction’ (2017) *Child Abuse & Neglect* 68, 72. See also Department of Family and Community Services (NSW) *Responding to Prenatal Reports Policy* (Endorsed March 2008, Updated June 2011), 8.

211 Stephanie Taplin and Richard P Mattick, ‘The Nature and Extent of Child Protection Involvement Among Heroin-Using Mothers in Treatment: High Rates of Reports, Removals at Birth and Children in Care’ (2015) *Drug and Alcohol Review* 31.

212 Ibid 31, 33.

213 NSW Health, *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* (2013), [9.8.3]

214 Menka Tsantefski, Cathy Humphreys, and Alun C Jackson, ‘Family Engagement in the Perinatal Period and Infant Rights’ (2011) 90(4) *Child Welfare* 79, 91.

215 Stephanie Taplin, ‘Prenatal Reporting to Child Protection: Characteristics and Services Responses in One Australian Jurisdiction’ (2017) *Child Abuse & Neglect* 68, 74; Frank Ainsworth and Patricia Hansen, ‘Babies for the Deserving: Developments in Foster Care and Adoption in One Australian State—Others to Follow?’ (2009) 50 *Just Policy* 23, 27.

216 Australian Institute of Health and Welfare, *Australia’s Mothers and Babies: 2016-In Brief* (Perinatal Statistics Series No 34, 2018), 44.

217 Department of Family and Community Services (NSW) *Responding to Prenatal Reports Policy* (Endorsed March 2008, Updated June 2011), 2.

218 Ibid.

219 Ibid 2.



If allocated to a caseworker, the Safety and Risk Assessment (SARA) tools should be used to assess the safety and risk of the unborn child.²²⁰ After a safety assessment, a safety plan can be developed for an expectant parent of an unborn child. If the dangers are resolved during the pregnancy or upon birth, another safety assessment must be completed before closing the case.²²¹ If an expectant parent refuses intervention for an unborn child, or it is anticipated that intervention will be ineffective, the case must remain open and 'a Review Safety Assessment *must* be completed upon birth and a KiDS Alert added to KiDS'.²²² If there are 'high risk indicators' in the case (see the table above) *and* the pregnant woman is '(i) unable to be engaged with services; and/or (ii) resistant to support intervention; and/or (iii) transient, i.e., has no fixed address, a High Risk Birth Alert (HRBA) should be issued to NSW Health'.²²³ If an unborn child is 'in need of care and protection', a case plan should be developed to work with the unborn child's parents.

Under the *Care Act*, mandatory reporters are required to make a report when the child is born if: they are aware that the child was the subject of a pre-natal report under s 25; and that 'the birth mother of the child did not engage successfully with support services to eliminate or minimise to the lowest level reasonably practical, the risk factors that give risk to the report'.²²⁴ In practice, hospitals are made aware of these facts by virtue of the 'Unborn Child High Risk Birth Alert Form' that is sent by FACS to the relevant local health district or private health practitioner (or both).²²⁵ The provisions of the legislation effectively mean that, after receiving a HRBA, hospital staff are required to make a further risk of significant harm report to the department upon the birth of the child.²²⁶

The nature and extent of prenatal reporting in NSW

In 2016–17 there were 4,540 prenatal ROSH reports received in NSW (Figure 82), a third of which were reports relating to Aboriginal children (n=1,497). ROSH reports for unborn children amounted to 2.9% of total ROSH reports received in that year. Some children received multiple ROSH reports and looked at a different way, the data also highlight that almost 2953 children were reported at ROSH before they were born in that year (including 847 Aboriginal children, who represented 28.7% of all children reported before they were born) (Figure 83). Further, according to the AIHW, in 2016–17 there were 1,024 'substantiated' notifications relating to unborn children in NSW.²²⁷ Just a third of these (n=356) related to Indigenous children.²²⁸ National data indicates that prenatal reporting is 'becoming increasingly common across Australia'.²²⁹ The scope of the problem in Aboriginal communities in NSW can be seen in the

220 These tools are discussed in Chapters 5 and 12.

221 Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012) 11.

222 Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012) 11, 26

223 Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012) 11.

224 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 23(f).

225 Note that these are issued under Ch 16A or s 248 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

226 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 23(f), 27.

227 Australian Institute of Health and Welfare, *Child Protection Australia 2016–17* (2018), Table S10. A 'substantiated report' is a report that was investigated and finalised, with the conclusion being that there was 'reasonable cause to believe that the child had been, was being, or was likely to be, abused, neglected or otherwise harmed': Australian Institute of Health and Welfare, *Child Protection Australia 2016–17* (2018), Box 3.1, 18.

228 Australian Institute of Health and Welfare, *Child Protection Australia 2016–17* (2018), Table S10.

229 Stephanie Taplin, 'Prenatal Reporting to Child Protection: Characteristics and Services Responses in One Australian Jurisdiction' (2017) *Child Abuse & Neglect* 68, 73. See also Michelle Wickham, 'Who's Left Holding the Woman? Practice Issues Facing Hospital Social Workers Working with Women who have Infants Removed at Birth by NSW Department of Community Services' (2009) 34(4) *Children Australia* 29.

fact that Seeding Success data show that almost 10% of all Aboriginal children who were born in NSW in the study period were ‘screened in’ with a prenatal report before they were born (one in ten Aboriginal children).²³⁰

However, there is very little published information on a number of other important issues relating to newborn removals, such as ‘at what point these ‘unborn children’ are being identified, the reasons they are reported, by whom they are reported, and what interventions are put in place’.²³¹ Further, there is no information about whether prenatal reporting leads to improved outcomes for the child and whether it reduces the likelihood of the unborn child being removed at or shortly after birth.²³² There is some information on the characteristics of mothers who are the subject of prenatal reports. For example, research conducted in the ACT has revealed that women who were the subject of prenatal reports were generally young and disadvantaged, and that Aboriginal women appeared to be over-represented in the cohort that was studied.²³³ Women also tended to be reported late in the pregnancy, most commonly by health workers.²³⁴

As discussed below, evidence derived from this Review reveals that prenatal reporting and newborn removals are of great concern to Aboriginal families and communities. It is essential that greater research be undertaken to understand the characteristics and needs of those who are the subject of prenatal reports, and to monitor and evaluate child protection interventions with pregnant women.²³⁵ Without this evidence base, it is impossible to devise effective targeted early intervention responses for pregnant mothers, to accurately identify newborns at risk of significant harm, to support mothers and fathers post-removal, to increase the likelihood of successful restoration of babies to their parents, and to reduce the trauma inflicted on parents during the removal process. In particular, there is an urgent need for research specifically examining prenatal reporting for Aboriginal parents, an issue which must be rectified given that Aboriginal parents are ‘likely to have different substance use and family violence profiles’ than non-Aboriginal parents.²³⁶

Recommendation 41: The Department of Communities and Justice should work with Aboriginal stakeholders and community to design a comprehensive system for the collection and reporting of data around assumption into care or removal of Aboriginal children at or shortly after birth, as well as data about the characteristics of parents who are the subject of pre-natal notifications, numbers and reasons for high risk birth alerts, and pre entry into care casework completed with Aboriginal mothers in the prenatal period.

230 Kathleen Falster and Mark Hanly, ‘Childhood child protection services involvement and developmental outcomes among Aboriginal and non-Aboriginal Kindergarten children in New South Wales: Findings from a population-based, cross-sectoral data linkage study (The Seeding Success Study)’ (Report for the Family is Culture Review. Sydney: UNSW Sydney Centre for Big Data Research in Health, 2019).

231 Stephanie Taplin, ‘Prenatal Reporting to Child Protection: Characteristics and Services Responses in One Australian Jurisdiction’ (2017) *Child Abuse & Neglect* 68, 69.

232 Ibid.

233 However, in many cases, Aboriginality was not recorded on the file analysed: Stephanie Taplin, ‘Prenatal Reporting to Child Protection: Characteristics and Services Responses in One Australian Jurisdiction’ (2017) *Child Abuse & Neglect* 68, 70.

234 Ibid 73.

235 Celine Harrison, Maria Harries and Mark Liddiard, ‘Removal at Birth and Infants in Care: Maternity Under Stress’ (2015) 9(2) *Communities, Children and Families Australia* 39, 49.

236 Lillian De Bortoli, Jane Coles and Mairead Dolan, ‘Linking Illicit Substance Misuse During Pregnancy and Child Abuse: What is the Quality of the Evidence?’ (2014) 19 *Child and Family Social Work* 136, 144.



Newborn removals

In some circumstances, the department may remove a newborn child from his or her mother and father. The newborn may be removed at the hospital immediately after his or her birth in a planned or unplanned assumption of care.²³⁷ In a planned assumption, the mother may or may not be aware that her child is to be removed. In some cases, if the mother is deemed to be a ‘flight risk’, the removal may be planned and organised with hospital staff, although the mother will not be aware it is going to occur.²³⁸ As Marsh et al note, an assumption of care

usually occurs within 4 hours from the time of birth and the woman is kept in the birthing environment until FACS arrives. Security is heightened, the birthing unit is placed in lock down with all visitors in the unit confined to either the birthing room or the outside waiting area, and the police are always in attendance. It is the FACS case managers’ role to physically remove the baby from the mother. However how this plays out can be negotiated between the woman, the caseworker, the midwives and other staff in the woman’s room.²³⁹

In an unplanned assumption, FACS is advised of the birth of the child, at which point it completes a safety assessment. If the outcome is ‘unsafe’, the newborn is assumed into care.²⁴⁰

Newborn removals are highly traumatic for the birth parents, with birth mothers recounting feelings of shock, pain, sorrow, disbelief, anxiety, guilt, shame and emptiness upon the removal of their babies. Birth mothers and fathers are left to live in an ‘in-between state where their child is gone but did not die’,²⁴¹ and the complexity and depth of their grief can lead to serious and longstanding psychological damage.²⁴² This may then have a significantly detrimental effect on their later experiences of pregnancy and parenthood.²⁴³ It is widely recognised on the literature relating to compulsory child removals that many women suffer ‘a downturn in functioning’ post removal.²⁴⁴ Anecdotal evidence indicates that women may ‘seek comfort in a further pregnancy’.²⁴⁵ This may lead to successive removals of newborns from the woman’s care.²⁴⁶ For

237 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 44.

238 Christine A Marsh et al, ‘Making the Hidden Seen: A Narrative Analysis of the Experiences of Assumption of Care at Birth’ (2018), <https://doi.org/10.1016/j.wombi.2018.04.009>, 2.

239 Ibid.

240 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 44.

241 Christine A Marsh et al, ‘Making the Hidden Seen: A Narrative Analysis of the Experiences of Assumption of Care at Birth’ (2018), <https://doi.org/10.1016/j.wombi.2018.04.009>, 2.

242 Michelle Wickham, ‘Who’s Left Holding the Woman? Practice Issues Facing Hospital Social Workers Working with Women who have Infants Removed at Birth by NSW Department of Community Services’ (2009) 34(4) *Children Australia* 29, 31; Karen Broadhurst and Claire Mason, ‘Maternal Outcasts: Raising the Profile of Women who are Vulnerable to Successive, Compulsory Removals of their Children—A Plea for Preventative Action’ (2013) 35(3) *Journal of Social Welfare and Family Law* 291; Frank Ainsworth and Patricia Hansen, ‘Babies for the Deserving: Developments in Foster Care and Adoption in One Australian State—Others to Follow?’ (2009) 50 *Just Policy* 23, 26–27.

243 Karen Broadhurst and Claire Mason, ‘Maternal Outcasts: Raising the Profile of Women who are Vulnerable to Successive, Compulsory Removals of their Children—A Plea for Preventative Action’ (2013) 35(3) *Journal of Social Welfare and Family Law* 291, 293–294; Christine A Marsh et al, ‘Making the Hidden Seen: A Narrative Analysis of the Experiences of Assumption of Care at Birth’ (2018), <https://doi.org/10.1016/j.wombi.2018.04.009>, 7–8; Teresa Hinton, ‘Breaking the Cycle: Supporting Tasmanian Parents to Prevent Recurrent Child Removals’ (Report, AnglicareTas and Social Action & Research Centre, 2018), 8.

244 Karen Broadhurst and Claire Mason, ‘Maternal Outcasts: Raising the Profile of Women who are Vulnerable to Successive, Compulsory Removals of their Children—A Plea for Preventative Action’ (2013) 35(3) *Journal of Social Welfare and Family Law* 291, 293.

245 Stephanie Taplin, ‘Prenatal Reporting to Child Protection: Characteristics and Services Responses in One Australian Jurisdiction’ (2017) *Child Abuse & Neglect* 68, 74. See also Karen Broadhurst and Claire Mason, ‘Maternal Outcasts: Raising the Profile of Women who are Vulnerable to Successive, Compulsory Removals of their Children—A Plea for Preventative Action’ (2013) 35(3) *Journal of Social Welfare and Family Law* 291, 293; Grant et al 2011; Karen Broadhurst et al, ‘Vulnerable Birth Mothers and Repeat Losses of Infants to Public Care: Is Targeted Reproductive Health Care Ethically Defensible?’ (2015) 37(1) *Journal of Social Welfare and Family Law* 84, 92.

246 Martha Canfield et al, ‘Maternal Substance Use and Child Protection: A Rapid Evidence Assessment of Factors Associated with Loss of Child Care’ (2018) 70 *Child Abuse & Neglect* 11, 22–23.

example, a study in Tasmania indicated that one-fifth of mothers who had a child removed from their care would experience a further removal of a child (typically a newborn or infant).²⁴⁷ As Harrison et al argue, 'birth mothers who lose the care of their infants need to be considered 'at risk' to the population and as vulnerable in their own right'.²⁴⁸

Marsh et al set out the following midwife's account of a removal of a newborn by FACS in NSW:

I was with a young Indigenous girl who was supported well by her mum in labour and birth. There was no plan for an AOC, however as a prenatal report had been made, a notification of birth was required. That's when FACS informed us of the AOC. The grandmother was part of the stolen generation and so when the police and FACS came, the grandmother immediately knew what was happening. She was really threatened and became quite hysterical. The young mother was yelling out, 'You're not taking my baby.' They were grabbing the baby and there was a tussle. The grandmother ran after them and tried to get through the doors to NICU. She had to be restrained by the police. It didn't seem right and witnessing this was very heart-wrenching.²⁴⁹

In some circumstances, new mothers are given extremely limited time with their child and no opportunity to take photographs, keep a memento (such as a cot card) or give anything special to the baby.

I was hysterical. I only had seconds and I was trying to kiss him, say goodbye and that I'm sorry. FACS said to put him in the cradle at once and stop crying because I was upsetting him. FACS came and went really, really fast. I got really confused. I've sort of separated myself.²⁵⁰

After the removal of their babies, mothers rarely remain in hospital for postnatal care.

Staying when other mums have their baby would have destroyed me. I could have stayed in the birthing room but I knew that he was next door in the nursery. If he couldn't be with me I just needed to get out of there and go home. I was in a state. I'd had a bleed and they tried to talk to me into staying but I signed myself out against medical advice.²⁵¹

The newborn baby may or not be breastfed by his or her birth mother. One mother in Marsh et al's study noted that:

I wanted to breastfeed, express and freeze my milk for him. The midwives and social workers encouraged me to, however, FACS said they couldn't trust me to do the sterilising and freezing properly and wouldn't allow him to have it.²⁵²

247 Teresa Hinton, 'Breaking the Cycle: Supporting Tasmanian Parents to Prevent Recurrent Child Removals' (Report, AnglicareTas and Social Action & Research Centre, 2018), 8

248 Celine Harrison, Maria Harries and Mark Liddiard, 'Removal at Birth and Infants in Care: Maternity Under Stress' (2015) 9(2) *Communities, Children and Families Australia* 39, 52.

249 Christine A Marsh et al, 'Making the Hidden Seen: A Narrative Analysis of the Experiences of Assumption of Care at Birth' (2018), <https://doi.org/10.1016/j.wombi.2018.04.009>, 5.

250 Ibid.

251 Ibid 7.

252 Ibid 7.



Newborn removals also pose ‘clinical, moral and ethical challenges’²⁵³ for midwives, who in some circumstances question the need for the removal and resent being unable to inform the mother of an impending assumption of care.²⁵⁴ Midwives can also be frustrated at the lack of opportunity to collaborate with the department to ensure the safety and wellbeing of the mother and her child.

FACS’s attitude is that their information is all confidential. Midwives are expected to provide information to FACS but there is limited information from FACS in return. As the midwifery team leader, I get angry and resentful when we notify FACS of a woman’s arrival or a birth and they won’t divulge if there’s to be AOC. How can we plan for ongoing care and safety? The woman will need to remain in the birthing unit and security needs to be notified. It’s f—en useless to be told by FACS that they can’t disclose any information.²⁵⁵

FACS caseworkers may also struggle with the ethical ramifications of the removal of newborn babies:

It’s difficult when the mother’s pulling at you, crying and begging you to leave the baby with her. It’s very hard when it’s over. You remember the flashes of the woman’s faces, you don’t forget.

I get extreme nervousness and stutter every time. It’s barbaric to take a child as soon as they’re born, it’s tough and I feel really horrible, I don’t want to be there, but that’s what we do. I do want parents to have a relationship with their baby but the decision’s been made. Having the mother look up at you with the baby on their breast saying just give me one more chance blows me away. I would rather they scream and yell and call me all the names under the sun. We walk in, assume, make a screaming mess of the mother and then we walk out and leave the midwives to deal with it all.²⁵⁶

In addition to being damaging for the health and wellbeing of the parents, the separation can have ‘profoundly damaging physical and psychological effects on the infant’.²⁵⁷ As the Australian Law Reform Commission has noted:

Separation can prevent a mother from breastfeeding an infant. Numerous studies have shown that breastfeeding promotes an infant’s sensory and cognitive development and lowers infant morbidity and mortality. In addition, separation can prevent or hinder an infant’s attachment to his or her parents. Attachment assists an infant’s physical, psychological and social development ... The United Nations Declaration of the Rights of the Child 1989 provides that, ‘a child of tender years shall not, save in exceptional circumstances, be separated from his mother’.²⁵⁸

253 Christine A Marsh et al, ‘Guilty Until Proven Innocent? The Assumption of Care of a Baby at Birth’ (2015) 28 *Women and Birth* 65, 66

254 Christine A Marsh et al, ‘Making the Hidden Seen: A Narrative Analysis of the Experiences of Assumption of Care at Birth’ (2018), <https://doi.org/10.1016/j.wombi.2018.04.009> 3, 5-6; Everitt L, Fenwick J, Homer C. Midwives experiences of removal of a newborn baby in New South Wales, Australia : Being in the ‘head’ and ‘heart’ space. *Women Birth* 2014;28(2).

255 Christine A Marsh et al, ‘Making the Hidden Seen: A Narrative Analysis of the Experiences of Assumption of Care at Birth’ (2018), <https://doi.org/10.1016/j.wombi.2018.04.009>, 6.

256 Ibid.

257 Australian Law Reform Commission, *Same Crime, Same Time: Sentencing of Federal Offenders* (ALRC Report 103, 2006), [29.93].

258 Ibid [29.29] (footnotes omitted).

Aboriginal newborns may experience unique health needs that mean that their health and wellbeing may be more at risk than that of non-Aboriginal newborns. For example, newborns born to Aboriginal mothers are more likely to be born prematurely, have a low birth weight, be admitted for specialised care, and to be at risk of perinatal death.²⁵⁹ For Aboriginal newborns, breastfeeding may be highly important.

In NSW, the legal ramifications of the removal of a newborn baby are significant. Under s 106A of the *Care Act* (discussed further below), the Children’s Court must admit evidence that a parent has previously had a child removed from his or her care, and this then becomes prima facie evidence (or proof) that the child who is the subject of the proceedings is in need of care and protection.²⁶⁰ To rebut this evidence, the parent must satisfy the Children’s Court on the balance of probabilities that ‘the circumstances that gave rise to the previous removal of the child or young person concerned no longer exist’.²⁶¹ Further, one of the ‘high risk indicators’ that gives rise to a high risk birth alert is that a sibling of the unborn child has been removed.

For some women, this legislative provision helps perpetuate a cycle of successive newborn removals, an issue that is ‘of utmost moral urgency’ that ‘warrants a co-ordinated policy response’.²⁶² For example, in their study of 171 opioid dependant mothers involved with child protection services, Taplin and Mattick found that ‘none of the 32 mothers who had a child removed at birth and gave birth subsequently retained care of their new baby’.²⁶³ This is of particular concern for Aboriginal women, who on average ‘have more children during their reproductive life than non-Indigenous women’.²⁶⁴ Recurrent removals also affect the children removed, with siblings often being placed separately.

Despite the importance of the issue, ‘there is limited publicly available Australian data about the removal of newborns from maternity hospitals prior to discharge of their mothers’.²⁶⁵ However, a number of commentators have observed that the removal of newborns is increasing in NSW.²⁶⁶ This appears to reflect a general trend around Australia.²⁶⁷

In this Review, team members were surprised by the evidence revealing the extent of removal of Aboriginal newborns and by the practice relating to the removal process. For example,

- In Case 37, the child was assumed into care at 4 am, after birth, when FACS had told the parents that they would be supported to attend rehabilitation under a safety plan. There was

259 Australian Institute of Health and Welfare, *Australia’s Mothers and Babies: 2016-In Brief* (Perinatal Statistics Series No 34, 2018), 47–50.

260 *R v Jacobson* [1931] AD 466.

261 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 106A (3)(a).

262 Karen Broadhurst et al, ‘Vulnerable Birth Mothers and Repeat Losses of Infants to Public Care: Is Targeted Reproductive Health Care Ethically Defensible?’ (2015) 37(1) *Journal of Social Welfare and Family Law* 84, 86, 87.

263 Stephanie Taplin and Richard P Mattick, ‘The Nature and Extent of Child Protection Involvement Among Heroin-Using Mothers in Treatment: High Rates of Reports, Removals at Birth and Children in Care’ (2015) *Drug and Alcohol Review* 31, 33–34. Note that Broadhurst et al have described birth mothers involved in recurrent care proceedings as a sizeable, but neglected, population: Karen Broadhurst et al, ‘Vulnerable Birth Mothers and Repeat Losses of Infants to Public Care: Is Targeted Reproductive Health Care Ethically Defensible?’ (2015) 37(1) *Journal of Social Welfare and Family Law* 84, 85.

264 Marilyn Clarke and Jacqueline Boyle, ‘Antenatal Care for Aboriginal and Torres Strait Islander Women’ (2014) 43 (1–2) *Australian Family Physician* 20, 21.

265 Celine Harrison, Maria Harries and Mark Liddiard, ‘Removal at Birth and Infants in Care: Maternity Under Stress’ (2015) 9(2) *Communities, Children and Families Australia* 39, 45.

266 See, for example, Michelle Wickham, ‘Who’s Left Holding the Woman? Practice Issues Facing Hospital Social Workers Working with Women who have Infants Removed at Birth by NSW Department of Community Services’ (2009) 34(4) *Children Australia* 29, 30.

267 See, example, Celine Harrison, Maria Harries and Mark Liddiard, ‘Removal at Birth and Infants in Care: Maternity Under Stress’ (2015) 9(2) *Communities, Children and Families Australia* 39. See also Donnell et al, ‘Infant removals: The need to address the over-representation of Aboriginal infants and community concerns of another ‘stolen generation’ (2019) 90 *Child Abuse & Neglect* 88, 92.



no safety assessment prior to the child entering care and the Review determined that the entry into care was not the least intrusive option to FACS available at the time.

- In Case 131, FACS conducted a full safety assessment of an Aboriginal mother (without the support or assistance of family members) and assumed care of her new baby less than 24 hours after she had given birth via caesarean section.
- In Case 99, there were nine reports made about the child prior to his birth. However, no steps were taken to work with the child's parents at this critical time and a caseworker was only assigned to the case after the child's birth. FACS informed the child's family that they would be consulted before the child was taken into care. This did not happen. The child was assumed into care at the hospital despite FACS being informed by the child's grandmother that this did not need to happen as there were family members willing and available to care for him.
- In Case 213, the child's mother had effectively engaged with FACS and other services prior to birth to build her parenting capacity. The father only became aware of the child's paternity following the birth. However, four days after the child's birth, FACS arranged to meet with his parents to discuss the child's care and undertake a safety assessment. Immediately following this meeting, the child was assumed into care on the basis that FACS assessed him as being at risk of significant harm due to his mother's drug and alcohol use during pregnancy and her transience during pregnancy. FACS did not accurately assess the capacity of the father to care for the child despite the fact that he was already caring for his two other children.
- In Case 214, FACS conducted a safety assessment with the child's mother two weeks prior to the child's birth. At this point, the child was declared to be 'safe with a plan'. The child's mother was tasked with ensuring that the child was not withdrawing from substances at birth (and in fact the child tested negative for substances at birth). At the time of the child's birth, the child's mother was attempting to make positive changes—she had sought accommodation and was on the waiting list for a residential drug detox centre. However, the child was removed into care on the day of his birth, with FACS stating that it had long had concerns for his older siblings (who had been removed so that s 106A applied to the case), and that it was concerned about the child's mother's drug use and the fact that she had no protective adults in her home or the family network. In this case, it is important to note that the child's mother was herself removed from her family at the age of six and that the first of her seven children was born when she was in state care. The child's mother has also indicated that her grandmother and great-grandfather were part of the Stolen Generation.
- In Case 183, the child was assumed into OOHC shortly after her birth due to concerns with her mother's transience and homelessness, drug use and experience of domestic violence (perpetrated by her partner). FACS first received a report outlining these concerns in the first trimester of the mother's pregnancy. However, no action was taken in response to the reports and no planning occurred with regard to the potential removal of the child at birth. Following the child's removal, she was placed with non-Aboriginal carers in a 3-month 'emergency placement' managed by Life Without Barriers. There were two maternal relatives available and willing to provide care for the child after she was born, however FACS refused to formally assess them based on an opinion formed that they would not be appropriate carers.

Other case files relating to and concerning newborn removal practice are discussed in Chapter 12.

Stakeholder concerns

A number of stakeholders raised issues relating to prenatal reporting and newborn removals. One midwife informed the Review that there was a lack of procedural fairness and transparency around the removal process, particularly with young mothers, single mothers, and mothers with a history of child removals.²⁶⁸ The midwife noted that caseworkers often had a pre-determined view about whether a newborn child needed to be removed and conducted interviews with mothers in a manner that set them up to fail. In addition, the Review was informed that certain staff funded to engage in prenatal work with Aboriginal women held cultural biases, such as opinions about the importance of a ‘nuclear family’ approach to child rearing, and offered services that were culturally inappropriate and unsafe, resulting in high rates of removals of Aboriginal babies.²⁶⁹

The Review was also informed that pregnant Aboriginal women were not approaching FACS because they were scared of having their babies removed.²⁷⁰ Some mothers were reported to be taking great lengths to attempt to prevent their children being removed, such as paying for urinalysis throughout their pregnancy in order to have some evidence to fight removal at the time of birth.²⁷¹

The Northern Rivers Community Legal Centre submitted that service providers had reported that FACS did not engage with expecting parents and did not respond when contacted by the parents.²⁷² The Women’s Legal Service NSW noted that its clients found it particularly traumatic when babies are removed in hospital immediately after birth.²⁷³ The Redfern Legal Centre submitted that it was aware of instances where babies were born at home, with no antenatal care or medical assistance, due to the mother’s fear of being reported to FACS.²⁷⁴ It also submitted that pregnant mothers, particularly in the later stages of pregnancy, were not confident that seeking assistance from FACS would lead to any outcome other than the assumption of their baby into care at birth.²⁷⁵ It provided an example of a case study in which FACS failed to understand an expecting mother’s fear of welfare services and expressed the view that FACS needed to work harder to engage with Aboriginal mothers, develop relationships or trust, and increase awareness of the services that FACS can offer expecting parents by way of support.²⁷⁶ One suggested method was that FACS release case studies about Aboriginal women who have worked successfully with FACS to retain care of their babies.²⁷⁷

The Review received positive feedback on the prenatal programs implemented by FACS.²⁷⁸ The Redfern Legal Centre submitted that the Perinatal Family Conferencing program had enabled expecting mothers to access legal and other support while engaging with FACS. As the program

268 Confidential, *Consultation*, FIC 70.

269 Confidential, *Consultation*, FIC 70.

270 Confidential, *Consultation*, FIC 63.

271 Confidential, *Consultation*, FIC 23.

272 Northern Rivers Community Legal Centre, Submission No 16 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 6.

273 Women’s Legal Services NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, 14 December 2017, [10.9].

274 Redfern Legal Centre, Submission No 14 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 6.

275 Ibid.

276 Ibid 7.

277 Ibid.

278 Confidential, *Consultation*, FIC 70.



involves three conferences, ‘sufficient time is available for the client to make changes and implement a plan to remedy any issue raised by FACS’.²⁷⁹ It also submitted that the conferences could be improved by encouraging a support person to attend with the Aboriginal woman to increase the woman’s confidence in her interactions with FACS. Further, the presence of a respected elder could assist in ensuring FACS did not misinterpret any Aboriginal child rearing practices.²⁸⁰

The Women’s Legal Service NSW also referred to FACS’ ‘prenatal program’, which was operating in at least three local districts in NSW and aimed to engage and support mothers during their pregnancy. It stated that it was of the view that the program was responsive and proactive in assisting its clients. However, it noted that little was known about this program and recommended that there be better community education about the program, which could also help to address the fear within Aboriginal communities that engaging with services will lead to the removal of their children.²⁸¹

Data findings

FACS (Administrative) data indicates that around 10% of Aboriginal children who entered care during the cohort period, entered care within two weeks of their birth (Figure 80). Altogether, nearly one fifth of the Aboriginal children who entered care, entered before they were six months old (18%).²⁸²

in almost a quarter of cases Aboriginal children were assumed into care at birth or from the hospital in the period after their birth.

Similarly, qualitative data findings highlight that in almost a quarter of cases in the sample (n= 47, 23.5%), a figure slightly higher than the FACS (Administrative) data figure, Aboriginal children were assumed into care at birth or from the hospital in the period after their birth. These data highlight that at least 17 of these children were assumed following an HRBA being issued. Almost all (n=44, 94% of cases where children were assumed at birth) of the cases where children were assumed at birth were identified as demonstrating serious deficiencies in casework provided to the families prior to the child’s birth. Deficiencies in casework included that no support was provided by FACS to the family prior to the child’s birth, cases were closed without casework being completed with HRBAs being put in place, key services were unavailable or delayed , interventions were limited to cold referrals rather than coordinated, holistic and trauma-informed interventions, and family were not included in casework where it was evidently appropriate to do so. In one concerning case, a mother who had proactively sought help from FACS received a letter in which FACS declined to allocate her case, and simply outlined services she may wish to contact. Her child was subsequently assumed from the hospital at birth.

279 Redfern Legal Centre, Submission No 14 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 10.

280 bid.

281 Women’s Legal Services NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, 14 December 2017.

282 It should be noted that this figure is divergent from the cohort figure due to FACS administrative data counts. This is explained further in the methodology section to this report.

Four of the children who were assumed into care at birth were assumed without a safety assessment being completed. In at least 12 further cases it was identified that there were issues with the safety assessment used to justify the removal. Issues with safety assessment included that incorrect dangers were nominated, safety assessment procedures were not followed and dangers identified in the assessment were no longer necessarily present at the time of the removal, but had been identified to justify the removal of older children.

Of the children who were assumed at birth, 40.5% (n=19) were placed with an Aboriginal kinship carer at the time of the Review and a further 17% were placed with non-Aboriginal relatives or kin (17%). Further, 32% (n=15) of children who were assumed at birth were in foster care at the time of the Review, mostly in non-Aboriginal foster care arrangements (n=8, 17% of all children assumed). Only three children who were assumed at birth had been restored to their parents; one had been placed with their father and one child had been exited from care on a guardianship order to an Aboriginal relative.

In a number of cases, the assumption related to concerns around the mother's capacity to look after the child, mostly due to intellectual disability issues. There was little investigation in these cases of options of supported care or other accommodation options that could have helped the family to remain together.

Particular issues of concern

The following discussion outlines particular issues of concern that, if resolved, will help to reduce the number of Aboriginal newborns removed at birth, while simultaneously keeping them safe. The section includes a discussion of the draft revised FACS policy, *Responding to Prenatal Reports* that, at the time of writing, had been circulated among stakeholders for comment.

Outdated and inadequate policy

FACS' *Responding to Prenatal Reports Policy* was developed in 2008 and updated in 2011. As such, much of its content is out of date. For example, it contains reference to a risk assessment framework (the Secondary Risk of Harm Assessment Framework) which was replaced in 2011 (by the Structured Decision Making approach).²⁸³ Further, the 'List of Maternity Services in NSW' contained in the policy has not been updated since June 2011 and the 'prenatal research summary' attached to the policy contains outdated research into and evidence about prenatal reports and support programs.

Notably, the policy contains no reference to Aboriginal women. It does not note their socioeconomic or psychosocial characteristics, or explain historical approaches taken by the state to the birth of Aboriginal babies such as forced evacuation to regional areas and forced adoption under Stolen Generation policies. It does not examine cultural approaches to pregnancy and birthing, pregnancy outcomes for Aboriginal women, the effects of intergenerational trauma on Aboriginal parents, or the particular health concerns of Aboriginal women and babies. It does not discuss the need to consult with Aboriginal parents, families and communities.

Further, FACS' policy does not specify who is a 'flight risk' or what evidence is required to justify

283 Note that the policy states that it will be adjusted after the SDM is rolled out. However, this does not appear to have occurred.



this conclusion, how a removal should be conducted in practice, how a caseworker should serve a court order, where police officers should be located during the assumption of care, and a myriad of other issues that relate to the ‘emotional, professional and social safety of all of those involved’.²⁸⁴ It does not set out what services should be provided to women after the removal (i.e. it does not contain a post-removal protocol).

The draft revised policy, circulated to stakeholders for comment, remedies some of the above deficiencies in the old policy. In particular, it contains more detailed information about removal practices, including instructions not to arrive at the hospital unannounced, not to fax the order to assume a newborn into care to the hospital, to allow the mother an opportunity to provide skin-to-skin contact with the child, and where advised that it is appropriate by hospital staff, to breastfeed the child. It also contains more detailed information about working with fathers and referring pregnant mothers to legal services at an early opportunity. It does not, however, contain any information about when it is or is not appropriate to use police during a removal, or when a mother should or should not be considered a ‘flight risk’. Further, it does not consider post-removal support for the parents of the newborn child.

The policy’s section on Aboriginal families is particularly brief. Given the evidence derived in this Review that up to one quarter of Aboriginal children in OOHC are removed at birth, this is concerning. It does not contain any reference to intergenerational trauma or the Stolen Generations, to birthing on country, to unique Aboriginal maternal and newborn health issues, to Aboriginal specific family-finding services, or to the need to partner with Aboriginal community representatives when decision-making around the safety of an unborn or newborn Aboriginal child. Further, it does not contain any reference to the importance of identifying expectant Aboriginal parents with disability in order to ensure that early casework and planning adequately accommodates the parent’s unique needs. In light of the devastating impact of newborn removals on the rate of Aboriginal children entering OOHC and the unique casework considerations when working with expectant Aboriginal families, the Review recommends that a specific Aboriginal prenatal reporting and newborn removal policy be prepared (in partnership with Aboriginal community groups and representatives).

Recommendation 42: The Department of Communities and Justice should devise, in partnership with Aboriginal community groups and representatives, a comprehensive Prenatal Reporting and Newborn Removal Policy for Aboriginal children that includes, among other things, case studies of good practice intervention with expectant Aboriginal parents and a link to an external, up-to-date list of relevant services and supports for pregnant Aboriginal mothers.

Recommendation 43: The Department of Communities and Justice should publish case studies of good-practice intervention with expectant Aboriginal parents on its website, as well as distributing these case studies to relevant stakeholders, including Aboriginal families in contact with the child protection system, Aboriginal community representatives and organisations, and relevant service providers.

284 Christine A Marsh et al, ‘Guilty Until Proven Innocent? The Assumption of Care of a Baby at Birth’ (2015) 28 *Women and Birth* 65, 66.

Insufficient engagement with expectant parents

Research has demonstrated that women with high risk behaviours or those involved in the child protection system may be ‘highly motivated’ to change during pregnancy,²⁸⁵ whether due to concern for the health of the unborn baby, fear of the removal, or both.²⁸⁶ Further, in light of the adverse health consequences and poor developmental outcomes for a child exposed to illicit drugs and alcohol in utero,²⁸⁷ and the link between maternal substance misuse and subsequent child abuse and neglect,²⁸⁸ it is critical to intervene early with pregnant women to address substance misuse and other risk factors that increase the likelihood of child removal (such as homelessness, unemployment, mental health disorders and low social support).²⁸⁹

In NSW there is a legislative and policy framework that actively brings parents of at risk unborn children to the attention of FACS—that is, a framework that both legitimates and encourages prenatal reporting. For example, FACS policy recognises that a prenatal report should result in the provision of support to the expectant parent(s) in order to ‘reduce risks to the safety of the unborn baby, help parents build their skills and prepare them to keep the baby safely in their care once it is born’.²⁹⁰ Similarly, s 25 of the *Care Act* contains a note that states that the intention of the section is to ‘allow assistance and support to be provided to an expectant parent to reduce the likelihood that the parent’s child, when born, will need to be placed in out-of-home care’.

However, this legislative and policy framework is ‘coupled with a service system, and practices, that lack sufficient capacity for action’.²⁹¹ Accordingly, prenatal reports are routinely made by health workers and other reporters with the expectation that they will lead to collaborative early intervention with the mother and unborn baby that will reduce the likelihood of harm to the baby in the future. A large proportion of prenatal reports about unborn children result from the mother’s disclosure of substance use to health professionals in the prenatal period.²⁹² In reality, however, little or no casework is provided to the expectant mother and father during the course of the pregnancy.²⁹³ In many cases, the report will simply lead to the issuing of a High Risk Birth Alert.

This problem has been highlighted by scholarship in this area. For instance, in their research into newborn assumptions into care, Marsh et al interviewed three mothers who had their babies removed at birth in NSW. None had been provided with support during their pregnancies. For example, one mother noted that:

285 Stephanie Taplin, ‘Prenatal Reporting to Child Protection: Characteristics and Services Responses in One Australian Jurisdiction’ (2017) *Child Abuse & Neglect* 68, 74; Stephanie Taplin and Richard P Mattick, ‘The Nature and Extent of Child Protection Involvement Among Heroin-Using Mothers in Treatment: High Rates of Reports, Removals at Birth and Children in Care’ (2015) *Drug and Alcohol Review* 31; Karen Broadhurst and Claire Mason, ‘*Maternal Outcasts*: Raising the Profile of Women who are Vulnerable to Successive, Compulsory Removals of their Children—A Plea for Preventative Action’ (2013) 35(3) *Journal of Social Welfare and Family Law* 291, 297; Celine Harrison, Maria Harries and Mark Liddiard, ‘Removal at Birth and Infants in Care: Maternity Under Stress’ (2015) 9(2) *Communities, Children and Families Australia* 39, 40.

286 Lillian De Bortoli, Jane Coles and Mairead Dolan, ‘Linking Illicit Substance Misuse During Pregnancy and Child Abuse: What is the Quality of the Evidence?’ (2014) 19 *Child and Family Social Work* 136, 139.

287 John J Prindle, Ivy Hammond, Emily Putnam-Hornstein, ‘Prenatal Substance Exposure Diagnosed at Birth and Infant Involvement with Child Protective Services’ (2018) 76 *Child Abuse & Neglect* 75, 76; Martha Canfield et al, ‘Maternal Substance Use and Child Protection: A Rapid Evidence Assessment of Factors Associated with Loss of Child Care’ (2018) 70 *Child Abuse & Neglect* 11, 12.

288 Martha Canfield et al, ‘Maternal Substance Use and Child Protection: A Rapid Evidence Assessment of Factors Associated with Loss of Child Care’ (2018) 70 *Child Abuse & Neglect* 11, 11.

289 Ibid 20–22.

290 Department of Family and Community Services (NSW), *Assessing and Planning with Expectant Parents (Prenatal)* (Casework Practice Mandate, FACS Intranet).

291 Menka Tsantefski, Cathy Humphreys, and Alun C Jackson, ‘Family Engagement in the Perinatal Period and Infant Rights’ (2011) 90(4) *Child Welfare* 79, 93.

292 Celine Harrison, Maria Harries and Mark Liddiard, ‘Removal at Birth and Infants in Care: Maternity Under Stress’ (2015) 9(2) *Communities, Children and Families Australia* 39, 41.

293 Michelle Wickham, ‘Who’s Left Holding the Woman? Practice Issues Facing Hospital Social Workers Working with Women who have Infants Removed at Birth by NSW Department of Community Services’ (2009) 34(4) *Children Australia* 29, 32.



when I got my file notes for court, FACS had known about my situation the entire time I was pregnant and never offered any rehab or support to leave him. I first saw FACS when I was about 20 weeks and we met a few times after that. I was never allocated a case manager and when I was nearly due FACS told me that my baby would be going into care.²⁹⁴

A social worker interviewed for the study noted that FACS often cited the fact that the expectant mother could be a ‘flight risk’ to justify not notifying her of the impending assumption of her baby.

A ‘flight risk’ is the most overused excuse for not telling women and one of the biggest causes of our frustration. FACS do use the excuse that she’ll take off or she’ll harm herself but I can think of only three situations in at least a hundred where I would agree that the woman shouldn’t be told. People have the right to know as much information about what’s going to happen to them as we can tell them. It feels dishonest having information and they don’t know and that doesn’t sit ethically well. When a woman doesn’t know, everybody’s distressed and tense over how they’re going to react. It’s just the anticipation and that’s a really horrible feeling.²⁹⁵

This Review saw further evidence of the problem illustrated quite graphically in its file reviews. The Review saw little evidence of effective early intervention occurring with expectant Aboriginal parents who were the subject of ROSH reports. The reasons for this are unclear, but may relate to resourcing. For example, FACS practice guidance notes that ‘it can be difficult to find resources at the Community Service Centres to respond to a prenatal report when there are other reports involving children who are at risk now’.²⁹⁶ Conversely, however, it also notes that allocating a prenatal report provides FACS with the opportunity to ‘make responsive and targeted referrals for a family’ and ‘capitalises on a point in life when parents are often motivated to change’.²⁹⁷ FACS also advises that some cases should be considered for urgent allocation—that is, if the expectant mother is of more than 37 weeks gestation or is in ‘critical danger’.²⁹⁸

One NSW initiative that is promising but limited in scope is the Pregnancy Family Conferencing program operating in the Burwood, Central and Lakemba Community Services Centres.²⁹⁹ This program involves a partnership between the department and the Local Sydney Health District. It involves both agencies working with the expectant mother and her family to ensure the safety of the child. It has been reported that ‘25 of the 28 families taking part in the program were able to care for their newborns, including all six of the Aboriginal families referred to the program’.³⁰⁰ The success of this program reflects the views of scholars who have argued that family group conferences during the prenatal period may reduce child protection activity, increase collaboration between disparate service providers, and allow ‘a greater number of infants to remain in maternal care’.³⁰¹

294 Christine A Marsh et al, ‘Making the Hidden Seen: A Narrative Analysis of the Experiences of Assumption of Care at Birth’(2018), <https://doi.org/10.1016/j.wombi.2018.04.009>, 4.

295 Ibid.

296 Department of Family and Community Services (NSW), *Assessing and Planning with Expectant Parents (Prenatal)* (Casework Practice Mandate, FACS Intranet).

297 Ibid.

298 Ibid.

299 See, eg, Esther Han, ‘Sydney’s Most Vulnerable Mothers Keep their Newborns Thanks to Program’ *Sydney Morning Herald* (online, 25 March 2018) < <https://www.smh.com.au/national/nsw/sydney-s-most-vulnerable-mothers-keep-their-newborns-thanks-to-program-20180321-p4z5gh.html>>.

300 Department of Family and Community Services (NSW) ‘Well Done SSECNS district—Keeping Newborns Safe’ (FACS Intranet, 1 February 2018).

301 Menka Tsantefski, Cathy Humphreys, and Alun C Jackson, ‘Family Engagement in the Perinatal Period and Infant Rights’ (2011) 90(4) *Child Welfare* 79, 92.

Other possible early intervention programs include nurse home visitation programs that have been implemented to support first-time mothers in England and the United States.³⁰²

The Review notes that early casework with expectant parents should ideally be delivered by specialist prenatal caseworkers who are trained in effective intervention approaches for expectant parents and skilled in the inter-agency coordination of services. For this reason, the Review recommends that the DCJ invest in the substantial expansion of the number of prenatal caseworkers in NSW. Further, the Review recommends that the DCJ develop, trial and publicly report on a 'triage' system for prenatal reports that ensures that the parents of the most frequently reported unborn babies are given priority access to early casework support and early intervention services. This will also help to reduce the number of newborn Aboriginal babies removed from their families.

Recommendation 44: The Department of Communities and Justice should expand the Pregnancy Family Conferencing program and monitor and report on its effectiveness in reducing entries into out-of-home care.

Recommendation 45: The Department of Communities and Justice should significantly expand the number of specialised prenatal caseworkers to ensure that expectant Aboriginal parents have access to early, targeted and coordinated intervention services and support.

Recommendation 46: The Department of Communities and Justice should develop, trial and publicly report on a 'triage' system for prenatal reports that ensures that the parents of the most frequently report unborn babies are given priority access to early casework support and early intervention services.

Post removal support for mothers and fathers

There are strong humanitarian and economic arguments for the implementation of a post-removal protocol for parents of newborn children removed by DCJ. These include to break the cycle of successive pregnancies and newborn removals, and to seek to improve working relationships between DCJ and birth parents. Post-removal support may also help to prevent the trauma caused by the removal of a newborn child from exacerbating any existing problems faced by Aboriginal parents and thereby making the possibility of restoration of the baby less likely in the future. While women who have lost newborn children to miscarriage or stillbirth are offered counselling and support, 'in the context of stigmatised losses to care, it is far harder to access appropriate help'.³⁰³

Broadhurst et al argue that there should be a 'national statutory mandate to provide *post removal support* for parents of removed children'. This is particularly so in light of evidence that mothers can experience a range of adverse psychological and health consequences as a result of the removal

302 Martha Canfield et al, 'Maternal Substance Use and Child Protection: A Rapid Evidence Assessment of Factors Associated with Loss of Child Care' (2018) 70 *Child Abuse & Neglect* 11, 22.

303 Karen Broadhurst et al, 'Vulnerable Birth Mothers and Repeat Losses of Infants to Public Care: Is Targeted Reproductive Health Care Ethically Defensible?' (2015) 37(1) *Journal of Social Welfare and Family Law* 84, 93.



of their newborn, which in turn ‘exacerbates the risks for unplanned pregnancy’.³⁰⁴ As Harrison notes, intensive and trauma-informed support post-removal can help to ‘provide a firmer base for the parenting of any future children’.³⁰⁵ In the United Kingdom, there are some innovative projects offering ‘comprehensive services to mothers who have had children removed before’.³⁰⁶ Although not yet comprehensively evaluated, ‘initial indications are that a proactive approach which aims to assist women to exercise control over many aspects of their lives can help mothers exit a cycle of repeat pregnancy and repeat legal proceedings’.³⁰⁷

The need for high levels of support for parents who have had their children removed at birth is also evident in the fact that, legally, they now have less time to demonstrate that they can safely care for their baby. Under the permanency planning principles, a decision about restoration about a child who is less than 2 years of age must be made within 12 months (while decisions about restoration for older children must be made within 24 months). The provision of support to parents of children who have been removed at birth is possible pursuant to s 21 of the *Care Act*, which provides that a parent of a child may seek assistance from the Secretary in order to obtain services that will enable the child to return to the care of his or her family.

Recommendation 47: The Department of Communities and Justice should design and implement, in partnership with Aboriginal community groups and representatives, a system of post-removal support for Aboriginal mothers and fathers who have had newborn or infant children removed from their care. The system should include the mandatory provision of information to parents about their ability to seek post-removal support from the Secretary of the Department of Communities and Justice under s 21 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Section 106A of the Care Act

Section 106A was introduced in late 2006 in response to concerns that caseworkers were not adequately protecting the siblings of children who were known to the Department of Community Services (DOCS).³⁰⁸ The 2006 report on reviewable deaths by the NSW Ombudsman had revealed that 15% of the parents of children who had died, had previously had children removed from their care.³⁰⁹ There was minimal community consultation about the amendment,³¹⁰ which was introduced to ‘remove any technical obstruction to the court considering evidence of a parent or carer’s past history in relation to the removal of other children’.³¹¹ A number of community organisations raised concern about the provision at the time it was introduced on the basis that it represented a ‘departure from existing legal convention’, failed to address the systems failures that lead to child removals, and placed an unfair burden on

304 Ibid 88.

305 Teresa Hinton, ‘Breaking the Cycle: Supporting Tasmanian Parents to Prevent Recurrent Child Removals’ (Report, AnglicareTas and Social Action & Research Centre, 2018), 9.

306 Karen Broadhurst et al, ‘Vulnerable Birth Mothers and Repeat Losses of Infants to Public Care: Is Targeted Reproductive Health Care Ethically Defensible?’ (2015) 37(1) *Journal of Social Welfare and Family Law* 84, 88.

307 Ibid.

308 *Children and Young Persons (Care and Protection) Miscellaneous Amendments Act 2006* (NSW).

309 Michelle Wickham, ‘Who’s Left Holding the Woman? Practice Issues Facing Hospital Social Workers Working with Women who have Infants Removed at Birth by NSW Department of Community Services’ (2009) 34(4) *Children Australia* 29, 30.

310 Ibid.

311 New South Wales, *Parliamentary Debates*, Legislative Assembly, 24 October 2006 (Reba Meagher).

parents and caregivers of limited financial resources.³¹²

Section 106A provides as follows:

- (1) The Children’s Court must admit in proceedings before it any evidence adduced that a parent or primary care-giver of a child or young person the subject of a care application:
 - (a) is a person:
 - (i) from whose care and protection a child or young person was previously removed by a court under this Act or the Children (Care and Protection) Act 1987, or by a court of another jurisdiction under an Act of that jurisdiction, and
 - (ii) to whose care and protection the child or young person has not been restored, or
 - (b) is a person who has been named or otherwise identified by the coroner or a police officer (whether by use of the term “person of interest” or otherwise) as a person who may have been involved in causing a reviewable death of a child or young person.
- (2) Evidence adduced under subsection (1) is prima facie evidence that the child or young person the subject of the care application is in need of care and protection.
- (3) A parent or primary care-giver in respect of whom evidence referred to in subsection (1) has been adduced may rebut the prima facie evidence referred to in subsection (2) by satisfying the Children’s Court that, on the balance of probabilities:
 - (a) the circumstances that gave rise to the previous removal of the child or young person concerned no longer exist, or
 - (b) the parent or primary care-giver concerned was not involved in causing the relevant reviewable death of the child or young person, as the case may require.
- (4) This section has effect despite section 93 and despite anything to the contrary in the Evidence Act 1995.
- (5) In this section, ‘reviewable death of a child or young person’ means a death of a child or young person that is reviewable by the Ombudsman under Part 6 of the Community Services (Complaints, Reviews and Monitoring) Act 1993

Section 106A is an evidential provision. It does not provide a separate ground upon which it can be concluded that the child is in need of care and protection.³¹³ The grounds upon which a court can make a care and protection order are set out in s 71 of the *Care Act*. The FACS *Responding to Prenatal Reports Policy* recognises this when it states that ‘section 106A is relevant when responding to a risk of significant harm prenatal report *only* when a thorough risk

312 New South Wales, *Parliamentary Debates*, Legislative Assembly, 14 November 2006, 3843 (Gladys Berejiklian).

313 *SB v Parramatta Children’s Court* [2007] NSWSC 1297 (20 November 2007), [51].



assessment has been completed and it has been determined that it is necessary to commence care proceedings.³¹⁴ Prior to the removal of a newborn to whom s 106A applies, a ‘thorough assessment should be completed with consideration given to both the family’s child protection history and their current circumstances’.³¹⁵

It has been argued that the introduction of s 106A changed the practice surrounding newborn removals. Whereas caseworkers previously used the birth mother’s postnatal stay as an opportunity to investigate the newborn baby’s safety and wellbeing, after the introduction of s 106A babies were increasingly assumed into care immediately after birth, as the ‘need for ongoing assessment and evidence building was no longer pressed as an issue’.³¹⁶ The Review saw evidence of this in its case file review. For example, in Case 212, the pre-assessment consultation revealed that FACS had determined that it would not support the child’s mother to keep her baby due to the removal of her previous three children. This conclusion was made prior to the completion of any safety or risk assessment in respect of the baby. Later safety and risk assessments appear to have been completed with a view to supporting this decision and contained inaccurate and out-of-date material.



ALMOST A QUARTER

Qualitative data findings highlight that in almost a quarter of cases in the sample (n=47, 23.5%) ... Aboriginal children were assumed into care at birth or from the hospital in the period after their birth.

The Review is of the opinion that s 106A(1)(a) is not necessary to ensure the safety and wellbeing of children and may unduly encourage poor casework practice in respect of expectant parents and parents of newborn children. It is important that DCJ assess the situation of each individual child at the point in time of his or her birth. While the prior removal of children maybe considered a risk factor, it is not necessary for s 106A to reverse the onus of proof regarding the need for the care and protection of the child, particularly in light of the fact that many Aboriginal parents face difficulties in obtaining legal advice and support for care and protection proceedings. Further, proceedings relating to the removal of a child may commence very quickly after the child’s birth (limiting the time in which parents can obtain legal advice and gather evidence to support their case, and their emotional capacity to do so). For these reasons, the Review recommends the repeal of s 106A(1)(a) of the *Care Act*.

Recommendation 48: The NSW Government should repeal s 106A(1)(a) of the *Children and Young Persons (Care and Protection) Act 1998 (NSW)*.

314 Department of Family and Community Services (NSW) *Responding to Prenatal Reports Policy* (Endorsed March 2008, Updated June 2011), 2.

315 *Ibid* 7.

316 Michelle Wickham, ‘Who’s Left Holding the Woman? Practice Issues Facing Hospital Social Workers Working with Women who have Infants Removed at Birth by NSW Department of Community Services’ (2009) 34(4) *Children Australia* 29, 30.

11. Considering alternatives to removal

In its analysis of the case files of children in the cohort, the Independent Review Team noted that FACS was often quick to remove Aboriginal children without considering less intrusive options as is required under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*).³¹⁷ There are several existing options that could be utilised by the department to support parents to make changes to avoid removal, including Parental Responsibility Contracts, Parent Capacity Orders, Temporary Care Arrangements, and Family Group Conferences. These mechanisms are outlined below. The Review is of the perspective that the Children’s Court could play a more active role in ensuring that such alternatives are used to ensure compliance with the *Care Act* and reduce entries into care.

Requirement to take ‘least intrusive action’

Section 9(c) of the *Care Act* requires that ‘the last intrusive action’ must be taken to protect a child from harm. This means that alternatives must be considered prior to removal, which is the most intrusive option. Prior to making a care application, s 63 of the *Care Act* requires the Secretary to furnish details to the Children’s Court about the support and assistance provided for the safety, welfare and wellbeing of the child, and the alternatives to a care order that were considered before the application was made. However, data for the Review suggest that less intrusive options are rarely being considered for Aboriginal children who enter the OOHC system.

A number of stakeholders specifically noted that there are few consequences for failure to undertake such ‘prior alternative action’.³¹⁸ Women’s Legal Service NSW noted that ‘prior alternative action’ should include parents being provided formal written notification of the issues that must be addressed, referred for early legal advice, consulted about the development of a plan about how to address the issues, and provided with assistance to access support services. It argued that ‘prior alternative action’ should include child protection workers making effective referrals of parents or primary caregivers to early legal advice and other support.³¹⁹

For the Northern Rivers Community Legal Centre, specific early interventions would include:

direct intervention, including “unpacking” the parental responsibilities, how to navigate the system, supports available and timeliness of information could increase early corrective actions and preventative strategies to help keep the children safe at home and prevent them from going into care.³²⁰

Four Family Violence Prevention Legal Services also noted that the key to early intervention was community engagement and education in how to navigate the system. It advocated for a broader focus than education about parental responsibilities and the mechanisms that make up the system, such as including education on how to navigate and utilise supports to keep children safe in the family home.³²¹

317 *Children and Young Persons (Care and Protection) Act 1998* (NSW).

318 Women’s Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, [52]; Legal Aid NSW, Submission No 6 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 5.

319 Women’s Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 12.

320 Northern Rivers Community Legal Centre, Submission No 16 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 3-4.

321 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 7.



Data findings

In 72 of the 200 cases in the qualitative sample (36%) it was specifically identified that FACS did not consider less intrusive actions for children in the cohort and instead moved to the most intrusive option, namely, removal. Reviewers noted in these cases that less intrusive options were often available and should have been further explored. In a number of cases, the child's removal was described as being reactionary rather than necessary on that day. In some cases, it was also specifically identified that family were available and willing to help care for children, yet FACS removed the children without sufficiently considering family options or the supportive role that family may have been able to play in caring for the children. In some cases, it was also specifically identified that the parents appeared to need support to address presenting issues, and that removal represented a harsh response to issues related to poverty such as issues with finances and housing. In one case, legal advice indicated that a Temporary Care Arrangement (TCA) could be appropriate, but FACS did not follow this advice and reasons for this are not clear. This was the only case to identify that the concept of less intrusive measures was discussed, but did not appear to then be properly considered by FACS in making its decision to remove the children.

In 14 cases, it was identified that FACS considered and used less intrusive options to removal, and in most of these cases this was identified as positive practice in that it enabled the parents to address presenting issues and safety care for their children. Many of these cases, including cases where TCAs were put in place, resulted in children remaining with family and many children ended up in successful family placements or returned to the care of their parents. Although some of the children ultimately entered care after less intrusive options were used, it was often positive that FACS had not escalated to the most intrusive option at the outset, giving the parents an opportunity to address presenting issues with further support and assistance. In Case 60 it was suggested that the less intrusive option was put in place but this was not positive for the family, as the way the TCA was employed did not promote stability for the vulnerable child. In this case, the reviewer noted that further exploration of family group placement options would have been a more appropriate response and would have also represented a less intrusive option to removal.

In only four cases in the sample was it specifically identified that FACS considered, but did not progress, less intrusive options to removal. In these cases, FACS appeared to genuinely consider these options although they were not ultimately progressed.

Qualitative data and Review findings highlight the importance of improving quantitative data collection around less intrusive options, including reasons for not progressing the many available options apart from removal. This will improve visibility of practice and compliance with s 9(c) of the *Care Act*.

Recommendation 49: The Department of Communities and Justice should record, collect and report data around the consideration of the use of less intrusive options prior to entry-into-care. These data should include whether or not these measures were considered and if they were not used, reasons should be recorded and reported on against each possible measure. This data collection should be designed and interpreted in partnership with Aboriginal stakeholders and community.

Existing alternatives to removal

There are several established mechanisms that could be used as an alternative to the most invasive response—removal of a child. The main alternatives are: Parental Responsibility Contracts, Parent Capacity Orders, Temporary Care Arrangements and Family Group Conferences. These are briefly outlined below. Stakeholders indicated that FACS were not using these alternatives, so an initial pressing reform effort is to increase the use of these alternatives by the department.

Parental Responsibility Contracts

Section 38A of the *Care Act* provides for the making of a Parental Responsibility Contract (PRC). A PRC is an agreement between the department and a child's parents that contains provisions to support the improvement of parenting skills of the primary care-givers and to encourage them to accept greater responsibility for the child. A PRC may make provision for attendance at a substance abuse centre, counselling, behavioural and financial management courses, and for the monitoring of compliance with the terms of the PRC. Before signing the PRC, parties must have a reasonable opportunity to obtain independent legal advice.³²²

Parent Capacity Orders

A Parent Capacity Order (PCO) may be made in accordance with Chapter 5, Part 3 of the *Care Act*. A PCO gives parents the opportunity to address problems related to a child's safety before a more intrusive intervention by FACS, such as child removal. Unlike a PRC, a PCO is made by the Children's Court and can be made by the Court on its own or by application by the department. Consent to a PCO is not required, although the Court will endeavour to find that consent. A PCO requires a parent to participate in a program, service, course, form of therapy or treatment to improve their parenting skills so they can provide a safe, nurturing home for their child. The duration of the PCO will depend upon the service, program or treatment required.³²³

Family Group Conferences

A Family Group Conference (FGC) is a way to bring family members together with an impartial facilitator to make a plan for their child or young person. The FGC could include extended family and kin, a support person or a community elder, and members of relevant government agencies. Depending on age and maturity, children may attend the FGC, or write down their thoughts so someone at the FGC can read these out.

A FGC has three stages: information sharing (where everyone introduces themselves and talks about the difficulties the family is having); family time (private, for the family to discuss and develop a plan about the concerns that were raised); and agreement to the plan (which is private and has to say what needs to be done, by who, and when). All participants need to agree to the plan and all will receive a signed copy of the plan. A review meeting will then be scheduled to discuss the plan.³²⁴

322 NSW Department of Family and Community Services, *Parent Responsibility Contracts* (Web Page) <<https://www.facs.nsw.gov.au/families/caseworker-visits/child-not-at-risk/chapters/prc>>.

323 NSW Department of Family and Community Services, *Parent Capacity Orders* (Web Page) <<https://www.facs.nsw.gov.au/families/caseworker-visits/child-not-at-risk/chapters/pco>>.

324 NSW Department of Family and Community Services, *Family Group Conferencing* (Web Page) <<https://www.facs.gov.au/families/out-of-home-care/parents-with-kids-in-oohc/caseworker/chapters/family-group-conferencing>>.



Temporary Care Arrangement

Another less intrusive option to removal that has been subject to scrutiny in this Review is the Temporary Care Arrangement (TCA). A TCA is a voluntary agreement entered into between the department and the parent of a child who is in need of ‘care and protection’.³²⁵ A TCA provides for the child to live with another person, often another member of the child’s family, for a period of up to three months, with an option for the period to be extended by a further three months.³²⁶ A TCA can generally only be made with the consent of a parent of the child and can only be made when a permanency goal of restoration is being pursued and as such a permanency plan involving restoration has been prepared.³²⁷ The consenting parent can terminate a TCA by request to DCJ and in some circumstances, may apply to the Children’s Court for review of the terms of the agreement.

It should be noted that while parents must voluntarily agree to the terms of the TCA, they often do so in the knowledge that FACS can, and may seek another means of acting to protect a child that they believe is in need of care and protection, including by formal assumption into care. As noted in an information sheet on TCAs produced by the Attorney General & Justice:

If Community Services is worried about the safety, welfare or wellbeing of your child in your care and you have not agreed to enter into a Temporary Care Arrangement, Community Services will have to find another way to protect your child. Community Services might do this by removing your child from you without your consent.³²⁸

In this sense, parental consent may be somewhat coerced and the TCA may not be seen as a less intrusive form of intervention if the grounds for formal removal or assumption are not actually present.

The Review found that only 13.2% (n=151) of the Aboriginal children in the cohort entered care on a TCA.³²⁹ These data reflect all Aboriginal children who entered care on a TCA during the cohort period. This low number is particularly concerning, considering how many children entered care overall and the Review’s findings regarding the number of cases where less intrusive measures were not considered and may have been appropriate (see Figure 14).

As noted above, during file reviews, the Review identified many cases where it appeared that a TCA could and should have been considered but was not referred to in the case file. The Review identified that TCAs were not being utilised as an effective means of supporting parents while ensuring the safety of their children, and that this may be as a result of policy guidance by FACS. For example, the FACS ‘mandate’ on TCAs states:

The parent is able to end a Temporary Care Arrangement at any time. It is therefore important that we only enter an arrangement if we would consider it safe for the child to return to their parents’ care. If this is not the case then

325 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 151. Note that a TCA can be made without the consent of the child’s parents if the Secretary is of the opinion that the child’s parents are incapable of consenting to the arrangement: s 151(3)(b).

326 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 152.

327 *Ibid* ss 151, 84.

328 Attorney General and Justice, *Information for Parents: Temporary Care Arrangements* (Web Page) <http://www.childrenscourt.justice.nsw.gov.au/Documents/jag2474_temporary%20care%20arrangements%20fact%20sheet_v3_sec.pdf>.

329 The data reflects the child/ren’s first entry into care during the cohort period. The data does not indicate whether children who first entered care on a TCA were then returned to their parents, or whether they were removed/assumed into care subsequently.

removal of the child may be a more suitable option.³³⁰

The statement does not adequately reflect FACS' ability to assess whether a child is at risk of serious harm *if and when* a parent terminates a TCA. Further, the mandate is at odds with the *Structured Decision Making System Policy and Procedures Manual*, which lists the TCA as an intervention that can occur when a child is not safe to remain at home and there are no safety plan interventions that can be utilised to overcome this situation.³³¹ The Review is of the position that the mandate relating to TCAs should be revised to ensure that TCAs are used when appropriate and as intended.

The case file review also encountered examples of cases where TCAs were used effectively to support parents to engage in services in order to ensure that their children would be safe in their care. Two examples are set out below.

- In Case 190, a TCA was effectively employed to support a mother suffering from an acute mental health episode. In this case, the children were placed in the temporary care of their maternal grandmother for three months under a TCA while their mother sought support for her mental health issues. Following a period of successful treatment and reduced strain, the children were successfully returned to her care.
- In Case 217, a mother agreed to a TCA for her child while she engaged with drug and alcohol services in an effort to cease her use of the drug ice. Her daughter was then restored to her care when she completed treatment.

However, in other cases, TCAs appeared to be wrongly terminated or misused by FACS caseworkers. For instance, in Case 218, a mother was suffering from a period of declining mental health and entered a TCA for the care of her child for a period of three months. However, the child was assumed into care one week after the TCA commenced when his mother was admitted to a mental health unit. In this case, caseworkers asserted that the mother could no longer consent to the continuation of the TCA despite the agreement being made at an earlier point in time and there being provision for the making of a TCA when a parent is incapable of consenting to the arrangement.³³²

In other case studies, caseworkers failed to ensure that the elements of the Aboriginal Child Placement Principle (ACPP) applied to children in TCAs in order to support the cultural needs of Aboriginal children in placements outside the family home, for example, by not developing cultural plans or considering cultural connection in alternative ways when organising placements.³³³ Further, FACS caseworkers sometimes supported families to enter into a TCA but then failed to offer them any other casework or support for the factors that led to the TCA being implemented.³³⁴

330 NSW Department of Family and Community Services, *Temporary Care Arrangement* (Web Page) <FACS Intranet>.

331 Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012) 10-11.

332 *Children and Young Persons (Care and Protection) Act 1998* (NSW) S 151(3)(b).

333 See Family is Culture Case 219.

334 See, for example, Family is Culture Case 220.



Recommendation 50: The Department of Communities and Justice should revise its mandate on Temporary Care Arrangements to ensure that the ability of a parent to terminate a Temporary Care Arrangement is not used to deter its use.

Recommendation 51: The Department of Communities and Justice should ensure that caseworkers receive training on the use of Temporary Care Arrangements in child protection casework. This should include the use of examples of the use of Temporary Care Arrangements with Aboriginal families in practice.

Increasing the use of alternatives to removal

Four Family Violence Prevention Legal Services noted that PRCs were rarely used in rural areas and recommended the better utilisation of s 38A of the *Care Act* before the situation escalates to court orders. It also argued that s 38A be used to refer clients to Family Violence Prevention Legal Services early.³³⁵

The Northern Rivers Community Legal Centre called for FACS to address the inconsistent practices across its offices in NSW, particularly in relation to the use of early intervention tools available in the legislation.³³⁶ It submitted that:

The findings of the Review of Legal Aid/Community Legal Centres Care Partner Program 2015–2016 indicate that whilst Community Legal Centres in NSW provided assistance to 451 clients in 2015, there were only seven instances where parental responsibility contracts were considered by FACS and only two appear to be implemented. Further, Care Partners reported only two matters involving parent capacity orders, with only one proceeding.³³⁷

Similarly, Legal Aid NSW noted that while the *Care Act* provides the above legislative alternatives to removal, these have not been adopted as standard casework procedure by caseworkers in many parts of NSW. It also noted ‘in our experience, the in-house legal teams in FACS are also often unfamiliar with the use of these alternatives’.³³⁸

Women’s Legal Services NSW noted that:

Concerns have been raised by legal assistance service providers about the low use of early support tools (a form of prior alternative action) such as parent responsibility contracts and parent capacity orders. We understand information about referrals for early legal advice has been included in FACS internal casework practice manual and flyers have been developed and provided to every FACS district. However, [submitter] receives very few referrals from FACS.³³⁹

335 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 3.

336 Northern Rivers Community Legal Centre, Submission No 16 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 8.

337 Ibid.

338 Legal Aid NSW, Submission No 6 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 5.

339 Women’s Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 16.

The Northern Rivers Community Legal Centre observed that while FACS stated that FGCs were taking place, Aboriginal workers stated that they were in fact not occurring

An example of the lack of the use of family group conferencing (FGC) to engage Aboriginal and Torres Strait Islander families to resolve FACS concerns regarding children was highlighted at [the submitter] recent EIRP sector development session. Workers from the local FACS office participated in the session and insisted that they had successfully increased the use of FGC particularly in relation to Aboriginal and Torres Strait Islander families. However, an Aboriginal Child and Family Service worker stated that FGC had not increased. Only two had been conducted in the region in the past year, one was successful and the Aboriginal family walked away from the other as FACS refused to engage an Aboriginal mediator.

Uniting submitted to the Review that PRCs and PCOs sometimes included requirements that could not be met due to service shortages. It stated that:

Uniting has been in a situation where we have been asked to case manage a family to assist them to meet the requirements of a parenting contract to attend certain services, where those services have not been available.³⁴⁰

Legislative obligation to consider alternatives to removal

In relation to increasing the use of alternative options to removal, Legal Aid NSW recommended that FACS must at the very least consider conducting an FGC, PRC, or PCO prior to removal.

Legal Aid NSW was of the view that the types of action that should be mandated include:

- Family Group Conferences (with added obligations of Family Finding and identification of government agencies or services that can offer support to the family, or both);
- Parental Responsibility Contracts; and
- Parent Capacity Orders.³⁴¹

It also noted that independent sources of information and legal advice were necessary prior to FGCs and the signing of plans and agreements.³⁴²

As discussed in Chapter 19, the department is now legislatively required to consider using alternative dispute resolution (ADR) processes when responding to every ROSH report, and to offer ADR processes to the family of a child who is at risk of significant harm before seeking any court orders in relation to the child.³⁴³ The Review commends this approach and recommends that similar provisions be introduced to mandate the consideration of the other alternatives to removal. The role of FACS is to promote family preservation, however much of the current casework practice has the effect of rupturing families. A statutory requirement to use alternatives to removal has the best chance of reorienting departmental practice towards

340 Uniting (NSW.ACT), Submission No 23 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, March 2018, 8.

341 Legal Aid NSW, Submission No 6 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 18.

342 Ibid 9.

343 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 37(1A).



family preservation. This is necessary given that the alternatives that currently exist are not being properly utilised.

Recommendation 52: The Department of Communities and Justice should ensure that Family Violence Prevention Legal Services and Community Legal Centres are adequately funded to provide legal advice to Aboriginal families to support their engagement with the Department of Communities and Justice and encourage the use of alternatives to removal.

Recommendation 53: The Department of Communities and Justice should update its policies and procedures to ensure that all Aboriginal families receive 'warm' referrals to legal advisors, with a preference for Aboriginal services, before child protection involvement escalates to the point where entry into care is considered a possibility.

Recommendation 55: The Children's Court of NSW should update its internal judicial guidance to ensure Magistrates require the Department of Communities and Justice to provide information to the Court about what prior alternative actions were considered and taken before children entered care.

12. Improving entry into care practice

The Review has identified issues with the way Aboriginal children are entering care, including with the department's Safety and Risk assessment processes (the processes which support decisions for children to enter care), and with the way the department is conducting child removals. This chapter discusses the first issue, while Chapter 13 discusses entry removal practice. This chapter highlights that while many children in the cohort had a safety and risk assessment completed as per the department's structured decision-making (SDM) approach prior to entering care, there were often deficiencies in the way the SDM tools were being executed, significantly impacting the quality of decision-making around Aboriginal children's entries into care.

Safety and risk assessment

Safety and Risk Assessment is the investigation and decision-making process that gives effect to s 30 of the *Care and Protection Act 1998* (NSW) (*Care Act*). This section states that on receipt of a report that a child is suspected of being at risk of significant harm:

- (a) the Secretary is to make such investigations and assessment as the Secretary considers necessary to determine whether the child or young person is at risk of significant harm, or
- (b) the Secretary may decide to take no further action if, on the basis of the information provided, the Secretary considers that there is insufficient reason to believe that the child or young person is at risk of significant harm

As noted in Chapter 4, when a risk of significant harm (ROSH) report is screened in, triaged and allocated, if a child or young person appears to be at risk of significant harm and there are sufficient resources to investigate the matter further, the case will be allocated to a caseworker for a field response. At this initial field response—a home visit—the caseworker conducts a safety assessment³⁴⁴ to determine whether the child is in immediate danger of serious harm, and what interventions can be used to ensure the child is appropriately protected from any dangers. The initial safety assessment considers both the dangers that may be faced by the child and the child and parents' protective abilities. The outcome of the safety assessment can be safe (no dangers identified), safe with plan (identified dangers can be mitigated by safety interventions) or unsafe (dangers identified cannot be mitigated by safety interventions). If the outcome is 'safe', nothing further happens until a risk assessment is completed. If the outcome is 'safe with plan', a safety plan must be developed (this is discussed later in this section). If the outcome is unsafe, then the child must be removed from the home, either into a temporary care arrangement (ss 151 and 152 of the Act), or into statutory OOH. Less intrusive options to removal are required to be considered under s 9(c) of the *Care Act* (as discussed in Chapter 10).

A risk assessment must then be conducted within 30 days of the initial safety assessment and this examines the likelihood that a child will experience abuse or neglect within the next 18 months. The risk assessment is designed to ascertain the likelihood of further incidents of neglect or abuse without further agency intervention. If this tool generates a risk level of high or very high, the child is deemed to be in need of care and protection. After this outcome, the child

³⁴⁴ For most children in the cohort this was in the form of a safety and risk assessment: Figure 45, Appendix A.



may continue to remain in the home dependent on the initial outcome of the safety assessment. For instance, if the child was determined to be safe or safe with plan in that initial assessment, DCJ will undertake further referral, case planning and casework with the family.

A risk re-assessment is then conducted when a child or young person who has received a risk assessment in the past remains in the home, or has been returned home.

These assessment items form the primary components of DCJ's SDM approach, the goals of which are to reduce reports, substantiations, injuries and foster placements and to expedite permanency for children.³⁴⁵ The objectives of the SDM approach are to identify critical decision points, increase decision-making reliability, increase decisional validity, target resources to families where there is the highest probability of future ill-treatment, and to use case-level data to inform agency decision-making.³⁴⁶ Together, these assessment items also form the internal decision-making gateway of children's entries into the OOHC, designed to ensure that decisions around how to manage children and families with presenting child protection issues including around entries into care are evidence-based and justified.

Issues with safety and risk assessment approaches in the department

Structured decision making tools, such as the safety and risk assessment (SARA), reflect the shift towards risk management in child protection practice across Australia and internationally.³⁴⁷ Despite their significant uptake in child protection practice, such risk management focused approaches have been criticised for representing flawed practices, including on the basis that they are subject to caseworker fallibility, despite the veneer of objectivity.³⁴⁸ A key problem with SDM tools is that they are completed by caseworkers who may be inexperienced, biased, or simply may take shortcuts in the way they process or receive information and reach decisions, including based on their own fixed or existing views. This reflects the fact that such caseworkers are human and approach their work from their own perspective and experience. According to Gillingham, child protection risk assessment studies highlight that:

Practitioners tend to use information selectively when making any assessment or decision for action and they may be subject to influences that are not readily apparent to themselves or an observer. Although it may be argued that the application of standardised risk-assessment tools may serve to identify and counteract the 'flaws' that arise in decision making in child protection practice ... these 'flaws' exist within, and are even masked by, the application of risk assessment tools.³⁴⁹

This issue has been identified in cases examined for this Review and discussed below. These limitations appear to reflect a form of cognitive bias. For Aboriginal children and families, even such SDM approaches, when employed by non-Indigenous caseworkers, appear vulnerable to beliefs, stereotypes and false judgements of Aboriginal people and families.

345 Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012) 2.

346 Ibid.

347 Philip Gillingham, 'Risk Assessment in Child Protection: Problem Rather than Solution?' (2006) 59(1) *Australian Social Work* 86, 86.

348 Ibid 95.

349 Ibid.

In NSW, the SDM attempts to guard against bias in the use of safety and risk assessment tools. The SDM guidance document notes that in conducting risk assessment for Aboriginal children, historical and contextual factors around Aboriginal peoples' engagements with child protection systems and state services must be taken into account in both using the tool, through caseworkers' language, and through devising casework responses to SDM issues identified. In relation to Aboriginal people, the SDM manual states:

Consulting about Safety and Risk Assessments with appropriate Aboriginal people who know the child/young person's family, background and community dynamics can assist caseworkers in making an informed and appropriate decision that is in the best interest of the child/young person. Engaging and consulting with appropriate Aboriginal people will also ensure that the critical characteristics of the SDM system (i.e., reliability, validity, equity and utility) are applied consistently and effectively in all assessments of Aboriginal children/young persons and families.³⁵⁰

The guidance also notes that getting to know the family and establishing protective allies in the family and local community are key aspects of using SDM approaches with Aboriginal children and families.³⁵¹ These reflect positive policy guidance by FACS, attuned to the importance of Aboriginal participation and engagement.

However, despite these strengths being contained in the SDM tool guidance itself, data from this Review highlight that in practice there is little Aboriginal consultation around safety and risk assessments occurring for Aboriginal children who enter care. The partnership approach, arguably envisaged by the guidance in the SDM and the layout of the tool, is not occurring in practice. This results in the critical characteristics of the SDM system (reliability, validity, equity and utility) not being applied consistently or effectively in all assessments of Aboriginal children. As data examined in the ACPP section of this report show, a significant proportion of Aboriginal children who entered care did not have Aboriginal consultation before they entered care. According to the SDM's own guidance documents, this considerably reduces the competency of the tool, as well as the tool's ability to support caseworkers to make informed and appropriate decisions about Aboriginal children and families.

In its consultations, the Review was informed that cultural bias affected the way in which caseworkers approached the assessment of risk with Aboriginal families. For example, one stakeholder noted that 'Aboriginal' was often used as a stand-alone risk factor.³⁵² Another noted that caseworkers viewed poverty as a risk factor, and equated poverty with abuse.³⁵³ A number of other stakeholders noted that caseworkers assessed risk through their own cultural lens,³⁵⁴ viewing things that were considered normal for Aboriginal people, such as mattresses on the floor, or 'overcrowded' houses as risk factors.³⁵⁵ One stakeholder observed that FACS caseworkers tended to have backgrounds in teaching or nursing—positions that required them to exercise an element of authority—and that these caseworkers tended to impose their world views onto the families that they worked with.³⁵⁶

350 Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012) 5, 6.

351 Ibid.

352 Confidential, *Consultation*, FIC 51.

353 Confidential, *Consultation*, FIC 69.

354 Confidential, *Consultation*, FIC 11.

355 Confidential, *Consultation*, FIC 5-9; Confidential, *Consultation*, FIC 53; Confidential, *Consultation*, FIC 11.

356 Confidential, *Consultation*, FIC 63.



The lack of consultation during the use of SARA tools, when combined with concerns around the cultural bias of caseworkers, raises considerable concerns about the competency, in practice, of current SARA decision-making for Aboriginal children and families.

Stakeholders observed that the criteria used during risk assessments needed to be changed so as to be applicable to Aboriginal families and communities, with one person commenting that at the moment the risk assessment system is ‘so white washed’.³⁵⁷ It was suggested that there needed to be a separate, parallel process of risk assessment for Aboriginal families.³⁵⁸

The lack of consultation during the use of SARA tools, when combined with concerns around the cultural bias of caseworkers, raises considerable concerns about the competency, in practice, of current SARA decision-making for Aboriginal children and families.

As the SARA SDM tool forms the decision-making pathway around whether a child is taken into care, it is also the lever that gives effect to s 34 of the *Care Act* which relates to the Secretary taking action in respect of children who are found to be in need of care and protection. According to this section:

(1) If the Secretary forms the opinion, on reasonable grounds, that a child or young person is in need of care and protection, the Secretary is to take whatever action is necessary to safeguard or promote the safety, welfare and well-being of the child or young person.

This section includes the Secretary applying for emergency removal under s 43 or s 44 of the *Care Act*. The majority of children in the cohort (71%) entered care under ss 43 or 44 of the *Care Act*.³⁵⁹

In 2017 the NSW Legislative Council General Purpose Standing Committee No 2 commented in respect of safety and risk assessment tools used by the department that:

While we understand that the department is using various screening and assessment tools to triage cases, we question how effective these tools are given concerns they are not suited to a wide variety of factors and circumstances, for example, to assess risk in Aboriginal families and communities or to assess child protection concerns in the context of domestic or family violence. It appears that existing tools may also be inadequate in assessing cumulative harm, which is troubling, given the long-term damage such harm can cause to a child.³⁶⁰

Further, the Legislative Council General Purpose Standing Committee No 2 highlighted the need for objective tools and frameworks, and for such tools and frameworks to be tailored in certain circumstances. It acknowledged that getting the balance right was a difficult exercise,

357 Confidential, *Consultation*, FIC 5–9.

358 Confidential, *Consultation*, FIC 61.

359 FACS Insights, Analysis and Research, *Family is Culture Framework Data Report: Review of Aboriginal Children and Young People in Care in NSW* (Report, May 2019) [39.1].

360 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) [3.127].

but an important one, given that such assessments were the trigger for further child protection intervention and response. It also noted that while resourcing in the department was a concern, this was not the root cause of the problem with safety and risk assessment processes. Rather, it argued the need for 'greater objectivity, better systems to pick up cumulative risk, and greater consistency in outcomes'.³⁶¹ The Legislative Council accordingly recommended:

That the NSW Government commission an independent review of the Department of Family and Community Services' screening and assessment tools and processes, to identify how they can be improved to enhance objectivity within child protection assessments.³⁶²

This independent review has not been undertaken. The NSW Government response indicates that Their Futures Matter will include a review of child protection intake, assessment and referral processes from within the cross agency implementation unit— independent of service agencies. The response notes that this review will focus on:

- Better identifying clients most at risk to enable early and effective responses;
- Reducing inefficiencies and duplication in intake, assessment, triage and referral processes;
- Increasing pathways and opportunities for early intervention;
- Enhancing access and contact points ensuring the system is easy for mandatory reporters and the community to navigate; and
- Enabling better responses for children and families below the statutory risk threshold.³⁶³

The Review is of the perspective that the response to the Legislative Council General Purpose Standing Committee No 2's recommendation does not attend comprehensively to issues identified, nor is it a sufficiently independent process to address issues identified in this Review.

Data findings

FACS (Review Tool) data indicate that most Aboriginal children in the cohort had a secondary assessment completed (usually a SARA, 86.5% of cohort).³⁶⁴ However, what is not clear from available information is when the safety assessment preceding a child's entry into care was completed and if it was in a period proximal to the entry into care. Insufficient guidance was provided to reviewers around the issue of when safety assessments were completed, likely resulting in inconsistency among reviewers' approaches to the question. For example a safety assessment may have occurred a significant period of time prior to a child's entry into care, or a child may have entered care at birth (for instance, after siblings had been removed in the months prior) without a new safety assessment having been completed. This data is accordingly unreliable due to the high probability that reviewers approached entering this information differently.

Even so, the data show that around 10% of Aboriginal children in the cohort entered care without a

361 Ibid. [3.128]–[3.130].

362 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) rec 4.

363 NSW Government, *NSW Government Response to Report 46 of the Legislative Council Portfolio Committee No. 2—Health and Community Services—Child Protection* (Report, September 2017).

364 Figure 45, Appendix A.



safety assessment being able to be located (10.2%).³⁶⁵ Further, for almost a quarter of children who had a SARA (23.2%), the outcome of the most recent assessment (prior to entry into care) was safe with plan. No subsequent assessment was conducted before these children entered care (Figure 50).

In light of the rationale for the SDM, and the legislative requirement that the Secretary form the opinion on reasonable grounds, that a child is in need of care and protection under the *Care Act*, this lack of structured decision-making and reasoning appears concerning.

Issues with safety assessment were also reflected in the qualitative sample analysis for the Review. In this sample, in 31 of the 200 cases (15.5%), it was identified that no safety assessment was completed before a child entered care—which is a figure slightly higher than the FACS data noted previously. In several cases this reflected that there was no identifiable safety assessment before that child entered care, or that there was no new assessment completed after circumstances had changed (such as a child being born after a SARA was completed for their siblings). In some cases, this lack of safety assessment at entry into care was also coupled with a lack of restoration goals provided to parents, meaning that there was little transparency around why children were removed and what parents were expected to do to have their children restored.

In a further 47 cases (23.5%, or almost a quarter of cases in the sample), issues were identified with the safety assessments completed prior to children entering care. In half of these cases (n=24), there were errors in the safety assessment, such as dangers being incorrectly identified or nominated in the assessment. Other identified issues included: the SARA assessment being completed months prior to the entry into care, delays in safety assessments being completed (i.e. not being completed within required time frames), children being taken into care having been assessed as safe where there was no evident change in circumstances to precipitate removal, and safety assessments setting out risks that did not reach the threshold of harm as per the SDM definitions.

These data when viewed together, suggest that while caseworkers may be completing safety assessments for most (but not all) children who enter care (i.e. engaging in SDM processes), there are errors and compliance issues around the way these assessments are being prepared and used. It would appear that tools frequently have errors and that these errors are often then communicated to the Children's Court and used to legally justify child removal or assumption. Systemic non-compliance with safety assessment processes and policies resulted in Professor Davis making many recommendations in individual case tools to FACS Districts around training and compliance with SARA.

It should be noted that the data show that of the children who had a SARA completed, most had a risk assessment completed (96.9%). Again these data do not make it clear whether the Risk Assessment was completed in the required time frame and qualitative data for the Review indicate that in a number of cases there was delay in the risk assessment being completed, contrary to policy guidelines. The data highlights that around half of children over the age of six years were interviewed for the purposes of risk assessment (52% of children aged 6–12 and 55.3% of children aged 13–17 years). This is a low rate of interview (see Figures 46–48).

Very few children (less than one in ten) had a risk re-assessment completed (8.1%, n=78).³⁶⁶

³⁶⁵ Figure 45, Appendix A.

³⁶⁶ Figure 49, Appendix A.

The Benevolent Society submitted to the Review that a FACS manager had informed it that FACS did not train their staff to use the SARA tools properly and that those who do not understand Aboriginal culture and kinship, ‘shape their conclusions so that they come to a punitive decision’.³⁶⁷

This punitive attitude to Aboriginal parents was evident in a number of cases in the Review. For example, in Case 396, the safety assessment (for four children of the mother) identified that the mother was a flight risk due to the fact that she had just been informed that one of her children had been removed by police. This was identified as an insensitive and punitive response to the mother’s clear distress at having been told, during the safety assessment, that the police had removed her child. Similarly, in Case 229, it was identified that in completing the safety assessment, FACS relied on historical risks as a means to select danger items in the safety assessment tool—meaning that historical drug results were used to justify removal even though there was no evidence that the parents had current drug issues. In this case it was identified that the safety assessment also included dangers that were not supported by evidence, and other dangers were incorrectly applied.

These issues, including the overreliance on historical factors to justify removal or assumption where those dangers were no longer presenting for the family, were common in the cases and are indicative of a punitive, inconsistent and unjustified approach to selecting dangers in the SARA process. It was also common that protective factors were not recorded in the safety assessment, despite reviewers identifying that these were present in the household at the time of the assessment being completed. These practices raised considerable concerns around the extent to which tools were being used to justify a pre-determined outcome, removal or assumption, for Aboriginal children and families.

Safety Planning

Another component of SDM is ‘safety planning’. According to the department’s SDM framework, if the outcome of an initial safety assessment is ‘safe with plan’, a safety plan must be developed with the family. As discussed in Chapter 4, a safety plan is ‘a written, mutually developed arrangement between the child protection service (the caseworker) and the family’.³⁶⁸ It aims to use the least intrusive safety interventions possible to address the safety concerns identified in the initial safety assessment.³⁶⁹ As such, it ‘permits a child/young person to remain home during the course of the investigation/assessment/ongoing work’.³⁷⁰ A safety plan is developed with the parent or caregiver ‘as well as relevant family members’.³⁷¹ It can include safety interventions such as planned care arrangements for a child if the parents or carers intend to drink alcohol or use drugs, respite care, in-home health care and transportation services.³⁷²

367 The Benevolent Society, Submission No 7 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 13.

368 Office of the Senior Practitioner (Department of Family and Community Services), ‘Safety Planning Resource’ (October 2016) 5. Note, however, that the safety plan may be developed verbally with a victim of domestic violence if the provision of a written safety plan may increase her risk of being subjected to violence: Office of the Senior Practitioner (Department of Family and Community Services), ‘Safety Planning Resource’ (October 2016) 22.

369 Safety plans are discussed further at Chapter 5.

370 Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012) 34.

371 Office of the Senior Practitioner (Department of Family and Community Services), ‘Safety Planning Resource’ (October 2016) 5.

372 Ibid 14.



A safety plan should be regularly monitored and may be adjusted or modified as needed.³⁷³ If the risk assessment (which is conducted within 30 days of the initial safety assessment) results in a risk level of 'high' or 'very high', a case plan must be developed and 'any previously identified safety interventions should be incorporated into the case plan'.³⁷⁴

Data findings

While there are reliability issues in the safety assessment information in the FACS (Review Tool) data (discussed above), the data notes that as a result of the SARA, a proportion of children were found 'safe with plan' (23.2%, n=230). Most children who were deemed 'safe with plan' had a safety plan developed (90.9%, n=209). It is not clear why 9.1% (21 children) did not have such a plan developed (Figure 50).

Of the children who had safety plans developed, less than half of these plans were identified as fully addressing the dangers identified in the safety assessment (46.9%, n=98). However, as reviewers were provided confusing advice in the tool about how to answer this question,³⁷⁵ it is not possible to distinguish meaningfully between safety plans that were said to 'not address the identified dangers' and those that were said to only 'partially identify the dangers assessed'. Nevertheless, combining these two categories, it is possible to deduce that for 53.1% of the children in the cohort who had a safety plan developed following a SARA, these safety plans did not address the identified dangers completely, or at all. These findings are particularly concerning as children in the cohort then entered care while these plans were on foot, or after parents had been unable to comply with these plans (Figure 51).

Similarly, deficits in safety planning were identified in the qualitative sample data for the Review, highlighting the need for further training and enhancements around the development and implementation of safety plans for Aboriginal families and children.

Discussion

The Review's findings into the issue of SARA highlight considerable deficiencies in the way SDM in safety and risk assessment is being utilised for Aboriginal children and families. For example, systemic non-compliance with safety assessment was evident from the case review sample, raising concerns about the ability of these tools to discharge requirements under ss 33 and 34 of the *Care Act*. Further, the types of non-compliance suggest both that caseworkers are not utilising SARA tools properly and that caseworkers may be (intentionally or otherwise) taking punitive approaches to assessing Aboriginal families.

These observations combined with the lack of Aboriginal consultation in these pre-entry into care cases, as noted above, reinforce the need for further training for caseworkers in the SDM tools and stronger requirements around participation and decision-making for Aboriginal family and community before children enter care. Only once these issues are addressed can the Secretary be said to properly be investigating and forming the opinion on reasonable grounds

³⁷³ Ibid 12.

³⁷⁴ Ibid.

³⁷⁵ The Aboriginal Care Review Tool notes that: 'As a guide look at the dangers identified in the safety assessment and see if they are covered off in the safety plan. For example if the safety assessment identifies 3 dangers, however safety plan only identifies 1 danger then the answer to this question would be No or Partially. Also consider the actions (what will be done) in the safety plan and determine if this is adequate. For example, the safety plan may say for "the mother to call Lifeline if she is having thoughts of suicide", however you are aware that the mother does not have a mobile phone then you would say that the safety plan did not address the identified danger'.

that Aboriginal children are in need of care and protection.³⁷⁶ These findings also highlight the need for an independent review of the content of the SDM tools, noting that concepts of risk and safety are not universal and the ability of the tools to reflect risks and strengths of Aboriginal families. This review should occur in partnership with Aboriginal community and stakeholders.

Recommendation 56: The Department of Communities and Justice should commission an independent review of its structured decision making tools and processes to identify how they can be improved to enhance objectivity within child protection assessments. This review should be undertaken in partnership with Aboriginal community and stakeholders to ensure that it examines the cultural adequacy of current risk and safety paradigms and tools.

Recommendation 57: The Department of Communities and Justice should implement internal improvements to chain of command decision-making and safety plan review, to ensure that all safety plans prepared for families respond comprehensively to all identified dangers and include relevant casework responding to all identified risk and safety issues.

Recommendation 58: The Department of Communities and Justice should ensure all staff receive commencement and regular refresher training in how to use the safety and risk assessment tools. The training should be delivered by Aboriginal educators and should incorporate training in cognitive bias and how to undertake safety and risk assessments with Aboriginal families and children.

³⁷⁶ *Children's and Young Persons (Care and Protection) Act (NSW) s 34.*



13. Poor removal practices

Having a child removed is a life-changing and traumatic event that has adverse ramifications for children and families for generations. It is likely the most intrusive action the state can take into peoples' and families' lives. Approaching child removal accordingly requires parents to be treated with understanding and respect, acknowledging the trauma that removing a child causes to the family, and respecting the dignity of all parties involved.

The Review, however, has significant concerns about the way removals are being executed by the department, and in particular, how distressing and punitive some entry into care approaches are in practice. During the Review, some stakeholders noted that FACS engaged in inappropriate removal practices that were unnecessarily traumatising. For example, the Review was informed of a case where children were removed while their mother was out shopping,³⁷⁷ when a young person was removed while attending her formal, as well as of removals that were conducted outside of normal business hours, such as at 2am, 6am or 8am.³⁷⁸ A number of stakeholders referred to removals that were conducted in a 'raid style'.³⁷⁹ The Review also heard that 'paperless removals' were becoming frequently common and occurred under the guise of 'respite care'.³⁸⁰ In the case file review process, the Review also identified many instances of insensitive and punitive removal practices—such as involving police unnecessarily in removals, removing babies from their mothers shortly after birth without any prior warning, and removing children without telling family. This section sets out a number of examples from the case file review to highlight some of the issues that arise in relation to removal practices.

Use of police in removals

The Review has concerns around the use of police officers to assist caseworkers to remove Aboriginal children from their families. Aboriginal people often have a deep mistrust of police.³⁸¹ Utilising police unnecessarily to assist in child removals exacerbates this mistrust and can be unnecessarily traumatic. The Australian Institute of Criminology has identified a number of reasons that Aboriginal women, in particular, are mistrustful of police, including

over and under-policing; the historical role of police in implementing former government policies including those relating to child removal; a history of conflict between police and Aboriginal and Torres Strait Islander communities; and the role of police and Aboriginal and Torres Strait Islander deaths in custody.³⁸²

In a number of cases the Review found that caseworkers were exposing Aboriginal children and families to emotional and psychological harm by inappropriately engaging police to assist them at the time of removal. It is the Review's perspective that the use of police at removals

³⁷⁷ Confidential, *Consultation*, FIC 5–9.

³⁷⁸ Confidential, *Consultation*, FIC 58.

³⁷⁹ Confidential, *Consultation*, FIC 58; Confidential, *Consultation*, FIC 41; Confidential, *Consultation*, FIC 42; Confidential, *Consultation*, FIC 54; Confidential, *Consultation*, FIC 80.

³⁸⁰ Confidential, *Consultation*, FIC 92; Confidential, *Consultation*, FIC 89.

³⁸¹ Australian Law Reform Commission, *Pathways to Justice—Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018), [14.11].

³⁸² Australian Law Reform Commission, *Pathways to Justice—Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018), [11.52]; discussing the research of Matthew Willis, 'Non-Disclosure of Violence in Australian Indigenous Communities' (Trends and Issues in Crime and Criminal Justice No 405, Australian Institute of Criminology, January 2011) 4–10.

compounds parents' grief and distress responses to the understandably traumatic event of their children being removed, contributing to personal distress for the children and their parents, and negatively impacting trust relationships between parents and the department.

Notable examples from the case studies include:

- In Case 48, FACS made the decision to apply for a search warrant and remove five children from their parents. In the casework leading up to removal, FACS did not consider alternatives to removal and few efforts were made to ensure protective factors (such as involvement of family), were encouraged to avoid the children's entry into care. The use of the police at the removal was identified as being punitive, and although this was designed to mitigate safety issues for caseworkers, more transparent work with the family may have eliminated this perceived risk. The reviewer noted that use of police in this case clearly criminalised ordinary reactions that should be expected when the State removes a parent's children (reactions that should be met with empathy and compassion, rather than further punishment).
- In Case 77, the decision to involve police in a removal intensified an already tense and high-conflict situation for the family. This was further inflamed by the fact that, following the removal, FACS made no attempts to advise the maternal grandmother about the removal and she later found out about the intervention when she contacted the FACS helpline having heard from a relative that her grandson had been removed.

While it is acknowledged that caseworkers executing child removals need to be safe, cases examined for the Review suggest that involving police in removals can be guarded against through earlier and more supportive casework and engagement with the family, making removal—should this have to occur—a less traumatic experience for children and their families. This is particularly relevant for Aboriginal families for whom police involvement has particularly negative connotations and can be perceived as even more punitive due to historical relationships between communities and the police. Further cases where police involvement was a feature of the removal process are outlined in the next section.

71%

The majority of children in the cohort (71%) entered care under ss 43 or 44 of the Care Act.

10%

around 10% of Aboriginal children in the cohort entered care without a safety assessment being able to be located (10.2%)



Other examples of inappropriate removal practices

The Review identified other inappropriate removal practices, raising concerns about the way FACS is exercising its powers under the *Care Act* and removing Aboriginal children from their families.

- In Case 300, FACS attended the year six formal of a child to assume her into care as a response to chronic neglect concerns. Given that FACS had an extensive history of casework with this family, the parents were currently engaging with FACS and that removal was in response to a chronic rather than an acute issue, the attendance of caseworkers at a milestone event for the child was identified as being unnecessary and traumatising for her. This removal could also easily have been avoided.
- In Case 228, it was unclear why the decision was made to remove the children, given there was no critical incident and FACS had known the risks to the children for approximately seven years. The decision to remove in this case was made more difficult to understand in light of the fact that FACS was aware that the children's mother was due to commence a drug detoxification program within four days of the removal and intensive support should have been provided to her and the family at this point to support her attempt to address her drug use issues. Further, in this removal there was no consultation with the family (immediate or extended) prior to removal, and no attempt was made at any stage to identify alternative care options for the children prior to removal, despite the department's long history of involvement with the family. In this case the children were also removed by police and separated between two police vehicles during the execution of the s 233 warrant.
- In Case 46, FACS had been working with the family for more than two months prior to the child's birth and had previously been involved with the family during the removal of the mother's older children. Despite this considerable history of current and historical engagement with the family, FACS failed to effectively engage with the family or take steps to minimise the trauma of assumption. The circumstances around removal were described as 'frenzied' and occurred nine hours after the child's birth at 1am in the morning, leaving the mother alone in her hospital room and the baby locked in another room in the hospital. The caseworker later acknowledged that FACS' response was poor and apologised to the mother, although it was identified in the review that the damage had at this stage already been done. FACS then allowed the mother supervised contact with her baby in the days following the birth. Given their earlier contact with this family, it was identified in this case that FACS should have considered earlier exploration of placement and support options, including through a Family Group Conference and, if it was appropriate to assume the child into care after birth, this should have been carried out in a planned and orderly manner with support workers on hand to assist the mother with her grief and trauma.
- In Case 191, FACS received several reports about the child's safety in the months prior to removal. Rather than acting proactively and undertaking a safety assessment or investigating an emergency placement, FACS caseworkers chose the most intrusive form of action at that point in time, removing child from her home and family on Christmas Eve. Given the history and reported concerns for the family, which were considerable, it was identified that FACS could have organised an emergency family meeting and executed a child protection case plan over the Christmas period.

- In Case 6, FACS assumed care of a prematurely born two-week-old child in hospital. The day after the child was removed, FACS withdrew the assumption order and returned the child to her mother the next day following an internal consultation. This consultation determined that resources should be put towards supporting the mother to parent the baby and took into account the mother's history of trauma at having an older child removed from her care. The outcome of this internal consultation reflected that the caseworker's decision to assume care of this child was hasty and largely unjustified. The reviewer noted that the mother found this engagement with FACS to be confusing and she described feeling judged by FACS when they removed this child from her care. When FACS returned the child to the mother's care, approaches to casework were overly directive towards the family, rather than responsive to the family's needs. It was identified in this case that FACS, in conjunction with an Aboriginal NGO, appeared to approach working with the mother in a somewhat threatening way, such as warning her that FACS would pursue court action if she did not engage with the case plan. This approach to working with a mother with intergenerational trauma issues was identified as not being adequately healing-centered and was productive of further fear and trauma. This case highlighted the considerable power that FACS wields over families and children.
- In Case 115, caseworkers were called to a home by a mother seeking help to leave her abusive partner (the father of one of her two children). While caseworkers were present in the home, the father assaulted the mother and he almost dropped his child from his arms in the course of his violent behaviour. He was also emotionally abusive towards the mother and the children. Caseworkers called the police and police officers attended the scene. The father then left for a period before returning to the house and abusing the mother further, making allegations about her excessive drinking to the caseworker. These allegations appeared to change the caseworkers' strategy from one of working with the mother to a strategy of removing the children, and apparently as a result of the father's allegations, FACS decided to remove the children without a warrant at the scene. When the mother was informed that FACS were removing the children, she was recorded as saying 'no, you aren't taking my babies, I called you for help today'. Police intervened and assisted caseworkers to leave the property with the children. In this case, FACS should have considered less intrusive options to removal and should have worked with the mother to help her and the children safely leave the home. Allegations made by the father around the mother's alcohol consumption should have been discussed and case planning coordinated. It is an example of particularly poor practice that allegations expressed in the context of domestic violence and abuse were taken on face value without further assessment or appropriate discussion with the mother. This goes to concerns about the department's knowledge in relation to domestic and family violence, as well as punitive practices around entry into care.

As a result of these concerns, the Review makes the following recommendations:



Recommendation 59: The Department of Communities and Justice should ensure that all caseworkers receive further training in harm minimisation strategies for assumption or removal and in the appropriate use of police to assist with assumptions or removals. This training should be designed to improve cultural knowledge and the knowledge of Aboriginal child protection history, including child removal policies in the protection and assimilation era, with particular focus on the NSW chapter of the Royal Commission into Aboriginal Deaths in Custody.

Recommendation 60: Except for in an unforeseen emergency, caseworkers from the Department of Communities and Justice should be required to seek the authorisation of a team leader before engaging police to assist them to undertake an assumption or removal. In circumstances where caseworkers employ the assistance of police without prior authorisation, caseworkers must be required to justify why they engaged police to their team leader at the earliest opportunity following the assumption or removal. These reasons must be recorded on the child's file and presented to the Children's Court of NSW.

Recommendation 61: Caseworkers from the Department of Communities and Justice should be required to set out a detailed justification for the timing, location and basis for all assumptions and removals that are not conducted on an emergency basis prior to the assumption or removal occurring, and to demonstrate that their proposed method of assumption or removal is the least intrusive method that could be employed.

14. Recognising the harm of removal

Over the years as a carer I have come to know and understand many different traumas. The trauma that brought the child in to care; the trauma of having complete strangers in control of your life; the trauma of being placed with complete strangers; the trauma of never truly belonging; the trauma of never having your voice heard; the trauma of contact; and the trauma of an ongoing system with department, NGOs and a constant change.³⁸³

While there is still a lack of comprehensive data about outcomes for children in out-of-home care (OOHC), there is growing evidence that OOHC status is linked to poorer outcomes for children. This chapter examines the ‘harm of removal’, or the potential adverse consequences of removal on an Aboriginal child, family and community. It begins by discussing an issue that has been raised in many previous inquiries and remains of significant concern to the Aboriginal community—that is, the issue of abuse in care—and outlines the evidence gathered by this Review about the abuse in care experiences of Aboriginal children in the case review cohort. It then considers harm more broadly, examining other domains of harm associated with the removal of Aboriginal children from their families and community.

Abuse in care

Currently, there is no reliable national data about child abuse occurring in OOHC.³⁸⁴ This may be because, as Canadian scholar Cindy Blackstock has observed, there is a general reluctance to uncover the extent of the problem.³⁸⁵ This lack of focus on abuse in care is problematic, as it can ultimately lead to a situation where the state becomes ‘an omnipotent parent immune from the very obligations it enforces on families’.³⁸⁶

While existing data on abuse in care is incomplete and inadequate, the fact that children actually experience this abuse (both physical and psychological) has been noted in numerous previous inquiries.³⁸⁷ Most recently, in 2017, the Royal Commission into Institutional Responses to Child Sexual Abuse noted that it had heard from 257 people who had been sexually abused in contemporary OOHC (since 1990). The majority of these people were sexually abused in home-based care arrangements (66%), while the remainder were abused in residential care (37%).³⁸⁸

Other studies examining abuse in OOHC have reported that young people removed from families can be victimised in placements by carers and co-tenants, and may also be vulnerable to victimisation by people outside of the home.³⁸⁹ Additionally, other reports have highlighted

383 Legislative Council General Purpose Standing Committee No. 2, Inquiry into Child Protection, *Transcript*, 26 September 2016, 3.

384 Katherine McFarlane, ‘Child Protection Report Lacks Crucial National Detail on Abuse in Out-of-Home Care’ *The Conversation* (Online, 9 March 2018).

385 Cindy Blackstock, ‘Should Governments be above the Law article? The Canadian Human Rights Tribunal on First Nations Child Welfare’ (2015) 40(2) *Children Australia* 95, 101.

386 *Ibid.*

387 See, for example, Senate Community Affairs References Committee, *Forgotten Australians: A Report on Australians who Experienced Institutional or Out-of-Home Care as Children* (Report, August 2004).

388 *Royal Commission into Institutional Responses to Child Sexual Abuse*, (Final Report, Volume 12, Contemporary Out-of-Home Care, 2017), 12.

389 N Biehal, ‘Maltreatment in Foster Care: A Review of the Evidence’ 23 *Child Abuse Review* 48, cited in CREATE Foundation, *Youth Justice Report: Consultation with Young People in Out-of-Home Care about their Experiences with Police, Courts and Detention* (Report, 2018), 63.



systematic failings in residential workers' and child protection department responses to young people being exploited by adult predators. For example, the Victorian Commission for Children and Young People heard evidence in its review into the sexual abuse of children in residential care, that 'residential workers failed to assist with transporting young people at night—young people who were subsequently sexually assaulted. In addition, young people known to associate with older adults were not reported to police.'³⁹⁰

In NSW, the Office of the Children's Guardian (OCG) collects information about allegations of abuse in care. In 2017–18 it received notifications concerning 131 allegations of sexual misconduct or serious physical assault of a child or young person in statutory OOHC.³⁹¹ It is important to note, however, that any evidence about abuse in care is likely an undercount of the true prevalence of the problem. With this in mind, the data the Review gathered about abuse in care of Aboriginal children in OOHC is discussed below.

Data findings

The Review obtained FACS (Administrative) data about safety and abuse in care. These data show that Aboriginal children were more likely than non-Aboriginal children to experience substantiated actual or risk of harm while in OOHC (8.6% of Aboriginal children who entered care during the cohort period, versus 5.2% of non-Aboriginal children who entered care during the cohort period).³⁹² For most Aboriginal children who experienced abuse in care, the highest number experienced abuse from a current carer (40.4%), followed by a carer's friend or relative (aged over 18 years) (12.3%) or a parent (10.5%).³⁹³ Most (65.8%) Aboriginal children experienced abuse in an authorised FACS relative care setting (note that there is no indication as to whether the perpetrator was Aboriginal or non-Aboriginal), as did the highest number of non-Aboriginal children (45%).³⁹⁴

Half of Aboriginal children who experienced substantiated actual or risk of harm while in OOHC (52.6%) remained in the same placement where the harm or risk occurred after it had been reported (Figure 55). According to FACS (Administrative) data, where children remained in the same placement where substantiated harm or risk occurred, either a support or plan was put in place or the harm or risk was not related to the placement—although no data were provided to support this statement.³⁹⁵

It should be noted that the POCLS Wave 4 data provided to the Review also goes to the issue of safety in care, focusing on child reported data around feelings of safety, as well as feelings of being settled and happy in placements. Questions concerning safety in care were part of the Wave 4 interview. The children interviewed in the POCLS were aged 7–17 years and included children living in foster care, relative or kinship care, residential care, children who had been

390 CREATE Foundation, *Youth Justice Report: Consultation with Young People in Out-of-Home Care about their Experiences with Police, Courts and Detention* (Report, 2018) 6, citing findings from the Commission for Children and Young People (Victoria), '... As a good parent would ...': *Inquiry into the Adequacy of the Provision of Residential Care Services to Victorian Children and Young People who have been Subject to Sexual Abuse or Sexual Exploitation while Residing in Residential Care* (Report, August 2015).

391 Office of the Children's Guardian (NSW) *Annual Report 2017–18* (Report, 2018), 26.

392 Figure 52, Appendix A. It should be noted that this does not mean that the risk or harm that the child experienced was during an OOHC placement or an episode during this period. The risk or harm may have occurred during an OOHC placement or episode prior to the child's 2015/2016 entry into care.

393 Figure 53, Appendix A.

394 Figure 54, Appendix A.

395 Figure 55, Appendix A. According to FACSIR this statement is based on the reasons captured in the FACS administrative data. The data were not presented as children can have multiple substantiations each with a reason so it adds to more than the number of children.

restored and children who had been adopted.³⁹⁶ However, these data have not been used in this Review due to the small sample size of Aboriginal children, the lack of clarity about where children who were answering questions were placed, and the preclusion on the Review involving Aboriginal stakeholders in interpreting this data.

Submissions and consultations

The Review received several submissions addressing the risk of abuse for children in OOHC. For example the Benevolent Society stated that the overwhelming response of Aboriginal people it consulted with for the purposes of its submission, was that FACS and the child protection system caused ‘great fear and trauma for Aboriginal children, young people and their families’.³⁹⁷ It provided an account of an Aboriginal grandmother who had voiced her concerns about the likelihood of possible sexual assault of the grandchildren who were in the care of the Minister if they were placed with their paternal family for a week over Christmas.

I raised that to FACS at the time, the response was from the Acting Manager Client Services and it was:

‘I am letting you know, the children will have access to their paternal family, it will be for week.’

And she went so far as to bang her hand on the table.

I said ‘ok, that’s fine, alright so you’re saying my grandchildren aren’t at risk’ and I had it minuted and everything.

So in that week, my eldest grandchild was sexually assaulted by the 15-year-old at the house.

...

But in terms of support for my grandson, they’ve not given me any support at all. He was eight when he was assaulted, and my sister got him to a paediatrician, but he placed him on a heavy medication and when I got him I had to wean him off that, because he was falling asleep, he wasn’t responsive at school - nowhere.

But when your grandchild says to you ‘Nan, what do I do, I can’t sleep, all I can see, I just want to hurt my brothers and sisters’ and so I’m the last person to go to sleep in my house every night, and we’re trying lots of different things but in support from FACS? – no.³⁹⁸

In addition, Redfern Legal Centre submitted that many Aboriginal children suffer ‘significant and horrific abuse’ while in OOHC. It noted that Aboriginal young people rarely seek help for this trauma after leaving OOHC ‘due to shame, embarrassment or inability to identify a suitable agency to assist them’.³⁹⁹

396 NSW Department of Family and Community Services Insights Analysis and Research, *Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care* (Internal report on Wave 4 quantitative data for the Independent Review of Aboriginal Children in OOHC, 2019).

397 The Benevolent Society, Submission No 7 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

398 Ibid.

399 Redfern Legal Centre, Submission No 14 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 8.



Several case studies highlight some of the issues and complexities around abuse in care and the vulnerability of children who have been removed from their families and placed in state care. In Case 211, for example, FACS removed three children, including four year old twins, from their parents only for the older child to be sexually abused in care and for the twins to endure various short term separate crisis placements, significantly contributing to their experience of trauma, grief and loss.

In Case 29, two siblings were removed from a foster care placement after allegations of abuse and neglect were made against the carer, but two of the other siblings remained in this care arrangement. The reviewer raised concerns about the children's ongoing safety, including from the carer's older child, whose children had recently been taken into care. The rationale for leaving two of the children in this placement was not clear and separating the siblings was also identified as a weakness of practice in the case.

In another case, Case 59, a child was removed from her parents and placed in OOHC where she experienced inappropriate behaviour from the carer's son. The child was taken from this placement, but later returned after a safety plan was put in place with the carers. The reviewer raised concerns about the long-term welfare of the child in this placement and the adequacy of the safety plan.

In a similar case, Case 92, the carer's son had been convicted of sexual offences against a school peer. FACS had created a safety plan with the family which required the carers not to allow the Aboriginal child to be left alone with their son. Concerns were also raised in this placement about inappropriate disciplinary practices, including forcing the children to stand against the wall with their hands on their heads as punishment for misbehaviour. It did not appear that FACS ever responded to the excessive discipline issues raised in the case.

These cases not only highlight the vulnerability of Aboriginal children in OOHC, but also demonstrate some of the challenges around identifying abuse in care for the purposes of data collection and response. In many cases, it was identified that there was a lack of clarity around what the department considered abuse in care and what was considered discipline or punishment. Given the serious impact these experiences can have on children, further attention needs to be paid to the issue of abuse of children in state care across the range of different placement types. In particular, to uncover the full extent of the issue of abuse in care, children must be encouraged and supported to report allegations of abuse.

Recommendation 62: The Department of Communities and Justice should, in partnership with young Aboriginal people and Aboriginal community organisations, develop and implement a child-friendly system to encourage children in out-of-home care to report safety concerns and harm occasioned in out-of-home care placements.

The urgent need for data

In response to the evidence it was provided, the Royal Commission into Institutional Responses to Child Sexual Abuse recommended improving the Child Protection National Minimum Data Set to include information about children who had been sexually abused in OOHC.⁴⁰⁰

This Review repeats the view that there is an urgent need to improve data collection and reporting about abuse in OOHC, particularly as it relates to Aboriginal children. Data prepared for this Review relating to issues of safety in care, was limited to substantiated ROSH reports and there was little information on the cohort children's files where abuse in care issues were raised to indicate the consequence of disciplinary or other action taken against carers. In many cases, there was no indication as to whether or not disciplinary action or further reporting, for instance to the OCG, was taken at all. Improving Aboriginal children and young people's safety in care requires, as a first step, improving transparency around the nature and consequences of abuse in care allegations.

Recommendation 63: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community, design and implement a system for the collection, analysis and reporting of data around abuse of Aboriginal children in out-of-home care, including to disaggregate by the care placement type, who perpetrated the abuse, the department's response to the abuse, and whether the abuse was subject to further investigation or action.

The broader harms of removal

In addition to abuse in care, research indicates that children who are removed also often suffer physical, mental and cultural neglect across multiple agencies,⁴⁰¹ and that this can have a devastating effect on other indicators of success for a child or young person throughout the course of their life. For example, research from the United States has demonstrated 'those placed in foster care are far more likely than other children to commit crimes, drop out of school, join welfare, experience substance abuse problems, or enter the homeless population'.⁴⁰²

In Australia, the harm of removal also includes the process of 'care criminalisation'—that is, the process whereby children placed in OOHC are more likely to be involved in the juvenile justice system *by virtue of their OOHC status*.⁴⁰³ While data around this intersection between OOHC and juvenile justice is lacking, the Australian Law Reform Commission has recognised the importance of the link, noting that:

the incarceration rate of adult Aboriginal and Torres Strait Islander peoples cannot be fully and satisfactorily addressed without a national review of Aboriginal and Torres Strait Islander children in child protection, and the state and territory laws

400 Royal Commission into Institutional Responses to Child Protection (Final Report, 2017) rec 12.2.

401 Commission for Children and Young People, *Always Was, Always Will Be Koori Children: Systemic Inquiry into Services Provided to Aboriginal Children and Young People in Out-of-Home Care in Victoria* (2016), [345], [385], Table A16.

402 See Joseph Doyle, 'Child Protection and Child Outcomes: Measuring the Effects of Foster Care' 97 *American Economic Review* 1583.

403 Care criminalisation is discussed in Chapter 15.



that see such children placed into out-of-home care.⁴⁰⁴

As noted in Chapter 1, Their Futures Matter currently holds a large combined governmental dataset that includes data about the overlap between children in OOHC and children in the juvenile justice system. The Review was not able to access this data, however, once released it is hoped it will provide further insight into the ‘care criminalisation’ of Aboriginal children in OOHC.

Data relating to the Stolen Generations may also be useful to inform and frame the issue of the harm of removal for Aboriginal children. For example, data from the Australian Institute of Health and Welfare (AIHW)⁴⁰⁵ indicates that members of the Stolen Generation were more likely to have been charged by police, been to jail and felt discriminated against, as well as being less likely to own their own home and be in good health.⁴⁰⁶ The effects also appear to be intergenerational. The AIHW found that the descendants of this population were also consistently more likely to have experienced adverse outcomes across numerous health, socioeconomic and cultural indicators compared with a reference group of Indigenous people aged 18 years and over, who reported not being removed themselves, nor having relatives removed.⁴⁰⁷

Submissions received by the Review addressed the issue of the harm of removal. For example, some stakeholders expressed concern that there is an apparent policy assumption that ‘a life in care will provide better outcomes for children at risk than any alternative’⁴⁰⁸ and that FACS operates on the assumption that a ‘better’ child protection system is one that removes more children, as opposed to one that avoids removal by supporting families.⁴⁰⁹ Others noted that FACS fails to acknowledge that the removal of Aboriginal children from their families often exposes them to danger and ‘immense trauma’, as opposed to ‘protection’,⁴¹⁰ and that FACS intervention in and of itself is an extremely arduous, traumatic process that is actively harmful to all involved, particularly children.⁴¹¹

Further, the National Congress of Australia’s First Peoples noted that children who entered OOHC were likely to suffer negative long-term outcomes, including encounters with the justice system.⁴¹² Children and young people leaving OOHC were more likely to have poor education, be unemployed, underemployed or earning low wages, be homeless, have children at a young age, have health and substance abuse problems, and lack social support.⁴¹³

The issue of the ‘harm of removal’ was raised in 2017 during the Legislative Council General

404 Australian Law Reform Commission, *Pathways to Justice—Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC 133, 2018) [15.4].

405 Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Stolen Generations and Descendants Numbers, demographic characteristics and Selected Outcomes* August 2018 (accessed 30 June 2019) <<https://www.aihw.gov.au/getmedia/a6c077c3-e1af-40de-847f-e8a3e3456c44/aihw-ihw-195.pdf.aspx?inline=true>>.

406 Ibid.

407 Ibid.

408 National Congress of Australia’s First Peoples, Submission No 22 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 3.

409 Ibid 1.

410 Ibid 2, 7.

411 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 2.

412 National Congress of Australia’s First Peoples, Submission No 22 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018.

413 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 8.

Purpose Standing Committee No 2's inquiry into child protection in NSW. During the course of the Review, the Committee was informed that existing provisions of the *Care Act* were sufficiently broad to enable the Children's Court to take into account the harm of removing a child from his or her family. For example, underpinning the general principles of the *Care Act* was the acknowledgement that the removal of a child may damage the child or young person, and the concept of the welfare and wellbeing of the child, which is always considered by the court, encompassed a consideration of the harm of removal.⁴¹⁴ Further, the Committee heard that, through experience, magistrates of the Children's Court had a detailed knowledge of the damage that could be caused by removal, in addition to the damage that could be caused by leaving a child at risk. Thus they were well-equipped and able to balance these relevant considerations when making their judgments.⁴¹⁵

The General Purpose Standing Committee No 2, however, was not convinced that it had been demonstrated that the Children's Court adequately took into account the body of evidence about the intergenerational nature of child removals, or the effect of child removal on other wellbeing indicators, such as 'educational performance, substance abuse, work opportunities and life expectancy'.⁴¹⁶ Accordingly, it recommended

that the NSW Government amend the Children and Young Persons (Care and Protection) Act 1998 to include a specific provision requiring the Children's Court of New South Wales to consider the known risks of harm to a child of being removed from their parents or carer and placed into care, together with the risks of leaving the child in their current circumstances, when making a decision on potential child removal in care and protection proceedings.⁴¹⁷

In its response to the Review, the NSW Government submitted that an amendment to the *Care Act* was not required as its provisions sufficiently enabled the Children's Court to take into account the impact of removal on the child, including any detriment to the child, when making an order.⁴¹⁸ Further, the NSW Government submitted that the provisions of the *Care Act*, as supported by FACS policies, including as strengthened by a revised practice framework that was due to be released in October 2017, ensured the transparency of FACS' decisions concerning the risk of harm of removal and enriched the monitoring of quality assurance measures.⁴¹⁹

414 National Congress of Australia's First Peoples, Submission No 22 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018.

415 Answers to questions on Notice, Judge Johnstone, cited in Legislative Council General Purpose Standing Committee No 2 (NSW), *Child Protection* (2017), [4.50].

416 Legislative Council General Purpose Standing Committee No 2 (NSW), *Child Protection* (2017), [4.51].

417 Legislative Council General Purpose Standing Committee No 2 (NSW), *Child Protection* (2017), rec 281.

418 Specifically ss 79(3) and 9 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

419 New South Wales Government, *Response to Report 46 of the Legislative Council Portfolio Committee No 2—Health and Community Services—Child Protection* (September 2017), 12–13.



The need for legislative reform

The Review remains concerned that the harm of removal may not be adequately taken into account by Children’s Court Magistrates when adjudicating care and protection proceedings. The Review concurs with the recommendation of the General Purpose Standing Committee No 2 that the *Care Act* should be amended to include a provision directing the Children’s Court to consider the harm of removal when making decisions to remove children from their families, or maintain the separation of children from their families.

The Review accepts that Children’s Court Magistrates are experienced judicial officers and that by virtue of their role, will have an appreciation of the need to balance the risk of harm if a child remains in their home environment with the risk of harm if a child is removed. However, the Review also notes that the depth of knowledge of individual Magistrates will vary, according to their level of experience, and notes that some Children’s Court matters in regional areas are dealt with by non-specialist Magistrates, who may have little time to devote to the care and protection matter while adjudicating a busy court list. The inclusion of a legislative provision directing attention to the harm of removal will unambiguously signal to all Magistrates that removal is often a harmful practice that must be undertaken with due care.

The Review also considers that data about the harm of removal is in its infancy and that it is important to contain a legislative reminder that judicial officers should keep abreast of this emerging empirical evidence. This should be weighed and balanced in care and protection proceedings. For example, new information has emerged recently about the sexual abuse of children in OOHC as a result of the Royal Commission into Institutional Responses to Child Sexual Abuse and as discussed above, there is a growing body of data about the link between OOHC status and involvement in the juvenile justice system. This Review has also noted that the evidence it has analysed indicates that one quarter of mothers of children in the cohort had previously been in an OOHC arrangement themselves as a child (25.5%), suggesting that OOHC issues may have intergenerational dimensions.⁴²⁰

Further, evidence uncovered by the Review about the frequency with which FACS presents misleading information to the Children’s Court during care and protection proceedings calls into question the court’s ability to adequately balance the relevant harms on the basis of the information provided to it.⁴²¹ The withholding of evidence may also affect the Court’s ability to engage in the relevant judicial balancing act by obscuring the issue of the harm of OOHC. For example, in *In the Matter of Mr Donaghy (Costs)*, the Children’s Court Magistrate observed that:

The reason for the matter not being completed was not the fault of any of the practitioners involved. Mr Donaghy for the mother cross-examined the principal caseworker who disclosed that the children had been mistreated by the foster carers arranged by Life Without Barriers, and that they had recently been relocated. This mistreatment included assaults and being locked inside their rooms for extended periods, with locks on the outside of the doors. There was nothing in the affidavit material by Departmental officers to indicate these dreadful occurrences.⁴²²

420 See Chapter 23.

421 See Chapter 6.

422 *In the matter of Mr Donaghy (Costs)* [2012] NSWChC 11 (emphasis added) <<https://www.caselaw.nsw.gov.au/decision/54a637ae3004de94513d9af2>>.

While a legislative provision instructing judicial officers to consider the harm of removal will not necessarily ameliorate the problem of the Children’s Court not being provided with all of the relevant evidence upon which to base its decision, or being provided with misleading information, it will serve as a constant legislative reminder of the need to closely scrutinise the quality of the evidence presented to justify the removal of a child from his or her family, or justify an argument that a child should not be restored to his or her family.

Finally, the Review is of the perspective that there is a specific element of cultural harm that the Court should consider in matters involving Aboriginal children. In Part E, the Review discusses how the elements of the Aboriginal Child Placement Principle (ACPP) are poorly understood in NSW. In particular the Review notes with concern that Aboriginal carers are often overlooked when placing Aboriginal children in OOHC. There is also often limited compliance with requirements of the ACPP to ensure that children in OOHC remain connected to their family by way of placement with siblings, sibling and family contact and cultural planning and connected to their country. Accordingly, it is important to recognise that removal of an Aboriginal child may damage the child’s connection to culture.

Recommendation 64: The NSW Government amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to require judicial officers to consider the known risks of harm to an Aboriginal child of being removed from the child’s parents or carer in child protection matters involving Aboriginal children.



15. Care criminalisation

Background

The link between out-of-home care (OOHC) and involvement in the criminal justice system is well established in Australia.⁴²³ As early as 1991, the Royal Commission into Aboriginal Deaths in Custody noted that almost half of the 99 Aboriginal and Torres Strait Islanders whose deaths had been reviewed had been removed from their families, either through ‘intervention by the State, mission organisations or other institutions’.⁴²⁴ More recently, the Australian Institute of Health and Welfare found that children and young people who were in OOHC were 16 times more likely than other children to be under youth justice supervision.⁴²⁵

In NSW, the correlation between a child or young person’s placement in OOHC and his or her involvement in criminal offending has been noted in a number of recent reports and academic articles.⁴²⁶ For example, a 2012 study of the Children’s Court in New South Wales (NSW) stated that:

a central issue that emerged from the data analysis relates to the overlap between the two jurisdictions of the Children’s Court. Many of the young people in the juvenile justice system have a history of contact with the statutory department and multiple foster care placements.⁴²⁷

Similarly, a 2015 study by scholar Kath McFarlane revealed that children in OOHC were grossly over-represented in criminal proceedings, with almost half of the 160 children whose cases were reviewed as part of the study having a history of OOHC and over half of these children being identified as Indigenous.⁴²⁸ This overlap between OOHC and involvement in the criminal justice system has been shown to continue into early adulthood.⁴²⁹

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- 423 See, example, Alison Gerard et al, ‘“I’m not getting out of bed!” The criminalisation of young people in residential care’ (2019) 52(1) *Australian & New Zealand Journal of Criminology* 76; Kath McFarlane, ‘Care- criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system’ (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412; CG Malvaso and P Delfabbro, ‘Offending behaviour among young people with complex needs in the Australian out-of-home care system’ (2015) 24(12) *Journal of Child and Family Studies* 3561; Clare Ringland, Don Weatherburn and Suzanne Poynton, ‘Can child protection data improve the prediction of re-offending in young persons?’ (2015) 188 *NSW Bureau of Crime Statistics and Research: Crime and Justice Bulletin* 1.
- 424 *Royal Commission into Aboriginal Deaths in Custody* (Final Report, 1991) vol 1, 2.2.9; Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (Report, 1997) 166.
- 425 Australian Institute of Health and Welfare, *Young people in child protection and under youth justice supervision 1 July 2013 to 30 June 2017* (Report, No 24, 2018) 16. See also *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report) vol 3B; House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Doing Time—Time for Doing: Indigenous youth in the criminal justice system* (Report, June 2011) 3.134; Joy Wundersitz *Indigenous perpetrators of violence: Prevalence and risk factors for offending* (Report, No 105, 2010).
- 426 Judge Peter Johnstone, ‘Cross-Over Kids—The Drift of Children From the Child Protection System Into the Criminal Justice System’ (Speech, Noah’s on the Beach, 5 August 2016) 22; Elizabeth Fernandez et al, *A study of the Children’s Court of New South Wales* (Report, 2014) 25; Kath McFarlane, ‘Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system’ (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412, 418.
- 427 Elizabeth Fernandez et al, *A study of the Children’s Court of New South Wales* (Report, 2014) 25.
- 428 Kath McFarlane, ‘Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system’ (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412, 418.
- 429 *Ibid* 413, 418.

Why are children in OOHC over-represented in the criminal justice system?

What is less clear, however, is *why* children in OOHC are over-represented in the criminal justice system. One theory, for example, is that the pre-care experiences of children who are removed from their homes (such as abuse, neglect and exposure to domestic violence) give rise to risk factors for delinquency (such as emotional and behavioural problems or substance misuse).⁴³⁰ Another theory is that these pre-existing risk factors are then 'exacerbated at key transition points, such as moving into or exiting the care system, which may then initiate or aggravate offending'.⁴³¹ Further, it has been noted that Aboriginal children face additional pre-care difficulties that may impact on later criminal behaviour that arise 'from the legacy of racist policies of past forcible removal, intergenerational trauma and disconnection from culture'.⁴³²

However, there is also now 'strong evidence' for the negative effects of the placement of children and young people with a history of maltreatment in OOHC, particularly in residential care.⁴³³ In other words, it has now been demonstrated that placement in OOHC exacerbates the existing risk that maltreated children will become involved in criminal offending. This occurs by way of a 'care-criminalisation' process, by which children and young people in OOHC are arrested for behaviour that would usually result in a disciplinary response from parents and not a criminal justice related response from police officers. For example, children may be arrested for offences that occur in their placements, such as damage to property or assaults against staff or kinship carers.⁴³⁴ As Victoria Legal Aid has noted:

Typically, a minor confrontation over, for example, a failure to obey an instruction by a staff member triggers an outburst by the young person and a display of challenging behaviour. Unit staff call police and the young person is charged with assault, criminal damage or other related offences. In many instances, the attendance of the police further escalates the situation, with the young person then sometimes accruing additional charges for resisting arrest or assaulting police.⁴³⁵

CREATE Foundation noted:

biological parents may be more concerned about the ongoing effects conviction would have on their relationship, whereas in the OOHC environment caregivers may need to file a report to the police to access insurance claims, or experience pressure to adhere to OOHC care policies and procedures.⁴³⁶

430 See, for example, *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report) vol 3B, 17.

431 See Kath McFarlane, 'Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system' (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412, 415.

432 Victoria Legal Aid, *Care not Custody* (Report, 2017) 7.

433 Catia G Malvaso, Paul H Delfabbro and Andrew Day, 'Risk factors that influence the maltreatment-offending association: A systematic review of prospective and longitudinal studies' (2016) 31 *Aggression and Violent Behavior* 1, 6.

434 Judy Cashmore, *The link between child maltreatment and adolescent offending: Systems neglect of adolescents* (Report, No 89, 2011); Kath McFarlane, 'Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system' (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412, 416; Kath McFarlane, 'From care to custody: Young women in out-of-home care in the criminal justice system' (2010) 22(2) *Current Issues in Criminal Justice* 345; Victoria Legal Aid, *Care not Custody* (Report, 2017); Alison Gerard et al, 'I'm not getting out of bed!' The criminalisation of young people in residential care' (2019) 52(1) *Australian and New Zealand Journal of Criminology* 76.

435 Victoria Legal Aid, *Care not Custody: Consultation with young people in out-of-home care about their experiences with police, courts and detention* (Report, 2017) 11.

436 Create Foundation, *Youth Justice Report* (Report, 2018) 62.



In addition, the process of ‘care criminalisation’ may occur when children in OOHC are arrested for breach of bail conditions ‘arising from over-scrutiny and policing of residential care homes.’⁴³⁷ Further, children in OOHC are also more likely to be remanded in custody, ‘often because they have insecure accommodation or lack a support network’.⁴³⁸ As the former President of the NSW Children’s Court has observed

often the young person will remain in custody and bail refused until appropriate accommodation can be found ... some argue (with justification) that these young persons remain improperly in custody essentially for welfare reasons rather than justice-related reasons’.⁴³⁹

In addition to this clear process of ‘care-criminalisation’, there are other features of the OOHC system that exacerbate the risk of criminal offending. For example, ‘placement instability’, or having multiple OOHC placements, has also been consistently shown to have a detrimental effect on later criminal behaviour.⁴⁴⁰ As Sarah DeGue and Cathy Widom explain:

although these multiple placement changes may be, in part, because of pre-existing behaviour problems, our results pointed to an independent effect of placement instability on adult arrest risk when controlling for early behavioural problems and delinquency. Thus, it may be that other potential effects of placement instability, such as reduced opportunities for bonding and social support, school and neighbourhood changes, continued system involvement and monitoring, and increased anger or anxiety resulting from the loss of multiple caregivers or siblings, could compound any initial behavioural difficulties and result in a steady increase in criminality risk over time.⁴⁴¹

The loss of connection to family and culture may also increase the risk that Aboriginal children in OOHC will become involved in the criminal justice system. As the Senate Standing Committee on Social Welfare observed in 1985:

The process of care, particularly wardship, has a momentum of its own that carries a child through a series of placements and through a series of officers, so that family and kin ties are weakened, personal identity is confused, and self-esteem is low, to the point where anti-social behaviour makes correctional care necessary.⁴⁴²

Other features of OOHC that may increase the risk of criminal offending include: the lack of

437 Kath McFarlane, ‘Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system’ (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412, 416.

438 Alison Gerard et al, ‘I’m not getting out of bed!’ The criminalisation of young people in residential care’ (2019) 52(1) *Australian and New Zealand Journal of Criminology* 76; Kath McFarlane et al, ‘Just another policy document? Can a protocol end the criminalisation of kids in care?’ (2019) 44(1) *Alternative Law Journal* 37.

439 Kath McFarlane, ‘Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system’ (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412, 155.

440 See, example, Sara Goodkind et al, ‘From Child Welfare to Juvenile Justice: Race, Gender, and System Experiences’ (2012) 11(3) *Youth Violence and Juvenile Justice* 249, 251, 265; S DeGue and C Spatz Widom, ‘Does out-of-home placement mediate the relationship between child maltreatment and adult criminality?’ (2009) 14(4) *Child Maltreatment* 344, 352; Kath McFarlane, ‘Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system’ (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412, 421; Catia G Malvaso, Paul H Delfabbro and Andrew Day, ‘Risk factors that influence the maltreatment-offending association: A systematic review of prospective and longitudinal studies’ (2016) 31 *Aggression and Violent Behavior* 1, 7; Judy Cashmore, *The link between child maltreatment and adolescent offending: Systems neglect of adolescents* (Report, No 89, 2011) 35.

441 S DeGue and C Spatz Widom, ‘Does out-of-home placement mediate the relationship between child maltreatment and adult criminality?’ (2009) 14(4) *Child Maltreatment* 344, 352. See also Goodkind et al, who state that ‘placement instability often precedes justice system involvement and thus is an identifiable risk factor’: Sara Goodkind et al, ‘From Child Welfare to Juvenile Justice: Race, Gender, and System Experiences’ (2012) 11(3) *Youth Violence and Juvenile Justice* 249, 265.

442 Senate Standing Committee on Social Welfare, *Inquiry into Children in Institutional and Other Forms of Care: A National Perspective* (Report, 1985) 18.

access to support services to address a child's trauma, mental health problems or learning difficulties; the risk of trauma occurring in OOHC (for example, as a result of abuse by a carer); the criminalising influence of other children in residential care; failed restoration attempts; and limited support for OOHC leavers.⁴⁴³ Further, a 2017 report by the NSW Ombudsman found that school attendance for children in OOHC was poor, with 128 out of 295 children (43%) missing 20 or more school days in 2016 for reasons other than illness.⁴⁴⁴ This finding is of particular concern, as education reduces the risk that a child will become involved in criminal behaviour.⁴⁴⁵

Submissions and consultations

The President of the Children's Court of NSW, Judge Peter Johnstone, submitted that he was acutely aware of the need to address the 'cross-over' of children and young people from the care jurisdiction into the crime jurisdiction of the Children's Court.⁴⁴⁶ He expressed concern that roughly 40 percent of children in residential OOHC do not attend school, noting that 'education is the biggest protective factor against engagement in criminal behaviour', and recommended that consideration be given to improving school attendance for children in OOHC. Further, he noted that connection to culture and community was another important protective factor that reduced the likelihood that Aboriginal children would engage in criminal behaviour.⁴⁴⁷

Kath McFarlane, a scholar at Charles Sturt University, addressed the issue of the interaction between the OOHC system and the criminal justice system in detail in her submission. After outlining her prior doctoral and professional research into the issue, she submitted that the 'care-criminalisation policy vacuum has serious implications for practice'.⁴⁴⁸ She also submitted that s 28 of the *Bail Act 2013* (NSW), which permits a court to order bail on the condition that the child obtains suitable accommodation, means that a child 'may be detained in circumstances where a homeless adult, charged with a like offence would not'.⁴⁴⁹

The lack of support from the department

The plight of children in OOHC involved in the criminal justice system is further compounded by the fact that they do not always receive support from the department—when the department is their 'parent'—during police investigations or the court proceedings.⁴⁵⁰ In a 2016 national survey of children in OOHC, CREATE Foundation found that 34% of children and young people in care did not receive support from the relevant child protection agency when being interviewed by police.⁴⁵¹ In her 2015 study of NSW Children's Court cases, Kath McFarlane noted that:

443 Victoria Legal Aid, *Care not Custody: Consultation with young people in out-of-home care about their experiences with police, courts and detention* (Report, 2017) 7.

444 NSW Ombudsman, *NSW Ombudsman Inquiry into behaviour management in schools: A special report to Parliament under s 31 of the Ombudsman Act 1974*, (Report, August 2017) xi.

445 The Victoria Institute, *Education at the Heart of the Children's Court Evaluation of the Education Justice Initiative* (Final Report, December 2015) 2.

446 Children's Court of New South Wales, Submission No 18 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, November 2017.

447 Ibid.

448 Dr Kath McFarlane, Submission No 19 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

449 Ibid.

450 NSW Law Reform Commission, *Young Offenders* (Report, No 104, 2005) 8.142.

451 Create Foundation 2016 National Survey, cited in *Royal Commission into the Protection and Detention of Children in the Northern Territory* (Final Report) vol 3B, 25.



although 58% of the children had been placed in OOHC until age 18, in over a third of the files there was no evidence of assistance being provided by the child welfare department or a non-government organisation. That is, the children were not supported at the police station or at court, and no background report or other documentation was on file. In another third of cases, this had led to complaints about departmental inaction by other agencies, such as police, juvenile justice or a legal service. Only half of the under-13 cohort was accompanied at court by a caseworker, and an agency background report or letter in support had been provided to the Court in just five cases (42%).⁴⁵²

The failure to provide a support person to a child or young person in OOHC who is in contact with the juvenile justice system is highly undesirable. As a result of this failure, ‘the Court misses out on the full information about the young person’s circumstances ... and the young person misses out on the guidance and assistance of a support person’.⁴⁵³ Currently, the Children’s Court may require one or more *parents* to attend criminal proceedings relating to their child.⁴⁵⁴ However, there is no obligation, legislative or otherwise, on a representative of DCJ or a non-government OOHC agency to attend court as a support person. Under the Joint Operational Practice Guidelines that accompany the existing memorandum of understanding between FACS and the Department of Juvenile Justice, support is to be provided to a young person appearing before court in a criminal matter and this ‘may include’ attendance by a support person at the court proceeding.⁴⁵⁵

The NSW Law Reform Commission has recommended that consideration be given to amending the definition of ‘parent’ in the *Children (Protection and Parental Responsibility) Act 1998* (NSW) to ensure that a representative of the department appears at criminal hearings involving children in OOHC, or at the least the Children’s Court be granted the power to order the attendance of a delegate of the Secretary of FACS.⁴⁵⁶ Similarly, a report for the Minister of Juvenile Justice prepared in 2010 recommended that ‘Community Services attend court with children and young people under the care of the Minister for Community Services...’.⁴⁵⁷

It is important to note, however, that the presence of a caseworker from the department or a non-government OOHC provider does not necessarily indicate that appropriate support will be given to the child in question. For example, it is of great concern that Kath McFarlane’s study revealed that at times FACS ‘lobbied for children to remain in custody “for their own protection”’.⁴⁵⁸ This approach is clearly in contravention of the domestic and international principle that imprisonment should be a sanction of last resort,⁴⁵⁹ and is also in contravention of the view of FACS and Juvenile Justice that ‘it is not acceptable for a child/young person to enter or remain on remand, solely due to a lack of suitable alternative accommodation/placement’.⁴⁶⁰

452 Kath McFarlane, ‘Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system’ (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412, 421.

453 NSW Law Reform Commission, *Young Offenders* (Report, No 104, 2005) 8.142.

454 *Children (Protection and Parental Responsibility) Act 1997* (NSW) s 7.

455 Family and Community Services and NSW Justice, *Joint operational practice guidelines to accompany the memorandum of understanding between Department of Family and Community Services and Department of Justice, Juvenile Justice about children or young people who are shared clients of Family and Community Services and Juvenile Justice* (Report, 2014) 7.4.

456 NSW Law Reform Commission, *Young Offenders* (Report, No 104, 2005) 8.8.

457 Noetic Solutions, *A Strategic Review of the NSW Juvenile Justice System: Report for the Minister for Juvenile Justice* (Report, April 2010) 105.

458 Kath McFarlane, ‘Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system’ (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412, 424.

459 See, for example, art 37 CROC;

460 Family and Community Services and NSW Justice, *Joint operational practice guidelines to accompany the memorandum of understanding between Department of Family and Community Services and Department of Justice, Juvenile Justice about children or*

The Review is of the position that it is unacceptable for Aboriginal children to be required to navigate the court system without the assistance of an adult who has parental responsibility for the child. In particular, the provision of support to a child during court proceedings may reduce his or her fear and anxiety (by providing emotional or practical support) and help to facilitate better justice outcomes (by, for example, demonstrating that the child has support to follow bail conditions).⁴⁶¹ In research conducted by CREATE Foundation, 8 out of 86 young offenders specifically identified the need for more support from departmental caseworkers during their contact with the criminal justice system.⁴⁶²

There is no reason, in principle or practice, that FACS should not have a legal obligation corresponding to that placed on parents to attend a criminal hearing if requested by a court. For this reason, the Review is of the opinion that a court should have the power to mandate the attendance of a DCJ caseworker in individual cases. This power should be available regardless of whether or not the child is case managed by a non-government OOHC provider. In almost all cases, caseworkers from both DCJ *and* the non-government OOHC provider should be present. This will enable the timely resolution of issues about the child's placement. For example, the presence of a DCJ caseworker is highly desirable in circumstances where the funded OOHC provider is unable to guarantee the safety of the child if the child is released on bail and it appears that the transfer of case management back to DCJ is required. It may also help to ensure that children who receive a bail condition that requires suitable arrangements for their accommodation to be made before they are released on bail (an 'accommodation requirement'),⁴⁶³ are released from custody more expeditiously.

Recommendation 65: The NSW Government should amend s 7 of the *Children (Protection and Parental Responsibility) Act 1998* (NSW) to enable a court exercising criminal jurisdiction, with respect to a child, to require the attendance of a delegate of the Secretary of the Department of Communities and Justice in circumstances where the Secretary has parental responsibility of the child.

young people who are shared clients of Family and Community Services and Juvenile Justice (Report, 2014) 5.7.

461 Create Foundation, *Youth Justice Report* (Report, 2018) 16.

462 Ibid 52.

463 *Bail Act 2013* (NSW) s 28.



The response of the criminal justice system

Despite being aware of the existence of ‘cross-over kids’, stakeholders in the criminal justice system may not be sufficiently aware of, or receptive to, their vulnerability. For example, judicial officers may not seek to tailor their sentences or bail conditions to accommodate the unique circumstances of children in OOHC.⁴⁶⁴ Research indicates that some young people believe that magistrates hold ‘prejudiced attitudes’ towards them based on their OOHC status.⁴⁶⁵ CREATE Foundation has argued that there is a need for a more trauma informed justice system that recognises the impact of trauma on behaviour and cognitive processes, screens for trauma, uses non-stigmatising language, refrains from punitive responses and reduces the risk of re-traumatisation.⁴⁶⁶

In the United Kingdom, greater attention has been placed on the issue of ‘looked after’ children in the criminal justice system. For example, in the UK the decision to prosecute a looked after child for a low-level offence committed within a children’s home should only be made by a youth specialist, and the Crown Prosecution Service has published guidance as to why children in residential homes are at high risk of offending behaviour, which are to be considered when making a decision about whether or not to prosecute a child.⁴⁶⁷ Further, the Sentencing Council has published guidance on the matters that judicial officers should bear in mind when dealing with ‘looked after’ children, including their ‘additional complex vulnerabilities’, that they may receive limited parental-type support throughout the criminal justice process, that they may have been charged with a low-level offence that would not be the subject of criminal proceedings ‘if it had occurred in an ordinary family setting’, and the impact any sentence may have on a young person’s transition out of care.⁴⁶⁸

It is imperative that the drift of children in OOHC to the criminal justice system is addressed as a matter of urgency

There is a need to ensure judicial awareness of care criminalisation and of the matters that should be considered when sentencing or otherwise dealing with children in OOHC. It is well recognised that juvenile detention is a ‘key driver of adult incarceration’ for Aboriginal people⁴⁶⁹ and that many children are placed in OOHC due to parental incarceration.⁴⁷⁰ Further, having a criminal record increases the likelihood of poor socioeconomic outcomes, such as unemployment, substance abuse and poverty,⁴⁷¹ and poor socioeconomic status is also linked to child removals. It is imperative that the drift of children in OOHC to the criminal justice system is addressed as a matter of urgency to reduce the number of Aboriginal children in OOHC in the future.

464 Kath McFarlane, ‘Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system’ (2018) 51(3) *Australian and New Zealand Journal of Criminology* 412, 416.

465 Create Foundation, *Youth Justice Report* (Report, 2018) 59.

466 Ibid 65

467 Crown Prosecution Service, Legal Guidance Youth Offenders, available at <https://www.cps.gov.uk/legal-guidance/youth-offenders>.

468 Sentencing Council, *Sentencing Children and Young People: Overarching Principles and Offence Specific Guidelines for Sexual Offences and Robbery, Definitive Guideline* (Report, 1 June 2017) 1.16.

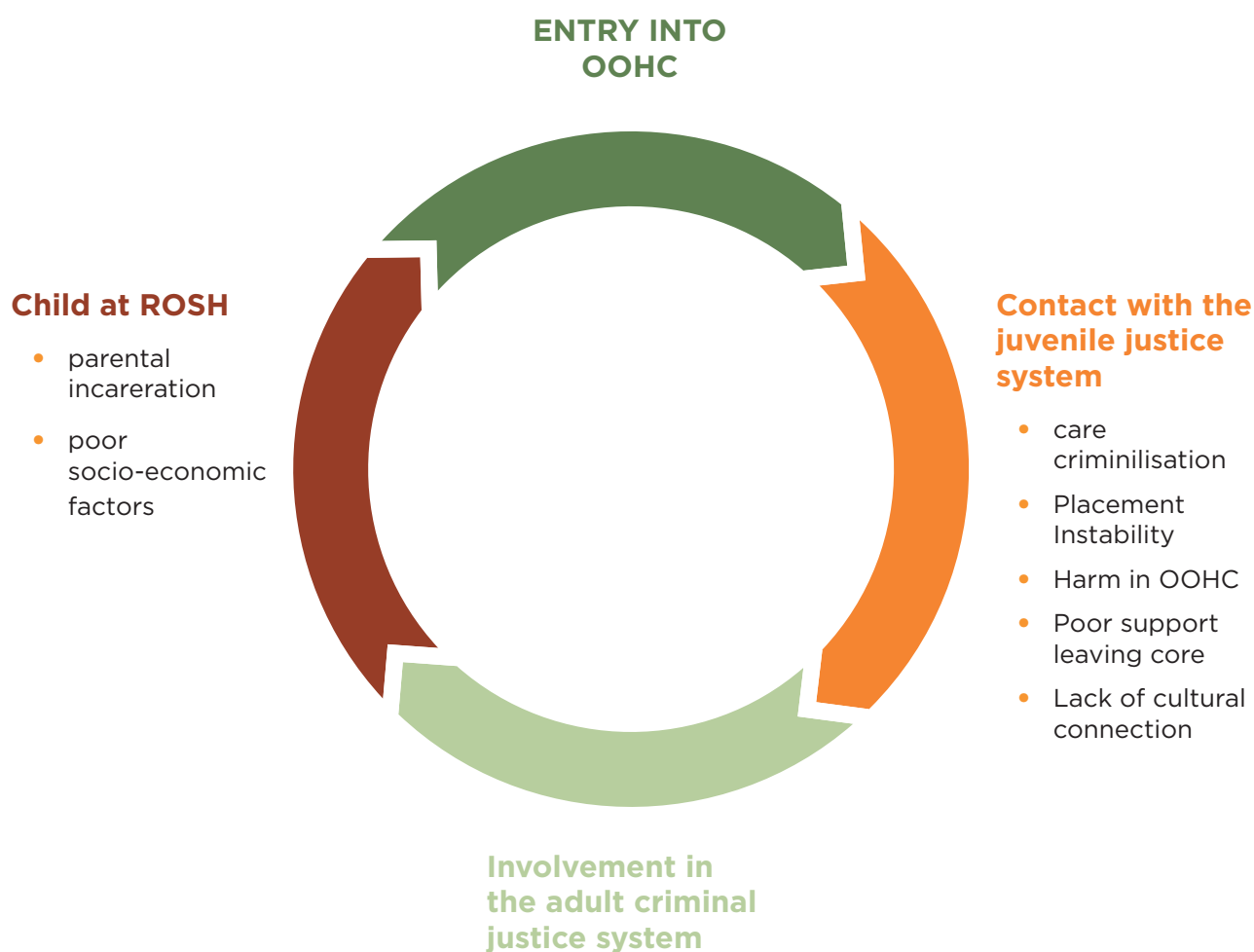
469 Australian Law Reform Commission, *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Final Report, December 2017) 15.6.

470 See Standing Committee on Law and Justice, *Crime Prevention through Social Support Second Report* (Report, 2000) 471.

471 Australian Law Reform Commission, *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Final Report, December 2017) 15.6.

Recommendation 66: The Judicial Commission of NSW should prepare and publish information to further guide and inform judicial decision-making involving children in out-of-home care in the criminal jurisdiction.

Care criminalisation





The 'Joint Protocol'

In NSW, some reform was attempted with the implementation of the *Joint Protocol to reduce the contact of young people in residential OOHC with the criminal justice system* (signed in August 2016). The joint protocol aims to prevent the criminalisation of children in residential placements by providing guidance to OOHC staff and police about appropriate responses to incidents in residential OOHC services. Developed by the NSW Ombudsman (in consultation with NSW Police, Legal Aid NSW, FACS and several OOHC providers), it states that police should not generally be called to respond to 'challenging behaviours' (unless there is a safety risk), and that the arrest and detention of a young person should only be used as a last resort.⁴⁷² Instead, a trauma-informed approach should be adopted to address the behaviour of young people in OOHC.⁴⁷³

It is not yet clear whether the existence of the protocol will actually change practice in this area. As McFarlane et al noted, the protocol may become 'just another failed initiative unless supported and adequately communicated and resourced'.⁴⁷⁴ In particular, due to high staff turnover rates, residential OOHC care providers will need 'a programme of continuous training' to ensure the protocol is properly implemented.⁴⁷⁵ Despite this, it appears that arrangements for training staff about the protocol have not been finalised.⁴⁷⁶ FACS has stated that residential care providers 'must adhere to the Joint Protocol' and 'must also ensure that all staff to whom the Joint Protocol applies have undertaken the mandatory training, as identified by FACS'.⁴⁷⁷ In its submission to the Inquiry into the Adequacy of Youth Diversionary Programs in NSW,⁴⁷⁸ the Law Society of NSW noted that its members were:

Aware of instances where OOHC caseworkers and police have either not been aware of the joint protocol or have lacked an understanding of its operation. This has led to OOHC workers contacting the police without consulting the joint protocol and considering whether there is an alternative and appropriate means of dealing with an incident.⁴⁷⁹

An evaluation of the protocol has been commissioned and is due to report in 2018-19.⁴⁸⁰

The Review is of the opinion that the development of the Joint Protocol to reduce the contact of young people in OOHC with the criminal justice system is a laudable policy approach to the criminalisation of children in OOHC. However, for it to have any impact on the 'care-

472 NSW Ombudsman, *Joint Protocol to reduce the contact of young people in residential OOHC with the criminal justice system*, (August 2016), [1.1].

473 Ibid [2.1].

474 Kath McFarlane et al, 'Just another policy document? Can a protocol end the criminalisation of kids in care?' (2019) 44(1) *Alternative Law Journal* 37, 5.

475 Ibid 6.

476 Ibid 5. Note that it appears that a Joint Protocol Complex Training module is available online for all NSW residential care providers and staff, and that the NSW Police Force has developed an online training module available to all police staff: Legislative Assembly of NSW Law and Safety Committee, *The Adequacy of Youth Diversionary Programs in New South Wales* (Report, No 2, September 2018), 3.142, 3.145.

477 Family and Community Services, *Special Conditions for Residential Care Program Level Agreement (PLA) 2017-2018* (Report, August 2017).

478 Legislative Assembly of NSW Law and Safety Committee, *The Adequacy of Youth Diversionary Programs in New South Wales* (Report, No 2, September 2018).

479 Law Society of New South Wales, Submission to the Legislative Assembly's Committee on Law and Safety, *Inquiry into the Adequacy of Youth Diversionary Programs in NSW* (20 February 2018)12.

480 Kath McFarlane et al, 'Just another policy document? Can a protocol end the criminalisation of kids in care?' (2019) 44(1) *Alternative Law Journal* 37, 3.

criminalisation' process, it is imperative that OOHC and police officers are educated about the existence of the protocol and how it should operate in practice. To date, there has been insufficient commitment to the ongoing training of OOHC staff and police about the protocol, which increases the risk that it will become 'just another policy document'.⁴⁸¹ The Review has concluded that DCJ and the NSW Police Force should establish and fund an ongoing training program to ensure that *all* OOHC staff and police officers are aware of the aims and content of the protocol.

Recommendation 67: The Department of Communities and Justice and the NSW Police Force should establish and fund an ongoing program of training to ensure that all residential out-of-home care staff, and all NSW police officers, receive training on the *Joint Protocol to Reduce the Contact of Young People in Residential Out-of-Home Care with the Criminal Justice System*, in order to reduce the contact of young Aboriginal people in out-of-home care with the criminal justice system.

Recommendation 68: The new recommended NSW Child Protection Commission should monitor the implementation of the *Joint Protocol to Reduce the Contact of Young People in Residential Out-of-Home Care with the Criminal Justice System* to reduce the contact of young Aboriginal people in OOHC with the criminal justice system. This should include monitoring of the provision of training about the Joint Protocol, as well as the number and nature of calls by out-of-home care staff to the NSW Police Force that relate to the behaviour of children in out-of-home care.

Increased focus on data and research

The Joint Protocol, while vitally important, does not completely address the issue of the over-representation of children in OOHC in the juvenile justice system. It does not, for example, deal with the use of police by kinship or foster carers to control children's behaviour. Further, there are a number of other features of the OOHC system that exacerbate the risk that a child in OOHC will come into contact with the juvenile justice system, such as placement instability, loss of connection with family and culture and lack of appropriate services in OOHC. While recommendations elsewhere in this report, such as those relating to cultural connection and ensuring early placement stability, will go some way towards addressing these problems, the complexity and seriousness of the issue justifies the need for further sustained analysis and requires a comprehensive government response.

Despite the fact that the association between OOHC and the criminal justice system has been known for over 20 years, there is a paucity of research and data on 'cross-over kids' to inform policy and legislative responses to the issue. For example, the NSW Police Force does not require care status or Aboriginality to be recorded upon,⁴⁸² while Corrective Services NSW does not record the care status of children upon their entry into a correctional facility.⁴⁸³ Further, the NSW Government has not commissioned any research or studies of the 'crossover' population,

481 Ibid.

482 Kath McFarlane, 'Care-criminalisation: the involvement of children in out of home care in the NSW criminal justice system' (PhD Thesis, University of New South Wales, 2015) 186.

483 Ibid 193.



nor 'instituted any crime prevention programs targeted at the OOHC population'.⁴⁸⁴ The Review has concluded that it is of vital importance that data be collected and maintained about the link between OOHC and the juvenile justice system, and that research is undertaken as a matter of priority. This research could also address broader questions, such as the involvement of children who have transition from OOHC in the adult criminal justice system.

Recommendation 69: The Department of Communities and Justice should design and implement a system for the collection, analysis and reporting of data to ensure that information about children in OOHC who are also in contact with the criminal justice system is recorded and is readily available to inform strategic planning and monitor outcomes for this group of children. This system should identify which children are Aboriginal and which are non-Aboriginal.

Recommendation 70: The Department of Communities and Justice should conduct or commission further research regarding the involvement of Aboriginal children and young people in OOHC in the juvenile justice system to determine, among other things, the:

- number of Aboriginal children in OOHC involved in the juvenile justice system;
- nature of offences committed by Aboriginal children in out-of-home care (and whether these are influenced by their OOHC status);
- nature and level of assistance provided by FACS to Aboriginal children involved in the juvenile justice system; and
- outcomes for Aboriginal children involved in the juvenile justice system (and whether these are influenced by OOHC status).

484 Ibid 186.

PART E

Aboriginal child placement principle



16. Introduction to the Aboriginal Child Placement Principle

Introduction

The Terms of Reference for this Review centre around the need to improve implementation of the Aboriginal and Torres Strait Islander Child Placement Principle (ACPP).¹ This large, complex and multifaceted topic has been addressed in numerous prior reviews around Australia and was also the subject of a specific 2015 report in Victoria, *In the Child's Best Interests: Inquiry into compliance with the intent of the Aboriginal Child Placement Principle in Victoria*.² Further, there is a substantial amount of literature explaining the various elements of the ACPP and highlighting their vital importance to addressing the over-representation of Aboriginal children in out-of-home care (OOHC).

This Review does not intend to replicate the work of other inquiries and organisations in this area. Instead, the following chapters will analyse the implementation of the different elements of the ACPP in practice in NSW, drawing upon evidence gained during the Review's file review to illustrate areas of particular concern, and making recommendations for reform to remedy the deficiencies that exist in current policies and casework practice.

To the extent possible, the following chapters attempt to discuss the ACPP elements separately. However, the first element of the ACPP—prevention—is an expansive topic, the discussion of which is necessarily diffused throughout the report. In a broad sense, the majority of recommendations in this report are aimed at preventing the entry of Aboriginal children into OOHC. For example, the discussion of early intervention and service provision in Chapter 8 is clearly linked to this aim, as is the discussion of restoration in Chapter 20. In addition, it should be borne in mind that many of the elements of the ACPP are interrelated and overlap, so that, for example, better partnership and participation leads to better placement decisions, as well as enhanced connection with family and culture. Similarly, good placement decisions ensure that siblings are not separated, and thus help to maintain a child's connection to family and culture.

This chapter provides a broad overview of the ACPP (the second major lever to reduce the number of Aboriginal children in OOHC), before discussing the existing levels of compliance with the elements of the principle in NSW. It also includes a discussion of an important foundational issue—the identification of Aboriginal children. It concludes by making high-level recommendations that, if implemented, will improve overall compliance with the ACPP.

Finally, it is hoped that the inclusion of multiple examples of case practice from the cohort file review in these chapters will demonstrate—vividly and persuasively—the devastating impact that current non-compliance with the ACPP is having, and will continue to have, on Aboriginal families and communities in NSW.

1 As noted in the definitions section, the Review uses the term ACPP throughout this report.

2 Commission for Children and Young People, Victorian Government, *In the Child's Best Interests: Inquiry into compliance with the intent of the Aboriginal Child Placement Principle in Victoria* (Final Report, October 2016).



Background to the ACPP

The need for an ACPP was first identified in the 1970s.³ Concerned by the number of Aboriginal children in the care of non-Aboriginal families, and inspired by the *Indian Child Welfare Act 1978*⁴, Aboriginal community organisations campaigned for the issue of the placement of Aboriginal children removed from their families to be better considered by governments.⁵ In 1979, the Commonwealth Department of Aboriginal Affairs proposed the principle at a conference of the Council of Social Welfare Ministers and the next year it published policy guidelines for the placement of Aboriginal children.⁶ In 1986, a slightly different version of the principle was adopted by all states and territories at the Social Welfare Ministers' Conference.⁷ Today, every state and territory government has endorsed the principle.⁸ It is enshrined to varying degrees in legislation in every state and territory⁹ and is recognised in the National Framework for Protecting Australia's Children 2009–2020.¹⁰

In New South Wales, the principle first received legislative expression in s 87 of the *Children (Care and Protection) Act 1987* (NSW). This provision outlined the preferred order of placement for Aboriginal children, but only required consultation with Aboriginal people or organisations when a child was to be placed with a non-Aboriginal carer. A review of the provision in 1997 recommended that the requirement for consultation be extended so that Aboriginal families and communities were involved in *all* placement and other significant decisions under the Act.¹¹

In 1998, the provisions of the new *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*) dealing with the ACPP reflected this recommendation.¹² Only minor amendments have been made to these provisions since their introduction approximately 20 years ago.¹³ Section 11 of the *Care Act* states that Aboriginal people are to participate with the care and protection of their children 'with as much self-determination as possible'.¹⁴ Section 12 states that Aboriginal families, kinship groups, representative organisations and communities are to be given the opportunity to participate in placement decisions and other significant decisions under the Act. Finally, s 13 sets out the hierarchy of preferred placement options for Aboriginal children and sets out requirements for children to maintain contact with their families.

3 New South Wales Law Reform Commission, *The Aboriginal Child Placement Principle* (Research Report 7, 1997), [3.15].

4 *Indian Child Welfare Act of 1978* 25 U.S.C §§ 1901–1963 (1978).

5 *Ibid* [3.15].

6 *Ibid* [3.20]–[3.21].

7 New South Wales Law Reform Commission, *The Aboriginal Child Placement Principle* (Research Report 7, 1997), 3.26.

8 Commission for Children and Young People, Victorian Government, *In the Child's Best Interests: Inquiry into compliance with the intent of the Aboriginal Child Placement Principle in Victoria* (Final Report, October 2016) 9.

9 See for example: *Children and Young People (Safety) Act 2017* (SA) ss 12, 14; *Care and Protection of Children Act 2007* (NT) s 12; *Children Protection Act 1999* (Qld) s 5C s 83; *Children, Youth and Families Act 2005* (Vic) ss 12–14; *Children and Community Services Act 2004* (WA) ss 12–13; *Children, Young Persons and Their Families Act 1997* (Tas) s 10.

10 Council of Australian Governments, *Protecting Children is Everyone's Business, National Framework for Protecting Australia's Children 2009–2020*, (April 2009), 30.

11 James Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW* (November 2008) [11.13]–[11.17].

12 *Children and Young Persons Act 1998* (NSW) ss 11–12. Note that Part 2 of the Act refers to the 'Aboriginal and Torres Strait Islander Principles'. However, in keeping with much of the scholarly and grey literature in this area, this report will use the term 'ACPP'.

13 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 11–13.

14 Note that 'self-determination' is not defined in the *Care Act*, and is often used inconsistently in legal and political discourse throughout Australia. For further discussion of self-determination, see Chapter 7.

The ACPP explained

As can be seen above, and contrary to popular understanding, the ACPP is not simply a hierarchy of options for the physical placement of an Aboriginal child in OOHC. The ACPP is one broad principle made up of five elements that are aimed at enhancing and preserving Aboriginal children's sense of identity, as well as their connection to their culture, heritage, family and community.¹⁵

It is now widely recognised, as the Secretariat of National Aboriginal and Islander Child Care (SNAICC) has stated, that the principle in fact contains five inter-related elements—(i) prevention; (ii) partnership; (iii) placement; (iv) participation; and (v) connection.¹⁶ These elements capture the original intent and purpose of the ACPP and reflect that the ACPP 'is a tool to assist child protection decision makers—government and non-government—to make good decisions about children's care and protection'.¹⁷

The element of prevention recognises that Aboriginal children should be brought up by their own family and community, while the element of partnership recognises that Aboriginal community representatives should be involved in all child protection decision making. The element of placement deals with where an Aboriginal child should be placed if removed from his or her family. The element of participation aims to ensure that Aboriginal children and parents participate in all child protection decisions. Finally, the element of connection recognises that Aboriginal children in OOHC must be supported to maintain their connection to their family, community and culture.¹⁸

Today, the five elements of the ACPP are recognised at a national level. The Fourth Action Plan of the *National Framework for Protecting Australia's Children 2009–2020* contains a commitment to 'an increased, joint effort toward ensuring that all five elements of the Aboriginal and Torres Strait Islander Child Placement Principle are upheld'.¹⁹ It includes a call to state and territory governments and non-government organisations to work together to 'choose useful indicators for each of the five elements of the Principle to report on nationally'.²⁰

The Review is concerned, however, that the provisions of the *Care Act* do not reflect the above interpretation of the ACPP. For example, s 13 of the *Care Act* is titled 'Aboriginal and Torres Strait Islander Child and Young Person Placement Principles', although the provision only deals with the placement and connection elements of the ACPP. This legislative drafting may contribute to the common misunderstanding of the scope of the ACPP, and in particular, may encourage the incorrect belief that the ACPP is simply a sliding placement hierarchy. For this reason, the Review recommends that the *Care Act* be amended to more adequately reflect the different elements of the ACPP.

15 Legislative Council General Purpose Standing Committee No 2, *Child Protection*, (March 2017), 7.34; NSW Government, 'Keep Them Safe 2009, A shared approach to child wellbeing', (March 2009), 34; AbSec, 'What You Told Us—Aboriginal case management policy consultations', (August 2017), 12.

16 Tilbury C, 'Aboriginal and Torres Strait Islander Child Placement Principle: Aims and Core Elements' (Prepared for Secretariat of National Aboriginal and Islander Child Care, June 2013), 3. See also AbSec, 'Policy Brief Aboriginal Child Placement Principle', AbSec, Web Page, (2 July 2019), <<https://www.absec.org.au/images/downloads/Policy-Brief-Aboriginal-Child-Placement-Principle.pdf>>.

17 Tilbury C, 'Aboriginal and Torres Strait Islander Child Placement Principle: Aims and Core Elements' (Prepared for Secretariat of National Aboriginal and Islander Child Care, June 2013), 7.

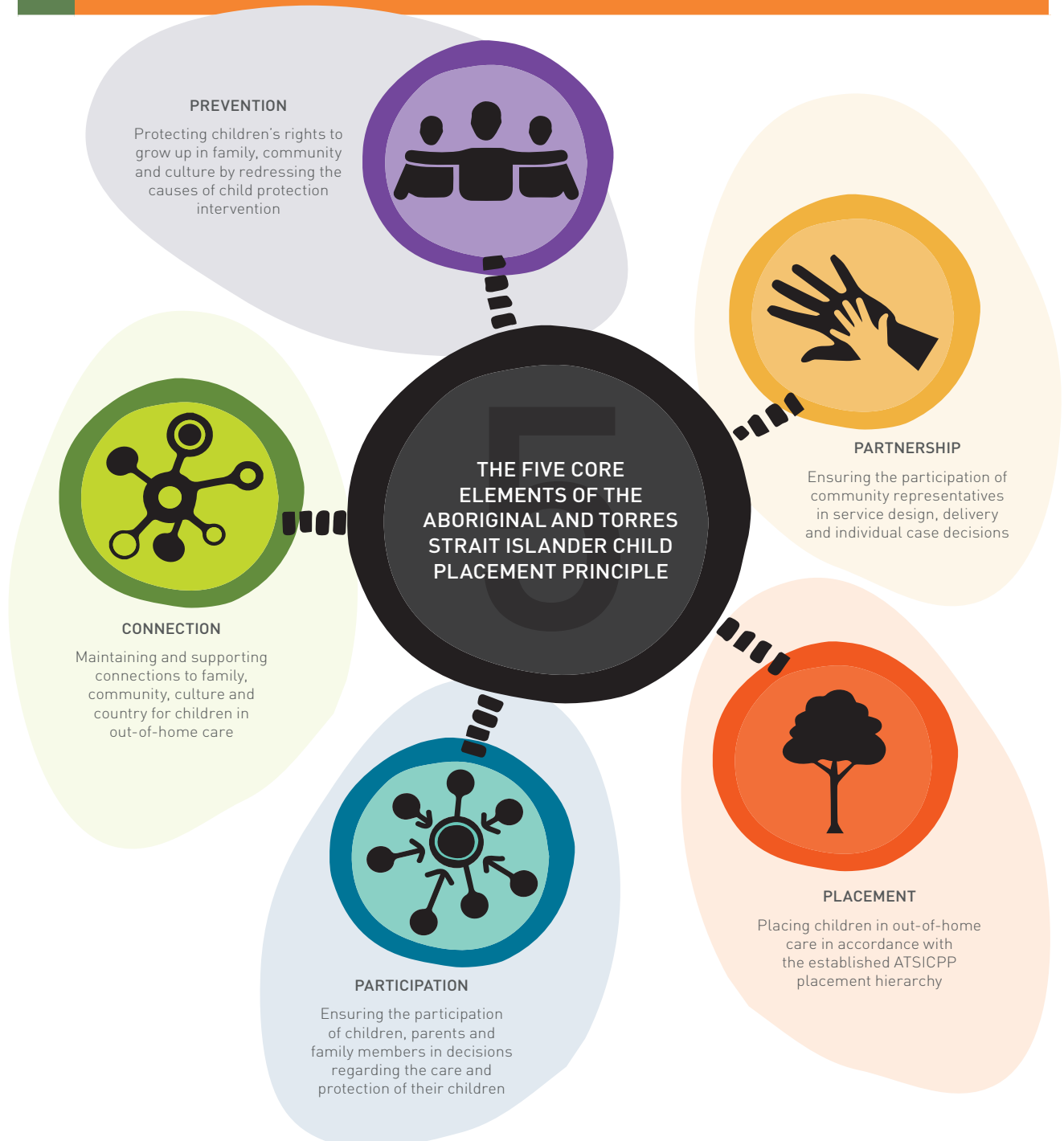
18 Ibid 8.

19 Australian Government, Department of Social Services, *Protecting Children is Everyone's Business, National Framework for Protecting Australia's Children 2009–2020 – Fourth Action Plan 2018–2020* (April 2009), 5.

20 Ibid Action 1.3, 6.



Recommendation 71: The New South Wales Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to ensure that its provisions adequately reflect the five different elements of the Aboriginal Child Placement Principle, namely, prevention, partnership, participation, placement and connection.



The five core elements of the Aboriginal and Torres Strait Islander Child Placement Principle

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Concerns about compliance with the ACPP in NSW

Despite the fact the ACPP has been enshrined in legislation, and its elements recognised by all states and territories, there are widespread concerns about the way in which the ACPP is interpreted and applied throughout Australia. For instance, in 2012 the United Nations Committee on the Rights of the Child noted that poor implementation of the ACPP in Australia was compromising the rights of Aboriginal children in OOH. ²¹

The extant literature (comprising government and non-government reports, academic publications and stakeholder submissions) has identified several implementation issues. First, there are widespread concerns about the collection and use of data regarding compliance with the principle (discussed further below). Second, there are concerns about widespread non-compliance with the principle,²² including concerns that the principle is ignored in practice or applied in a narrow or tokenistic manner.²³ Third, there are concerns about the fact that there are no penalties for non-compliance with the principle,²⁴ and finally, it has been noted that there are differences in the way the principle is interpreted and applied.²⁵

Concerns about compliance with the ACPP have existed for at least 20 years in NSW. The Wood Report, released in 2008, raised a number of issues about the implementation of the ACPP, including that the ACPP provisions were only being considered at the final stages of a matter as opposed to prior to any court attendance.²⁶ The Wood Report found that there was inconsistent compliance with the ACPP both at a regional and individual caseworker level.²⁷ Again in 2017, the Legislative Council General Purpose Standing Committee No 2 noted that stakeholders to its inquiry on child protection had raised concerns that the principle was not being complied with, and that statistics collected relating to compliance with the principle did not adequately reveal if all aspects of the principle, including the requirement for consultation with Aboriginal organisations, were being complied with.²⁸ Also in 2017, Aboriginal stakeholders in NSW expressed frustration about the fact that the ACPP is not adhered to in practice.²⁹

Lack of compliance with the ACPP is not unique to NSW. A review of child protection in South Australia noted that ‘the Agency continues to be challenged by its ability to comply with the Aboriginal and Torres Strait Islander Child Placement Principle (ATSIPP)’.³⁰ It observed that compliance with the principle ‘requires more than simply following a hierarchy of care options’ and that the Agency had not always complied with its obligation to work in partnership with

21 United Nations Committee on the Rights of the Child, *Committee on the Rights of the Child*, (Sixtieth session 29th May–15th June 2012).

22 Senate Community Affairs References Committee, *Out of Home Care* (Report, 2015) 8.60.

23 Legislative Council General Purpose Standing Committee No 3, *Reparations for the Stolen Generations: Unfinished business* (2016) [10.55]; Senate Community Affairs References Committee, *Out of Home Care* (Report, 2015).

24 Legislative Council General Purpose Standing Committee No 3, *Reparations for the Stolen Generations: Unfinished business* (2016) [10.54]–[10.57], [10.60].

25 Senate Community Affairs References Committee, *Out of Home Care* (Report, 2015) 8.56.

26 James Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW* (November 2008), [11.150].

27 James Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW* (November 2008), [11.149].

28 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) [7.37]–[7.42].

29 AbSec, ‘What You Told Us—Aboriginal case management policy consultations’, *Aboriginal Child, Family and Community Care State Secretariat* (Web Page, August 2017) < <https://www.absec.org.au/images/downloads/AbSec-Developing-Aboriginal-Case-Management-Policy-and-Guidelines-Consultant-Report-What-You-Told-Us-Aug17.pdf>>.

30 Margaret Nylan, *The life they deserve, Child Protection Systems Royal Commission Report*, State of South Australia, (August 2016), xxv.



Aboriginal organisations when making decisions about the care and protection of Aboriginal children.³¹

Similarly, a review of compliance with the intent of the ACPP in Victoria found there was minimal adherence in practice to the various policy and programs that have been devised to meet the requirements of the ACPP.³² Of concern was the fact that of 65 files reviewed, ‘not one Aboriginal child experienced complete compliance with all ACPP requirements’.³³ While the review identified multiple reasons for non-compliance, two main systemic barriers to the transformation of commendable policy into practice were identified—namely: (i) a lack of accountability for non-compliance; and (ii) a lack of resources.

A number of submissions to this Review raised the issue of the lack of compliance with the ACPP. Uniting submitted that its experience had shown that the elements of the ACPP are poorly applied and that child protection officers require better training and guidance on how they should be applied in practice. It submitted that in circumstances where the placement hierarchy does not apply, such as in emergency or short-term placements, it was still necessary to comply with other aspects of the principle, such as the requirement to consult with the Aboriginal community.³⁴

The Aboriginal Child, Family and Community Care State Secretariat (AbSec) submitted that the lack of full compliance with the ACPP was a ‘significant concern’.³⁵ It noted that the ACPP was widely misunderstood as ‘a simple placement hierarchy’. It noted that while there was no data in NSW, research in other jurisdictions revealed that full compliance with the principle was rare.³⁶ It noted that the proportion of Aboriginal children placed with relatives had dropped from 68.7% to 57.6% in the last ten years.³⁷ AbSec also submitted that the principle enjoyed ‘almost universal support from Aboriginal communities’, but its lack of proper implementation had undermined its effectiveness.

The Women’s Legal Service NSW expressed concern about poor practice in relation to the implementation of the ACPP, while acknowledging the efforts of the President of the Children’s Court to improve practice in this area.³⁸ The President of the Children’s Court of NSW submitted that the Children’s Court was interested to hear any suggestions to improve the application of the ACPP.³⁹

Grandmothers Against Removal NSW submitted that any orders, including Short Term Care Orders, should comply with the ACPP.⁴⁰ It submitted that placing Aboriginal children with non-

31 Ibid.

32 Ibid.

33 Commission for Children and Young People (Vic), *In the Child’s Best Interests: Inquiry into compliance with the intent of the Aboriginal Child Placement Principle in Victoria* (Final Report, October 2016), 24.

34 Uniting (NSW.ACT), Submission No 23 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, March 2018.

35 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 9.

36 Ibid.

37 Ibid 11.

38 Women’s Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 24.

39 Children’s Court of New South Wales, Submission No 18 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, November 2017.

40 Grandmothers Against Removal NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 6.

Aboriginal carers resulted in them being cut off from their families, which was ‘active, state-sanctioned cultural genocide.’⁴¹ The National Congress noted that the ACPP was ‘an essential aspect of the well-being of Aboriginal and Torres Strait Islander young people placed in OOHC’ as it recognised the ‘protective and healing qualities of connection to family and culture’.⁴² In light of this, it submitted that it was essential that the ACPP be honoured in practice.⁴³

It is difficult to ascertain with any precision the reason why the ACPP is not complied with in practice. It is in all likelihood a combination of factors, including but not limited to a lack of: institutional and individual accountability in relation to implementation of the principle; sanctions for non-compliance; guidance around the implementation of the principle in practice; cultural awareness and confidence among FACS caseworkers; and an institutional culture that does not value genuine partnership with the Aboriginal community.

Examples of failure to implement the ACPP in practice

The following chapters contain numerous examples of casework practice in relation to particular elements of the ACPP, such as cultural planning (connection) and family finding (placement). However, it is important to note that the Review’s file reviews revealed that in many cases, the four elements of the ACPP discussed in this Part—partnership, participation, placement and connection—were ignored in their entirety in casework practice. The following provide examples from the files reviewed of the failure of FACS caseworkers to engage with multiple elements of the ACPP when dealing with Aboriginal children.

- In Case 81, there was little documented engagement with the children’s family or Aboriginal community. The children’s family were not consulted prior to the children’s assumption, or after they were taken into care. It is unclear whether any extended family members were considered as carers. It is unclear why the children were not placed with their grandmother, who had looked after them for an extended period of time under a previous safety plan. The children were separated in at least one of the placements. Only three of the children’s placements were with Aboriginal carers. No cultural plans were prepared for the children. It is unclear whether any of the children’s carers received cultural competency training. There was no consultation with the children’s family or community about maintaining their connection to culture while in OOHC. It is unclear how much contact the children had with their other siblings while in OOHC.
- In Case 97, there was no consultation with the children’s immediate or extended family (or with any other Aboriginal community members) about the removal of the children. The children were separated on removal (one child was placed separately from his two siblings). Despite the fact that the children had a large, extended Aboriginal family, they were initially placed with non-Aboriginal foster carers. It is unclear whether FACS ever followed up the children’s mother’s request that the children be placed with her sister. Several cultural plans were developed for the children over the years (one joint plan was developed two months after the children’s removal, and then individual plans were developed since this date).

41 Ibid.

42 National Congress of Australia’s First Peoples, Submission No 22 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018, 6.

43 Ibid 9.



However, there was no consultation with the children's family about these cultural plans and the plans contain limited information about how the children will maintain their connection to culture in OOHC (in particular their connection to their maternal mob). It is unclear what contact the children have with their maternal grandmother or any other members of their extended maternal family while in OOHC.⁴⁴

- In Case 8, there was no engagement with the child's paternal Aboriginal family prior to his removal, or during his period in care under a Temporary Care Agreement (TCA). While subject to the TCA, the child was placed with a non-Aboriginal foster carer for 10 days before moving into his grandmother's care and there appears to have been no consideration given to his Aboriginality or to placing him with Aboriginal relatives or kin. No consultations with Aboriginal community representatives occurred and the child's Aboriginal family were not involved in any decision-making in the case (including FACS' decision to support the child leaving the jurisdiction).

Lack of official training or guidance on the ACPP

First and foremost, it is important to note that the department provides extremely limited policy guidance about the ACPP to its caseworkers and to caseworkers from non-government OOHC providers. While there is mention of the ACPP in a number of different departmental documents, such as the carer assessment manual⁴⁵ and the Aboriginal Consultation Guide,⁴⁶ there is no stand-alone document outlining the intent and importance of the ACPP, the way in which the principle should be implemented in practice, or the need to monitor and evaluate the implementation of the principle. It has been noted that a 'consistent and thorough understanding of the intent of the ACPP is important to ensure that decisions and actions are consistent with that intent'.⁴⁷

It is vital that caseworkers do not view compliance with the ACPP as an optional element of casework.

This lack of policy guidance is disappointing, particularly in light of the fact that over 20 years ago the Wood Report noted that 'clear guidelines need to be developed and implemented to assist caseworkers to consistently and meaningfully apply the Aboriginal Placement Principles'.⁴⁸ In 2016, the Victoria Commission for Children and Young People recommended that the department (in partnership with ACCOs) define and promote the intention of the ACPP and that any future amendments to legislation articulate this underlying intent of the ACPP.⁴⁹ The Review is of the opinion that a similar recommendation is appropriate in NSW. It is vital that caseworkers do not view compliance with the ACPP as an optional element of casework.

44 Note that the children are currently placed in a kinship care arrangement and are noted to be growing up connected to their culture.

45 Department of Family and Community Services (NSW), *Carer Assessment: Manual for Assessors* (September 2009, FACS Intranet).

46 Department of Family and Community Services (NSW), *Aboriginal consultation guide*, (June 2011).

47 Commission for Children and Young People (Vic), *In the Child's Best Interests: Inquiry into compliance with the intent of the Aboriginal Child Placement Principle in Victoria* (Final Report, October 2016), 12.

48 James Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW* (November 2008), 11.161.

49 Commission for Children and Young People (Vic) *In the Child's Best Interests: Inquiry into compliance with the intent of the Aboriginal Child Placement Principle in Victoria* (Final Report, October 2016), rec 1.

Recommendation 72: The Department of Communities and Justice should develop guidance for caseworkers on the purpose of the Aboriginal Child Placement Principle (ACPP), the elements of the ACPP, and how to apply these elements during casework. This guide should be developed in partnership with Aboriginal community organisations and after consideration of the existing resources on the ACPP, such as those already developed by the Secretariat of National Aboriginal and Islander Child Care, which the Review regards as best practice.

Recommendation 73: The Department of Communities and Justice should implement an ongoing program of training to test and enhance staff knowledge of the Aboriginal Child Placement Principle. This program should be delivered in partnership with the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec).

Limited and inadequate data about compliance with the ACPP

Currently, data on compliance with the ACPP is limited and inadequate. There is some data that relates to the placement of Aboriginal children. For example, data from NSW indicates that, of the 6,766 Aboriginal and Torres Strait Islander children in OOHC at 30 June 2018, 4,967 (approximately 73%) were placed with relatives, kin or Aboriginal or Torres Strait Islander carers.⁵⁰ This percentage of children placed with relatives, kin or Aboriginal or Torres Strait Islander carers fell from the previous year, when it measured approximately 79% (as at 30 June 2017).⁵¹

However, data relating to the physical placement of Aboriginal children needs to be interpreted with care when assessing compliance with the ACPP for several reasons. First, as the Productivity Commission and other stakeholders have noted on a number of occasions, this data only measures placement ‘outcomes’,⁵² as opposed to genuine compliance with the principle.⁵³ It reflects the common misconception that the ACPP is simply a placement hierarchy and does not reflect the application of the broader elements of prevention, partnership, participation and connection. In addition, when reporting on the placement of a child, it does not differentiate between levels of the hierarchy and does not reveal whether or not placing the child at a higher level of the hierarchy was considered.⁵⁴

Another limitation of the data is that it only represents a point in time assessment of where Aboriginal children are physically placed. While a child may be counted as being in a ‘compliant’

50 Australian Government Productivity Commission, *Report on Government Services 2019*, (Web Page, 2 July 2019), Table 16A.21 <<https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services/child-protection>>.

51 Ibid.

52 Note that in this context, ‘outcomes’ refers to the physical placement of a child.

53 Australian Government Productivity Commission, *Report on Government Services 2018*, Ch 16 Child Protection Services, Box 16.9 <<https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services/child-protection>>; Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) [7.41].

54 Commission for Children and Young People (Vic) *In the Child's Best Interests: Inquiry into compliance with the intent of the Aboriginal Child Placement Principle in Victoria* (Final Report, October 2016), 16.



placement, he or she may have been in multiple placements with non-Aboriginal carers in the past (a fact which is not reflected in the data). In addition, the data does not capture children and young people who are not identified as Indigenous at the time of placement,⁵⁵ and does not address whether consultation occurred during decision making about the safety, welfare and wellbeing of the child.

The NSW Government has been aware of the deficiencies in collection of data to enable the monitoring of compliance with the ACPP for some time and has committed to resolving them. For example, in response to the Inquiry into reparations for the Stolen Generations in NSW it stated that:

The NSW Government will introduce a new client management system, Child Story, to support caseworkers in implementing the Aboriginal placement principles and, as part of the Improving Aboriginal Child Protection and Out-of-Home Care Outcomes research project, test frontline worker understanding of the Aboriginal Child Placement Principles and review systems/procedures. The NSW Government will also work with the Secretariat of National Aboriginal and Islander Child Care to implement a national reporting and compliance framework.⁵⁶

However, the introduction of ChildStory has been protracted and beset by difficulties. The Review's experience reveals that the department remains no closer to being in a position to monitor and report on compliance with the ACPP than it was at the time of the previous inquiries discussed above.

Currently, there is 'no adequate definition ... of what constitutes compliance with the intent of the ACPP, or how compliance with the ACPP should be measured'.⁵⁷ In its inquiry into compliance with the intent of the ACPP in Victoria, the Commission for Children and Young People created a 'compliance rubric' which comprised 20 'compliance points', which were then mapped to the five ACPP elements.⁵⁸ The Review has concluded that it is imperative that DCJ more effectively monitor compliance with the ACPP and recommends that it consult with Aboriginal stakeholders to design and implement a system of improved data collection and reporting around *all elements* of the ACPP. This data should be made publicly available.

55 Australian Government Productivity Commission, *Report on Government Services 2018*, Ch 16 Child Protection Services, Box, 16.9, <<https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/community-services/child-protection>>.

56 Correspondence from The Hon Leslie Williams, MP, Former Minister for Aboriginal Affairs, to the Clerk of the Parliaments, providing government response to the *Inquiry into the Reparations for the Stolen Generations in New South Wales: Unfinished Business*, (2 December 2016), 16, cited in Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) [7.45].

57 Commission for Children and Young People (Vic) *In the Child's Best Interests: Inquiry into compliance with the intent of the Aboriginal Child Placement Principle in Victoria* (Final Report, October 2016), 16.

58 Ibid 89-90.

Recommendation 74: The Department of Communities and Justice should engage with Aboriginal stakeholders and community members to design and implement a system of data collection and reporting around all elements of the Aboriginal Child Placement Principle (ACPP). In particular, the data should address:

- a. Aboriginal children's contact with their Aboriginal birth parents, siblings (including half-siblings) and extended family, kin and community;
- b. Aboriginal children's placement with siblings (including half-siblings) and;
- c. Cultural planning for Aboriginal children in care, including information about who participated to develop a child's cultural plan, and what these cultural plans contain in relation to the five domains of the ACPP.

Recommendation 75: The Department of Communities and Justice should publish data on its compliance with all elements of the Aboriginal Child Placement Principle on an annual basis.

Aboriginal identification and 'de-identification'

In order for the ACPP to be applied effectively, it is essential Aboriginal children in the child protection system have their cultural background identified promptly and accurately. As SNAICC has noted, 'without correct and early cultural identification, Aboriginal and Torres Strait Islander children at all levels of child protection involvement are at risk of being deprived of culturally safe support, case planning and placements.'⁵⁹

Section 32 of the *Care Act* places the obligation on DCJ to determine whether a child or young person in contact with the child protection system is Aboriginal. It provides the following:

If the Secretary has reason to believe that a child or young person who is the subject of a report may be an Aboriginal or Torres Strait Islander, the Secretary is to make such inquiries as are reasonable in the circumstances to determine whether the child or young person is in fact an Aboriginal or Torres Strait Islander.

The *Care Act* defines an Aboriginal person as:

- (a) is a member of the Aboriginal race of Australia, and
- (b) identifies as an Aboriginal person, and
- (c) is accepted by the Aboriginal community as an Aboriginal person.⁶⁰

⁵⁹ SNAICC, *The Aboriginal and Torres Strait Islander Child Placement Principle: A Guide to Support Implementation* (2018), 7.

⁶⁰ *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 5; *Aboriginal Land Rights Act 1983* (NSW) s 4.



Stakeholders and academics have raised concerns about the process of identifying and ‘de-identifying’ Aboriginal children in contact with the child protection system in practice. In 2006, Valentine and Gray noted that one of the ways child protection workers could bypass the ACPP was to ignore or dispute a child’s Aboriginality based on their skin colour.⁶¹ The authors also noted that ‘there may be situations where a child is first identified as having an Aboriginal or Torres Strait Islander background when in contact with the child protection system, with no prior cultural contact or engagement, and there is no guidance or pathways for dealing with this situation.’⁶²

In 2017, the Legislative Council inquiry into child protection noted that stakeholders had raised concerns about the late identification of the Aboriginality of children in OOHC.⁶³ It was advised of one case where the Aboriginality of a number of Aboriginal siblings had been denied, despite FACS being presented with relevant documentation confirming the children’s heritage.⁶⁴ It also heard concerns ‘that the Department is deliberately redefining Indigenous children as non-Indigenous, so as to avoid their legislative obligations when dealing with Indigenous children, for example, to provide cultural support plans’.⁶⁵

Stakeholders to this Review also raised the issue of the identification of Aboriginal children. Uniting submitted that early identification of a child’s Aboriginality was essential to ensure compliance with the ACPP and noted that in some cases a child’s Aboriginality is only discovered when adoption is being considered.⁶⁶ It observed that it was often very difficult to determine whether a child who is placed with Uniting is Aboriginal and submitted that ‘more systematic efforts are required by FACS to identify and confirm Aboriginal or Torres Strait Islander identity at a much earlier point’.⁶⁷ In consultations, one stakeholder expressed concern about the ‘de-identification’ of Aboriginal children, which resulted in them being denied access to their culture.⁶⁸ The stakeholder argued that all children should be classified as Aboriginal until proven otherwise (to ensure the Aboriginality of children was not overlooked).⁶⁹ Further, de-identification should never be done by a caseworker, should not be done without proper consultation with the Aboriginal community, and should only ever be done by the Secretary with all required processes had been followed and there had been community consultation and agreement about the ‘de-identification’.⁷⁰ Finally, another stakeholder noted that there were ‘not advantages to being Aboriginal in our system’ and that this should be acknowledged in order to counter concerns about non-Aboriginal people in contact with the child protection system claiming to be Aboriginal.⁷¹

In September 2018, the Honourable David Shoebridge MP raised the issue of the ‘de-identification’ of Aboriginal children with the former Minister for Family and Community

61 Valentine and Gray, ‘Keeping Them Home: Aboriginal Out-of-Home Care in Australia’ (2006) 87 (4) *Families in Society: The Journal of Contemporary Social Services* 537, 539.

62 Australian Institute of Family Studies, *Enhancing the Implementation of the ACPP*, (August 2015), 13.

63 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) [7.45]–[7.51].

64 Ibid [7.48].

65 Legislative Council General Purpose Standing Committee No 2, *Consultation with Indigenous community members, 8 September 2016*, as attached to The Law Society of New South Wales, Submission No 3 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

66 Uniting (NSW.ACT), Submission No 23 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, March 2018, 10.

67 Ibid 11.

68 Confidential, *Consultation*, FIC 66.

69 Confidential, *Consultation*, FIC 66.

70 Confidential, *Consultation*, FIC 66.

71 Confidential, *Consultation*, FIC 26.

Services. He noted that:

... there is a very real concern that the process of de-identification is one of the ways that has been used by the department, consciously or unconsciously, to drive down the proportion of Aboriginal children in the system.⁷²

The former Minister rejected this suggestion as ‘abhorrent’ and the department advised that the reason fewer Aboriginal children were being taken into care related to better services and earlier intervention with Aboriginal families.⁷³ In response to a question on notice about whether the department could write a program to extract information from their data systems about how many children who had entered FACS with an identified Aboriginal status had later had this status changed to ‘non-Aboriginal’, the department advised:

- A preliminary data examination of ChildStory indicates that there is no evidence of systemic bias in changing of Aboriginal and Torres Strait Islander status values to non-Aboriginal and Torres Strait Islander status values (for all children and young persons records, not just OOHC).
- There is no evidence that ChildStory users are changing records in order to reduce the number of children and young people identifying as Aboriginal or Torres Strait Islander.
- Such changes to records typically occur to reflect additional information that has become available, or to correct information that was incorrectly entered.⁷⁴

The following section outlines the findings of the Review’s cohort review regarding the issue of the identification and de-identification of Aboriginal children. In summary, the Review found several problems with casework in this area, including the late identification of Aboriginal children and the erroneous recording of information about particular details of a child’s cultural heritage, such as the child’s language group. The Review also found several concerning examples about the active ‘de-identification’ of Aboriginal children. However, it is important to note that other children who had been ‘de-identified’ by the department may not have been included in the Review’s cohort as they would have been classified as being of non-Aboriginal background. Accordingly, without relevant data it is impossible to determine the extent of the issue of de-identification of Aboriginal children.

Data and Review findings

In a number of cases in the Review’s qualitative sample, FACS did not comprehensively identify children’s Aboriginality on their systems (with flow on effects in their casework and work with families). In 19 cases in the sample, there were significant delays in ascertaining children’s Aboriginality, or at the time of the Review, children’s Aboriginality remained incomplete on FACS systems. For instance, in Case 38, despite FACS having an extensive history with the cohort child prior to entry into care, the child was not identified as being an Aboriginal child for a significant period of time after they entered care. This suggests that Aboriginal identity, despite being squarely relevant to children’s supportive networks, appropriate responses and ways of working with family, was not always considered a priority by the department in child protection practice. In a number of cases FACS failed to identify children as Aboriginal on one

72 New South Wales, *Parliamentary Debates*, Legislative Council, 5 September 2018, 20.

73 Ibid.

74 Department of Family and Community Services (NSW), *Social Housing, Prevention of Domestic Violence and Sexual Assault—Minister Goward*, September 2018, Department of Family and Community Services (NSW), Web Page, (2 July 2019), <<https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2499#tab-otherdocuments>>.



of their parents' sides. Taken together, these components suggest an inattention to issues of cultural identity, and onward issues in respect of cultural planning, for children in the cohort.

In 21 cases in the sample, other administrative issues were identified in relation to Aboriginal identification. Issues included that children's language groups were not identified on FACS systems, or that due to children's parents having cultural disconnection, children were not treated as Aboriginal children subject to ACPP. For instance, in Case 82 the department and an OOHC provider were described as having continuously questioned the child's Aboriginality, despite the family identifying this, and having failed to undertake any cultural planning or engage any Aboriginal consultation in the case. This not only highlights poor participation and issues around ACPP, but also demonstrates the flow on effect of questioning children's Aboriginal identification without appropriate casework to address these issues.

Further, in Case 102, FACS failed to identify all siblings as Aboriginal, despite all children being in OOHC and the children self-identifying as Aboriginal. Three out of four siblings were not identified as Aboriginal on FACS systems. Failing to record the children's Aboriginality in this case had a flow on effect in terms of cultural planning and casework for the children and has limited their connections to culture in OOHC.

It was concerning that in Case 48, the child's case plan stated that the child was 'too young' to identify as Aboriginal, which was identified as an issue that would have been framed differently by a culturally responsive worker or organisation. A more responsive approach would have indicated that the child was Aboriginal on their father's side and treated that child as Aboriginal. The reviewer noted in this case that this disregard for Aboriginality highlighted the structural racism of FACS as an organisation.

Errors were also identified in children's language groups in at least 22 cases in the sample. Often the reviewer was able to identify that FACS systems nominated the incorrect language group for children or their family members (or both), and in other cases, family language groups were not recorded at all despite reviewers frequently being able to ascertain these from other information on the file. These errors are particularly concerning, as correctly identifying children's language groups is fundamental to case planning, cultural planning and understanding the identity and history of children and their families in the OOHC system. Apathy towards this knowledge within the department is very concerning.

Further, as noted previously, most Aboriginal children who entered care had a care application filed with the Children's Court (83.6%), and for the majority of these children (94.8%), the care application identified them as being Aboriginal (Figure 13, Figure 22). However, for 39 children in the cohort (4.1% of Aboriginal children who had a care application filed), the care application did not identify them as being Aboriginal.

In three cases in the sample, issues were identified around FACS' processes for de-identifying children as Aboriginal.

In Case 198, an Aboriginal consultation with an Aboriginal FACS caseworker was conducted. It is recorded that the paternal grandmother had stated she 'had Aboriginal heritage' but that she and other family members did not identify as Aboriginal. Therefore, it was decided FACS would not identify the children as Aboriginal and they were later de-identified on KiDS. There is no evidence that the children were consulted about the decision to de-identify them as Aboriginal and no notes about any consultation with the family regarding FACS' intention to de-identify the children as Aboriginal.

In Case 155, the children's mother identified as Aboriginal. However, FACS de-identified the children's mother and two of the children after a complex case review meeting. The de-identification occurred as FACS was of the opinion that the children's mother had not provided sufficient evidence of Aboriginality and that her Aboriginality was not confirmed by her family. The children's mother claims her Aboriginality has been disrupted due to her great grandmother being part of the Stolen Generations. FACS did not refer the matter to Link-Up to investigate information about the mother's Aboriginality prior to de-identifying the children. Although the children's mother has met the minimum outcomes for restoration and the children have regularly attempted to 'self-place' with her, at the time of writing, the children had not been restored, and the carers of the children (who have now been identified as 'non- Aboriginal') appear to be seeking to adopt the children.

Finally, in Case 20, the children were identified as Aboriginal when they entered care due to their mother suspecting she had Aboriginal heritage (she had been adopted as a child and believed one of her biological parents was Aboriginal). The children were de-identified as Aboriginal following a Link-Up investigation which concluded that it was not possible to confirm or deny the family's Aboriginality. FACS did not undertake any consultation with the Aboriginal community about the de-identification. It would appear the children were simply de-identified as Aboriginal in FACS' records with no consideration of their right to culture, and little formal processing.

Other cases not included in the sample analysed for the purposes of gathering qualitative data also revealed issues concerning the 'de-identification' of Aboriginal children. While the Review does not have a precise figure of the number of cases raising issues of de-identification, the following case study provides another example of issues surrounding the process of 'de- identification'.

Case Study

In Case 202, a caseworker met with the father of the child who identified himself as Aboriginal but stated that he was disconnected from his culture. FACS attempted to contact the father on a number of occasions to discuss his Aboriginality further, with no success. However, the father's stepmother confirmed that he and his siblings would talk about being Aboriginal from his maternal side.

Despite having this information, later court documents record the child's Aboriginality as 'unknown'. After final court orders were made, FACS and a non-government OOHC provider referred the family to Link-Up to investigate the child's family ancestry. FACS was informed that this process would take between six and 12 months. In the meantime, an Aboriginal Advisory Panel meeting was convened, and was informed that the child's father claimed his Aboriginality from his Aboriginal stepmother. This was factually incorrect. Based on this incorrect information, the Panel recommended that the child be de-identified as Aboriginal, and FACS approved and actioned this recommendation (despite the fact that there was still a pending Link-Up report).

The Link-Up report later confirmed the child's Aboriginality.

The Review is concerned that there are insufficient rules governing the identification and 'de-identification' of Aboriginal children by FACS employees. Research has demonstrated that issues relating to Aboriginal identification are complex, with people's propensity to identify



as Aboriginal varying with their age, gender and geographic location.⁷⁵ Further, there are numerous barriers to identification.⁷⁶ For example, as the new *Aboriginal Case Management Rules and Practice Guidance* notes, it is not unusual for people to be reluctant to self-identify to FACS in light of the history of the injustices perpetrated on Aboriginal families by child protection services.⁷⁷ For this reason, ‘caseworkers are encouraged to take a curious stand and to proactively identify every family’s cultural background, engaging them in a robust, iterative process to unpack each family’s unique history and heritage’.⁷⁸ Beyond this, there is little guidance available about best practice approaches to investigating the issue of Aboriginality. For instance, there is no guidance about the recommended approach if the caseworker has difficulty obtaining information about a child’s Aboriginality, if there are doubts about a child’s Aboriginality, if a child’s parents do not wish to be identified as Aboriginal, if a child’s parents or a child are disengaged from their culture, or if there is a suggestion that a child should be ‘de-identified’ as Aboriginal. As the above evidence from the cohort file review reveals, these issues can and do come up in casework practice, and the way that they are resolved has far reaching ramifications for the child in question.

In light of the fundamental importance of the issue, the Review recommends that the NSW Government develop regulations about the identification of Aboriginality in respect to children in OOHC, as well as the circumstances in which it is possible and appropriate to ‘de-identify’ a child as Aboriginal, and the procedure to be followed when doing so. These regulations, to be included in the *Children and Young Persons (Care and Protection) Regulation 2012* (NSW), should be developed in partnership with the Aboriginal community. Further, DCJ should develop policy guidance to ensure adherence to the requirements of the regulations. This policy guidance should explicitly state that no de-identification of an Aboriginal child should occur unless the requirements of the regulations have been satisfied.

Further, it is important that DCJ collect and publish data about the de-identification of Aboriginal children and the reasons for de-identification. Finally, the Review considers that the Judicial Commission of New South Wales should develop educational materials for all judicial officers about the identification and de-identification of Aboriginal children in judicial proceedings.

Recommendation 76: The New South Wales Government should, in partnership with relevant Aboriginal community groups and members, develop regulations about identifying and ‘de-identifying’ children in contact with the child protection system as Aboriginal for inclusion in the *Children and Young Persons (Care and Protection) Regulation 2012* (NSW).

Recommendation 77: The Department of Communities and Justice should develop a policy to assist in the implementation of the new regulation about the identification and ‘de-identification’ of children in contact with the child protection as Aboriginal.

75 NSW Aboriginal Affairs, *Aboriginal identification: the way forward. An Aboriginal peoples’ perspective* (Report, 2015), 7.

76 Ibid 7.

77 Department of Family and Community Services (NSW), *Aboriginal Case Management Rules and Practice Guidance*, (2019), 5.

78 Ibid 5.

Recommendation 78: The Department of Communities and Justice should ensure that it is mandatory for caseworkers to complete the Aboriginal or Torres Strait Islander status field on ChildStory.

Recommendation 79: The Department of Communities and Justice should collect and publish information about the number of children who are 'de-identified' as Aboriginal and the reasons for the de-identification on an annual basis.

Recommendation 80: The Judicial Commission of New South Wales should develop educational materials for all judicial officers about the identification and de-identification of Aboriginal children in judicial proceedings.

Implementing the Aboriginal Case Management Policy and Guidelines

In 2017, FACS requested that AbSec lead the development of an Aboriginal Case Management Policy, with an accompanying practice guidance handbook.⁷⁹ On 19 October 2018, after AbSec had conducted a statewide consultation process, FACS endorsed the *Aboriginal Case Management Policy*. The policy provides an 'operational framework for all practitioners working with Aboriginal children, young people and families' in NSW.⁸⁰ It was designed to 'sit alongside' the *Permanency Case Management Policy* and provides 'specialised guidance on achieving safety, stability and cultural continuity for Aboriginal children and young people'.⁸¹ At the same time, FACS also endorsed the *Aboriginal Case Management Rules and Practice Guidance*, a comprehensive document which provides detailed practice advice about engaging in casework with an Aboriginal family at all stages of the child protection continuum (including in relation to Aboriginal family-led assessments, Aboriginal family-led decision making, Aboriginal case planning and engagement with Aboriginal Community Controlled Mechanisms and Aboriginal Community Controlled Organisations).

AbSec submitted to this Review that:

If implemented well, and properly resourced, this policy seeks to integrate many of the Aboriginal and Torres Strait Islander Placement Principles into practice across the service system. However, it is noted that policy change is insufficient, and broader systemic change is needed in order to establish an effective Aboriginal child and family system.

The Review agrees that, if implemented properly, the *Aboriginal Case Management Policy* and the *Aboriginal Case Management Rules and Practice Guidance* could resolve many of the issues relating to non-compliance with the ACPP that have been identified in this Review. For this reason, it is essential that the department actively funds and supports the implementation of the new policy and guidance and reports publicly on its activity in this regard.

79 AbSec, 'Aboriginal Case Management Policy', AbSec, Web Page, (2 July 2019), <<https://www.absec.org.au/aboriginal-case-management-policy-guidelines.html>>.

80 Department of Family and Community Services (NSW), *Aboriginal Case Management Rules and Practice Guidance*, (2019), 2.

81 Ibid.



Management Rules and Practice Guidance and report publicly on its activity in this domain.

Recommendation 81: The Department of Communities and Justice should actively fund and support the implementation of the *Aboriginal Case Management Policy* and the *Aboriginal Case*

The need for greater oversight by the Children’s Court

When applying to the Children’s Court for a care order for the removal of a child from his or her parents, the Secretary must consider whether there is a realistic possibility of the child being restored to his or her parents.⁸² If the Secretary is of the opinion that restoration is a possibility, the Secretary must prepare a ‘permanency plan’ involving restoration and submit it to the Children’s Court.⁸³ If the Secretary is of the opinion that restoration is not feasible, they must prepare a permanency plan for another long-term placement and submit it to the Children’s Court.⁸⁴

Under s 78A(3) of the *Care Act*, a permanency plan for an Aboriginal or Torres Strait Islander child that is submitted to the Court must address how the plan has complied with the ACPP in s 13 of the Act. Finally, pursuant to s 83(7), the Children’s Court must not make a final care order unless it expressly finds that ‘permanency planning for the child or young person has been appropriately and adequately addressed’.

This combination of provisions provides a unique opportunity for the Children’s Court of New South Wales to actively supervise departmental compliance with the placement principle of the ACPP (as outlined in s 13 of the *Care Act*). Specialist Children’s Court Magistrates who have received training from Aboriginal organisations about the ACPP can ensure that placement plans provided to the Court clearly demonstrated that the department has:

- (i) made genuine and comprehensive efforts to locate family or kinship carers from the child’s Aboriginal community;
- (ii) supported family and kinship carers to obtain the necessary carer authorisation;
- (iii) consulted with family, kinship groups and Aboriginal organisations about the placement that will be in the best interests of the child;
- (iv) consulted with the child about his or her wishes regarding placement; and
- (v) ensured that the child will have continuing contact with his or her family, community and culture.

⁸² See Chapter 21 for a detailed discussion of restoration.

⁸³ *Children and Young Persons (Care and Protection) Act 1998 (NSW)* s 83(2).

⁸⁴ *Ibid.*

If these elements have not been addressed in the permanency plan, it would be difficult for the Court to expressly find that permanency planning has been ‘appropriately and adequately addressed’.

However, for the Court to adopt a more active role in ensuring compliance with the ACPP, and thereby improving outcomes for Aboriginal children in the Child Protection system, it is necessary for all care and protection matters to be heard by specialist magistrates (as recommended in Chapter 22). It is also necessary for all Magistrates to have a deep and comprehensive understanding of the ACPP—its intent and its elements—to guide judicial decision making.

Recommendation 82: The Judicial Commission of NSW should, in consultation with the Children’s Court of NSW and the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec), design and implement an ongoing program of judicial education for Magistrates regarding the intent and elements of the Aboriginal Child Placement Principle, as well as how judicial decision making may help to support their implementation.



17. Partnership

What needs to be taken into account is the mistrust relationship between government and Aboriginal people. So they need to get Aboriginal leaders within their communities to work in partnership to build trust within these organisations.

...It's not about pointing the fingers and saying you guys are doing this and doing that. We need to work in partnership, together, on the same level ... And children is everybody's responsibility. So, to have kids unsafe just isn't okay. One child unsafe is too many.⁸⁵

Introduction

This chapter analyses the second element of the Aboriginal Child Placement Principle (ACPP)—partnership. It discusses the meaning of the term and highlights that it is related to, but theoretically distinct from, self-determination. It then examines the way in which this element of the ACPP is approached in legislation and FACS policies, before outlining findings from the Review's file review relevant to the element.

What is partnership?

The element of partnership requires the NSW Government to commit to seek the genuine participation of Aboriginal communities at each and every stage of the child protection system. Representatives of the Aboriginal community, external to the statutory agency, should be engaged as partners:

- (i) in the design and delivery of child protection policies, strategies and services;
- (ii) when decisions are being made about the 'intake, assessment, intervention, placement and care' of individual Aboriginal children; and
- (iii) in judicial decision-making processes.⁸⁶

This element is reflected in s 12 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*), which provides that Aboriginal representative organisations and communities

are to be given the opportunity, by means approved by the Minister, to participate in decisions made concerning the placement of their children and young persons and in other significant decisions made under this Act that concern their children and young persons.

The element of partnership is related to, but distinct from, the concept of self-determination (recognised in s 11 of the *Care Act* and discussed in Chapter 6 of this report). While partnership

⁸⁵ Consultation conducted with AbSec Youth Ambassadors (Sydney, New South Wales), 16–24 years of age, 18 August 2018, cited in Australian Child Rights Taskforce, *The Children's Report: Australia's NGO coalition report to the United Nations Committee on the Rights of the Child* (2018) 25.

⁸⁶ SNAICC, *The Aboriginal and Torres Strait Islander Child Placement Principle: A Guide to Support Implementation* (2018) 31.

can create an environment conducive to greater self-determination, it is not synonymous with it. As noted in the 1997 *Bringing Them Home Report*:

Self-determination requires more than consultation because consultation alone does not confer any decision-making authority or control over outcomes. Self-determination also requires more than participation in service delivery because in a participation model the nature of the service and the ways in which the service is provided have not been determined by Indigenous peoples. Inherent in the right of self-determination is Indigenous decision-making carried through into implementation.⁸⁷

The element of partnership is also reflected in some NSW policies and strategies, such as the *Aboriginal Consultation Guide*, the *Guiding Principles for Strengthening the Participation of Local Aboriginal Community in Child Protection Decision Making*, and in the most recently designed *Aboriginal Case Management Policy and Guidelines*. Further, there are a variety of additional promising local initiatives being pursued throughout NSW. Local Advisory Groups have now established in ten areas and Protecting Aboriginal Children Together (PACT), an Aboriginal service which provides advice about risk assessments and other decisions to be made by departmental staff, continues to operate in at least two locations. Finally, Their Futures Matter (a whole-of-government approach to creating a new service system for vulnerable children and families), has launched an Aboriginal Evidence Building in Partnership program, which involves working with Aboriginal communities to co-design evidence-based supports and services for Aboriginal children and families.⁸⁸

While these initiatives are promising, the Review is concerned that they are not always appropriately funded and supported by the NSW Government. As Valentine and Gray noted over a decade ago, ‘if the ACPP is to be fully implemented, there is a need to develop planning and funding models in consultation with and as agreed to by each Aboriginal community.’⁸⁹ In its submission to this Review, SNAICC noted that:

while there is a legislative and policy position allowing, encouraging, and in some cases requiring community participation in decision-making, there is no resourced role for ACCOs to do this except in two locations according to a limited Department funded program. The trial and subsequent de-funding of ACCO-delivered Aboriginal and Torres Strait Islander Family-Led Decision-Making as a means for family and community participation is another example of a lack of resourced ACCO-led programming. These examples—and the limited resourcing of ACCO-operated prevention and early intervention services, with ACCOs operating only four of the ten Intensive Family Based Services (Aboriginal) funded through the Department—demonstrate New South Wales’ over-reliance on trials, un-sustained approaches, and lack of comprehensive state-wide strategy.⁹⁰

The Review notes that there is a clear need to ensure ‘structures and processes are developed to support the partnership including governance, facilitation, and agreements’.⁹¹ Unfortunately,

87 Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997) 276.

88 Department of Family and Community Services (NSW), ‘Aboriginal Co-Design and Evidence’ (Web Page, 2 July 2019), <<https://www.theirfuturesmatter.nsw.gov.au/implementing-the-reform/needs-based-supports/aboriginal-co-design-and-evidence>>.

89 Bruce Valentine and Mel Gray, ‘Keeping Them Home: Aboriginal Out-of-Home Care in Australia’ (2006) 87(4) *Families in Society: The Journal of Contemporary Social Services*, 537, 539.

90 SNAICC, *Baseline Analysis of Best Practice Implementation of the Aboriginal and Torres Strait Islander Child Placement Principle*, (April 2018), 3 attached to Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

91 SNAICC, *The Aboriginal and Torres Strait Islander Child Placement Principle: A guide to support implementation*, (December 2018),



as experience has long demonstrated, it is simply not sufficient to trust that the NSW Government will actually fund, support and effectively implement any of the programs designed to enhance Aboriginal partnership in the child protection system. As such, there is also a clear need for greater oversight in this area—to ensure that Government commitments to policies and strategies to work in partnership with Aboriginal communities are actually honoured in practice. The new independent NSW Child Protection Commission, recommended in Chapter 7, should provide this oversight. It should also ensure that DCJ’s activities in this area are transparent—for example, that relevant data is published, such as data about the number of ACCOs providing OOHC and the number of Local Advisory Groups that have been established.

Further, to ensure partnership is strong, genuine and respectful, the department *must* work to ensure that relationships are built on trust and mutual understanding. To this end, and until self-determination is fully realised in this child protection sector, the department must ensure that it moves beyond the ‘command-and-control’ approach to the delivery of the child protection system. It is imperative that the ‘rhetoric of empowerment, participatory governance ... and family-and community-engaged practice’⁹² be honoured in practice. As discussed in Chapter 2, the Review experienced a lack of genuine commitment to partnership when FACS refused to allow the Review to share data with its Aboriginal Reference Group for interpretation purposes. The failure to engage in genuine partnership can also be seen in the fact that many of the more recent reforms to the child protection system—for example, the introduction of mandatory alternative dispute resolution (discussed below) and the new evidence-based, family-based preservation and restoration programs—have been implemented and designed without any significant consultation with the Aboriginal community.⁹³ It can also be seen in the approach that FACS has taken to acknowledging, but then overriding, the views of the Aboriginal community on the adoption of Aboriginal children.⁹⁴

the department must ensure that it moves beyond the ‘command-and-control’ approach to the delivery of the child protection system.

Moving beyond policies and programs, the element of partnership also includes the participation of external Aboriginal community representatives when decisions are being made about individual children.⁹⁵ While these external representatives do not take the place of the family when it comes to decision-making regarding the child’s placement, contact arrangements and other case planning decisions, they can provide valuable information to FACS, including information about:

35.

92 G Burford, J Braithwaite and V Braithwaite, *Restorative and Responsive Human Services*, (Routledge, 2011), 12.

93 SNAICC, *Baseline Analysis of Best Practice Implementation of the Aboriginal and Torres Strait Islander Child Placement Principle New South Wales*, (April 2018), 16.

94 This issue is discussed further in Chapter 22.

95 SNAICC, *Understanding and applying the Aboriginal and Torres Strait Islander child placement principle a resource for legislation, policy, and program development*, (2017), 4.

- local cultural norms and beliefs including Aboriginal parenting practices;
- local cultural perspectives and approaches to holistic wellbeing;
- the child and family dynamics as well as community dynamics;
- community strategies to build on strengths and resilience within the wider family, kinship network and community-appropriate referral pathways to community support services that the family are likely to feel more supported and comfortable with;
- extended family and community networks to involve in decision-making, who may be potential carers or who could form part of the child's Lifetime Network;
- the identity and role of Elders in the community and ways to approach and involve them in the life of the child and family;
- family tracing and reunification; and
- trans-generational impacts of past welfare practices.⁹⁶

One concern is that in practice the concepts of partnership, participation, consultation and self-determination are often conflated. Further, terms are used interchangeably in policy documentation and regularly confused in practice. For example, the case files analysed revealed a tendency to assume that a case involving an Aboriginal child required 'consultation', and once that box was checked, business could proceed as usual. However, in the vast majority of cases, there was no appreciation that consultation is simply a component of the partnership and participation elements of the ACPP and holding a consultation with an Aboriginal person does not, in and of itself, satisfy the requirements of the ACPP.

It is important to note that consultation with an Aboriginal FACS worker does not satisfy the requirements for participation of external Aboriginal community representatives in child protection processes. As was noted in the 2008 Wood Report, there was (and remains) a tendency of caseworkers to rely on consultation with internal Aboriginal staff to satisfy the consultation component of the legislative provisions, even when the views of these workers did not necessarily reflect the views of community members outside the department.⁹⁷ As one stakeholder to the federal Senate Inquiry into OOHC submitted, when FACS consults with internal staff, 'really what they are doing is consulting with themselves, and therefore what they do then is tick the box on that process'.⁹⁸ While Aboriginal staff could and should be involved in partnership activities, they should be involved along with external Aboriginal community groups and representatives. The construction of Aboriginal caseworkers in the workplace as authoritative figureheads, representing the views and wishes of Aboriginal communities, places an unduly onerous burden on the Aboriginal caseworker. In our stakeholder engagement, many current and former Aboriginal caseworkers felt this burden acutely.

96 Department of Family and Community Services (NSW), *Cultural Practice with Aboriginal Communities* (Casework Practice Advice, FACS Intranet).

97 James Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW* (November 2008), 11.148, 11.155.

98 Senate Community Affairs References Committee, *Out of Home Care* (Report, 2015) 8.94.



Data findings

This section outlines the data that the Review collected during the course of its file review process. The data collected for the quantitative analysis required reviewers to check whether ‘formal consultation’ had occurred with Aboriginal people or agencies, as opposed to unplanned, informal consultation or consultation with family. In light of this, ‘consultation’ is used in the following discussion to mean consultation that would satisfy the partnership element of the ACPP—that is, formal consultation with Aboriginal representatives outside of the child’s family and extended network.

While the data reveals much about the pervasive nature of the failure to consult with the Aboriginal community, it is important to note that it does little to reveal whether any consultations that actually occurred were in fact effective and meaningful. In other words, consultation is not synonymous with decision-making in partnership with the Aboriginal community. For instance, the data do not provide any information about the subject matter addressed in the consultation, or the way in which the consultation was conducted in practice. Further, in many cases, any consultation that occurred appears to have been undertaken for the purposes of ‘ticking the box’. This was due to the recommendations from the consultation never being implemented, or alternatively, no records about the recommendations existing at all. It is also important to note that data discussed in Chapter 3 show that most Aboriginal children in the cohort were known to FACS for a significant period of time and received numerous risk of significant harm reports before entry into care. In practice, there are very few surprises when it comes to entry into care, and as such, FACS has often had a prolonged period of time which they had the opportunity to partner with the Aboriginal community about the circumstances of an individual child.

Below are some examples of casework practice encountered during the case file review:

- In Case 11, one consultation occurred in May 2015 and one was requested in February 2016. However, it is unclear from the records whether this second consultation occurred.
- In Case 13, there was limited information about Aboriginal consultations. While safety and risk assessment records note that an Aboriginal consultation occurred prior to the child’s entry into OOH, there is no further information about this consultation. An Aboriginal consultation is recorded to have occurred in January 2018, however there are no details of the nature of this consultation.
- In Case 113, an Aboriginal consultation was held in July 2016. However, it is not clear what the recommendations were from this consultation. There was also a prior consultation held in May 2016, but again it is unclear what actions or recommendations flowed from this consultation.
- In Case 26, the recommendations of the Hunter Aboriginal Panel relating to cultural connection for the child (for example, a recommendation to connect the child’s uncle with ‘Finding Your Mob’) were not followed up.
- In Case 18, the recommendation of the Protecting Aboriginal Children Together (PACT) initiative that the child’s grandmother be assessed for respite care did not progress, nor did the recommendation for the children to be linked with local Aboriginal services and attend local cultural events in the community.

- In Case 126, there were three engagements with the Aboriginal consultation panel after the child was removed, but the panel's recommendation that 'Jane' be appointed as the child's carer and its recommendation that FACS further inquire into paternal family were ignored. In the third panel meeting, the Aboriginal consultation form was not attached and the record was incomplete.

Aboriginal consultation before children entered care

FACS (Review Tool) data indicate that formal Aboriginal consultation is rarely occurring for Aboriginal children before they enter OOHHC.

The data show that Aboriginal consultation occurred for less than 10% of Aboriginal children (and often well less than 10%) at the Helpline, Community Service Centre, triage, pre assessment consultation, assessment consultation, safety assessment, safety assessment review, risk assessment, child protection case planning and risk re-assessment stages.⁹⁹ For 80.9% of children in the cohort, there was no formal Aboriginal consultation during the pre-entry to care stage (Figure 56).¹⁰⁰ These are concerning statistics.

In over one third of cases where consultation did occur during the pre-entry into care stage, the consultation was with a single internal FACS Aboriginal staff member only. In only 6.4% of these cases did consultation occur with a panel comprising internal Aboriginal staff and external Aboriginal staff representing agencies. In no cases did pre-entry into care consultation involve a panel comprising internal staff, external staff and Aboriginal community members. Almost none of the children in the cohort benefited from the engagement of an Aboriginal panel including external staff and community members at any stage before they entered care (Figure 57).¹⁰¹

Data also highlight that at key child protection casework points, such as during safety and risk assessment, very few children's cases were subject to formal Aboriginal consultation (less than 6% of the cohort in each category). These data suggest that there is significant need for improvements in adherence to the ACPP and specifically giving effect to partnership and decision-making aspects of the principle.

The qualitative data highlights that there are also issues where Aboriginal consultations occur. In 22 of the cases in the sample, reviewers raised concerns including that Aboriginal consultation recommendations (made both historically and proximal to a child entering care) were not being clearly recorded on FACS systems, or were being apparently ignored. This highlights, amongst other things, the importance of not relying on Aboriginal consultations to signify cultural competency within practice.

In a number of cases reviewers specifically identified that Aboriginal consultation and partnership would have improved FACS' work with Aboriginal families and may have changed the trajectory of the case – avoiding children's entries into care.

There were few strengths identified in case tools. However, in one case it was identified that it was a strength of practice that Aboriginal consultation prior to the children entering care

99 Figure 56, Appendix A. It should be noted that not all Aboriginal children were involved in all stages (for instance, risk re-assessment).

100 It should be noted that reviewers were not provided written guidance in the Aboriginal Care Review Tool defining the term pre-entry into care. Therefore, there may be some reliability issues in some variables of this data.

101 The data suggests that this occurred in 0% of cases in each stage prior to entry into care, although three additional categories have been numerically suppressed due to the numbers amounting to less than 5 children per category.



was meaningful, prevention-focused, and focused on supporting family, including the parents, around care of the children. The importance of early, ongoing and prevention-focused Aboriginal consultation and partnership was also specifically highlighted in a number of review tools.

Aboriginal consultation after children entered care

FACS (Review Tool) data indicate that formal Aboriginal consultation is rarely occurring at key practice and casework points for Aboriginal children after they enter OOHC. It should be noted that similar data is not routinely available through FACS administrative data systems.

The data show that very few children in the cohort received Aboriginal consultation in respect of their initial placement (14.3%) and few received Aboriginal consultations in relation to placement changes (14.5%). For a higher proportion of children Aboriginal consultation occurred during long-term care considerations (41.4%), during cultural planning case management (34.8%) and for OOHC case planning (25%). However, across the board, most Aboriginal children did not have Aboriginal consultations at these case management stages (Figure 56).

Further, the data highlight that panel consultations involving Aboriginal staff or community members occurred for very few Aboriginal children (these consultations occurred for less than 5% of Aboriginal children during casework stages such as long term care considerations, placement changes, OOHC case planning, and cultural planning).¹⁰² These figures demonstrate that very little formal partnership is occurring with Aboriginal staff outside of FACS, and with Aboriginal community members.

In addition to confirming the lack of consultation at key practice points for children in care, the qualitative sample data also highlight that recommendations made via formal Aboriginal consultations (where these are held) are not always being progressed. In many cases it was not clear from records whether any recommendations had been progressed, in many other cases it was identified that while a consultation had taken place, there was no record about what recommendations or actions flowed from the consultation.

The qualitative and quantitative data, when considered together, raise serious issues around partnership aspects of ACPP. Not only do these data highlight profound deficiencies in Aboriginal consultation for Aboriginal children who are in care, they highlight a concerning lack of partnership with external Aboriginal community members as is required by ACPP. Further, the data suggest that even where consultation does occur, in many cases FACS and NGOs are not clearly recording or progressing recommendations of these consultations; suggesting that the exercise of Aboriginal consultation is being used as a 'check-box', rather than in a way which values the knowledge and expertise of those Aboriginal people consulted.

Recommendation 83: The Department of Communities and Justice should ensure that recommendations made by Aboriginal staff or community members in all consultation processes relating to Aboriginal children are tracked and implemented and that data about the content and implementation of these recommendations is recorded in ChildStory and made publicly available

18. Placement

Introduction

This chapter continues to examine ways in which to enhance compliance with the Aboriginal Child Placement Principle (ACPP) in NSW. It focuses on the fourth principle of the ACPP—that is, the principle that deals with the placement of Aboriginal children in out-of-home care (OOHC). It begins by examining the legislative requirement to place Aboriginal children with family or kin first, before considering other placement options in the ‘placement hierarchy’. It then analyses data about the placement of Aboriginal children in OOHC, including data about the first and current placements of children in the Review cohort. It discusses the need for placement stability, and in particular, the need to plan for a stable placement for an Aboriginal child prior to the child’s entry into care. It concludes by discussing a number of issues affecting the recruitment, assessment and support of Aboriginal carers.

Placement of Aboriginal children

Aboriginal children have a right to grow up with their family and their community and a right to grow up living with their culture.¹⁰³ Section 13 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*) recognises these human rights and sets out a hierarchy of placement for Aboriginal children in OOHC. In summary, in order of preference, Aboriginal children are to be placed with

- (a) a member of the child’s extended family or kinship group;
- (b) a member of the Aboriginal or Torres Strait Islander community to which the child belongs;
- (c) a member of some other Aboriginal or Torres Strait Islander family residing in the vicinity of the child’s usual place of residence, or
- (d) a suitable person approved by the Secretary after consultation with:
 - (i) members of the child’s extended family or kinship group, and
 - (ii) such Aboriginal or Torres Strait Islander organisations as are appropriate to the child or young person.

A child should only be placed with a carer on a lower level of the hierarchy if it is not practicable or it is in the best interests of the child to be placed with a carer in the category above.¹⁰⁴ The child’s wishes and whether or not the child identifies as Aboriginal must also be taken into account when determining where he or she will be placed.¹⁰⁵ If a child has one Aboriginal

103 *Convention on the Rights of the Child*, 20 November 1989, [1991] ATS 4, (entered into force generally on September 1990), art 30.

104 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 13.

105 *Ibid* s 13(2).



and one non-Aboriginal parent, placement should be with the person who will best serve the child's best interests. The placement hierarchy does not apply to emergency placements and placements for a duration of less than two weeks.¹⁰⁶

80.9%

For 80.9% of children in the cohort, there was no formal Aboriginal consultation during the pre-entry to care stage

Where are Aboriginal children placed?

As noted in Chapter 16, there is some limited data available about the physical placement of Aboriginal children in OOHC. This data indicates that, as at June 2018, 73% of Aboriginal children in care were placed with either a relative, kinship carer, or Aboriginal carer. However, as also noted in Chapter 16, this placement data needs to be interpreted with caution. In particular, it is not correct to say that a placement demonstrates 'compliance with the ACPP', or even the placement element of the ACPP, simply because it falls within one of the paragraphs of s 13 of the *Care Act*. A particular limitation with this data is there is no evidence to show whether or not the placement has been arrived at after a proper application of the hierarchy—that is, whether a child's placement was made after it was determined that he or she could not be placed 'higher' on the hierarchy. Another limitation is that this approach to data collection does not reflect whether a child's previous placements were arranged after a proper application of the placement hierarchy.

The following section discusses data about where Aboriginal children in the Review cohort were initially placed when they first entered OOHC, as well as data about the children's placements at the time of the Review.

106 Ibid s 13(7).

Data findings

First placement

Unfortunately, due to limitations in FACS (Review Tool) data, the Review was unable to accurately ascertain under which sub-section of s 13 of the *Care Act* children in the Review cohort were placed when they first entered care, or at the time of the Review.¹⁰⁷ However, it was possible to determine from the FACS (Review Tool) data that just over a quarter of children were placed in non-Aboriginal foster care placements when they first entered care (n=306, 26.7%), while 8.3% of children were placed in a motel, and 2.4% were placed with a residential agency. Only around 40.1% of children were placed with Aboriginal or non-Aboriginal kin and 3.1% were placed with a parent (Figure 59).

Overall, only 35.1% of the cohort were first placed with an Aboriginal carer and almost two-thirds (63.5%) of the children were first placed with a non-Aboriginal carer (Figure 60). These findings are concerning.

Current placement

According to FACS (Review Tool) data, only about half of children who remained in care at the time of the Review were placed with an Aboriginal carer (53.1%).¹⁰⁸ These are also concerning findings and are similar to those arising from the Seeding Success data, which indicate that Aboriginal children were placed with Aboriginal carers for almost half of all OOHc placements before their fifth birthday, including placements in kinship care, foster care, or residential care.¹⁰⁹

FACS (Review Tool) data also show that around half of the children who were in OOHc at the time of the Review were in a FACS kinship care placement (29.8% were placed with Aboriginal carers, and 22% with non-Aboriginal carers). Of the children in foster care at the time of the Review, 16% were placed with non-Aboriginal carers, while 13.2% were placed with Aboriginal foster carers (Figure 20).

Qualitative research findings

In over half of the cases in the qualitative sample (n=117, 58.5%), issues were expressly identified with the application of the placement hierarchy in s 13 of the *Care Act*. In most cases, issues with the hierarchy were identified alongside issues with family participation in decision-making (n=101, 86% of cases where issues were identified with the application of the hierarchy).

While in many cases children were placed under a category contained in s 13, the case file review highlighted numerous procedural failings in the application of the hierarchy under

107 These data required reviewers to make a determination about which sub-section of the s 13 hierarchy applied to a child's placement. In the Aboriginal Care Review Tool, there was no option to select placement under s 13(4) which is the placement category for children with one Aboriginal and one non-Aboriginal parent. Instead, s 13(5)(a) of the *Care Act* was included as a 'placement category' and as a proxy for 'non-Aboriginal relative carer'. However, s 13(5)(a) is not a placement category. Further, no equivalent proxy was provided for children with one Aboriginal and one non-Aboriginal parent who were placed with an Aboriginal relative carer (as could be anticipated under the mirror provision of s 13(5)(b)). The inclusion of 13(5)(a) but omission of 13(5)(b) in the Review Tool may also have falsely inflated other categories of data (such as 13(1)(a)) in cases where children with one Aboriginal and one non-Aboriginal parent were placed with an Aboriginal relative.

108 Figure 19, Appendix A.

109 Kathleen Falster and Mark Hanly, 'Childhood child protection services involvement and developmental outcomes among Aboriginal and non-Aboriginal Kindergarten children in New South Wales: Findings from a population-based, cross-sectoral data linkage study (The Seeding Success Study)' (Report for the Family is Culture Review, Sydney: UNSW Sydney Centre for Big Data Research in Health, 2019).



this provision, including the failure to consider the provision as setting out a *hierarchy* which preferences placement under s 13(1)(a). For instance, in many cases children were placed with non-Aboriginal carers under a lower section of the hierarchy without adequate investigation or assessment of Aboriginal family or kin care options. In several cases, it was identified that the consultation requirements around placing Aboriginal children with non-Aboriginal foster carers required under the *Care Act* were not being discharged. For children who had one Aboriginal and one non-Aboriginal parent, a number of cases raised concern about decisions being made to place the child with non-Aboriginal family, without sufficient consideration of Aboriginal placements or sufficient consultation with Aboriginal family members.

Failures to observe the hierarchy often appeared to be related to issues of carer assessment, specifically failures to progress assessment of interested or available family or kin care options. These issues are discussed specifically later in this chapter.

Finally, in many cases FACS recorded placements as aligning with s 13 without specifying which sub-section of the hierarchy the child was placed under. It would appear that since this Review cohort, the issue may have been remedied by updates to record-keeping software through ChildStory, which now prompts users to input information about which section of the hierarchy an Aboriginal child is placed under (with onward prompts where required in accordance with the legislation).

Case studies

The following section sets out three case examples to illustrate some of the problems with the initial or ongoing placement of Aboriginal children in OOHC.

- In Case 9, FACS investigated placing the children with Aboriginal foster carers after they entered care. FACS did not, however, contact the children's Aboriginal family to discuss the placement of the children and did not canvass the family for help locating family or kinship carers. Family members appeared to seek a Family Group Conference, but no conference was ever convened by FACS. The children's older sister approached FACS and expressed interest in caring for the children, but her offer was never followed up. When one of the children's care placements broke down, FACS 'considered' kin placement options. Again, however, the children's family were not engaged in the process of canvassing for, or deciding upon, a carer. The children are currently placed off-country with non-Aboriginal foster carers. Two of the children are placed together and one is placed separately. The children do not currently have any contact with their parents, their siblings, or their extended family. None of the children's non-Aboriginal foster carers appear to have received cultural competency training. The children have expressed feeling disconnected from their family and mob and have stated they want to abscond from their placements to return to family and country.
- In Case 10, the child had one Aboriginal and one non-Aboriginal parent. After the child entered care, he was initially placed with his Aboriginal aunt, before being placed with his non-Aboriginal grandmother several months later. The reason for the placement change were not clear from FACS' records. The child's Aboriginal relatives expressed concern about this placement not being in the child's best interests (as required under the *Care Act*). It appears their concerns were ignored. There was no evidence of engagement with the child's Aboriginal family members about his placement, or about ensuring his cultural connections in his placement with a non-Aboriginal carer. Aboriginal family members sought to be assessed as carers for the child, but this did not occur (it was unclear why these carers were

not assessed). Although the child has contact with his mother and siblings in his current placement, there is no information to suggest that FACS has supported him to maintain his connection with his extended Aboriginal family. His non-Aboriginal carer has not had cultural competency training. The child's original cultural plan was not developed with his family and has never been reviewed despite the child's changing cultural needs.

- In Case 46, the child was initially placed in a short-term placement with non-Aboriginal foster carers under s 13(7) of the Act, therefore, the statutory placement hierarchy did not apply. Although the child's placement was intended to be short-term, it has since become a long-term placement without any Aboriginal consultation occurring. The child's family and community have never been involved in placement decision-making for the child. Although some family care options were considered, none were fully progressed and the outcome of the one family carer assessment that was completed is not clear from available FACS records. FACS has not attempted to identify the child's father and has never sought to include the child's paternal family in case decision making. The child is currently located an eight hour drive away from her siblings, whom she sees only four times per year. She also has limited contact with her mother (who seeks more contact). The child's cultural plan is limited and it is evident from the case file that the child is experiencing cultural disconnection.

Discussion

The quantitative and qualitative data set out above, as well as the case studies from the case file review, highlight considerable issues in practice around the placement of Aboriginal children in OOHC. First, it appears that a significant number of Aboriginal children were placed with non-Aboriginal foster carers immediately upon removal, while almost 16% of Aboriginal children in the Review cohort remain in non-Aboriginal foster care placements. As the POCLS data show, Aboriginal children in that study who were placed in households with at least one Aboriginal carer appeared to be more likely to be involved in cultural activities over time, have discussions about cultural heritage, and have contact with their birth communities. In light of this finding, the high proportion of Aboriginal children who are not placed with an Aboriginal carer is particularly concerning, as this is likely to have an adverse impact on Aboriginal children's cultural development and connections while in care.¹¹⁰

Second, it appears that the placement options set out in s 13 of the Act are not always considered and applied as a hierarchy (as intended by the legislation), and that placement of an Aboriginal child in any one of these placement options is considered a proxy for 'compliance with the ACPP'. The recommendations in Chapter 16 regarding the development of guidance and training programs for caseworkers about the ACPP will assist in remedying this problem, while the recommendation for a new system of data collection and reporting about compliance with all elements of the ACPP will provide further information about compliance with the placement principle for all of a child's placements.

Third, the Review notes the high number of 'emergency' and 'short term' OOHC placements for Aboriginal children immediately post-removal (discussed further below).

Finally, the Review is concerned that there is widespread and systemic non-compliance in practice with the statutory requirement to consult with child's family or kinship group and

¹¹⁰ Paul Delfabbro, 'Aboriginal children in out-of-home care in NSW: Developmental outcomes and cultural and family connections. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care' (Research Report Number 11. Sydney. NSW Department of Family and Community Services) 6.



appropriate Aboriginal organisations before placing the child with a person under s 13(d). The recommendations in Chapter 8 designed to improve oversight of casework practice, and the recommendations in the chapter regarding the ACPP element of participation, will work together to help to rectify the problem with non-compliance with consultation requirements in the *Care Act*.

Placement instability

The importance of placement stability for children in OOHC is well-established.¹¹¹ As the *National Framework for Protecting Australia's Children 2009–2020* indicates, a 'sense of security, stability, continuity and social support are strong predictors of better outcomes for young people's long term outcomes after leaving care'.¹¹² Children in stable placements 'tend to have better learning and psychosocial outcomes than children experiencing instability'.¹¹³ Further, as discussed in Chapter 15, placement instability increases the risk of involvement in the criminal justice system. In NSW, a number of 'permanency reforms' have been implemented post-2014 to attempt to ensure that children removed from their families can live in stable placements.

Data findings

There is little available data about stability of Aboriginal children's placements in OOHC. However, FACS (Administrative) data provided to the Review indicated that most Aboriginal children had one placement (60%), two placements (23.5%), or three placements (9.5%) within 24 months of their entry into OOHC. No information is available about how these placements are mapped to s 13 of the *Care Act*. Non-permanent placements of less than seven days were excluded from these counts¹¹⁴ and it is not clear what effect this had on the overall numbers (Figure 78).

The POCLS data from Delfabbro's report suggest that Aboriginal children may be more likely to experience placement breakdown as compared to non-Aboriginal children. The data shows that a quarter of Aboriginal children in that cohort having at least one placement breakdown (24.5%) compared to 18.8% for non-Aboriginal children.¹¹⁵ Further, in this study, caseworkers reported that it was quite challenging to find suitable alternative placements for Aboriginal children that were culturally matched and with siblings.¹¹⁶

Qualitative research findings

In 35 of the cases in the qualitative sample, it was specifically identified that Aboriginal children (including often multiple children from the same family) experienced placement instability

111 See, eg, David Rubin et al, 'The Impact of Placement Stability on Behavioral Well-Being for Children in Foster Care' (2007) 119(2) *Pediatrics* 336.

112 Council of Australian Governments, *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020*, 25.

113 Australian Institute of Health and Welfare, 'National Framework for Protecting Australia's children indicators' (Web Report), <<https://www.aihw.gov.au/reports/child-protection/nfpac/contents/summary>>.

114 For example, short term respite and emergency placements.

115 Noting also the findings in F Wulczyn and L Chen, *Placement Changes Among Children and Young People in Out-of-Home Care. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care*. (Research Report Number 8, 2017, NSW Department of Family and Community Services).

116 Paul Delfabbro, 'Aboriginal children in out-of-home care in NSW: Developmental outcomes and cultural and family connections. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care' (Research Report Number 11, Sydney, NSW Department of Family and Community Services) 7. This data is derived from caseworker survey data rather than FACS administrative data.

while in care. Although no set definition of ‘placement instability’ was applied when assessing cases, the term appeared to be interpreted as children changing placement multiple times, often within short periods of time. In a number of cases this included children moving through multiple emergency foster care placements with no stability after entry into care, or between other placements. Placement breakdowns often seemed to result from children’s behavioural issues, which themselves appeared to be a manifestation of trauma related to the children’s care experiences, including their often unstable care experiences, and separation from family and community. It was common that children’s placements were not organised in compliance with the the ACPP, as family often did not appear to be consulted or made aware of children’s placements and were not often invited to make decisions about where children should be placed. Often children were young during periods of placement instability, which may have affected their attachment and behaviour.

There were several extremely concerning cases among the cohort sample which raised serious questions about the harm of child removal and the safety and welfare of children in care.¹¹⁷ For example, in Case 86 an Aboriginal child in care was described as having changed placement 16 times in less than two years, moving between residential care, juvenile justice detention, rehabilitation, and hotels rooms. This child was also profoundly disconnected from culture and it was identified that no attempts were made to promote his cultural connections and family relationships while he was in care.

In Case 107, the children had 12 different placements (with eight different foster carers) within approximately two years. In another, Case 123, a group of older children in care experienced significant placement instability, including one sister who was identified as having lived in at least ten placements (including motel accommodation and residential care) since entering OOHC. At the time of the Review, she was living permanently in motel accommodation, supervised by youth workers and was herself expecting a child. One child, in Case 176, was removed from a placement due to allegations of sexual assault, which were unsubstantiated. After leaving this placement the child was moved over 20 times. In Case 200, two brothers were separated during the nine months that they were in care, with one of the children moving through six foster care placements during this time, five of which were with non-Aboriginal foster carers.

It was concerning that several of the children who experienced placement instability also allegedly experienced abuse in their OOHC placements. These included two children who were moved due to inappropriate disciplinary techniques used by non-Aboriginal foster carers and another child who was placed in a short-term placement following physical violence by his former carer. Further data around abuse in care is outlined in Chapter 14.

The need to plan for a child’s first placement

The case file review revealed that the placement of Aboriginal children immediately post-removal was an issue that significantly contributed to placement stability. In particular, the case file review revealed many instances where children were removed from their homes, only to be placed in multiple short-term placements with non-Aboriginal carers while a suitable long-term carer was sought. In cases involving siblings, the children were often separated during this time period, thereby exacerbating the trauma of the removal.

117 Note that the harm of removal is discussed in further detail in Chapter 14.



In the majority of these cases, the child's removal was an 'emergency removal' under ss 43 or 44 of the *Care Act*. The Review's case file analysis revealed that 311 (27.2%) of children in the Review cohort were removed pursuant to s 43, while 501 (43.8%) were removed pursuant to s 44. Accordingly, a total of 812 children (71%) were the subject of emergency removals (Figure 14). It is important to note that the placement hierarchy and the consultation requirements in s 13(1) of the *Care Act* (and discussed above) do not apply to 'an emergency placement made to protect a child or young person from serious risk of immediate harm' or to a placement for a duration of less than two weeks.¹¹⁸

For example, in Case 81, the children were assumed into care without any consultation with the child's family or any Aboriginal community organisations. It is unclear whether any family members were considered as carers or why the children were not placed with their grandmother, who had looked after them for an extended period of time under a previous safety plan. The children had seven different placements prior to being restored 10 months after their removal.

In Case 148, a newborn child was removed from her mother. There was no consultation with the child's mother, father or extended family prior to the removal. The newborn child was initially placed in a short-term placement with a non-Aboriginal carer for a period of six months, before being moved into a long-term placement with an Aboriginal carer. It is highly undesirable that a newborn child should be placed in such a short-term care arrangement. In this case, FACS had issued a high risk birth alert one month prior to the child's birth, at which point in time efforts should have been made to organise a permanent, culturally appropriate placement for the newborn child in the event that it would be required.

However, the Review also saw many examples of good practice—that is, cases in which caseworkers worked hard to ensure that siblings were not separated upon removal and to ensure that they were placed with familiar family members to whom they already had an emotional attachment immediately upon their removal. For example, in Case 203, three children were removed from their mother's care and immediately placed with their Aboriginal maternal grandmother. The caseworker conducted an emergency carer assessment to approve the children's grandmother to care for the children while a full carer assessment was completed.

In Case 122, two children were removed from their parents pursuant to s 44 of the Act. However, the caseworker had conducted two consultations (one with Aboriginal staff, and one with a potential carer for the children) prior to the children's removal. This 'parallel planning' ensured that upon their removal, the children were immediately placed together in a long-term placement with an Aboriginal carer with whom they were familiar.

In Case 125, three children were immediately placed together with their Aboriginal maternal great uncle upon their removal. The children's mother and grandmother had both nominated this person as the children's best placement option. The placement assessment was completed as a priority on the day of the children's removal and that it was noted that it was in the children's best interests to be immediately placed with family.

118 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 13(7). However, if an emergency placement is made, the Secretary 'must consult with the appropriate Aboriginal or Torres Strait Islander community as soon as practicable after the safety of the child or young person has been secured': s 13(7).

Discussion

The Review notes that there is limited data about placement stability for Aboriginal children in OOHC. However, the case file review process revealed that placement instability is a serious problem for some Aboriginal children. Further data about this issue will assist in identifying the nature and extent of the problem, as well as how to ameliorate it (for example, through the provision of better support to carers).

As a number of cases from the cohort file review demonstrate, it is possible and highly desirable to engage with Aboriginal family members to plan for the placement of a child prior to the child's removal (in cases where removal becomes necessary). This type of planning—known as 'parallel planning', 'concurrent planning' or 'twin track' planning—is already utilised by a number of jurisdictions after children have entered care in order to secure the child a permanent placement. For example, the Department for Child Protection and Support in Western Australia states that it will explore permanent placement options for a child whose permanency goal is reunification, 'just in case the child's parents are unable to make the necessary changes within the time frame that has been set'.¹¹⁹

The Review recommends that this type of 'parallel planning' be utilised much earlier in the continuum of intervention, namely at the 'pre-entry into care' stage. In many of the cases reviewed, it appeared that it would have been possible for caseworkers to consult with family members about placement options for their children in the event that it became necessary to remove them from the home. This type of collaborative parallel planning could have ensured that willing, suitable and familiar carers were promptly identified for Aboriginal children at risk of removal and could have enabled these potential carers to prepare for the carer assessment process. Greater use of provisional or emergency carer approvals could have also ensured that Aboriginal children were not unnecessarily separated from their siblings and placed in short-term placements with unknown, often non-Aboriginal, foster carers while their family or kin sought formal carer authorisation.

The Review notes that a number of recommendations throughout the report will, if implemented properly, help to reduce placement instability, including the recommendations below relating to carer authorisation and support. It also recommends that DCJ develop a policy and guidance relating to best-practice casework in respect of the placement of Aboriginal children immediately post-removal. The Review notes that the policy and guidance should address the importance of parallel planning at the pre-entry into care stage of the child protection system.

Recommendation 84: The Department of Communities and Justice should work with Aboriginal stakeholders and community to design a system for the collection and reporting of data about the placement stability of Aboriginal children in out-of-home care.

Recommendation 85: The Department of Communities and Justice should develop a policy and guidelines that incorporate information about good-practice casework regarding the placement of a child immediately post removal and include guidance on parallel planning at the pre-entry into care stage of the child protection system.

¹¹⁹ 'Permanency Planning' *Government of Western Australia, Department for Child Protection and Family Support*, (Information Sheet) <<http://www.dcp.wa.gov.au/FosteringandAdoption/CurrentFosterCarers/Documents/Permanency%20Planning%20Information%20Sheet.pdf>>.



Finding appropriate carers

A number of stakeholders informed the Review that there were problems with finding, assessing and supporting potential family and kinship carers for Aboriginal children in OOHC. The following section discusses the process of finding appropriate carers for Aboriginal children in OOHC. It examines some of the identified barriers to the location and recruitment of carers, such as the reluctance of many Aboriginal people to engage with child protection services, the fact that the department's efforts to locate potential family or kinship carers are often limited and ineffective, and the practice of caseworkers ignoring or overlooking potential family or kinship carers.

Reluctance to engage with the department

FACS employees, parents and carers informed the Review that there is a significant amount of mistrust between Aboriginal families and the department.¹²⁰ One stakeholder discussed how Aboriginal peoples' lives revolve around how to 'fight' or 'dodge' the system,¹²¹ while a caseworker noted that the mistrust was 'so deep' that it hindered the ability of Aboriginal families to achieve the goals that the department sets for them to enable them to keep their children in their care.¹²² The system was seen as driving 'a wedge through the community'¹²³ and stakeholders noted that this mistrust was both caused and complicated by ongoing intergenerational trauma. For example, in one consultation, the Review was informed that one particular grandfather was stolen as a child and charged with neglect by the state. At the time, his father fought to get him and his brothers back and at the time of the Review, he was similarly attempting to have his granddaughter returned to the family.¹²⁴ The Review was informed that families who witness children being removed become scared of the department and live with the trauma caused by the removal, and in fear of their children being taken.¹²⁵

there is a significant amount of mistrust between Aboriginal families and the department.

In addition to fear of the department, the Review heard that many Aboriginal families do not trust the child protection system as a whole. In several consultations, stakeholders observed that the removal of Aboriginal children was an 'industry'. It was noted that the system makes 'money off Aboriginal misery',¹²⁶ that large amounts of money were poured into the system, and that for those in the system 'it's about money and keeping their jobs'.¹²⁷

This deeply entrenched mistrust of FACS also affects the number of potential Aboriginal carers who approach FACS to volunteer their services. For example, the Law Society of NSW submitted that fear of FACS may prevent some Aboriginal family members from nominating themselves as carers, as this could lead to FACS intervention into their own family.¹²⁸ The Review

120 Confidential, *Consultation*, FIC 84.

121 Confidential, *Consultation*, FIC 56.

122 Confidential, *Consultation*, FIC 2.

123 Confidential, *Consultation*, FIC 54.

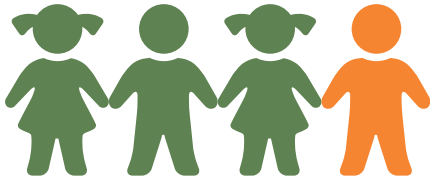
124 Confidential, *Consultation*, FIC 12.

125 Confidential, *Consultation*, FIC 57.

126 Confidential, *Consultation*, FIC 69.

127 Confidential, *Consultation*, FIC 91.

128 From the Law Society of NSW's submission to the Legislative Council Inquiry into child protection, attached to The Law Society of New South Wales, Submission No 3 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.



just over a quarter of children were placed in non-Aboriginal foster care placements when they first entered care (n=306, 26.7%), while 8.3% of children were placed in a motel, and 2.4% were placed with a residential agency.



Almost two-thirds (63.5%) of the children were first placed with a non-Aboriginal carer

was also informed that there had been instances where Aboriginal people who had informally cared for children since their birth had attempted to be approved as carers, only to be refused carer authorisation and to have the children already in their care removed.¹²⁹ The Review was also informed that many Aboriginal people would prefer to avoid formal kinship care arrangements and care for children ‘unofficially’ because when formal care arrangements were established FACS imposed restrictions on who could enter and leave the house.¹³⁰

Poor family finding

For a child to be placed with family, it is first important for that family to be located. The Review notes that the ‘Family Finding’ model developed by Kevin Campbell in the United States is popular in NSW, having been adopted by FACS in 2016, and may assist caseworkers in this process. The Family Finding model encourages caseworkers to, among other things, work with urgency, be persistent in seeking family members, and think about ‘permanency’ as ‘permanent belonging’ (as opposed to simply legal permanency).¹³¹ The model, which is intended to be used early in casework with a family, challenges caseworkers to work with families to find ‘no fewer than 40 relatives or other meaningful connections’ for the child in question.¹³² In many ways this model is simplistic in that it informs caseworkers to ‘use search engines or social media searches’ to find family and to go through files and take notes of people involved in the child’s life.¹³³ The Review acknowledges, however, that this type of instruction may be necessary to ensure that the family of children involved with the system are located in a timely manner. Part of the model involves building a ‘Lifetime Network’ of support for the child, which also helps to ensure that the child will have support in the event they enter, and exit, OOHC.¹³⁴

129 Consultation, *Confidential*, FIC 68.

130 Consultation, *Confidential*, FIC 5–9,

131 Department of Family and Community Services (NSW), *Building Connections for Children through Family Finding* (Casework Practice Advice, FACS Intranet).

132 Ibid.

133 Ibid.

134 Ibid.



53.1%

Only about half of the children who remained in care at the time of the Review were placed with an Aboriginal carer (53.1%)

43.5%

Aboriginal families were involved in making decisions around the child's first placement for less than half of the children in the cohort (43.5%)

The recently introduced *Aboriginal Case Management Rules and Practice Guidance* provides that FACS caseworkers are to engage with Aboriginal communities through established local mechanisms before carrying out a safety and risk assessment to identify, among other things, family networks for initial assessment of family placements.¹³⁵

The issue of family finding was addressed by numerous stakeholders to the Review. The Women's Legal Service NSW expressed concern about poor practice in relation to family finding. It stated that it had been informed that NGOs often received no information from FACS regarding a child or young person's Aboriginal family. In cases where a child or young person has both an Aboriginal and non-Aboriginal parent, the genogram provided by FACS frequently focuses 'exclusively on the non-Aboriginal side of the family'. Further, when NGOs, after undertaking their own inquiries, provided information to FACS about the identity of a child or young person's family members, this information was not acted upon. The Women's Legal Service NSW submitted that it was informed that, when queried, FACS advised that they 'phoned the family member but they did not get back to them'.

The Benevolent Society submitted that the Aboriginal people it had spoken to for the purposes of drafting its submission were critical of FACS' family finding practice. It submitted that this practice was 'seen as inadequate and cursory and is blamed for the high number of Aboriginal children and young people who find themselves in mainstream placements'.¹³⁶ The Law Society of NSW submitted that families in contact with the child protection system should be assisted to identify safe carers at an early stage.¹³⁷

The Women's Legal Service NSW noted that Link-Up and local ACCOs required additional funding to ensure that family finding occurred in a timely fashion. It also submitted that FACS should be required to present the Children's Court with detailed evidence of searches made for Aboriginal family and suggested that this should be done by way of an attachment to the 'Care and Cultural Plan'. It noted that Children's Court Magistrates must hold FACS accountable for compliance with

¹³⁵ Department of Family and Community Services (NSW), *Aboriginal Case Management Rules and Practice Guidance*, (2019)

¹³⁶ The Benevolent Society, Submission No 7 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

¹³⁷ The Law Society of New South Wales, Submission No 3 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

this requirement and that FACS senior management must hold caseworkers accountable for failing to satisfy the Court that the searches for Aboriginal family have been undertaken properly.

However, some stakeholders noted that family complexities could affect a caseworker's ability to find family or kinship carers for a child. For example, some parents could request that caseworkers keep the fact that their child was being removed confidential (and not, for example, inform other family members), which then impeded the ability of caseworkers to find family or kinship carers.¹³⁸

Discussion

The Review agrees that it is vitally important for the family members of an Aboriginal child to be identified at an early stage to minimise placement instability in the period immediately after removal, and to secure an appropriate long-term placement for a child. Ideally, the finding of family members who may be willing and able to care for an Aboriginal child in OOHC should be a collaborative process between the department and the child's family. The Review is concerned about stakeholder feedback about poor practice in this area and noted multiple examples in the case file reviews where there appeared to have been scant effort to locate appropriate family members who may wish to care for the child (for example, the father of a child). The Review notes that many of the recommendations in this report, including recommendations about enhancing departmental knowledge of the ACPP, implementing the *Aboriginal Case Management Policy* and the *Aboriginal Case Management Rules and Practice Guidance*, and increasing the oversight and accountability of caseworkers, will assist to remedy problems in this area.

Informal carer assessment

The identification of appropriate potential carers is the first step in the process of ensuring that Aboriginal children are placed in accordance with the placement element in the ACPP. However, once identified, issues remain relating to the authorisation of the carer. This section discusses 'informal' carer assessment, with a particular focus on the problem of potential carers for Aboriginal children being ignored or overlooked by the department.

Potential carers ignored or overlooked

For many years, stakeholders and commentators have expressed concern about the shortage of Aboriginal carers for Aboriginal children in OOHC. For example, the Wood Report noted that lack of Aboriginal carers was an issue in some regions,¹³⁹ as did the 2017 Legislative Council inquiry into child protection.¹⁴⁰ OOHC agencies actively attempt to recruit more Aboriginal carers¹⁴¹ and the mainstream media often reports on the lack of Aboriginal carers for Aboriginal children.¹⁴² Research studies also discuss the difficulty that child protection professionals face

138 Confidential, *Consultation*, FIC 61; Confidential, *Consultation*, FIC 26.

139 James Wood, Report of the Special Commission of Inquiry into Child Protection Services in NSW (November 2008), Vol 2 11.58.

140 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) 96, [5.45].

141 Aboriginal and Torres Strait Islander children and carers', *My Forever Family NSW* (Web Page) <<https://www.myforeverfamily.org.au/page/71/atsi-children>>.

142 See for example: Avani Dias, 'Aboriginal foster parents needed desperately to provide support for NSW Indigenous foster kids', *ABC News* (online, 12 September 2017) <<https://www.abc.net.au/news/2017-09-12/aboriginal-foster-parents-needed-desperately-in-nsw/8900022>>.



when attempting to recruit Aboriginal carers.¹⁴³

In light of this, the Review was surprised to discover that in a substantial number of the cases in the cohort, Aboriginal family members or kin had approached FACS to offer to care for particular Aboriginal children. In a significant number of these cases, these potential carers were not contacted again and no reasons for this decision were recorded on the child's FACS file. In other cases, FACS appeared to make an informal decision not to proceed with the formal carer assessment process, again not always recording reasons for this decision on the file. When reasons were recorded, they often did not relate to the carer's ability to ensure a child's safety and wellbeing. These findings, discussed in more detail below, challenge the assumption that there are always insufficient Aboriginal carers for children and highlights an urgent need to improve the department's practice and processes in this area. Examples of issues in the case file reviews include:

- In Case 50, several family members approached FACS and requested to be assessed to care for the children after the children were removed, including two of the children's aunts, a maternal family member and the children's great aunt. FACS caseworkers determined that these placement options were not appropriate. No reasons were recorded for these decisions on the department's files.
- In Case 81, FACS did not consult with any family members about the children's placement after they were assumed into care. It is unclear whether any extended family members were considered as carers. It is unclear why the children were not placed with their grandmother, who had looked after them for an extended period of time under a previous safety plan. The children (aged five and two) had seven different placements before being restored to their parents ten months after their removal. They were separated in at least one of their placements. There are allegations that they were mistreated while in OOHC.
- In Case 209, a newborn child was removed and placed with a non-Aboriginal carer for six months before being moved into a placement with an Aboriginal carer. Of concern is the fact that the child's Aboriginal grandmother was not assessed as a carer due to the fact that two of her biological children were incarcerated. The child's Aboriginal grandmother was an authorised carer for another of her grandchildren when this decision was made. Failure to properly assess the child's Aboriginal grandmother deprived the child of the opportunity of being raised by family.

In consultations, the Review was informed that caseworkers often did not consult the child's family or kin to ascertain whether anyone was willing to care for the child¹⁴⁴ and often deliberately failed to pursue kinship options.¹⁴⁵ Stakeholders noted that caseworkers were often rude or 'spoke down' to potential carers.¹⁴⁶ Stakeholders felt that caseworkers intruded into their lives unnecessarily when assessing their ability to care for a child, for example, examining whether they could afford to take another child into the house.¹⁴⁷ Caseworkers were also often concerned about previous minor offences, such as drink driving, when assessing potential carers.¹⁴⁸ It was noted that there is a need for clear guidelines or protocols to guide caseworkers

143 See for example, Leah Bromfield et al, 'Why is there a shortage of Aboriginal and Torres Strait Islander Carers? Perspectives of professionals from Aboriginal and Torres Strait Islander agencies, non-government agencies and government departments' (Australian Institute of Family Studies, 2007).

144 Confidential, *Consultation*, FIC 91.

145 Confidential, *Consultation*, FIC 91.

146 Confidential, *Consultation*, FIC 56.

147 Confidential, *Consultation*, FIC 84.

148 Confidential, *Consultation*, FIC 84.

when assessing whether a carer is suitable or not and that this would make it easier for the department to be held accountable and would also enable potential carers to know if they meet the relevant criteria, and whether they may challenge an unfavourable outcome.¹⁴⁹

Data findings

As noted above, the qualitative sample data raised concerns about the assessment processes around Aboriginal family or kin, highlighting that in almost half of the cases examined in the qualitative sample (97 out of 200), there were issues with carer assessment identified in the children's cases.

The most common issue identified in the sample was that family members or kin who expressed willingness or interest in caring for Aboriginal children in OOHC, or family members who were nominated as potential carers, were never subject to a comprehensive carer assessment. This was a feature in 37% of cases in the sample (n=74), which is a considerable proportion.

The reasons why 'formal' carer assessments did not progress were mostly unable to be ascertained from review of FACS records. In many cases it would appear that FACS did not contact or follow up with family members to commence carer assessment processes after carers contacted FACS, or at the time of family members being nominated as potential carers before or after children entered care. In fewer cases, FACS did not support family members to progress assessment forms or documentation once the department had provided these.

The most common issue was that family members or kin who expressed willingness or interest in caring for Aboriginal children in OOHC, or family members who were nominated as potential carers, were never subject to a comprehensive carer assessment.

The lack of documented reasons as to why there was failure to progress carer assessments of Aboriginal family members raises concern about the level of transparency and accountability in FACS' decision-making. It also raises concern about the limited opportunities available to family members to appeal FACS' decisions not to progress their carer assessments when they are not given reasons why they have been deemed unsuitable to care for children in OOHC.

In some cases, carer assessments did not progress due to 'issues' arising with family members' pre-assessment checks (such as criminal history and FACS history checks). It is not always clear from FACS' records how these checks impacted on the progress of carer assessment, or how these checks would have impacted the carer's ability to care for the children. It was often not clear whether family members failed these checks due to issues of current or historical concern, whether the checks themselves created a barrier to family wishing to continue with assessment (that family never progressed to undertaking pre-assessment checks) or whether FACS made the decision not to progress formal carer assessment based on pre-assessment check outcomes. Across these cases, there was a lack of documentation of FACS' decisions not to progress formal assessments where that decision related to pre-assessment checks.

149 Confidential, *Consultation*, FIC 98.



The sample also highlighted that the failure to formally assess family or kin members affected carers who were closely bonded to, or were caring for, children in family arrangements before the children entered care. For instance, in Case 88, the children's paternal Aboriginal grandmother was not formally assessed as a carer on the basis of 'probity checks' and her failure to fill out the relative or kinship form. The grandmother had been caring for the children since birth and the children were bonded to her. FACS provided limited assistance to the grandmother to effect the carer assessment, which did not progress. The children are currently split between different kinship and Aboriginal foster care placements off country and do not have regular contact with their maternal and paternal Aboriginal family members.

There were also a number of cases in the sample where FACS stated reasons for not progressing formal carer assessment, however they were based on seemingly inappropriate grounds. For instance, in Case 98, no formal carer assessment was conducted of the Aboriginal maternal grandmother and another kind relative because of their age. As a consequence, the child in the cohort remains in Aboriginal foster care at the time of writing this report. Similarly, in Case 150, FACS did not progress carer assessments of the children's Aboriginal relatives due to historical criminal offences and the fact that the male family member had been 'named as a person of interest in over 121 police events'. Consequently, the child in the cohort remains in Aboriginal foster care at the time of writing. FACS' informal decision to withhold formal assessment from these family members on the basis of age and being known to police (rather than that family member having a criminal record for offences that would likely impact their ability to care for the child), is concerning.

Discussion

As noted above, it was unclear as to why the Aboriginal family members in these case examples were not considered as carers by FACS or why FACS informally decided not to pursue carer authorisation for the family member due to judgements made by caseworkers about their suitability to be carers. However, the Review considers that a possible explanation for this is caseworkers' discriminatory attitudes towards Aboriginal people, and more specifically, Aboriginal kinship carers. This perception of Aboriginal carers may be reinforced by formal advice given to caseworkers in this area. The *FACS Information Guide Assessment and Full Authorisation of Relative and Kinship Carers*, last revised on 6 March 2018, states that relative and kinship placements have benefits such as minimising disruption to a child's life and maintaining a child's attachment to their 'family, community and culture'. However, it then states that these types of care arrangements present 'a number of challenges', and that these benefits need to be balanced against the following risks:

- placing a child at a higher risk of harm due to continuation of exposure to inter- generational patterns of dysfunction;
- assuming that children are at lesser risk because they are placed with family or kin;
- unauthorised, unsupervised and inappropriate contact with parents, potentially exposing the child to further risk of harm;
- relative and kinship carers not effectively managing appropriate boundaries, roles and responsibilities in relation to the child's parents; and
- relative and kinship carers underestimating or denying the impact of abuse or neglect on the child. This can lead to a failure to provide appropriate protective measures or supports to address the impact of abuse or neglect.¹⁵⁰

150 *FACS Information Guide Assessment and Full Authorisation of Relative and Kinship Carers*, 1–2.

While this policy does not specifically state that it applies only to Aboriginal relative and kinship care, its reference to connection to culture and ‘inter-generational dysfunction’—combined with the number of Aboriginal children in OOHC and the statutory requirement to place them with family and kin where possible—makes the policy appear directed towards Aboriginal carers. Further, in light of the over-representation of Aboriginal children in OOHC, this guidance will have a disproportionate effect on Aboriginal relative and kinship carers. The long list of potential risks in the policy are not evidence-based and reflect an attitude within the department about the ability of Aboriginal family members and kin to protect a child from harm, or to promote a child’s safety and wellbeing. Many stakeholders referred to this as a concrete example of ‘institutional racism’. This has been one of the driving motivations behind the movement of Aboriginal grandmothers who seek to care for their grandchildren and relatives. It also reflects a clear implication that Aboriginal children are safer with non-Aboriginal carers who have not been subjected to ‘inter-generational patterns of dysfunction’ and who are considered to be more trustworthy when it comes to contact with the child’s parents. It is almost impossible to reconcile this policy with the following extract from the FACS publication *Cultural Practice with Aboriginal Communities*:

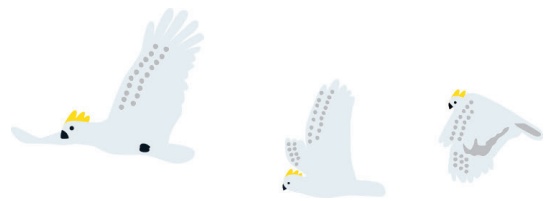
As the agency responsible for keeping children safe in NSW, we must not repeat the past. Through our policies and daily work with families, we must always be looking for ways to understand and address the disproportionate number of Aboriginal and Torres Strait Islander children in our system.

The Review recommends that this policy be revised as a matter of urgency. Further, the Review recommends that the revised policy includes a focus on evidence that demonstrates that placing a child with family or kin is often highly protective of the child’s lifelong wellbeing,¹⁵¹ as well as evidence-based risks that may be present in this type of placement.

Further, the Review notes the need for greater transparency around how and why decisions are made about potential carers for Aboriginal children and more formalised processes regarding pre-assessment decision making and the giving and recording of reasons in this area. These changes are likely necessary to improve the likelihood of Aboriginal family members being authorised to care for Aboriginal children who enter care. They will also improve Aboriginal children’s networks of respite carers.

The above evidence suggests that overall, there appears to be a lack of consistency in how decisions not to progress formal carer assessments are made and recorded within FACS. The informality of these decisions, as well as the lack of consistency and transparency in decision-making, create further barriers for family who seek to care for Aboriginal children in OOHC. Due to the limited external scrutiny over these processes, such inconsistency and informality in approaches to carer assessment can limit family members’ access to justice where decisions may be improperly made.

¹⁵¹ See, eg, Meredith Kiraly, Julieanne James and Cathy Humphreys, ‘It’s a Family Responsibility’: Family and Cultural Connection for Aboriginal Children in Kinship Care’ (2014) 40(1) *Children Australia* 23; Albert Zhou et al, ‘Kinship Care for Children in New South Wales’ (2010) 5(2) *Communities, Children and Families* 60; Sun Koh, ‘Permanency outcomes of children in kinship and non-kinship foster care: Testing the external validity of kinship effects’ (2010) 32(3) *Children and Youth Services Review* 389; James Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW* (November 2008), vol 2, [16.104]–[16.106].



Case study

One individual ('Anne') provided the Review with a submission that outlined her experience of attempting to become a carer for two children who were related to her. First, Anne stated that she was not contacted by FACS about whether she wished to be assessed as a carer for the children. Upon contacting FACS herself, she was advised that they were desperate for carers for the children and she was assessed by two caseworkers using the 'Winangay' assessment tool. After several weeks, Anne was informed she had not passed the assessment, but was not advised of the reason and could not get any of the caseworkers to return her telephone calls. After lodging a complaint and engaging a solicitor, the children were ultimately placed with her (some two months after the initial assessment). By this stage, the children had lived in multiple placements.

After approximately five months, Anne was informed that the children were being restored to their parents. They left her care after almost seven months, and despite being assured by her caseworker that she would have an opportunity for further contact with them in the future, she has not seen the children since. She noted that the restoration was not conducted gradually, and that the children were simply removed (from both her care and their local school and child care centre) and placed at home again. After being informed by FACS that she would be a good foster carer for other children and indicating that she would provide foster care again, FACS has not contacted Anne again.

Recommendation 86: The Department of Communities and Justice should revise the *FACS Information Guide Assessment and Full Authorisation of Relative and Kinship Carers* to ensure that it reflects evidence-based knowledge about the protective benefits of a child's placement with family and kin.

Recommendation 87: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community members, develop and implement a policy whereby family or kin who are nominated or nominate themselves as a potential carer for an Aboriginal child entering out-of-home care are subject to formal carer assessment using a culturally appropriate tool. This carer assessment is to occur expediently, before or shortly after the children enter care. If formal carer assessment of a family or kin member is not progressed, the department should record clear reasons for failure to progress this assessment on ChildStory and provide these reasons in writing to the family or kin member being informally assessed, along with information about ways that family or kin member may challenge this informal assessment.

Probity checks for potential carers

Potential carers must undergo a number of ‘probity’ or background checks before they can be approved as a foster or kinship carer for a child in OOHC. These include a check of records held by community services, a check of police records, a Working with Children Check (WWCC), a health check and a home inspection.¹⁵² Any other adult residing with a potential carer must also have a WWCC clearance.¹⁵³ A person who is a relative or kin of a child (or is otherwise known to a child), may also be ‘provisionally authorised’ as a carer in an ‘emergency’.¹⁵⁴ What constitutes an emergency is not defined in the legislation. If a person is provisionally authorised, FACS policy requires that he or she proceed to ‘full authorisation’ within 90 days of the placement.

Generally, FACS conducts these carer assessments. However, non-government OOHC providers may also assess carers. The *Permanency Case Management Policy Rules and Practice Guidance 2018* (released during the course of this Review) set out the following steps in relation to the identification and assessment of carers:

- When FACS identifies a member of a child’s family/kin or other suitable person that is appropriate to be assessed as an authorised carer:
 - FACS conducts a provisional and/or full assessment of the applicant carer; or
 - FACS considers asking a funded service provider to conduct the provisional and/or full assessment.
- If FACS cannot identify a member of a child’s family/kin or other suitable person that is appropriate to be assessed as an authorised carer, the FACS Child and Family District Unit makes a placement broadcast to funded service providers, seeking an authorised carer for the child.
- If a suitable placement cannot be provided by any funded service provider, the child is placed with a FACS carer.
- Funded service providers consider whether they have operational capacity to conduct provisional and/or full assessments of new carers that are relative/kin of a child, or other suitable person, if requested by FACS (this is not mandatory).¹⁵⁵

Some stakeholders informed the Review that existing carer probity checks may deter suitable and willing people from applying to be authorised as carers for Aboriginal children in OOHC. For example, the Review was informed that many potential Aboriginal carers are reluctant to undertake the full physical and mental health check that is required before they can be authorised as a carer.¹⁵⁶ This may be due to past experiences of racism and discrimination in health care settings, or anticipation of racism and discrimination occurring.¹⁵⁷ Alternatively,

152 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 137, *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) Pt 6, div 2, sch 2. Department of Family and Community Services (NSW), *Probity Checks* (Casework Practice Mandate, FACS Intranet). Note that both FACS and non-government OOHC agencies can authorise carers.

153 *Child Protection (Working with Children) Act 2012* s 6(3), (8), 10. However, note that the Children’s Guardian can give special consideration to children who turn 18 while in OOHC so that they are able to remain in the household despite being refused a WWCC, but only if there are sufficient supports in place to mitigate the risk: *Child Protection (Working with Children) Act 2012* (NSW) s 11D.

154 *Children and Young Persons (Care and Protection) Regulation 2012* (NSW), cl 31(1).

155 Department of Family and Community Services (NSW) *Permanency Case Management Policy Rules and Practice Guidance* (31 July 2018), 22.

156 Department of Family and Community Services (NSW), *Consultation*, FIC 99; Family is Culture Reference Group Meeting, 7 June 2019.

157 See, for example, NSW Ministry of Health, *Respecting the Difference: An Aboriginal Cultural Training Framework for NSW Health* (November 2011).



it may be due to other barriers to access to health services, such as geographic isolation, transport, and reluctance to leave family and community to attend medical appointments.¹⁵⁸

In addition, stakeholders noted that the carer assessment process specially affects family or kin with a police history, as they may not be deemed suitable to be carer,¹⁵⁹ and may not pass the required police check or Working with Children Check (this is discussed in more detail in the next section).¹⁶⁰ Stakeholders also noted that potential carers may be deemed unsuitable if they have previously been the victim of domestic violence.¹⁶¹ Grandparents may be deemed unsuitable carers because they have previously had children removed when they were younger,¹⁶² or because they are viewed by the department as being responsible for their child's current situation.¹⁶³ Finally, the Review was informed by stakeholders that there were strict legislative time frames for lodging of applications for carer authorisation and that prospective Aboriginal carers were not given sufficient, or often any, support to navigate the carer application process.¹⁶⁴

The Review was informed that the criteria for carer authorisation needed to be reviewed, particularly taking into account that Aboriginal people were more likely to have 'had a run in with the law' due to aspects such as socioeconomic disadvantage, over policing and trauma.¹⁶⁵ It was argued that the department should have the capacity to exercise their discretion to waive particular issues and approve carers when to do so presented no risk to the child.¹⁶⁶

The Review notes these concerns and recommends that the Department of Communities and Justice review the formal probity checks required of carers, as well as the process for obtaining these checks, to ensure that they are not unduly limiting the ability of potential Aboriginal carers to safely care for Aboriginal children in OOH. It may be, for example, that a health check should only be required in cases where there is existing evidence (beyond age alone) to indicate that a potential carer's physical or mental health may impede that person's ability to care for a child. The review of formal probity checks required of potential carers should also include consideration of the introduction of a discretion to enable a person to care for a child (or continue to care for a child), despite not satisfying or completing the formal probity checks where to do so would be in the best interests of the child.

Recommendation 88: The Department of Communities and Justice should review the formal probity checks required of carers, and the process for obtaining these checks, to ensure that they are not unduly limiting the ability of potential Aboriginal carers to safely care for Aboriginal children in out-of-home care. The review should include consideration of the introduction of a discretion to enable a person to care for a child in out-of-home care despite not satisfying or completing the formal probity checks, when to do so would be in the best interests of the child.

Working with Children Checks

158 Ibid.

159 Confidential, *Consultation*, FIC 5-9.

160 Confidential, *Consultation*, FIC 61.

161 Confidential, *Consultation*, FIC 5-9.

162 Confidential, *Consultation*, FIC 18.

163 Confidential, *Consultation*, FIC 98.

164 Confidential, *Consultation*, FIC 5-9.

165 Confidential, *Consultation*, FIC 61.

166 Confidential, *Consultation*, FIC 61.

The WWCC is one of the required checks for potential carers. It is discussed separately, and in detail in this section, in light of the impact that the current scheme has on potential Aboriginal carers.

The *Child Protection (Working With Children) Act 2012* (NSW) is designed to protect children by ensuring that people who pose a risk to children’s safety, welfare and wellbeing, are not permitted to work with them.¹⁶⁷ The Act contains a list of disqualifying offences.¹⁶⁸ If a carer has been charged or convicted of any of these offences as an adult—including the offences of murder, sexual assault, and other sexual offences against children—he or she will be automatically barred from working with children.¹⁶⁹

If a carer has been charged or convicted with other listed offences, he or she will need to undergo a ‘risk assessment’.¹⁷⁰ At this point, the Office of the Children’s Guardian (OCG) collects further information, including information in relation to the applicants’ interstate criminal history.¹⁷¹ The applicant’s risk is then assessed, taking into account criteria set out in the Act.¹⁷² The applicant is informed of any concerns and given an opportunity to comment on them,¹⁷³ and is also given reasons for the WWCC outcome.¹⁷⁴ The OCG may also impose an ‘interim bar’ on an applicant for a WWC clearance if she is of the view that it is likely that there is a risk to the safety of children if the applicant engages in child-related work pending the determination of an application.¹⁷⁵ The OCG has noted that risk assessments are ‘undertaken by officers with expertise in child protection, being drawn from backgrounds of psychology, social work and criminology’.¹⁷⁶

In 2017–18, 375,094 WWCC applications were processed in NSW, and 768 people were refused a WWCC clearance.¹⁷⁷ In this same year, 87 applications were made to the NSW Civil and Administrative Tribunal (NCAT) to review WWCC-related decisions.¹⁷⁸

Impact on potential Aboriginal carers

One concern that has been raised in the literature about the ACPP is the impact of criminal history and care history checks on Aboriginal carers. For example, the Australian Institute of Family Studies (AIFS) has noted that these types of tests may ‘limit the number of adults who can be registered as carers because of higher rates of adult imprisonment, criminal history and substantiations of child maltreatment in the Aboriginal and Torres Strait Islander population’.¹⁷⁹ As noted previously, this issue was also raised in submissions to this Review and was evident from the qualitative research findings.

167 Office of the Children’s Guardian, *Statutory Review of the Child Protection (Working with Children) Act* (August 2017) 1.

168 *Child Protection (Working With Children) Act 2012* (NSW), sch 2.

169 *Ibid* s 18.

170 *Ibid* ss 14, 15, sch 1.

171 Office of the Children’s Guardian, *Statutory Review of the Child Protection (Working with Children) Act*, August 2017, 20.

172 *Child Protection (Working with Children) Act 2012* (NSW) s 15(4). See also the ‘reasonable person’ test in *Child Protection (Working with Children) Act 2012* s 15(4A).

173 *Ibid* s 19.

174 *Ibid* s 20.

175 *Ibid* s 17.

176 Office of Children’s Guardian, *Statutory Review of the Child Protection (Working with Children) Act* (August 2017), 21. See also: *Child Protection (Working with Children) Act 2012* (NSW) s 42A (expert advisory panel).

177 Office of the Children’s Guardian, *Annual Report 2017–18* (Report, 2018), 12.

178 *Ibid* 15.

179 Australian Institute of Family Studies, ‘Enhancing the Implementation of the Aboriginal and Torres Strait Islander Child Placement Principles’, (Web Page), <<https://aifs.gov.au/cfca/publications/enhancing-implementation-aboriginal-and-torres-strait-islander-child/export>>.



Several stakeholders raised concerns about the application of the WWCC to potential Aboriginal carers. The Law Society of NSW submitted that the WWCC ‘should be reviewed in respect of Aboriginal people wishing to become authorised carers, to ensure that it is not inadvertently excluding people who would in fact be safe and appropriate carers’.¹⁸⁰ It noted that the existing WWCC system may exclude carers because of historical criminal convictions ‘which do not reflect the current ability of those individuals to care for their family members’.¹⁸¹

Redfern Legal Centre submitted that in some cases WWCC provided ‘an unreasonably onerous barrier’ for potential kinship carers.¹⁸² It submitted that the consequences of intergenerational trauma—namely, drug and alcohol problems, and criminal offending—meant that many potential kin carers cannot pass the WWCC.¹⁸³ As a result, children were being placed with non-Aboriginal carers. It submitted that WWCC laws and policies should be reviewed ‘with a view to more appropriately balancing the priorities of safety and kinship care for Aboriginal children removed from their parents’.¹⁸⁴

In 2017, in response to recommendations by the Royal Commission into Institutional Responses to Child Sexual Abuse, the OCG recommended that the list of offences that trigger a risk assessment be broadened to include arson and other fire related offences and drug offences.¹⁸⁵ In addition, the OCG recommended that other offences also trigger a risk assessment, such as domestic and family violence offences that indicate a pattern of behaviour that may cause risk to a child, regardless of whether children are present at the time of the offence,¹⁸⁶ and ‘personal violence offences’.¹⁸⁷ These recommendations have not yet been implemented. The second reading speech for the *Child Protection (Working with Children) Amendment (Statutory Review) Bill 2018* (NSW), noted a second tranche of reforms to the Act after stakeholder consultation. Any expansion of the scope of offences that trigger a risk assessment will likely affect the potential of some Aboriginal carers to be approved as carers for Aboriginal children.

The OCG completed a statutory review of the operation of the *Child Protection (Working with Children) Act 2012* (NSW) in late 2017.¹⁸⁸ The review did not consider the way in which the Act may operate in respect of Aboriginal applicants who wish to care for Aboriginal children in statutory OOHC. However, the Children’s Guardian has noted that the WWCC process may operate unequally when applied to potential carers and has stated as follows:

To this end I have committed to working towards finding a new approach for working with Aboriginal communities to develop a better way to support them to create safer places for their children. Whilst we do not at this point collect data about people’s cultural background through the working with children check, we are conscious that we need to develop an end-to-end experience that is much better for Aboriginal people through the working with children check. We recognise that there are structural and historic reasons that have led to Aboriginal people being overrepresented in our

180 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 3.

181 Ibid.

182 Redfern Legal Centre, Submission No 14 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 12.

183 Ibid 10.

184 Ibid 12.

185 *Royal Commission into Institutional Responses to Child Sexual Abuse*, ‘Working with Children Checks Report’, (August 2015) rec 21.

186 Office of the Children’s Guardian, *Statutory Review of the Child Protection (Working with Children) Act* (August 2017) 21, 23.

187 *Crimes (Domestic and Personal Violence) Act (NSW) 2007* (NSW) 6. See Office of the Children’s Guardian *Statutory Review of the Child Protection (Working with Children) Act* (August 2017) 23–24.

188 Office of the Children’s Guardian, *Statutory Review of the Child Protection (Working with Children) Act* (August 2017).

criminal justice system, and that means there are a higher proportion of Aboriginal applicants within the scope of the working with children check.

We are really seeking the balance between making sure our check remains robust while acknowledging the impact that these complex factors have on the outcomes of and experience for Aboriginal applicants. This is a complex and sensitive area, where we are considering a number of approaches to better achieve this balance. Overall, though, I acknowledge the leadership communities have to determine what works best for them, and the hope and aspiration they have for their children and their safety.¹⁸⁹

Despite the acknowledgement of the unequal impact of the WWCC scheme on Aboriginal applicants, the OCG has not taken any steps to review the scheme to remedy this problem.

Recommendation 89: The Office of the Children’s Guardian and the Department of Communities and Justice should work together to ensure that data are collected and reported about the number of potential Aboriginal carers who lodge applications for working with children check clearances, the length of time taken to determine the applications, and the outcome of those applications.

Recommendation 90: The Office of the Children’s Guardian should undertake a review of the impact of the Working with Children Check scheme on Aboriginal applicants.

Delays in processing working with children checks

The WWCC process involves a check of the national police database and workplace misconduct records—a process that ‘can take a few days, but can take longer depending on your personal information’.¹⁹⁰ If the applicant has a police or workplace misconduct record, then all records relating to the applicant are reviewed. This process, which may involve retrieving old or interstate records, ‘can take up to a few months’.¹⁹¹ The OCG may also be required to conduct a risk assessment, the OCG’s website stating:

The high demand for the Working With Children Check can mean delays in processing applications where a risk assessment is required. It can take more than 12 months to evaluate a person’s suitability for child-related work. It is important that you only apply for a check when required. This will help to avoid delays in processing your check.¹⁹²

The Royal Commission into Institutional Responses to Child Sexual Abuse recommended that WWCC applications generally be processed within five working days, or 21 working days ‘for more complex cases’.¹⁹³ The NSW Government noted, in response, that applications requiring a comprehensive risk assessment in NSW require, on average, six months to process.¹⁹⁴

189 Parliament of NSW Joint Committee on Children and Young People, *Review of the Annual Report of the Advocate for Children and Young People and Functions of the Children’s Guardian* (30 April 2018), 3.

190 Office of the Children’s Guardian, ‘Working with children check results’ (Web Page) <https://www.kidsguardian.nsw.gov.au/child-safe-organisations/working-with-children-check/working-with-children-check-results>.

191 Ibid.

192 Ibid.

193 *Royal Commission into Institutional Responses to Child Sexual Abuse*, ‘Working with Children Checks Report’ (August 2015) rec 27.

194 NSW Government response to Royal Commission ‘Working with Children Checks Report’, contained in Office of the Children’s



This delay in processing WWCC's may cause difficulties for prospective Aboriginal carers. FACS policy does not allow a carer to be 'fully authorised' until all adults in the home have a cleared and verified WWCC.¹⁹⁵ A provisional authorisation, which can be granted once a prospective carer has made an application for a WWCC, cannot last for longer than three months.¹⁹⁶ In these cases, a delay in processing an application for a WWCC may result in the department being required to change a child's placement.

The Redfern Legal Centre also submitted that it often took several weeks for a family member to be assessed provisionally for a WWCC, during which time the Aboriginal child or young person may have been placed with a non-Aboriginal carer.

Similar issues were identified from reviewing the casefiles of children in the cohort. The following provides some examples of issues that arose in practice in relation to WWCC's and Aboriginal carers:

- In Case 42, the children were assumed into care due to concerns their mother could not care for them because of her acquired brain injury. The children's great aunt asked to be a long-term carer for the children, however, after three months, her partner's WWCC had still not been approved. At this point, the FACS caseworker determined that the department was unable to wait any longer for the results of the WWCC as the children's emotional state indicated that they required a permanent placement. It was decided that the children would be placed with a non-family carer.
- In Case 32, the children were removed from their family due to concerns about their mother's drug use and the level of care they were receiving at home. Shortly after their removal, the children's aunt and uncle indicated that they wished to be carers for the children. However, it took 10 months for them to be approved as carers because the OCG was required to conduct a risk assessment of the children's uncle prior to granting him a WWCC clearance. During the 10 months prior to approval the children (aged four and two) remained in a temporary placement with non-Aboriginal carers.
- In Case 201, the child's maternal grandfather requested to be the child's carer while she was in OOHHC and FACS informed the Children's Court that the child would be placed with her grandfather when he was authorised as a carer. However, the child's grandfather was not approved as a carer for a period of almost 5 months, and his carer training took several more weeks to organise. During this time, the child lived with a non-Aboriginal foster carer who had not received any cultural competency training and who was not connected to any Aboriginal organisations or support services. Ultimately, the child was never placed with her grandfather, as a decision was made to restore her to her mother.

Guardian, *Statutory Review of the Child Protection (Working with Children) Act* (August 2017) Appendix 3, 6.

195 Department of Family and Community Services (NSW), *Probity Checks* (Casework Practice Mandate, FACS Intranet).

196 Ibid.

- In Case 32, the children’s maternal aunt and her partner applied to be carers for the children when they entered OOHC. However, due to a delay in obtaining a risk assessment for one of the applicants through the OCG, the children were required to remain in a non-Aboriginal placement for a year before being placed with their family.

Recommendation 91: The Office of the Children’s Guardian should prioritise the processing of applications for working with children check clearances made by Aboriginal applicants wishing to become authorised carers for Aboriginal children.

Recommendation 92: The Department of Communities and Justice should revise its policy on the provisional authorisation of carers to ensure that provisionally authorised carers do not have children in their care removed solely because of delays in the processing of their application for a working with children check clearance.

Time taken to review Working with Children Check clearance decisions

As noted above, a decision by the OCG to refuse the granting of a WWCC can be reviewed by the NCAT. When reviewing the decision, the NCAT must consider a number of issues, such as the seriousness of the offences or matters that caused the clearance to be refused, as well as the period of time since those offences occurred.¹⁹⁷ It must also use the ‘reasonable person’ test—that is, it must consider whether the reasonable person ‘would allow his or her child to have direct contact with the affected person that was not directly supervised by another person while the affected person was engaging in any child-related work’.¹⁹⁸ In addition, the NCAT must be satisfied that it is in the public interest to make the order.¹⁹⁹

As at June 2017, 518 applicants who had been refused a WWCC clearance had lodged applications with NCAT for review of the OCG’s decision.²⁰⁰ Of these 518, 180 matters were dismissed and 327 decisions were made.²⁰¹ In almost half of the 327 decisions (n=167, 49%), the Tribunal overturned the OCG’s initial decision to refuse the applicant a WWCC clearance. Almost half of these decisions (82 cases) were matters where the OCG had no discretion and was required to automatically bar the applicant. Accordingly, in approximately 25% of decisions (85 cases), the NCAT disagreed with the outcome of the OCG’s assessment of risk when deciding whether or not to grant a WWCC clearance.²⁰²

In its submission to this Review, AbSec observed that delays in the review of a WWCC clearance decision by the NCAT ‘can be a significant concern in the context of out-of-home decision making and the need for stability and to maintain significant relationships for children and

197 *Child Protection (Working with Children) Act 2012* (NSW) s 30(1).

198 *Ibid* s 30(1A)(a).

199 *Ibid* s 30(1A)(b).

200 Answers to questions on notice, State Parliament of NSW, Sydney, 22 May 2018, Office of the Children’s Guardian, <<https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2481#tab-otherdocuments>>.

201 Note that 11 decisions were still pending: *Ibid*.

202 *Ibid*.



young people within the statutory system'.²⁰³ It recommended that 'priority access may support the long term wellbeing of children by resolving such disputes quickly'.

The Review agrees that priority access to the NCAT is in the best interests of Aboriginal children in the OOH system. Evidence from the cohort file review indicates that delays in authorising carers can have significant and long term ramifications for individual children who need to be placed in stable and secure placements as soon as possible after their removal from their families.

Recommendation 93: The NSW Civil and Administrative Tribunal should prioritise applications for review of decisions made by the Office of the Children's Guardian that relate to the working with children check clearance of potential or current carers for Aboriginal children and young people in out-of-home care.

Formal carer assessment

If a carer 'passes' the formal probity checks, the carer then proceeds to the 'assessment stage'. This section discusses the data of how many carers were formally assessed to care for Aboriginal children in the cohort and some of the issues that were identified as problematic in respect of carer assessment in the case file review process. It then discusses the need for a culturally appropriate carer assessment tool for potential Aboriginal carers.

Data findings

According to FACS (Review Tool) data, for almost half of all children in the cohort, family or kin were assessed and authorised to care for the child (47.5%). Unfortunately, there was no data collected to indicate whether family or kin actually ended up caring for the child after they were assessed and authorised.²⁰⁴

It is concerning that for 43.8% of children in the cohort, Aboriginal family or kin were not assessed. Reviewers were not provided any definition of 'assessed' when entering tool data, making it difficult to depend on the reliability of this data, particularly in light of qualitative findings outlined in this section. Only 8.7% of children had family or kin assessed but not authorised to care for them (Figures 61–62).

Reviewers were not provided guidance on how to record data in cases where some Aboriginal family or kin were assessed and authorised but other Aboriginal family or kin were assessed but not authorised, further impacting the reliability of these data. This is similar to the data available on non-Aboriginal family and kin carers, suggesting many non-Aboriginal family and kin are also not being assessed to care for Aboriginal children.

²⁰³ AbSec, *Submission to Statutory Review of the Child Protection (Working with Children) Act 2012*.

²⁰⁴ Correspondence sighted indicates this was included in earlier versions of the tool.

Qualitative research findings

While the majority of issues with carer assessment identified in the qualitative sample related to family members not being formally assessed to care for Aboriginal children who entered care, in a number of cases there were other issues raised with the actual assessment process and outcome.

In eight of the cases in the sample, family members were subject to formal assessments, but were not approved as carers and FACS did not always record reasons for these unfavourable assessments. This incomplete record-keeping is concerning and limits scrutiny of the rationale given for family members not being authorised as carers.

Concerns were also raised about the cultural suitability of the carer assessment process used to approve Aboriginal children's placements in a number of cases (discussed further below). For instance, in Case 77, a non-Aboriginal assessor conducted the carer assessment of the child's paternal grandparents and it was identified that the assessment lacked depth in relation to assessing the cultural suitability of the carers (despite neither carer identifying as Aboriginal). Similarly, in Case 95, it was identified that the carer assessment and parental responsibility orders being made, which led to the Aboriginal child being placed with the paternal, non-Aboriginal grandparents, did not go into enough depth about cultural considerations. Considering data on cultural planning and ACPP compliance presented elsewhere in this report, this strengthens evidence regarding FACS' inattention to sustaining and promoting Aboriginal children's culture while they are in OOHC.

In 14 of the cases in the qualitative sample, strengths were identified in practice around carer assessment. Strengths identified included a case where FACS supported a relative to have the outcome of her initial relative assessment reviewed after this was unsuccessful. Unfortunately, many cases where strengths were identified also demonstrated weaknesses in areas such as record-keeping about carer assessment outcomes.

Discussion

Taken together, the above data highlight the importance of:

- Family and kin being prioritised as carers for Aboriginal children who enter OOHC;
- FACS supporting family and kin to participate in formal carer assessment processes;
- Formal carer assessment processes being culturally appropriate (see below);
- Formal carer assessment processes focusing on carers' capacity and ability to promote Aboriginal children's cultural development in OOHC;
- All carer assessment decision-making being transparent, recorded, and reasons for non-authorisation (or non-progression of an assessment), being provided to the person seeking assessment; and
- Carer assessment decisions (both formal and informal) being scrutinised and appealable.



Lack of culturally appropriate carer assessment

At the ‘assessment stage’, the department uses a tool, the *Relative and Kinship Carer Assessment Report for Full Authorisation*, to determine whether to approve or refuse the carer’s application. After completing at least two home visits and interviewing the applicants (and where possible other household members), the caseworker fills out the tool which deals with the following topics: (i) the applicant’s capacity to meet the child or young person’s needs; (ii) the applicant’s relationships, family history and parenting styles; (iii) how the applicant works with others; and (iv) the placement and home environment.

Concerns about the lack of culturally informed assessment tools for Aboriginal carers have existed for some time. For example, in its submission to the Legislative Council inquiry into child protection, McKillop Family Services ‘questioned the cultural appropriateness of assessment procedures, particularly for kinship carers’.²⁰⁵ In its submission to that inquiry, Uniting noted a study by the AIFS which found that standard carer assessment procedures are problematic when assessing potential Aboriginal carers as they do not account for cultural differences in parenting practices and living arrangements, and do not effectively determine a carer’s suitability to care for an Aboriginal child.²⁰⁶ Winagay Resources Inc highlighted the fact that existing carer assessment tools were often ‘predicated on the erroneous assumption that the child is not known to the carer’.²⁰⁷

It has been noted that culturally appropriate assessment tools work best when caseworkers:

- Allow time to build engagement and trust;
- Use story telling rather than lists of direct questions;
- Don’t ask questions when the information has been gathered elsewhere (e.g., a training session; informal communication with potential carer);
- Draw on community knowledge about the potential of a carer/family to provide care;
- Assess for the same general competencies as for non-Indigenous carers;
- Also assess for:
 - active participation in Aboriginal communities;
 - demonstration of an understanding of Aboriginal kinship systems;
 - knowledge of services for Aboriginal children and young people; and
 - an understanding of the impact of past welfare practices on Aboriginal people.²⁰⁸

Further, non-Aboriginal caseworkers must have an appropriate level of cultural competency and awareness before administering the assessment.²⁰⁹ The Review identified some cases in which

205 Legislative Council General Purpose Standing Committee No 2 *Child Protection* (2017) 96, [5.52].

206 Ibid [5.54].

207 Ibid 7.70.

208 JR Higgins and N Butler, ‘Assessing, training and recruiting Indigenous carers’ (2007) *Promising Practices in Out-of-Home Care for Aboriginal and Torres Strait Islander Carers, Children and Young People* (booklet 2), 7.

209 Ibid 11.

more culturally appropriate assessment tools were used by caseworkers to assess Aboriginal kin (namely, the Winangay Kinship Carer Assessment Tool).

The Winangay Kinship Carer Assessment Tool can be used for Aboriginal and non-Aboriginal people who have been identified as prospective carers for an Aboriginal child. The tool was originally developed with an Aboriginal Reference Group and in consultation with Aboriginal Elders, community members, carers, OOHHC providers, FACS workers, and key Aboriginal organisations.²¹⁰ It was then validated through a pilot evaluation and feedback process in 14 different sites across Australia.²¹¹ A study of practitioners in Queensland indicated that both Aboriginal and non-Aboriginal practitioners found the tool to be culturally appropriate, 'user-friendly, collaborative and innovative'.²¹² The tool collects information about the strengths of existing kinship carers, their ability to be effective carers, and identifies 'strategies to meet any unmet needs they may have'.²¹³

Another example of a culturally appropriate assessment tool that was developed in NSW in the early 2000s is *Step by Step*.²¹⁴ *Step by Step* was developed by the Association of Children's Welfare Agencies in collaboration with the Department of Community Services over a period of approximately five years between 2003 and 2007. The tool was developed after extensive community consultation, was piloted throughout NSW in 2006, and 'commenced usage' in 2007.²¹⁵ Aboriginal specific content included:

- assessing whether applicants had the ability to promote the positive identity of Aboriginal children;
- ensuring that the language used in the assessment was accessible;
- information about the context of foster care for Aboriginal children; and
- strategies to ensure Aboriginal assessment were conducted in a culturally appropriate way.²¹⁶

However, the Review did not see any evidence of this tool being used when assessing Aboriginal carers. Further, there is no mention of this tool in the policy and guidance about carer assessment that is issued to all caseworkers. In March 2009, a mainstream version of the carer assessment manual was produced. The Aboriginal specific resources developed for *Step by Step* were merged into this manual, resulting in a single manual for the assessment of all DOCS foster carer applicants.²¹⁷ The *Step by Step* tool appears to be another example of a promising initiative developed in collaboration with the Aboriginal community that was, quite simply, not effectively implemented.

210 Winangay, *Final Report to FaHCSIA on the Aboriginal kinship assessment tools project* (December 2011) 2.

211 Ibid 3.

212 Aunty Sue Blacklock, Jenna Meiksans, 'Acceptability of the Winangay Kinship Carer Assessment Tool' (2018) 27 *Child Abuse Review* 108.

213 Winangay, *Final Report to FaHCSIA on the Aboriginal kinship assessment tools project* (December 2011) 2.

214 Higgins, J.R. and Butler, N. 'Assessing, training and recruiting Indigenous carers' (2007) *Promising Practices in Out-of-Home Care for Aboriginal and Torres Strait Islander Carers, Children and Young People (booklet 2)*, 7.

215 Higgins, J.R. and Butler, N. 'Assessing, training and recruiting Indigenous carers' (2007) *Promising Practices in Out-of-Home Care for Aboriginal and Torres Strait Islander Carers, Children and Young People (booklet 2)*, 7.

216 New South Wales Department of Community Services, *Carer Assessment: manual for assessors*, (2009), 2.

217 Ibid.



it is important for Aboriginal carers to be assessed using a culturally appropriate tool that is based on Aboriginal concepts of family structure, approaches to child rearing, and cultural foundations.

The Review is of the perspective that it is important for Aboriginal carers to be assessed using a culturally appropriate tool that is based on Aboriginal concepts of family structure, approaches to child rearing, and cultural foundations. While the Winagay Assessment Tool is one that promotes culturally appropriate carer assessment, the Review did not hear enough feedback from the Aboriginal community about its use and general acceptance in communities to specifically recommend its usage. Accordingly, the Review recommends that the Department of Communities and Justice partner with Aboriginal community organisations and representatives to develop and implement a culturally appropriate carer assessment tool to be used in all carer assessments involving Aboriginal carers.

Recommendation 93: The Department of Communities and Justice should partner with Aboriginal community organisations and representatives to develop and implement a culturally appropriate carer assessment tool to be used in all carer assessments involving Aboriginal carers.

No right of review of decision not to authorise a carer

If a decision is made to refuse authorising an applicant as a carer, the applicant should be informed in writing. The decision not to authorise a carer cannot be reviewed by the NCAT.²¹⁸

Prior to 2015, decisions to authorise or not authorise a carer, to impose conditions on a carer authorisation, or to cancel or suspend a person's authorisation as a carer, were reviewable by the NCAT. However, in 2015 the *Child Protection Legislation Amendment Act 2015* (NSW) removed the jurisdiction of the NCAT to review decisions to refuse to authorise an applicant as an authorised carer. The second reading speech for the Bill introducing the changes stated that:

the industrial relations system already recognises that failure to appoint a person to a position is not generally a matter capable of review. To bring the child protection system in line with the industrial relations system, changes will be made in relation to the NSW Civil and Administrative Tribunal review rights. Consequently, a refusal to authorise an applicant as an authorised carer would no longer be reviewable by the Tribunal.²¹⁹

The Review is concerned about the lack of ability to challenge a decision by a DCJ caseworker, or a caseworker from a non-government OOHC agency to refuse to authorise a person as a carer for a child. It notes the decision whether or not to authorise a carer may be based on a subjective consideration of matters such as the applicant's health, or the suitability of the

²¹⁸ See *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW), *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 245, *DCF v Life Without Barriers* [2018] 142 NSWCATAD.

²¹⁹ Legislative Assembly, Brad Hazzard, Minister for Family and Community Services, and Minister for Social Housing, *Child Protection Legislation Amendment Bill 2015*, 3 June 2015.

applicant's home. This discretion is clearly appropriate, however, without the possibility for independent review of the use of the discretion it is open to abuse. The assertion that carer approval is analogous to a decision whether or not to hire a private employee, is unconvincing. Decisions made by designated agencies regarding the approval of carers have far reaching consequences for the private lives of individuals and potentially affect fundamental human rights. In these cases, it is important that these decisions are open to scrutiny and can be independently reviewed. The decision not to approve a carer is reviewable in the majority of states and territories in Australia.²²⁰

Although applicants are still able to apply for review of the decision if it appears discriminatory and may complain about carer authorisation decisions to the Ombudsman,²²¹ these avenues of review are incomplete and ineffective. For instance, in the cases examined by the Review, there was often no information available as to why the caseworker refused to authorise a carer, and hence there was no evidence to indicate that the decision was discriminatory. Further, as discussed in Chapter 8, the Ombudsman does not deal with a large number of the complaints that it receives every year, and its formal investigations are 'long and complex'.²²² Further, the Ombudsman has no power to enforce its decisions.

Recommendation 94: The NSW Government should ensure that the NSW Civil and Administrative Tribunal has jurisdiction to review a decision not to authorise a carer.

Review of other decisions about authorised carers

NCAT has the jurisdiction to review some child protection decisions made by DCJ.²²³ These are outlined in s 245 of the *Care Act* and mostly relate to decisions made about carers. Specifically, the following types of decisions can be reviewed by NCAT:

- A decision to suspend a person's authorisation as an authorised carer or to impose conditions on a person's authorisation.²²⁴
- A decision to cancel a person's authorisation as an authorised carer.²²⁵
- A decision to grant to, or to remove from, an authorised carer the responsibility for the daily care and control of the child.²²⁶

NCAT provides families with a faster, lower-cost and less formal mechanism to review a decision made by DCJ (as opposed to seeking to challenge the decision in a court). However, this review mechanism appears to be underutilised based on the number of s 245 decisions published

220 See for example, *Child Protection Act 1999* (Qld) s 136, sch 2; *Children, Youth and Families Act 2005* (Vic) ss 75, 118; *Children and Young People (Safety) Act 2017* (SA) ss 77, 158; *Children and Community Services Act 2004* (WA) s 94; *Children and Young People Act 2008* (ACT) ss 514B, 516, 839.

221 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 22.

222 NSW Ombudsman 'Our options when dealing with your complaint' (Web Page), <<https://www.ombo.nsw.gov.au/complaints/making-a-complaint/our-options-when-dealing-with-your-complaint>>.

223 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 28(1)(a); *Children And Young Persons (Care and Protection) Act 1998* (NSW) s 245.

224 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 245(1)(a).

225 Except where the authorisation was granted on a provisional basis or the decision was made on the occurrence of an event prescribed under s 137 (2)(e) of the Act: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 245(1)(a1).

226 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 245(1)(c).



online. In addition, the number of decisions in which FACS are a party appear to be limited.²²⁷

The Review was informed by FACS that the NCAT did not always consider or apply the ACPP when making its decisions. An analysis of the decisions published by NCAT reveals that there is little discussion of the ACPP in decisions about carers made in the Community Services List. For example, in one matter, an Aboriginal child's connection to culture was considered, and yet the Tribunal Member did not mention the ACPP.²²⁸

The NCAT conducts regular professional development sessions for Members and staff (for example, in 2017–18, 40 such sessions were held).²²⁹ It also has an induction program for new members. The Review recommends that training on the ACPP and its elements be included as part of the induction and ongoing training of Tribunal Members.

Recommendation 95: The NSW Civil and Administrative Tribunal should include training about the Aboriginal Child Placement Principle in its induction and ongoing training program for Tribunal Members. This program should be delivered in partnership with the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec).

Supporting Aboriginal carers

Carers must be properly supported to care for Aboriginal children and young people, including financially and through the provision of supportive services. Further, non-Aboriginal carers must also be supported through the provision of cultural training. However, the particular issue of providing appropriate support for Aboriginal foster carers was raised on many occasions by stakeholders to this Review.

Two foster carers for Aboriginal children provided submissions to the Review. Both recounted feeling disempowered by FACS caseworkers. One recounted feeling judged by caseworkers, who refused to return her calls,²³⁰ while another noted that caseworkers quoted legislation to shut down discussion and assert their power over the situation.²³¹

The foster carers also noted that FACS did little to ensure children's connection to culture. One of the foster carers noted that she was given one day of training before two Aboriginal children were placed in her care.²³² The other noted that only one out of five caseworkers involved in their case has attempted to work on the children's genealogical charts in order to provide them with information about their family.²³³

227 Some of the decisions of the NCAT are published online: <https://www.caselaw.nsw.gov.au/browse-court/54a634063004de94513d8289>.

228 *BXS v Department of Family and Community Services* [2015] NSWCATAD 269.

229 NSW Civil and Administrative Tribunal, *Annual Report 2017–18* (Report, 2018) 26.

230 Confidential, Submission No 10 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

231 Confidential, Submission No 21 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018.

232 Confidential, Submission No 10 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

233 Confidential, Submission No 21 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018.

Other stakeholders also raised the issue of carer support. Aunty Glendra Stubbs and Elizabeth Rice submitted that the level of care and support provided to children and young people in care, and their carers, was inadequate. Uniting submitted that it was unclear what steps FACS had taken to improve the assessment, training and support of statutory relative and kinship carers since deficiencies in this area were identified by the Wood Commission.²³⁴ It submitted that research indicated that different 'tiers' of support should be provided depending on the needs of the individual carers.²³⁵

Data findings

The POCLS data tables provided to the Review highlight that Aboriginal caregivers told interviewers during Wave 4 that they required additional support to care for children in OOHC. The following were identified as being of importance to Aboriginal caregivers:

- Caring, supportive and invested caseworkers, including caseworkers who will listen to and support the carers as well as the children;
- Supportive agencies;
- Strong family support;
- Financial support, including for extras such as camps, after school care, uniforms and school fees, and support for leisure activities for carers;
- Assistance accessing services such as NDIS and special schools;
- Access to more cultural information, more assistance with cultural information (one carer indicated they had sought information about Aboriginal Cultural organisations in their area, but had received no response);
- Mentoring and access to more online courses due to geographical issues in accessing courses;
- Assistance with household tasks (such as cleaning);
- Improved respite assistance, babysitting and services to help carers have time out for themselves;
- Less micromanagement by agencies; and
- Counselling, social work and healthcare access.²³⁶

Some carers in this study indicated that they did not feel they needed additional support, citing that they felt confident providing for the child in their care themselves. Others did not provide reasons as to why they did not feel as though they needed additional support.²³⁷

According to an additional POCLS analysis prepared for this Review by Eastman and Katz, both

²³⁴ Uniting (NSW.ACT), Submission No 23 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, March 2018, 12.

²³⁵ Ibid.

²³⁶ NSW Department of Family and Community Services Insights Analysis and Research, *Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care* (Internal report on Wave 4 quantitative data for the Independent Review of Aboriginal Children in OOHC, 2019)

²³⁷ Ibid.



Aboriginal and non-Aboriginal relative and kinship carers reported lower levels of satisfaction than other carers with their ability to contact their caseworker on entry to care.²³⁸ However this level of satisfaction improved over time. This study identified that the period shortly after children enter care may represent a good opportunity to identify carers who may like (or in fact, require) additional support.²³⁹ In interpreting and translating these results, more work needs to be done with Aboriginal stakeholders and advocates to ensure that the way the provision of additional support is approached is culturally sensitive, informed, and appropriate (for instance, offering support utilising Aboriginal controlled organisations and services). The analysis by Eastman and Katz does not appear to have been subject to such Aboriginal consultation at the time of writing and this needs to be urgently done if DCJ is to incorporate these findings into its practice with Aboriginal carers.

A number of cases in the qualitative sample also highlighted concerns around the level of support given to carers, including carers living interstate or in remote areas with Aboriginal children in their care. Further, work is likely needed to ensure that carers for Aboriginal children are sufficiently supported by the department or NGOs to care for children both early in the OOHC process and when children are placed, even where those children have been in different care placements for some time.

Recommendation 96: The Department of Communities and Justice should urgently engage with Aboriginal stakeholders and community to interpret findings from Wave 4 Pathways of Care Longitudinal Study (POCLS) in relation to the support needs of Aboriginal carers and translate these findings into policy and practice.

²³⁸ C Eastman and I Katz *Caseworker communication and socio-emotional outcomes of children aged 7 years and older in OOHC. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care* (Preliminary analysis from a forthcoming report for the Independent Review of Aboriginal Children in OOHC, 2019, NSW Department of Family and Community Services).

²³⁹ Ibid.

19. Participation

Aboriginal children belong with their families, with their communities, and on their country. When the state intervenes to remove an Aboriginal child from his or her place of belonging, it is engaging in a regulatory action, the magnitude of which is difficult to overstate. In light of this, when a child is to be removed from his or her family, it is vital that the child's family is afforded procedural justice—that family members are spoken to formally and respectfully, that their views are not only listened to, but heard, and that they have the opportunity to engage with the representatives of the state to craft a safe and secure life for their children.

Participation of parents and kin

Engagement with a child's family can only improve outcomes for the child in question. For example, it can help ensure stable placements for the child with people to whom the child already has an emotional attachment, and can help to ensure the child remains in contact with family members and his or her culture. Improving the outcomes of Aboriginal children in out-of-home care (OOHC) in this way will help to break the cycle of intergenerational trauma that plagues too many Aboriginal people and which was apparent in the evidence gathered by this Review.

Further, genuine and respectful consultation with Aboriginal family members may also go some way to repairing the relationship between Aboriginal people and child protection services.²⁴⁰ It has been noted that 'when people perceive authority acting in procedurally unfair ways, they are likely to see that authority as less legitimate, to trust it less, and withdraw cooperation'.²⁴¹ Viewed through this lens, any responsibility for a family 'disengaging' or not working with FACS, can and should be shared by the department.

Genuine consultation, conducted well and in good faith, is consistent with restorative justice and responsive regulation. As Ivec, Braithwaite and Harris have noted, both of these approaches

give rise to institutional arrangements that prioritise the importance of relationship building and repair. First, an understanding of the situation is sought through dialogue with all parties. In planning a way forward, access to services and resources is offered to encourage and assist in reaching compliance goals. Only when families fail to put their best foot forward to solve their problems do child protection authorities exert more pressure and consider interventions with the intent of enforcing compliance. Such interventions are designed to intrude incrementally as small steps up a regulatory pyramid. As pressure is increased with each intervention, parents lose a degree of freedom to decide what is best for their child. Both parents and agencies find that it is in their interests to work together at the bottom of the pyramid: parents have much greater say and freedom, while agencies find it easier to identify and implement successful solutions.²⁴²

Section 12 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*) states that Aboriginal people are to be given the opportunity to participate in decisions about the placement of their children and young people. Further, FACS policies are very clear about the need to ensure that Aboriginal children and families participate in decisions regarding

240 Australian Institute of Family Studies, *Enhancing the Implementation of the ATSI CPP: Policy and practice considerations* (2015), 16.

241 M Ivec, V Braithwaite and N Harris, "'Resetting the Relationship" in Indigenous Child Protection: Public Hope and Private Reality' (2012) 34 *Law & Policy* 80, 83.

242 Ibid 84.



the care and protection of their children. To illustrate, the *Safety, Risk and Risk Reassessment Policy and Procedures Manual* states that ‘consultation is REQUIRED for Aboriginal and Torres Strait Islander children/young persons’ when a caseworker conducts a safety assessment, a risk assessment or a risk re-assessment.²⁴³ The Case Planning Framework provides that child protection and OOHC case plans should ‘actively promote participation of Aboriginal and Torres Strait Islander children, young people and families’.²⁴⁴ In support of this framework, a number of FACS ‘mandates’, or casework imperatives, state that Aboriginal children, parents and family members should be consulted when case planning for family preservation, OOHC and restoration.²⁴⁵ FACS has also produced an *Aboriginal Consultation Guide*, which outlines why Aboriginal consultation is important, describes the Aboriginal consultation process and outlines what consultation looks like in practice.²⁴⁶

Children’s voices

The concept of participation also encompasses the participation of children in decision-making about matters that affect them. The *Convention on the Rights of the Child* recognises that all children have a right to participate in judicial or administrative proceedings that affect them (directly or indirectly).²⁴⁷ As SNAICC has noted, what participation ‘looks like in practice will differ depending on the age and maturity of the child in question’.²⁴⁸ However, it involves

creating opportunities for the child to express her or his views about their concerns; fears; hopes for the future; identity; connection to family, culture and community; feelings about siblings; who they would like to live with; and which adults they trust and feel safe with, as well as adults they do not trust or do not feel safe with.²⁴⁹

There are many benefits to encouraging and facilitating children’s involvement in decision making, both for the children themselves and the organisations involved with the children. For example, Cashmore has noted that enabling children to participate in decision making can have practical effects such as enhancing placement stability, as ‘planning and decision-making which take the children’s views into account are likely to be both more appropriate and more acceptable to the child’.²⁵⁰ Further, participation can build a child’s self-esteem and confidence, and help prepare a child who is transitioning to independence.²⁵¹

There are no available statistics about the rates of participation of children in child protection decision-making in NSW. Some potential barriers to participation are the age and maturity of the child, the nature of the subject matter to be discussed in the conference (and the impact

243 Structured Decision Making System, *Safety, Risk, and Risk Reassessment Policy and Procedures Manual* (Department of Family and Community Services, 2012) 32, 49, 59.

244 Department of Family and Community Services (NSW), *Case Planning Framework* (October 2014).

245 See, eg, Department of Family and Community Services (NSW), *Case Planning for Family Preservation* (Casework Practice Mandate, FACS Intranet); Department of Family and Community Services (NSW), *Family Group Conferencing* (Casework Practice Mandate, FACS Intranet); Department of Family and Community Services (NSW), *Case Planning in Out-of-Home Care* (Casework Practice Mandate, FACS Intranet); Department of Family and Community Services (NSW), *Guardianship Assessment and Planning* (Casework Practice Mandate, FACS Intranet).

246 Department of Family and Community Services (NSW), *Aboriginal Consultation Guide* (2011).

247 *Convention on the Rights of the Child*, 20 November 1989, [1991] ATS 4, (entered into force generally on September 1990), art 12.

248 SNAICC National Voice for our Children, *The Aboriginal and Torres Strait Islander Child Placement Principle: A Guide to Support Implementation* (2018) 62.

249 SNAICC National Voice for our Children, *The Aboriginal and Torres Strait Islander Child Placement Principle: A Guide to Support Implementation* (2018), 61.

250 J Cashmore, ‘Promoting the Participation of Children and Young People in Care’ (2002) 26 *Child Abuse & Neglect* 837, 839.

251 *Ibid*.

this will have on the child), the impact that hearing a child describe his or her suffering will have on caseworkers and other professionals, as well as the time, money and effort involved in including children in decision making (including scheduling consultations outside of school hours).²⁵² It has been noted that the presence of an advocate for the child is an important feature in consultations involving children, as it ‘begins to shift the power alignment so that children are more likely to express their hopes and have their hopes acknowledged’.²⁵³

The *Care Act* acknowledges the child’s right to participate in decision-making and requires that the Secretary provide the child with adequate information to enable the child to do so meaningfully.²⁵⁴ The NSW Child Safe Standards for Permanent Care also require children to be consulted before decisions are made and directs that notes about a child’s views about a decision should be recorded on file.²⁵⁵ It also states that ‘to the extent that it is possible’, children’s preferences should be reflected in decisions.

Family Group Conferences

One method of consultation promoted by FACS is the family group conference (FGC).²⁵⁶ Family group conferencing is a voluntary, ‘family-focused, strengths based form of alternative dispute resolution’.²⁵⁷ A FGC organised by the department has five stages, outlined in the diagram below.²⁵⁸ A key component of the process and one of the features that distinguishes the FGC from a family meeting, is ‘family time’. This is the time that a family spends alone to identify solutions to the concerns raised by the department and preparing a family plan.²⁵⁹

A FGC is conducted by an independent external facilitator, who is selected through a tender selection process.²⁶⁰ The facilitator is required to complete the FGC within four weeks.²⁶¹ He or she is not able to make any decisions about the outcome of the family plan,²⁶² which must be endorsed by FACS staff. The plan is generally reviewed 12 weeks after the FGC.

Children may attend the family group conference (depending on their age), and if they do not attend in person, the caseworker should help the child to ‘write down their thoughts and feelings’, to be read out by another person attending the conference.²⁶³

In 2016–17, FACS referred 527 families to Family Group Conferencing. Of these, 226 referrals (43%) were for Aboriginal families. A total of 351 family group conferences were actually convened. It is not known how many of these were convened for Aboriginal families.²⁶⁴

252 See, example, the discussion of ‘children’s hopes’ in Braithwaite J, *Restorative Justice and Responsive Regulation* (2002), 103, 108.

253 J Braithwaite, *Restorative Justice and Responsive Regulation* (2002), 112.

254 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 9, 10.

255 Department of Family and Community Services (NSW), *Child Safe Standards for Permanent Care*, Standard 6.

256 Note that Family Group Conferences are also discussed in Chapter 19.

257 Department of Family and Community Services (NSW), *OOHC resources and tools* (online) <<https://www.facs.nsw.gov.au/providers/children-families/oohc/resources/chapters/common-principles-for-contact>>.

258 Department of Family and Community Services (NSW), *Family Group Conferencing* (Casework Practice Mandate, FACS Intranet).

259 Ibid.

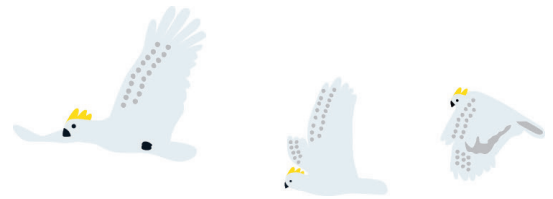
260 Ibid.

261 Department of Family and Community Services (NSW), *Family Group Conferencing: Facilitator Roles and Responsibilities* (2015).

262 Department of Family and Community Services (NSW), *Family Group Conferencing* (Casework Practice Mandate, FACS Intranet).

263 Ibid.

264 SNAICC National Voice for our Children, *The Aboriginal and Torres Strait Islander Child Placement Principle: A Guide to Support Implementation* (2018), 15.



Family and Community Services

family group conferencing

Family group conferencing is a family-focused, strengths based form of alternative dispute resolution that strengthens partnerships between families and encourages greater 'family' decision making and responsibility.

Care and protection practice framework

Our principles:

- we keep children at the centre of our practice with families
- we build relationships to create change
- we use contemporary skills and knowledge in a work culture that shares risk
- we respect culture and context.

The family group conferencing process has five stages:

1 The referral

Family group conference:

- there is a clear need for a decision
- participation is voluntary
- it is not crisis response casework
- the facilitator is impartial, with no casework responsibility.

2 Preparation

Preparation is the key to a successful family group conference.

Family negotiate with the facilitator who they want to attend.

Family are informed of concerns and issues to be discussed at a family group conference.

3 The conference

Information sharing - why are we all here?
What decisions need to be made?

Family time - for family to develop a plan.

Family Plan negotiated and agreed to with other agencies - have the child protection concerns been addressed?

4 Plan implementation

Who is going to make sure the plan is being followed through?

5 Review the plan

Is the plan working?

Does anything need to be changed?

What outcomes were achieved for the child or young person?



The conference should occur within four weeks from the date of referral.

Submissions and consultations

A number of submissions received by the Review addressed the issue of consultation in general and FGCs in particular. Some stakeholders were positive about the benefits of family group conferencing. For example, a group of four family violence prevention legal services (FVPLS)²⁶⁵ submitted that there should be mandatory and culturally sensitive family group conferencing prior to children going into care, and that there should be a family advocate to support women by providing access to rehabilitation, housing and other support services.²⁶⁶ A foster carer submitted that family group conferencing would have been useful to help resolve conflicts between herself and the children's birth mother and expressed disappointment that this was never offered.²⁶⁷ Other stakeholders noted that FGCs helped to address the power imbalance between FACS and Aboriginal families as they were conducted by independent facilitators and allowed the family to lead discussion.²⁶⁸

Other stakeholders were critical of the way in which consultation and FGCs occurred in practice. For example, the Benevolent Society submitted that child protection staff acknowledged that consultation with Aboriginal agencies and individuals 'is being implemented as a tick-the-box exercise'.²⁶⁹ In consultations, stakeholders reported concerns about the tone of voice and language used by caseworkers when consulting with Aboriginal people, with many considering that relationships with caseworkers were based on unequal power relations.²⁷⁰

Grandmothers Against Removal NSW submitted that ADR was not useful in practice, as caseworkers engaged in tokenistic consultation. It submitted that:

at best, they do not compromise on anything in these meetings because they have previously made up their minds and families feel further disempowered and damaged by the system; at worst, caseworkers use ADR to manufacture further evidence for their positions, regardless of the facts, and families can see this.²⁷¹

GMAR NSW submitted that any ADR conducted with Aboriginal families must, at a minimum, be conducted by Aboriginal mediators.²⁷²

The Northern Rivers Community Legal Centre submitted that caseworkers in a local FACS office had 'insisted that they had successfully increased the use of FGC particularly in relation to Aboriginal and Torres Strait Islander families'. However, information provided by an Aboriginal Child and Family Service worker indicated that this was incorrect and that only two FGCs had been conducted in the past year and one was not attended by the Aboriginal family after FACS

265 The services that made this combined submission are Many Rivers Family Violence Prevention Legal Service, Binaal Billa Family Violence Prevention Legal Service, Thayama-li Family Violence Service Inc NSW and Warra Warra Family Violence Prevention Legal Service.

266 Many Rivers Family Violence Prevention Legal Service, Binaal Billa Family Violence Prevention Legal Service, Thayama-li Family Violence Service Inc NSW and Warra Warra Family Violence Prevention.

267 Confidential, Submission No 10 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 2.

268 Confidential, *Consultation*, FIC 61; Confidential, *Consultation*, FIC 63.

269 The Benevolent Society, Submission No 7 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 7.

270 Confidential, *Consultation*, FIC 2; Confidential, *Consultation*, FIC 5-9; Confidential, *Consultation*, FIC 54.

271 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 5-6.

272 Ibid 5.



refused to engage an Aboriginal mediator.²⁷³

A number of stakeholders noted that Community Service Centres did not refer families to FGCs.²⁷⁴ Further, where referrals were made, a lack of staff (or trained staff) meant that the referrals weren't completed.²⁷⁵ It was submitted that there needed to be more stringent rules requiring referrals to FGCs, and training about the importance of FGCs, to remedy the lack of caseworker engagement with the process.²⁷⁶

AbSec submitted that FACS had limited the utility of family group conferencing by imposing its own approach to the process, rather than permitting family group conferences to be facilitated by Aboriginal community-controlled organisations.²⁷⁷

Data findings

As noted above, the *Care Act* provides that Aboriginal families should be given the opportunity 'by means approved by the Minister', to participate in decisions about their children made under the Act. The Minister, through numerous policy documents, has instructed FACS caseworkers to consult with Aboriginal families by conducting family meetings or FGCs. Despite these clear directives about the importance of consultation with Aboriginal families, and the need to work with families at all stages of the child protection continuum—from pre-entry into care to case planning to cultural planning—the Review found that FACS caseworkers routinely failed to consult with Aboriginal children, parents and family members during casework.

FACS (Review Tool) data highlight that Aboriginal families were involved in making decisions around the child's first placement for less than half of the children in the cohort (43.5%). It was rare that Aboriginal kinship (6%) and communities (1.7%) were involved in decisions. In almost half of all cases neither Aboriginal groups, people nor the children themselves were involved in making decisions about the child's first placement (47.5%).²⁷⁸ When looking to decision-making around children's current placements, a higher proportion of children had Aboriginal families (63.5%) and kin (13.1%) involved in decision-making around placement, although it is concerning that a significant proportion of children did not have any Aboriginal groups or family involved in decision-making (21.9%).²⁷⁹ While the proportions of consultation are higher overall compared to the child's first placement (and it is positive that families are more highly represented in

273 Northern Rivers Community Legal Centre, Submission No 16 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 7.

274 Confidential, *Consultation*, FIC 66; Confidential, *Consultation*, FIC 63; Confidential, *Consultation*, FIC 93; Confidential, *Consultation*, FIC 61.

275 Confidential, *Consultation*, FIC 66.

276 Confidential, *Consultation*, FIC 61.

277 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 12.

278 It should be noted that data around children being involved in placement decision-making does not take into account children's age at the time of placement decision-making and the percentage is calculated out of the whole of cohort number. It is accordingly not a reliable number from which to draw firm conclusions. Although the Review was subsequently offered further disaggregated data around this in response to this concern, there was insufficient time to progress this request.

279 Figure 21 and Figure 59, Appendix A. Limitations in this data include that 'decision-making' was not defined and it is not clear whether reviewers would have consistently entered information where family members were consulted, but the decision was made by other parties (such as FACS). 'Decision-making' should accordingly be approached with caution. It should also be noted that the Review Tool provided little guidance around differences between Aboriginal families, kinship groups, and communities, therefore making it likely that some of this data is unreliable. The data regarding who was not consulted is likely more reliable as it did not require reviewers to distinguish between multiple closely related categories without sufficient guidance.

decision-making in respect of the current placement), caution should be urged in interpreting these data based on the qualitative findings.²⁸⁰

The Review's qualitative sample data indicate that in some cases only some family members are consulted or involved in decision-making, and other family members are sidelined from this process. In the majority of cases in the qualitative sample (n=157, 78.5% of sample cases) issues were identified in respect of the participation component of the ACPP. In the majority of these cases it was identified that FACS did not adequately engage Aboriginal family in participation and decision-making around children's OOHC placements.

caseworkers routinely failed to consult with Aboriginal children, parents and family members during casework.

Reviewers identified a number of issues relating to the participation element of the ACPP, including that FACS did not contact immediate or extended family members or involve them in decision-making and that FACS would: make decisions and present these ready-made decisions to family members; cancel family group conferences and never reschedule them; arrange FGCs without inviting Aboriginal family members, or without inviting all relevant Aboriginal family members; organise FGCs in ways that did not protect the safety (and accordingly did not enable the participation) of Aboriginal family members; disregard the views of Aboriginal family members around placement; speak to one family member and seek their views, and either believe this was sufficient to discharge the principle, or believe that that family member would act as a 'messenger' for other family; and fail to consult with family members around children's placement beyond their first placement (for instance, in circumstances where a child's first placement broke down and the child required a new placement). Issues were also identified in respect of engaging in Aboriginal consultation or engaging with community members or organisations to support children's placement under ACPP. This is discussed further in the ACPP section around partnership.

Child participation

The department has developed guidance for caseworkers around the age or developmental level at which children should be consulted around their views on child protection matters.²⁸¹ Notwithstanding this guidance, quantitative and qualitative review data show that children who are old enough to express their views are not being consulted (either at all, or in good faith) about case planning issues and placement.

FACS (Review Tool) data highlight that of the Aboriginal children in the cohort who had a risk assessment completed, around half or less in each age group were interviewed for this assessment (Figure 81). While proportions of children being interviewed in very young age groups were understandably small (for instance, 1.9% of children aged under three years were interviewed), for older age groups it was concerning that numbers of children being interviewed

²⁸⁰ As with the data regarding the first placement, it should be noted that the Review Tool provided little guidance around the differences between Aboriginal families, kinship groups, and communities, or the meaning of 'decision-making' so it is possible that some of this data is unreliable. The data around non-participation is likely more reliable as it did not require reviewers to distinguish between multiple closely related categories without sufficient guidance.

²⁸¹ Office of the Senior Practitioner, Department of Family and Community Services (NSW), 'Talking to children and participation' (FACS Intranet).



remained low, despite children being of an appropriate age to participate. For children aged six years, only 51.8% of children were interviewed for risk assessment; for children aged seven to twelve years, 52% were interviewed in risk assessment and for children aged greater than twelve years, only 55.3% were interviewed in risk assessment. While only indicative of risk assessment, rather than children's participation in care and protection casework more broadly, these figures are concerning.

Qualitative sample data indicate that in 26 of the cases in the sample, issues were identified around children's participation. For the purposes of data for the Review, the age of six was selected as the age beyond which all children should be consulted about their views. This means that it was determined that all children should be consulted when they were six years old or older, acknowledging that many children will have the developmental capability to be consulted and have their views taken into account much earlier than this.²⁸² Many issues around participation concerned failures to ascertain the views or invite the input of much older children.

In the majority of cases where issues were identified (18 out of 26 cases), FACS did not seek children's views about placement or other child protection casework decisions despite children being identified as being above an appropriate age to be consulted. This is a concerning finding.

In some cases, while FACS involved the children in some decision-making, the reviewer identified that this consultation was not ongoing. Children have the right to be involved in decisions that affect them and impact their lives, and this failure to consult on an ongoing basis was identified as disempowering practice.

In a number of cases in the sample where children expressed their wishes, or their views were sought, these were not taken into account. This was particularly concerning, as while it is acknowledged that children may wish to remain with a parent in circumstances where it is not safe, in many cases further intensive family casework could have effected those children's wishes to live in safe placements with family.

Other issues identified included that FACS would seek children's input and consultation at inappropriate times and in inappropriate ways. For instance, in Case 144 FACS interviewed the children about alleged sexual assault at their school swimming carnival. This was identified as inappropriate practice. In Case 153, FACS interviewed the children after seeking their participation via leading and inappropriate questioning.

In a number of cases, strengths were identified in the way FACS invited children's participation. In several cases FACS engaged children throughout care and protection casework and decision-making and took their views into account. In one case a child's views were sought prior to a FGC occurring, which was identified as an approach that respected and responded to that child's views.

²⁸² The Review notes, however, that there may be reasons why a child above the age of six cannot be interviewed, such as when the child has a developmental delay or developmental disability.

Discussion

The data acquired during this Review supports the views of a number of stakeholders that consultation with parents, kin, families and children is not always undertaken, or is undertaken in an inappropriate or ineffective manner. While the department is now obliged to offer a family the opportunity to participate in a FGC prior to seeking an order from the Court (see below), the Review believes that caseworkers would benefit from further training about how to conduct less formal family meetings. Further training would enable caseworkers to confidentially and effectively engage Aboriginal family, kin and children in conversations about child welfare and safety at any time. Further, the Review has concluded that while the department is making some efforts to engage children in decision-making and case planning around their care and protection, it is evident that further work is needed to ensure participation is effected in practice. The Review's recommendations about improving caseworker accountability and ensuring that complaints processes are child-friendly (Chapter 8), as well as its recommendations to enhance knowledge about the ACPP (Chapter 16), will help to ensure that children are consulted as required by the department's policy and practice guidance.

Recommendation 97: The Department of Communities and Justice should develop and provide caseworkers with further training about how to organise and effectively conduct family meetings with Aboriginal families in contact with the child protection system.

The requirement to offer alternative dispute resolution to families of children at ROSH

In 2018, the NSW Government amended the *Care Act* to increase the use of alternative dispute resolution (ADR) in the child protection system. The Secretary must now consider using ADR processes when responding to every report and must offer the family of a child who is at risk of significant harm an ADR process before seeking any court orders in relation to the child.²⁸³ However, the Secretary is not obliged to offer ADR processes if he or she forms an opinion, on reasonable grounds, that the family's participation in ADR processes 'would not be appropriate due to exceptional circumstances'.²⁸⁴ There is no statutory definition of 'exceptional circumstances', however, FACS' guidance on the legislative changes states that exceptional circumstances include where there has been an emergency assumption or removal, or where women in the family have been subjected to domestic violence and would face a 'serious physical threat' during the conference.²⁸⁵ The method of ADR adopted by FACS is the FGC.²⁸⁶

Amendments to the *Care Act* made at the same time included amendments to enable the Children's Court to make: (i) an order allocating parental responsibility to a person if that order is by consent, without the need for a care application or the Court being satisfied that the child

283 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 37(1A).

284 *Ibid* s 37(1B).

285 Department of Family and Community Services (NSW), *Child Protection Legislative Amendments: Information for Permanency Support Program (PSP) Funded Service Providers on the Children and Young Persons (Care and Protection) Amendment Act 2018* (6 May 2019), 4.

286 *Ibid* 3.



is in need of care and protection; and (ii) a guardianship order without the need for the Court to be satisfied that there is no realistic possibility of restoration.²⁸⁷

The move towards greater ADR is laudable. As AbSec has noted, ‘family group conferencing, done well, remains a powerful tool for achieving real and sustainable change, engaging families and their broader networks in solutions to keep children safe within their family’.²⁸⁸

However, there are a number of concerns about the new system of mandatory ADR. Importantly, there is no comprehensive, publicly available framework outlining the way in which the family group conferencing system will work in practice. For instance, the number and cultural background of the FGC facilitators is unknown and it is unclear whether FACS intends to provide Aboriginal facilitators for FGCs involving Aboriginal families. It is also unclear how facilitators will identify the participants to be invited to the conference. Further, there appears to be very little guidance provided to facilitators regarding how best to work with Aboriginal families. A facilitator is simply required to ‘ensure reasonable adjustments are made in preparing for and convening a family group conference to account for a family’s cultural context and background’.²⁸⁹ Finally, there is no publicly available information about how the operation of the new mandatory family group conferencing system will be monitored and assessed over time. It is important that accurate and comprehensive data are collected about the number of conferences offered, the number of referrals accepted, the outcome of the conferences and the satisfaction of participants in the conferences.

Some stakeholders have suggested that Aboriginal people should receive legal support prior to and throughout the FGC process to help support them and rectify the power imbalances between FACS and families.²⁹⁰ While the department notes that families will be informed that they can obtain independent legal advice before accepting an offer of a FGC, it does not address the issue of the support of Aboriginal families during the conference. This appears to be a significant omission, given that decisions about the allocation of parental responsibility made in a FGC can now be easily affected by consent orders in the Children’s Court. In light of the evident power imbalance between DCJ and Aboriginal families, and the history of human rights abuses that has affected the relationship between child protection staff and Aboriginal families, the Review is of the view that it is important that Aboriginal families are permitted, on request, to have a support person present during any FGC.

AbSec has also noted that there is a concern that

current FGC processes that are FACS-administered and enabled to include the transfer of parental responsibility may act in a coercive fashion, undermining the social justice and participatory intent of such approaches. It is critical that such approaches are delivered by and for Aboriginal people, through our own processes and organisations, ensuring transparency and accountability for the outcomes they achieve promoting the strengthening of Aboriginal families so our children can thrive. This goal would be supported by the establishment of an Aboriginal commissioning body.²⁹¹

287 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 38(2A), (2B).

288 AbSec, *Submission to the Department of Family and Community Services “Shaping a Better Child Protection System”* (2017), 24.

289 Department of Family and Community Services (NSW), *Family Group Conferencing: Facilitator Roles and Responsibilities* (2015).

290 Community Legal Centres NSW, *Submission to the Department of Family and Community Services Shaping a Better Child Protection System Discussion Paper* (December 2017).

291 AbSec, *Submission to the Department of Family and Community Services Shaping a Better Child Protection System Discussion Paper* (December 2017), 26.

The SNAICC guide on the implementation on the ACPP clearly explains, among other things, what Aboriginal-led decision making looks like, creating an excellent reference and training tool:

- preparation is undertaken by the convenor with family and the child protection agency separately, to outline the process and content to be expected at the meeting. This includes discussing any contentious or critical information;
- decision-making is led by an Aboriginal or Torres Strait Islander convenor;
- active efforts are taken to ensure the child's needs are the focus of the meeting and their views are included with as much importance as the adults who are part of the process;
- families have adequate private time to discuss their solutions and create a family plan without professionals present;
- there is a shift of power from government agencies and processes to the family, and to strengthening the cultural authority and leadership of families and communities;
- family plans are endorsed at the meeting and, consequently, implementation is enabled immediately. This includes having a child protection agency representative present with authority to endorse family decisions; and
- the family and community agree to take ownership of family plans and agree to be accountable for their implementation.²⁹²

The Review agrees that it is essential that Aboriginal people are involved in the design and delivery of the FGC services and is of the view that the interaction and interrelation between the new ADR system and the recently released *Aboriginal Case Management Rules and Practice Guidance* should be clarified.

Recommendation 98: The Department of Communities and Justice should support the development and implementation of a family group conferencing model that is designed, led and delivered by Aboriginal Community Controlled Organisations.

Recommendation 99: Until Recommendation 98 is implemented, the Department of Communities and Justice should work with relevant Aboriginal organisations to develop guidance as to how to conduct culturally safe and appropriate family group conferences with Aboriginal participants.

Recommendation 100: The Department of Communities and Justice should publish information about how family group conferencing will be monitored and assessed over time.

²⁹² SNAICC, *The Aboriginal and Torres Strait Islander Child Placement Principle: A Guide to Support Implementation* (Report, December 2018) 66.



Recommendation 101: The Department of Communities and Justice ensure should ensure that support persons (such as Aboriginal Community Facilitators) are permitted to be participants in all family group conferences involving Aboriginal families.

Recommendation 102: The new recommended NSW Child Protection Commission should oversee, monitor and report on the operation of the new mandatory Alternative Dispute Resolution system introduced by the *Children and Young Persons (Care and Protection) Amendment Act 2018* (NSW).

20. Connection to family, community, culture and country

Introduction

Aboriginal communities in NSW are deeply committed to ensuring that their children grow up in safe, secure environments. However, there are times when Aboriginal children may need to be removed from their birth parents to ensure their safety and wellbeing. When it is necessary to remove an Aboriginal child from his or her family, it is crucial that the child is given the opportunity to stay connected with their family, community, culture and country. Connection to country is an integral characteristic of Aboriginal culture, as recognised by the High Court of Australia in *Mabo (No. 2)*,²⁹³ and the Australian people in native title and Aboriginal land rights legislation. The experiences of the Stolen Generation also provide stark evidence of the horrific damage that is inflicted upon Aboriginal children, families and communities when their familial, cultural and spiritual connections are forcibly severed.

This chapter examines the final Aboriginal Child Placement Principle (ACPP) element—the element of connection. A brief overview of connection is provided, before an examination of the way in which this element is realised in legislation and practice in NSW.

What is ‘connection’?

For Aboriginal and Torres Strait Islander people, ‘connection’ to family, community, culture and country is a fundamental concept which is central to one’s sense of identity, belonging and wellbeing. Aboriginal and Torres Strait Islander people understand ‘connection’ to be gained through social experience and involves interaction with families, communities and ancestors associated with a particular area that is related to them.²⁹⁴ In this sense, ‘connection’ refers to interdependent and reciprocal relationships between Aboriginal peoples and country which is sustained through cultural knowledge and practices.

‘Connection’ in the Aboriginal sense of the term is notoriously difficult to define as it is a concept which does not seem to hold non-Indigenous equivalence. Given this fact, the following definitions might be useful in attempting to translate connection for non-Indigenous readers. As Arrente and Luritja woman Catherine Liddle explains:

Connection to country is inherent, we are born to it, it is how we identify ourselves, it is our family, our laws, our responsibility, our inheritance and our legacy. To not know your country causes a painful disconnection, the impact of which is well documented in studies relating to health, wellbeing and life outcomes. Modern constructs of identification do not work for us, in fact they dismantle the fabric that holds us together. For example, it matters not that my licence says that I live in Sydney, it matters that I am guest in this place, I respect it because I am from the Arrente and Luritja lands, and it is this knowledge that enables me to identify who I am, who my family is, who my ancestors were and what my stories are. We are indistinguishable from our country

293 *Mabo v Queensland (1992) 175 CLR 1.*

294 ALRC, *Connection to Country: Review of the Native Title Act 1993 (Cth)* (Report no 126, April 2015) 175.



which is why we fight so hard to hang on.²⁹⁵

In the words of Palyku woman Ambelin Kwaymullina:

For Aboriginal peoples, country is much more than a place. Rock, tree, river, hill, animal, human – all were formed of the same substance by the Ancestors who continue to live in land, water, sky. Country is filled with relations speaking language and following Law, no matter whether the shape of that relation is human, rock, crow, wattle. Country is loved, needed, and cared for, and country loves, needs, and cares for her peoples in turn. Country is family, culture, identity. Country is self.²⁹⁶

Every Aboriginal child in out-of-home care (OOHC) has the right to maintain connections with his or her family and culture, although these two concepts are intrinsically related. To this end, the element of connection encompasses three main practical issues in respect of children in OOHC, namely: (i) arrangements to ensure that Aboriginal children have contact with their family including extended family; (ii) the placement of Aboriginal children with their siblings; and (iii) the maintenance of cultural connections.

For Aboriginal and Torres Strait Islander people, ‘connection’ to family, community, culture and country is a fundamental concept which is central to one’s sense of identity, belonging and wellbeing. Aboriginal and Torres Strait Islander people understand ‘connection’ to be gained through social experience and involves interaction with families, communities and ancestors associated with a particular area that is related to them

Research with Aboriginal children has revealed how important these issues are to a child’s overall wellbeing and sense of identity. For example, in one research study, when interviewed about their experiences in OOHC, Aboriginal children ‘focused almost exclusively on the importance they placed on connection to family, community and culture’.²⁹⁷ Children discussed missing their parents and brothers and sisters, being homesick and wanting to go home.²⁹⁸

Numerous stakeholders have noted the fundamental importance of connection to culture for Aboriginal children. For example, Fejo-King has argued that cultural identity and connection to the Aboriginal community are ‘formidable sources of resilience for Indigenous children and young people’.²⁹⁹ Krakouer, Wise and Connolly note that, for Aboriginal children, ‘cultural connection is just as important as placement stability. Consequently, permanent care orders

295 Celeste Liddle, ‘Why Connection to Country is So Important to Aboriginal Communities’ NITV Online. Accessed online: <https://www.sbs.com.au/nitv/article/2015/10/22/why-connection-country-so-important-aboriginal-communities>.

296 Ambelin Kwaymullina, ‘Seeing the Light: Aboriginal Law, Learning and Sustainable Living in Country’ (2005) 6 *Indigenous Law Bulletin* 11.

297 Australian Institute of Family Studies, ‘Protecting Indigenous Children: Views of carers and young people on ‘out-of-home care’ (2006) 75 *Family Matters* 42, 44.

298 *Ibid* 44.

299 Fejo-King, Fejo-King, C, *Why warriors live*, (2015), in C. Fejo-King, & J. Poona (Eds.), *Emerging from the margins: First Australians’ perspectives of social work*, (Magpie Goose Publishing, 2015), 5–36, cited in Krakouer et al, ‘“We Live and Breathe Through Culture”: Conceptualising Cultural Connection for Indigenous Australian Children in Out-of-home Care’ (2017), 71 *Australian Social Work* 269.

cannot necessarily achieve the connection to family, community, and culture that Indigenous children need to feel safe and well'.³⁰⁰ Further, the President of the Children's Court has described disconnection from cultural identity as 'one of the most significant causal factors for Aboriginal disadvantage generally, and the drift from care to crime more specifically'.³⁰¹

Issues relating to connection are addressed in several legislative provisions of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*). Section 9 of the Act provides that a child in OOHC is entitled to have a safe, nurturing, stable and secure environment, and that this includes contact with the child's 'birth or adoptive parents, siblings, extended family, peers, family friends and community'.³⁰² Further, various provisions of the Act deal with the making of contact orders.³⁰³ Section 9 also provides that children in OOHC are to be assisted and supported as far as possible to maintain their identity, language, cultural and religious connections,³⁰⁴ while s 13(6) provides that an Aboriginal child placed with a non-Aboriginal carer should have the opportunity for continuing contact with his or her family, community and culture.

Contact with family and kin

It is vitally important that Aboriginal children in OOHC remain in contact with their family, which commonly includes 'grandparents, aunts, uncles, cousins, nieces and nephews, and members of the community who are considered to be family'.³⁰⁵ As the Secretariat of National Aboriginal and Islander Child Care (SNAICC) has noted, 'family is the cornerstone of Aboriginal and Torres Strait Islander culture, spirituality and identity'.³⁰⁶

family is the cornerstone of Aboriginal and Torres Strait Islander culture, spirituality and identity

In NSW, contact with family is generally formalised in the Children's Court. A care plan must be presented to the Children's Court prior to the making of final orders, and this care plan must make provision for contact between the child and his or her parents, relatives, friends and other persons to whom the child is connected.³⁰⁷ The Children's Court may also make its own orders with respect to contact, including orders about the frequency and duration of contact and whether or not the contact is to be supervised.³⁰⁸ Court orders offer more certainty, but less flexibility, in respect of contact arrangements. If restoration is not a realistic possibility, the

300 Krakour et al, "'We Live and Breathe Through Culture": Conceptualising Cultural Connection for Indigenous Australian Children in Out-of-home Care'(2017), 71 *Australian Social Work* 269.

301 Johnstone J, 'Cross-Over Kids—the drift of children from the child protection system into the criminal justice system', (Speech, Aboriginal Legal Service Symposium, Newcastle, 5 August 2016).

302 *Children and Young Persons (Care and Protection) Act 1998* (NSW), 9(f).

303 See, example, *Children and Young Persons (Care and Protection) Act 1998* (NSW), s 86.

304 *Children and Young Persons (Care and Protection) Act 1998* (NSW), s 9(2)(d).

305 Secretariat of National Aboriginal and Islander Child Care, Connection to Family: Supporting Carers (Web Page, 2 June 2019) <<https://www.supportingcarers.snaicc.org.au/connecting-to-culture/connection-to-family/>>.

306 Secretariat of National Aboriginal and Islander Child Care, Connection to Family: Supporting Carers (Web Page, 2 June 2019) <<https://www.supportingcarers.snaicc.org.au/connecting-to-culture/connection-to-family/>>.

307 *Children and Young Persons (Care and Protection) Act 1998* (NSW), s78(2)(c).

308 *Ibid* s 86.



Children’s Court cannot make an order for contact that is greater than 12 months.³⁰⁹ Recent amendments to the *Care Act* enable contact orders of more than 12 months to be made in respect of a child who is the subject of a guardianship order, if this is in the best interests of the child.³¹⁰

The issue of contact with birth parents for all children in OOHC was addressed in the Legislative Council General Purpose Standing Committee No 2’s 2017 report on child protection in NSW. In this Inquiry, concerns were raised about children having too little contact with birth parents, and conversely too much contact with birth parents (which it was submitted could be unsettling for the child in care).³¹¹ In addition, the Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission) considered the issue of contact between children in OOHC and birth parents, noting that, where contact was safe for children, it was a significant protective factor as ‘research suggests that children mostly disclose instances of abuse to family and friends, with mothers being the family member children most frequently disclose to’.³¹² Further, contact between Aboriginal children in OOHC and their parents (and family more generally), is particularly important as research has shown that Aboriginal care leavers are more likely to return to their birth families than non-Aboriginal care leavers.³¹³ Or, in the words of one stakeholder to the Royal Commission,

we know most children in care go home. We want that experience to be really solid. We don’t want children to go home to experiences where they don’t actually know the family, they have had very minimal contact, and it sets them up to fail. It sets them up to have no social networks, no contacts.³¹⁴

A small number of stakeholders raised concerns about the level of contact that Aboriginal children had with their birth parents. For example, a group of four family violence prevention legal services submitted that, on average, parents had contact with removed children approximately six times a year.³¹⁵ It submitted that such limited contact made it difficult for parents to maintain their connection to their children and that this reduced connection in turn reduced the likelihood of restoration. The group further submitted that greater use should be made of s 86 of the *Care Act*, which allows the Children’s Court to make orders relating to contact, in order to ensure that children have more contact with their parents. This, in turn, could increase the success rate of applications for restoration made under s 90 of the *Care Act*.³¹⁶ CREATE Foundation submitted that young people who saw their fathers more reported feeling more connected to their cultural community. However, ‘fathers were also identified as having the least amount of contact when compared to other birth relatives’.³¹⁷

309 Ibid s 86(6).

310 Ibid s 86(8).

311 Legislative Council General Purpose Standing Committee No 2, *Child Protection*, (March 2017), [5.76]–[5.82].

312 *Royal Commission into Institutional Responses to Child Sexual Abuse*, ‘Working with Children Checks Report’ (August 2015), vol 12, 293.

313 P Mendes, B Saunders, and S Baidawi, *Indigenous care leavers in Victoria: final report* (Report, March 2016).

314 *Royal Commission into Institutional Responses to Child Sexual Abuse*, ‘Working with Children Checks Report’ (August 2015), vol 12, 293.

315 The services that made this combined submission are Many Rivers Family Violence Prevention Legal Service, Binaal Billa Family Violence Prevention Legal Service, Thayama-li Family Violence Service Inc NSW and Warra Warra Family Violence Prevention Legal Service.

316 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018.

317 CREATE Foundation, Submission No 4 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

Data findings

The Review gathered some data around the issue of contact between Aboriginal children and birth parents, siblings and extended family members. These data and their limitations are discussed below.

Contact with birth parents

The Review gathered some data around the issue of contact with birth parents. Unfortunately, a limitation with FACS (Review Tool) data, as well as the Pathways of Care Longitudinal Study (POCLS) data, is that contact information does not differentiate between children's Aboriginal and non-Aboriginal parents.³¹⁸ More work within the Department needs to be undertaken to ensure that data is accurately collected around children's contact with their Aboriginal parents and relatives.

According to FACS (Review Tool) data, the majority of children in the cohort who remained in care at the time of the Review were having contact with their mother (81.5%).³¹⁹ It is troubling, however, that for the highest number of children who were still in care and had contact with their mother, it was not clear from available information how frequently this contact was occurring (31.5%).³²⁰ Around 20% of children who remained in OOHc at the time of the Review were having contact with their mother, either fortnightly or more frequently than this, and about a quarter of children who remained in care were having contact with their mother monthly (25.8%).³²¹

For the vast majority of children who remained in care and had contact with their mother (78.3%), this contact was supervised (Figure 74). Although Delfabbro's analysis of the POCLS data suggests that parents had increasing rates of unsupervised and telephone contact with their children over time, it is concerning that FACS (Review Tool) data show that over the two years since the cohort children entered care, a high proportion of children continued to have supervised contact with their mothers, and that so many children continued to experience various forms of disconnection from family and culture often alongside this limited contact.³²²

Although a high proportion of children in care were having contact with their mother, it is concerning that almost 20% of children in care (18.5%) did not appear to have any contact with their mother at the time of the Review (Figure 72).

Just over half of children who remained in care were having contact with their father (54.2%) at the time of the Review (Figure 75). Of the children who had contact with their father, for over a third of these children it was not clear how frequently this contact was occurring (Figure 76). Around a quarter of children who had contact with their father had this contact monthly (24.2%). The vast majority of contact between fathers and children in care was supervised (76.2%).³²³

Although these data were not subject to Aboriginal interpretation and review, the qualitative sample

318 In Wave 5 of the POCLS additional questions have been added to attempt to differentiate between contact with non-Aboriginal and Aboriginal family members.

319 Figure 72, Appendix A. Guidance around answering this question in the Aboriginal Care Review Tool requests that reviewers capture the 'current level of contact', but the guidance is not sufficiently directive as to how reviewers are to assess 'current level of contact' and there may be differences not accounted for where current contact in practice is not meeting the contact suggested under FACS or NGO plans.

320 Figure 73, Appendix A.

321 Figure 73, Appendix A.

322 Paul Delfabbro, 'Aboriginal children in out-of-home care in NSW: Developmental outcomes and cultural and family connections. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care' (Research Report Number 11, Sydney, NSW Department of Family and Community Services) 6.

323 Figure 77, Appendix A.



data, which have been subject to such interpretation and review, enrich the FACS data findings around contact with mothers and fathers.

Cases often noted concerns about how frequently Aboriginal children in care were supported to have contact with their parents and the impact this had on those children's cultural and familial connections. Concerns were also raised in a number of cases that contact visits were unnecessarily supervised, with a number of cases recommending that these supervision requirements be revisited and re-assessed.

A number of reviewers also raised concerns about contact being reduced, including on the basis of restoration not being supported (for instance, Case 26). For example, in Case 46, a carer sought a reduction in the frequency of contact visits (and increase in the length of visits) to promote more 'quality time' between a child in care and their parents. It was not clear in this case why contact was being rationed in this way. It was likely that more contact for longer periods would have been a stronger way to promote that child's connection to their family and their attachment to their parents.

Reviewers also identified that there was often a difference between how frequently contact was supposed to occur under case plans and how frequently contact was occurring in practice. Although the FACS (Review Tool) data directed reviewers to check records to view the frequency of contact visits in practice at the time of the Review, the guidance reviewers were provided about how to proceed with data coding where there were significant discrepancies between how frequently contact was supposed to be occurring (under a child's case plan for instance), and how frequently contact was occurring in practice, was not clear. This is a limitation of this data.³²⁴

In some cases, reviewer's raised concerns about the lack of support provided to parents to facilitate their contact with children in geographically distant placements. In a number of cases, reviewers also raised concerns about contact arrangements breaking down due to FACS not addressing issues with contact visits, such as conflict between children in care and their mothers during visits. Regarding fathers in particular, reviewer's noted that in a number of cases FACS and OOHC providers had not done sufficient work to identify children's paternity or engage fathers in children's OOHC case planning.

The effect of parental incarceration on children's contact with birth parents was also identified as an issue. In 25 cases (12.5% of sample), the incarceration of the children's father was specifically identified as a barrier to contact between the father and children occurring. In only three of the 200 cases in the qualitative sample were children in contact with their incarcerated fathers.³²⁵ For a much larger number of children it was specifically identified that they did not have any contact with their fathers on the basis that they were incarcerated.³²⁶ In one of the 200 cases analysed for qualitative data purposes, a child was not in contact with her mother while her mother was in prison, although there were records of the mother sending letters and cards to the child.³²⁷ In another three cases, it was unclear whether children were having contact with their incarcerated mothers.³²⁸

³²⁴ The reviewers were provided the following guidance in the Aboriginal Care Review Tool survey: 'Capture the current level of contact for each of these and look for information about whether the contact is supervised and why? This may be difficult to find if the child is case managed by another agency, please answer the questions as best you can.'

³²⁵ Family is Culture Case 18; Case 54 and Case 156.

³²⁶ See, example, Family is Culture Case 6; Case 22; Case 25; Case 47; Case 59; Case 67; Case 69; Case 109; Case 112; Case 114; Case 117; Case 152; Case 193.

³²⁷ Case 88.

³²⁸ Case 205, Case 206, Case 207.

Contact with siblings

When siblings are separated in different placements, a sibling contact plan must be developed by the department or a non-government OOHC provider. This plan should be developed with the participation of all relevant people, including siblings and their carers, and is subject to quarterly reviews that are in addition to the annual case review.³²⁹ In 2019, the *Aboriginal Case Management Rules and Practice Guidance* stated that:

For an Aboriginal or Torres Strait Islander child and their siblings placed separately:

- their OOHC case plans include sibling contact time that enables them to participate in cultural activities 'on country' as a sibling group and
- their carers demonstrate they have sufficient understanding and appreciation of the children's Indigenous country, tribe, clan and language and
- their carers demonstrate they are committed to maintaining their cultural identity.³³⁰

The Review has been unable to gather meaningful quantitative data around sibling contact for children in the cohort. As KiDS and ChildStory do not consistently capture this information, the Review was reliant on the Aboriginal Care Review Tool to provide information about this issue. In addition to process limitations within this data, outlined previously in this report's data methodology chapter, there were specific limitations with the framing of the 'sibling contact' questions within this tool.³³¹

Recent POCLS data indicate that about one fifth of Aboriginal children (15.2%) did not have any or any direct face-to-face contact (6.6%) with siblings living in separate households to them. These data also highlight that almost half of children had supervised face-to-face contact with their siblings living in other households at least four times per year (46.4%).³³² A limitation of these data is that they do not appear to account sufficiently for Aboriginal children who may have a range of different contact arrangements with siblings placed separately to them—a relatively common situation observed during the qualitative case file review. Further, it is not clear how 'sibling' was defined, and whether the definition excluded paternal or maternal half-siblings.³³³ These data are also dependent on caseworker reporting of contact arrangements.³³⁴

Qualitative research findings from the sample suggest that sibling contact remains an issue for Aboriginal children in OOHC who are separated from their siblings, and for Aboriginal children

329 Department of Family and Community Services (NSW), *Aboriginal Case Management Rules and Practice Guidance*, (Web Page, 2 July 2019), < <https://www.facs.nsw.gov.au/providers/children-families/deliver-ppsp/aboriginal-case-management-policy/policy-statement2>>.

330 Ibid.

331 The framing of the specific Aboriginal Care Review Tool questions relating to sibling contact arrangements contained errors which made the first, and follow on questions, inconsistent. The way the questions were framed did not provide guidance as to the definition of 'sibling', and it is not clear whether reviewers consistently interpreted the questions as extending to include half-siblings or siblings who may be adults over the 18 years of age. The Aboriginal Care Review Tool also did not allow reviewers to enter multiple different contact arrangements for siblings (for instance, where a child had regular contact with one sibling, but no contact with another sibling), oversimplifying this complex data. Further, it did not contain guidance around which 'sibling arrangement' the reviewer should prioritise where children had different contact arrangements with multiple siblings in separate placements. These issues should be considered for future data reporting.

332 Paul Delfabbro, 'Aboriginal children in out-of-home care in NSW: Developmental outcomes and cultural and family connections. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care' (Research Report Number 11, Sydney, NSW Department of Family and Community Services) 56.

333 FACSIAR has advised that during their training interviewers for the study were advised that 'sibling' has a broad definition.

334 While caseworkers are able to select more than one arrangement under the survey in respect of sibling contact, it is not clear how 'sibling' is being defined and specific data about each contact arrangement with each sibling is not obtained.



who are separated from their siblings but have exited care on the basis of an order granting parental responsibility or guardianship to another person (for example, a relative).

While the qualitative sample data indicated that many Aboriginal children had contact with their siblings, others were placed separately and did not have contact with one another. When Aboriginal children were identified as being in contact with their siblings, this contact was not always regular, or did not always occur in respect of all of their siblings. In 20 cases (10% of total sample), children had contact with some but not all of their siblings (including half-siblings in some cases). Often children were not supported to have contact with older siblings, half-siblings, or siblings in geographically distant placements. In many cases it was unclear from FACS or non-government OOHC provider records how frequently sibling contact was occurring. Further, in many cases it was identified that FACS did not undertake sufficient work to promote sibling contact.

It was positive that in a number of cases family arrangements meant that siblings could have regular informal contact with one another and their parents. However, this was not the majority of cases in the sample.

Sibling contact remains a data gap within the department. There needs to be increased transparency into this issue. Further, sibling contact must be considered prior to a child's transfer to a permanent care arrangement such as a guardianship order, as the department retains little oversight of contact arrangements in these circumstances.

Contact with extended family and kin

The department does not routinely collect data about Aboriginal children's contact with extended family and kin while they are in OOHC and the Aboriginal Care Review Tool did not attempt to collect this information about the children in the cohort. The contact information collected in the tool was limited to contact with mother, father and siblings only.³³⁵ No information was collected about children's contact with community members.

Qualitative sample data highlights that many Aboriginal children were not supported to have enough, or in many cases, any, contact with their extended Aboriginal family members, kin or community. In 78 cases (39% of cases in the sample), it was identified that Aboriginal children were not having regular or any contact with one or both sides of their extended family. In most of these cases, (42 cases (21% of cases in the sample)), Aboriginal children appeared to be having no contact at all with at least one side of their extended family. In a number of cases, children were not having contact with Aboriginal family members who had been nominated as being central to the development of their cultural connections and identity (for instance, in the child's cultural plan).

³³⁵ The POCLS collects data from children 7 years and older, as well as their caregivers and caseworkers, about the nature and extent of the child's contact with extended family. These data relate to children in OOHC or children who have exited on a guardianship or adoption order. The POCLS data collection tool provides an option to select contact with 'other (specify)', and thus may capture contact with extended family and community members.

Discussion

The data discussed above raises concerns about the extent to which the department and non-government providers are supporting and promoting important familial and kinship connections for Aboriginal children in care. It is extremely important to developing children's connections and their wellbeing that Aboriginal children are supported to have regular, quality contact time with their family members while they are in OOHC. The department needs to ensure that contact between children and their parents occurs safely and any issues arising are addressed promptly, in the interest of both parties.

Not having the opportunity to have contact with extended Aboriginal family, kin and community, damages children's connection to culture and to family. To better gauge the scale of this deficit in Aboriginal children's care experiences, DCJ must ensure it is collecting and gathering clear information about children's contact with extended family from non-governmental OOHC providers. It must also ensure that it is prioritising these connections for Aboriginal children in OOHC through casework as a matter of urgency. Accordingly, the Review recommends that the department develop clear guidance about the desirability of promoting regular contact between Aboriginal children and their family, kin and community, how to promote this contact in practice, and about when supervision is necessary in contact arrangements.

As discussed above, another issue identified during the course of the case file review relates to the imprisonment of birth parents. FACS' policy provides some very brief guidance about organising contact with parents in correctional centres. For example, it notes that Corrective Services NSW provides a number of services for families of offenders in custody to facilitate contact with children, and that a correctional centre should be contacted seven days in advance of a contact visit.³³⁶

However, the level of guidance given on this issue is not commensurate with its importance in casework practice. Indeed, the lack of contact between children in OOHC and parents in prison was a significant area in which casework practice was identified to be deficient. From the Review's data, there is no doubt that there are many children in the cohort who are not having contact with their fathers in prison. For instance:

- In Case 204, the child's case plan stated that FACS had been unable to contact the child's father as he was in prison and they had no details for him.³³⁷ For this reason, no contact with the child's father was occurring; and
- In Case 208, the non-government OOHC provider did not provide any information to suggest that the children were having any contact with their parents. The children's most recent case plan records showed that both of their parents were incarcerated, with their release date marked as 'unknown'.

While the qualitative data analysis focused on the issue of contact with parents in custody, it also became apparent that parents' incarceration had an impact on case planning and the parents' ability to work towards restoration. For example, in Case 32, the child's mother was incarcerated for a year after the child's removal, which then affected her ability to work towards restoration goals. This scenario was similar in a number of other cases, both in relation

³³⁶ Department of Family and Community Services (NSW), 'Connections and contact for children in care' (Web Page, 2 July 2019), <<https://www.facs.nsw.gov.au/download?file=390185>>.

³³⁷ This case file was not included in the sample analysed for qualitative data purposes.



to incarcerated mothers and incarcerated fathers.³³⁸ In Case 209, the child's father was not provided with any restoration goals as he was incarcerated at the time of the Children's Court proceedings. He indicated that he wished his child to be restored and that he was working with methadone services, but was told by a caseworker that he would need to 'up the ante' as his child was 'well placed'.

The intersection of child protection issues and correctional services was also the subject of discussion in the Women's Legal Service NSW's submission to the Review. This submission noted that imprisonment of women, and particularly pregnant women and women caring for children, should be a last resort. Further, the service identified the need to increase the availability of programs that support mothers and children to live together in prisons and noted that when these programs were not available, mothers and children should be supported to maintain a connection to their children.³³⁹

Casework practice with respect to incarcerated parents should be improved. First, there is a need to ensure that Aboriginal children are actively supported to maintain contact with their parents at any time that one or both of them are in custody. To this end, the Review recommends that FACS develop policy guidance to assist caseworkers to work with Corrective Services NSW to ensure children are in contact with incarcerated parents. Further, the Review is of the perspective that there is a need to ensure that periods of incarceration do not unduly impact on Aboriginal parents' ability to work towards the restoration of their children. Mothers and fathers who spend time incarcerated should be able to access child protection targeted supports and services directly related to their child's FACS case plan. This enhanced collaboration between FACS and Corrective Services NSW (now both under the Department of Communities and Justice) would produce a two-fold benefit of providing children with the benefits of having healthier parents and improving parents' outcomes both during incarceration and while on parole. Further emphasis on this rebuilding of relationships and rehabilitation may also lead to a reduction in recidivism.

Recommendation 103: The Department of Communities and Justice should develop policy guidance for caseworkers that addresses the desirability of promoting regular contact between Aboriginal children and their family, kin and community; how to promote this contact in practice; and when supervision is necessary in contact arrangements.

Recommendation 104: The Department of Communities and Justice should develop policy guidance for caseworkers about the issue of contact with parents in custody. This guidance should include a discussion of the types of contact that can be facilitated between children and incarcerated parents, how to arrange the contact in practice, advice about methods of liaison with correctional services and information about facilities to enable contact in individual correctional centres.

³³⁸ Family is Culture Case 108 and Case 88.

³³⁹ Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OHC in NSW*, December 2017.

Recommendation 105: The Department of Communities and Justice and NSW Corrective Services should consider providing targeted supports and services to parents of Aboriginal children in out-of-home care that are directly related to the department's case plan (for example, a case plan with a goal of restoration).

Siblings in separate placements

Children who are removed from their parents should be placed with siblings wherever possible.³⁴⁰ As McDowall notes, the situation for children entering care falls within the definition of a 'crisis', and separation from siblings can exacerbate the crisis by, among other things, compounding a child's feelings of isolation, the sense that the child has 'lost a part of themselves', and the experience of 'missingness'.³⁴¹ Research has demonstrated that children with strong relationships to siblings have 'greater levels of social support, self-esteem, income, and continuing adult sibling relationships than those who did not have such childhood relationships'.³⁴² They are also more likely to have stable placements, and to be restored to their parents.³⁴³ For Aboriginal children, who often experience a cultural imperative to care for siblings, the desire to be placed with siblings is often fierce and desperate. In several research studies, Aboriginal children have voiced the deep longing they have to stay connected to their siblings:

Girl, 13: "I want to go back to [name of township], to mum and dad. Now. I miss my little brother and my mum and dad. I love them so much. I live with [names of carers]. I like it there where I'm living, it's nice and quiet there. I love it there. I want to move but I'm too scared to say it in front of [names of carers]. I want to live at [name of township] because they do lots of things. My Mum and Dad and my little brother. I want to go back to [name of township] so my little brother can be happy. He's lonely so I want to go back there."³⁴⁴

Caseworkers may face a difficult situation when a child who enters care already has a sibling in care. In these cases, if the first child's carer is not able and willing to take the second child, the need for sibling contact will conflict with the pursuit of permanency. FACS policy provides that, 'the general practice is that siblings be co-located in care',³⁴⁵ however, siblings need not be co-located where this would 'override other equally important policy principles such as each child's need for stability, permanence and safety'.³⁴⁶ Where siblings are placed separately, they should be placed as close to each other as possible and have regular contact.³⁴⁷ In the case of

340 For the purposes of this discussion, 'sibling' encompasses a broad range of relationships, including full or half-siblings, step-siblings, and other children living in the same kinship or foster home.

341 J McDowall, *Sibling Placement and Contact in Out-of-Home Care: Report Prepared for the CREATE Foundation* (2015).

342 Ibid 16.

343 Ibid 17.

344 Jenny R Higgins et al, 'Voices of Aboriginal and Torres Strait Islander Children and Young People in Care: Perspectives of Aboriginal and Torres Strait Islander Young People' (Research Paper 7, National Child Protection Clearinghouse, 2007), 6. See also Moore et al, 'They've gotta Listen: Aboriginal and Torres Strait Islander Young People in Out of Home Care', *Institute of Child Protection Studies*, (2007), 27-28.

345 Department of Family and Community Services (NSW), *Placement of Siblings in Out-of-Home-Care Policy* (January 2015). See also Department of Family and Community Services (NSW), *Permanency Support Program: Rules and Practice Guidance* (web page, 30 June 2019) <<https://www.facs.nsw.gov.au/families/permanency-support-program/permanency-case-management-policy/rules-and-practice-guidance>>.

346 Ibid.

347 Ibid.



Aboriginal children, the *Placement of Siblings in Out-of-Home Care Policy* states that:

To help identify a placement that best matches each child's needs for kinship, attachment and permanence, consultation should occur with members of the siblings' extended family or kinship group, Aboriginal organisations and Aboriginal caseworkers.³⁴⁸

Further, where Aboriginal siblings are placed separately, they should be supported to participate in cultural activities in their community together.³⁴⁹ When Aboriginal siblings are separated, the department and the non-government OOHC provider with case management responsibility for the child should consider respite care as an opportunity for sibling contact time.³⁵⁰ Carers should also be supported to enable a child in their care to spend time with their siblings.

The Law Society of New South Wales submitted to the Review that its members had noted that Aboriginal sibling groups were often separated and placed with different OOHC agencies. This presented 'significant difficulties in respect of contact and restoration planning for those families'.³⁵¹ It submitted that this was a particular issue for Aboriginal children who may come from large families where a number of children are subject to care and protection orders.

The Review's file review also revealed a number of cases where siblings appeared to have been unnecessarily separated in their placements. For example,

- In Case 210, a child was removed from his parents at birth and placed with his mother's cousin 'off country' in a placement outside of NSW. The child's three siblings were already placed with their non-Aboriginal maternal grandmother in Port Macquarie in NSW. The child's carer was not willing or able to facilitate contact with the child's siblings. In the jurisdiction where the child was placed, state legislation places the onus on the carers to arrange contact, and as such, FACS refused to financially support the parents to attend contact visits with the child.
- In Case 211, three children were removed from their parents, including four-year-old twins. When they were removed, the twins were separated and placed in various short term crisis placements.
- In Case 71, a child was removed from her family and placed with a non-Aboriginal family for several years. Her younger brother was removed from her mother's care at birth and placed with an Aboriginal carer (despite the fact that he was not Aboriginal). It is unclear why the two children were not placed together, particularly as FACS indicated to the Children's Court that the newborn child would be placed with his sister upon his discharge from hospital.

The following section provides further data gathered from the file review that is relevant to the issue of sibling placements.

348 Ibid.

349 Ibid.

350 Ibid.

351 The Law Society of New South Wales, Submission No 3 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

Data findings

Currently, the department's data does not clearly identify whether siblings in OOHC are being placed together or separately. Given its relationship to the element of connection under the ACPP, the issue of sibling placement requires greater analysis and further work around data design and collection. Partnership with Aboriginal stakeholders in undertaking this is necessary. Once collected, data about sibling placement can be used to inform policy and improve practice around placing children together and maintaining the connections of children in OOHC to family and culture. Unfortunately design limitations within the Review Tool precluded the sibling data that was collected from being usable for the Review and no quantitative data was available from FACS.

Although Delfabbro's POCLS publication presents information about sibling placements, there are a number of limitations with this data.³⁵² While the data highlights that Aboriginal children may be placed with some of their siblings, it is not clear how many siblings the children are *not* placed with. Further it is not clear how consistently the data accounts for half-siblings, on maternal or paternal sides. Contact with these siblings was an issue for Aboriginal children in many of the Review's case files.³⁵³

The Review's qualitative findings indicate that sibling placement has been an issue for Aboriginal children in the cohort. In at least 72 cases (36% of cases in the sample) it was identified that siblings in OOHC were either placed in separate placements or placed in OOHC when one or more siblings remained at home with the parents or carers from whom the child was removed. In most of these cases (n=64) siblings were placed in separate foster care or kinship arrangements.

In some cases, children were placed separately because they had different fathers or mothers, and thus different family arrangements. However, it was more common for children to be placed separately in different care arrangements. For example, some of the children in a family were placed with family, while others were placed with a foster carer. While it is acknowledged that it may be difficult to place multiple siblings together, it is important that consideration be given to ensuring siblings remain together in OOHC where possible.

In some cases, for instance in Case 50, children in the cohort were separated in geographically distant placements and were managed by different OOHC agencies. In Case 63, FACS attempted to place a child with his siblings in Queensland, however, this was opposed by the Queensland Department of Child Safety, which did not wish to 'jeopardise' the existing placements of the child's siblings. In several cases, children were placed with non-Aboriginal carers when their siblings, also often in the cohort, were placed with Aboriginal carers. Aboriginal children placed with non-Aboriginal carers and separated from their siblings are at high risk of cultural disconnection, particularly given that in many cases their cultural plans were non-existent, incomplete or inappropriate.

352 Paul Delfabbro, 'Aboriginal children in out-of-home care in NSW: Developmental outcomes and cultural and family connections. Pathways of Care Longitudinal Study: Outcomes of Children and Young People in Out-of-Home Care' (Research Report Number 11, Sydney, NSW Department of Family and Community Services) 55.

353 Other POCLS publications may contain some of this information.



Discussion

The Review notes that the department's policy states that siblings should be co-located in OOHC wherever possible. However, a number of stakeholders informed the Review that sibling placement was a particular issue for Aboriginal children. Further, the data findings discussed above, highlight the need for enhanced scrutiny around the issue of sibling placement. Recommendations made in Chapter 16 about the collection and reporting of data about compliance with all elements of the ACPP, including sibling placement, will help to ensure that relevant data is collected, and can then be used for policy development and case planning. The Review also notes that recommendations made in the Chapter 18 (designed to increase the number of Aboriginal children placed with family or kin), and recommendations made in Chapter 19 (designed to increase Aboriginal participation in decision-making about children in OOHC), will also help to address problems with sibling placement of Aboriginal children in OOHC.

78.8%

78.8% of children who remained in care had contact with their mother at the time of the review.

54.2%

54.2% of children who remained in care had contact with their father at the time of the review.

67.7%

67.7% of Aboriginal children in the cohort who remained in care at the time of the Review had a standalone cultural plan.

32.3%

While 32.3% of children did not have a cultural plan at the time of the Review.

Cultural connection

Existing literature confirms that ‘culture underpins and is integral to safety and wellbeing for Aboriginal and Torres Strait Islander children’.³⁵⁴ However, Aboriginal culture is rich and complex, a fact that is not always understood or recognised by stakeholders in the child protection system. An Aboriginal child should have the opportunity to learn about their language, family names, history and country, as well as their ‘laws, totem, skin and other aspects of identity’.³⁵⁵ Culture is also a protective factor, with Canadian research indicating that cultural connection may help to reduce rates of suicide among Indigenous young people.³⁵⁶

In one Australian study, Aboriginal children described culture as being incredibly important, noting that:

“culture holds you together, keeps you going”

“it’s like what helps you through”

“culture is who you are, so if you don’t know it you don’t know who you are”

“it’s like your family, where you come from, something you’ve got in common, it’s like everything”

“culture’s the thing that makes us different to other [young people]”³⁵⁷

Cultural planning

The primary way in which Aboriginal children are supported and encouraged to maintain contact with their culture, to the extent that this is divisible from family, is through the development of a ‘cultural care plan’. While there are no legislative provisions requiring cultural care plans for Aboriginal children in OOHC, departmental policy requires the completion of cultural plans.³⁵⁸ Since 9 January 2017 (after the commencement of this Review), the FACS Care Plan template—the template for the care plan lodged with the Children’s Court under s 78A of the *Care Act*—has included a mandatory template for a cultural plan for Aboriginal children.³⁵⁹

Prior to the introduction of this policy, FACS’ practice in the area of cultural planning was a source of consistent concern. For example, in the 2016 *Inquiry into Reparations for the Stolen Generations in NSW*, the General Purpose Standing Committee No 3 recommended that FACS review the quality and effectiveness of cultural care planning for Aboriginal children and young people in OOHC.³⁶⁰ The issue of cultural planning was also of concern to the judiciary. In his July 2016 submission to the NSW Legislative Council’s inquiry into child protection, the President of the Children’s Court stated:

354 Secretariat of National Aboriginal and Islander Child Care, *Understanding and Applying the Aboriginal and Torres Strait Islander Child Placement Principle: A Resource of Legislation, Policy and Program Development* (July 2017).

355 Ibid 13.

356 Ibid.

357 T Moore, B Bennett, and M McArthur, *They’ve Gotta Listen: Aboriginal and Torres Strait Islander Young People in Out of Home Care: Report Prepared for the ACT Department of Disability, Housing and Community Services* (2007), 29.

358 Department of Family and Community Services (NSW), *Care and Cultural Planning Policy* (web page, 30 June 2019) <<https://www.facs.nsw.gov.au/about/reforms/children-families/care-and-cultural-planning/chapters/resources>>.

359 Ibid.

360 Legislative Council General Purpose Standing Committee No 3, *Reparations for the Stolen Generations in New South Wales: Unfinished Business* (2016) rec 53.



I wish to place on record that this Court is increasingly frustrated by the lack of cultural knowledge and awareness displayed by some caseworkers and practitioners in their presentation of matters before it. The time has come for a more enlightened approach and a heightened attention to the necessary detail required, which may require specific training and education by the agencies and organisations involved.

...

The Court considers that it is critical to raise this issue until comprehensive cultural planning is embedded at all levels of the care and protection process. The Children's Court submits that caseworkers and legal practitioners will benefit from increased training and professional development in this area.³⁶¹

Currently, information on the department's website states that the cultural plan:

- Includes information on how the child will maintain his or her cultural identity and improve his or her cultural development.
- Requires minimum of four consultations with the child's Aboriginal family and community and minimum of 4 activities that encourage cultural participation.
- Details culturally appropriate services to be provided.³⁶²

Cultural plans developed after the conclusion of Children's Court proceedings are called 'Cultural Support Plans', which are attached to case plans.³⁶³ Pursuant to s 12 of the *Care Act*, Aboriginal families, kinship groups, organisations and communities should participate in cultural planning post-proceedings. They are essential to this process as the source of cultural knowledge.

Stakeholders to this Review discussed a number of issues relating to cultural connection. CREATE Foundation submitted that Aboriginal children and young people have highlighted the need to be placed in homes that maintain their cultural identity. However, it noted that its 2013 National Survey revealed that 35% of Aboriginal and Torres Strait Islander children 'reported having *no one* to teach them about their culture' and that 'this was the second highest rate in Australia'.³⁶⁴ CREATE Foundation also submitted that its 2013 National Survey had found that 'a young person's knowledge of their family story was the strongest predictor of strength and connection to culture'.³⁶⁵

The Law Society of New South Wales submitted that the merit test applied by Legal Aid NSW needed to be broadened to recognise Aboriginal family and kin structures. This would enable family members, such as grandparents, to make joinder applications to the Children's Court to seek the allocation of partial parental responsibility in respect of culture.³⁶⁶

361 Children's Court NSW, *Submission 80 to the NSW Legislative Council Inquiry into Child Protection* (July 2016).

362 Department of Family and Community Services (NSW), *Care and Cultural Planning Policy* (web page, 30 June 2019) <<https://www.facs.nsw.gov.au/about/reforms/children-families/care-and-cultural-planning/chapters/cultural-planning>>.

363 *Ibid.*

364 CREATE Foundation, *Submission No 4 to Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

365 *Ibid.*

366 The Law Society of New South Wales, *Submission No 3 to Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

A number of submissions dealt specifically with cultural plans. The Northern Rivers Community Legal Centre submitted that cultural plans for Aboriginal children were ‘often of poor quality’, many simply containing ‘one or two sentences that provide for the child to attend NAIDOC week events’.³⁶⁷ A group of four family violence prevention legal services submitted that cultural plans were either not prepared adequately or were tokenistic in nature.³⁶⁸

CREATE Foundation submitted that a significant number of children and young people were not aware of whether or not they had a cultural support plan. It submitted that cultural support plans needed to be utilised more effectively and ‘used in consultation with children and young people to promote their cultural identity’.³⁶⁹ Uniting submitted that cultural plans for children in OOHC in NSW were ‘often poor or non-existent’.³⁷⁰ It submitted that the new Care and Cultural Planning template was an ‘important starting point’ for improving cultural care plans and identifying policy and practice issues relating to cultural planning for Aboriginal children.³⁷¹ The Women’s Legal Service NSW submitted that accountability measures should ensure that FACS conducts regular and meaningful reviews of cultural care plans, ‘with input from affected children, parents, carers and other people significant to the child or young person’.³⁷² Finally, AbSec submitted that it was ‘pleased to note recent work being undertaken to improve cultural planning through Children’s Court processes’.³⁷³

The issue of cultural plans was also discussed during consultations. Stakeholders noted that families wanted their children to know their culture and that Aboriginal children were ‘thirsty for it’,³⁷⁴ while Aboriginal children off country felt lost.³⁷⁵ However, some stakeholders doubted whether a non-Aboriginal carer could effectively ensure a child’s connection to culture.³⁷⁶ It was stressed that it was important for cultural planning to occur to ensure that cultural development was being addressed by the child’s carer and for caseworkers to ensure that Aboriginal children in OOHC had a cultural identity.³⁷⁷

The Review was informed that some cultural plans were very good and were prepared in partnership with ‘strong Aboriginal families’, while others were ‘cut and paste from the internet’.³⁷⁸

367 Northern Rivers Community Legal Centre, Submission No 16 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

368 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

369 CREATE Foundation, Submission No 4 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

370 Uniting (NSW.ACT), Submission No 23 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, March 2018, 11.

371 Ibid.

372 Women’s Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017.

373 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 12.

374 Confidential, *Consultation*, FIC 62.

375 Confidential, *Consultation*, FIC 41; Confidential, *Consultation*, FIC 42.

376 Confidential, *Consultation*, FIC 18.

377 Confidential, *Consultation*, FIC 61.

378 Confidential, *Consultation*, FIC 71.



32.3%

Almost one third of children in the cohort did not have a cultural plan at the time of the Review (32.3%)

The Review was also informed that it was important to revisit cultural plans because children have different cultural needs at different development stages.³⁷⁹ Further, it was noted that the ‘threshold’ for cultural planning should be higher: while references to NAIDOC Day, NITV and Koori Knock Out could be included in cultural plans, it was important for a child to ‘experience their culture, feel strong in their culture, know their stories, know who they are, know their family, know their culture.’³⁸⁰ It was also noted that children placed with family members could easily lose contact with the Aboriginal side of their family.³⁸¹

Some stakeholders focused on the need to ensure that family members were involved in creating cultural plans and argued that there should be a process whereby family members could prepare a cultural plan independently of FACS (facilitated by, for example, a family group conference).³⁸² It was also submitted that cultural plans developed by FACS should be endorsed by an Aboriginal Community Controlled Organisation or a community elder.³⁸³ The Review was informed that in some cases family members, particularly grandparents, were pressured to sign cultural plans.³⁸⁴

Some stakeholders submitted that the department should provide more funding to enable Aboriginal children in OOHC to have access to their culture through activities, camps and programs that link children together. It was noted that FACS used to run cultural camps that were good. Stakeholders also noted that if carers were expected to connect children with their culture, they needed to have greater access to programs and support to enable them to do this effectively.

Finally, one stakeholder raised concerns about the department’s recording keeping practices with respect to culture. The stakeholder noted that the ‘culture table’ in the KiDS system was not used effectively and that cultural information was usually found in the general file notes and in case plans.³⁸⁵ The stakeholder observed that ChildStory should have an easy way to record a child’s cultural status, language group, as well as whether or not the child identified as Aboriginal, and where ‘on country’ was for the child.³⁸⁶

379 Confidential, *Consultation*, FIC 61.
380 Confidential, *Consultation*, FIC 61.
381 Confidential, *Consultation*, FIC 88.
382 Confidential, *Consultation*, FIC 61.
383 Confidential, *Consultation*, FIC 62.
384 Confidential, *Consultation*, FIC 68.
385 Confidential, *Consultation*, FIC 98.
386 Confidential, *Consultation*, FIC 98.

Data findings

FACS (Review Tool) data indicates that 67.7% of Aboriginal children in the cohort who remained in care at the time of the Review had a standalone cultural plan, while 32.3% of children did not have a cultural plan at the time of the Review (Figure 63).

Noting some reliability issues,³⁸⁷ the data indicates that for about half of the children who had a cultural plan (53.7%) this plan included evidence of promoting connection to country,³⁸⁸ and in just under half of plans there was no connection to country promoted by the plan (46.3%).³⁸⁹ About two-thirds of children's plans included evidence of age appropriate exposure to cultural elements (67.4%) and about a third of plans did not include such age appropriate elements (32.6%).³⁹⁰ It is not clear whether reviewers interpreted 'age appropriate exposure to cultural elements' consistently. In particular, it is not clear whether reviewers considered whether the exposure to cultural elements was age appropriate at the time of the cultural plan's drafting, which could have been years prior to the Review date, or at the the time of the Review.

For 40% of Aboriginal children in the cohort who had a cultural plan, the plan did not promote any engagement with Aboriginal services (39.8%). Engagement with Aboriginal services was included in 60.2% of children's cultural plans (Figure 66).³⁹¹

These quantitative data can be better understood through analysis of the qualitative sample data. In most cases in the sample, there were issues with cultural planning for Aboriginal children in OOHC (n=163, 81.5% of the sample). In 75 cases, children did not have cultural plans developed while they were in OOHC at all (37.5%, or over a third of the sample). This is a comparable (although slightly higher) figure to the cultural planning data outlined in the FACS (Review Tool) data presented above.

In many cases where children did not have cultural plans, FACS had no records indicating how the children were having their cultural connections sustained while in OOHC. Although it is acknowledged that many children were engaging in cultural activities while in OOHC, in some cases, FACS did not proactively investigate and record how carers were attempting to maintain these connections. Further, FACS did not appear to support carers to maintain these connections for the children in care.

In other cases, children did not have cultural plans despite case planning or Aboriginal consultation indicating that these plans were necessary and should be developed for the children. For instance, in Case 48, FACS identified the need to develop cultural plans in the children's care plans, although these plans were never completed. Other cases similarly

387 Many of the questions about cultural planning asked whether the plan contained 'evidence' of certain aspects (for instance, connection to country), and, it is not clear how the reviewers may have interpreted the prompt. For example, in defining 'evidence' reviewers may have looked for evidence of planning for a particular activity or aspect, or may alternatively have looked for evidence of the activity or aspect actually occurring. Thus it cannot be clearly identified whether data consistently relates to promoting or planning for an activity or aspect, or whether this activity or aspect was occurring for the child or children.

388 The way the questions were framed this relates to the text of the cultural plan, which may not reflect that a child is experiencing connection to country in practice.

389 Figure 64, Appendix A.

390 Figure 65, Appendix A.

391 The Aboriginal Care Review Tool also sought to collect information about the number and proportion of children and young people in the review cohort who had Aboriginal people involved in maintaining their cultural connection. This question was unfortunately not clearly framed in the tool, as it was not time limited and was calculated out of the total cohort number (rather than the children who were currently in OOHC). While it is relevant to know the extent to which FACS and OOHC providers are promoting children's connections to family and culture, the broad framing of the question impacts its reliability and useability and this data is accordingly not presented in this report.



identified that FACS had the intention to develop a cultural plan and sometimes this intention would be conveyed to the Children's Court. However, no plan was ever developed. In at least one case, there was evidence of cultural plan drafting, but no final plan was ever developed.

In some cases, it appears that FACS relied on the cultural knowledge of foster carers or family or kinship carers, eschewing the need for a cultural plan on the basis of the child's placement with an Aboriginal carer. Although Aboriginal relatives and carers are best placed to promote a child's connection to Aboriginal culture, it is concerning when foster or kinship carers either do not come from the same kinship group as the children, or may belong to one of the children's language groups (for instance, the maternal language group), with limited connections to other language groups to which the children may also belong (for instance, the paternal language group). This was evident in Case 12, where the kinship carer was a recognised Elder of one language group, but indicated that she had little knowledge of the children's maternal language group identity, or how to promote the child's connection to this identity. Similarly, in Case 22, although the children were living with Aboriginal foster carers, they indicated that they felt disconnected from their country, their family, and their culture in their placement. No efforts were made by FACS to develop cultural plans to further connect these children to their family and culture, and at the time of the Review, the children remain disconnected from their Aboriginal culture, country and family. In a few cases, there was evidence that the children's carers did not identify as Aboriginal, or did not have strong knowledge of their Aboriginal heritage and culture. This made the lack of cultural plan in these cases even more of an issue and illustrated FACS' lack of support for carers and children in regard to cultural issues.

It is particularly troubling that there was evidence in some cases of children being placed with non-Aboriginal carers, yet not having cultural plans developed to promote their cultural knowledge and development while in care. For instance, in Case 31, the non-Aboriginal kinship carers of a child were not supported to care for the child with a cultural plan. In this case, the child was also placed separately to her siblings and had limited contact with her Aboriginal maternal family and mother. This level of disconnection, and the department's inattention to the need for cultural planning, is problematic.

Some children had information about cultural connections in their case plans, however these plans were rarely detailed and did not meet the standard expected of a statutory agency with responsibility for maintaining and promoting the cultural connections of Aboriginal children and young people in OOHC.

Overall a high proportion of the children in the sample had no cultural plans at the time of the Review. It is particularly concerning that there appeared to be little scrutiny of this situation, or impetus for these issues to be rectified within FACS.

In almost half of the cases in the sample (n=94, 47%) the cultural plans developed by FACS for Aboriginal children in care did not meet the cultural needs of the child. The most common issue (24.5% of all cases in the sample, n=49) was that cultural plans were not extensive or specific enough to promote children's cultural connections. Many cultural plans failed to adequately map the child's cultural identity, or otherwise, did not go into detail about the child's language group, totem or country. Some plans did not contain extensive genograms or family information. In some cases, the onus of gathering cultural information was placed on the child's family. In Case 169, for example, the child's cultural plan put extensive pressure on the family to gather cultural information for the child, despite the family having experienced profound disconnection from their culture. FACS did not provide support in the way of referrals to assist the family in these

endeavours or provide appropriate cultural support to the child who was in care.

Another common issue identified with cultural plans (13.5%, n=27) was that they were not developed in consultation with family members. As a result, they often lacked detail and specificity with regards to cultural connections. In some cases, such as Case 133, no family consultation was conducted due to one of the child's parents being incarcerated, although this should not be an impediment to appropriate consultation for families whose children are in OOHC. In other cases, there was evidence of only one side of the child's Aboriginal family being consulted and included in the cultural planning process. This has a flow on effect for the quality of the children's cultural plans, as well as the ability of the plan to connect the children to all of their language groups.

Issues were also identified with cultural plans not being reviewed or updated (24 cases), and not being reviewed after placement changes (8 cases). The importance of cultural plans being considered a 'living document' was emphasised by a number of reviewers, and in a number of cases the need to regularly update the child's cultural plans was identified during casework, for instance, through Aboriginal consultation, but not progressed.

In 8 cases, the plan vested cultural development in inappropriate persons. For instance, in Case 7, an Aboriginal child's cultural development was vested in their Maori carer. In several other cases, responsibility for cultural development was vested in family members who were culturally disconnected. In Case 188, responsibility for the child's ongoing cultural connections was placed with the child's school and cultural connection was to be effected by the child's participation in general school-based activities.

In 15 cases, contact required under the cultural plan was not being observed. In many of these cases, a relative had been nominated to ensure the child's cultural learning, however no contact with that relative was occurring. In other cases, cultural plans did not promote ongoing contact between cultural custodians in families and Aboriginal children in care.

Several reviewers also criticised the standard of cultural plans that the Children's Court accepted—determining that the plans were inadequate despite there having been lodged at Court—and also identified that some plans were never lodged with the Court.

In four cases, plans could not be located for children in the cohort, although it would appear that these plans had been created. This is concerning and suggests that cultural plans are not being utilised in casework practice with families to the level that should be expected when promoting cultural connections for Aboriginal children in OOHC.

Finally, a number of plans evinced troubling mistakes. For instance, in Case 147, the child's cultural plan incorrectly identified her sibling (who was stillborn) as being grown up and culturally connected to the child in care. Further, in Case 163, the child's maternal aunt identified errors in the child's cultural plan, but there is no indication that these errors were ever addressed. These issues suggest a troubling apathy and lack of follow up regarding Aboriginal children's cultural plans when they enter care.



Strengths

Despite the sample revealing profound issues with cultural planning, with only 22 cases being identified as having a cultural plan that met the child's cultural needs, a number of strengths were also evident from the analysis. The strongest cultural plans were those that:

- were developed in consultation with family and community;
- were supported by contact schedules and plans which promoted extensive family contact (including with both maternal and paternal Aboriginal family where both sides identified as Aboriginal);
- promoted contact with country;
- were regularly reviewed and treated as a living document;
- named people and family members with whom children could connect and be connected as they grew;
- were supported by casework actions and monitoring; and
- were lodged with the Children's Court.

In Case 192, it was a strength of practice that the children's OOHC agency engaged the mother and two Aboriginal Elders to develop the children's cultural plans. This enabled active participation of family and community members in cultural planning and cultural support planning with the children's non-Aboriginal carers, before those children were eventually placed back with their family.

the department should ensure that Aboriginal children in OOHC have high-quality, up-to-date and individualised cultural plans that are designed by the children and their families.

Discussion

As discussed above, the department's approach to cultural planning was altered in 2017. The care plan provided to the Children's Court has been redesigned after consultations with stakeholders and now includes a mandatory cultural plan. It is unclear to what extent this change will ameliorate the problems with cultural planning identified by the Review. The Review notes, however, that many of the cultural plans prepared for children in the cohort were not of an acceptable standard and reiterates the view that the department should ensure that Aboriginal children in OOHC have high-quality, up-to-date and individualised cultural plans that are designed by the children and their families. As with the issue of sibling placement, the Review is of the perspective that recommendations made throughout this report, including recommendations about increased monitoring and oversight of casework practice, enhanced data collection in respect of the implementation of the ACPP, and greater participation of Aboriginal children and family in child protection decision-making, will help to address concerns about cultural planning.

PART F

Increasing exits from care



21. Restoration

Improving restoration practices

As noted throughout this report, there are three major levers through which to reduce the number of Aboriginal children in out-of-home care (OOHC) in New South Wales (NSW). One is to prevent entries into the system. The second is to enhance compliance with the ACPP, and the third is to increase exits from the system. The preferred method to increase exits from the system is through restoration. Restoration means physically returning children to their parents. This is the preferred NSW Government position, as reflected in the Permanent Placement Principles (PPPs) contained in s 10A(3) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*).

Stakeholders to the Review consistently highlighted the considerable power that the department has to remove children, and the opaque and confusing situation that families find themselves in once their children are removed. The lack of restoration (and lack of transparency around restoration decision-making), is supported by the data and case files examined by this Review. It is evident from the cohort that the majority of Aboriginal children who are removed never return home to live with their parents. There is accordingly a gap between the preferred legal and policy position in NSW, and the implementation of that position for Aboriginal children. This chapter considers the practical and legal barriers to restoration and makes recommendations about how to improve restoration rates.

Restoration as the preferred permanency position

NSW law and policy is directed towards permanency in arrangements for children who are removed from their parents. This legal and policy direction was the subject of the *Safe at Home for Life* reforms in 2014, which led to the amendment of the *Care Act* to include the PPPs. Permanency was further emphasised by the Their Futures Matter cross-government reforms in 2017, where permanency was the focus in the roll-out of the FACS Permanency Support Program. Permanency was also the subject of the My Forever Family reforms to the *Care Act* in 2018.

The PPPs are intended to guide the legal long-term placement for a child who has been removed from their parents. The objective of the PPPs is to provide a safe, nurturing, stable and secure environment for that child. The PPPs in the *Care Act* provide a hierarchy for placement in the situation when a child is removed from their parents.

- The first preference is for the child to be restored to their parent(s).¹
- If restoration is not in the best interests of the child, the second preference is for the child to be under the guardianship of a relative, kin or other suitable person.²

1 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 10A(3)(a).

2 *Ibid* s 10A(3)(b).



- If guardianship is not possible, then the next preference is adoption (except for Aboriginal and Torres Strait Islander children).³
- The final preference (for non-Indigenous children) is for the child to be placed under the parental responsibility of the Minister.⁴
- However, for Aboriginal and Torres Strait Islander children, these final two options are reversed, so that adoption is the final option for Aboriginal and Torres Strait Islander children.⁵

The Review supports the legislative and policy position of the NSW Government that restoration should be the preferred option for placement.

It notes that, restoration also very often accords with the desires of Aboriginal children. This was overwhelmingly the view of young people we spoke to during the course of the Review who had lived in OOHC. A 2006 survey from the Australian Institute of Family Studies (AIFS) highlighted how important it was to Aboriginal children that they be restored to their families. In this survey, Aboriginal children who were asked by AIFS about their experiences of OOHC consistently focused on the importance of connection to family, culture and community. For example, the desired outcomes of the children surveyed included to:

- ‘Get out of foster care’
- ‘To be with your family’
- ‘Go back to my mother’
- ‘We would really really want to be with our parents’
- ‘Would rather be back in [local community]’
- ‘Get my Dad back” [his father had died]’
- ‘Dad come to my house’
- ‘Have family together - Dad and Mum’.⁶

The AIFS also found that:

These themes of re-connection to community and family re-unification are important messages from young people. They do not spontaneously suggest concepts such as ‘stop the abuse’ or ‘stop the neglect’, but instead re-affirmed the importance of connection to people and place, even if those situations were deemed by authorities to be inadequate or placing the young person at risk. This was despite the child protection system having swung into action to protect these young people from harm and to prevent them from future harm.⁷

3 Ibid s 10A(3)(c).

4 Ibid s 10A(3)(d).

5 Ibid s 10A(3)(e). Note that adoption is discussed further in Chapter 22.

6 Daryl J Higgins et al., ‘Protecting Indigenous Children: Views of Carers and Young People on ‘Out-of-Home Care’ (2006) 75 *Family Matters* 42, 44.

7 Ibid.

In the context of Aboriginal child removals in NSW since the 1800s, the Review notes how important it is to respect the wishes of Aboriginal families to stay together and for the government to support families to ensure this can safely occur. The Review also notes the literature on the importance of listening and responding to children's views, in their own words, about their preferred placements.⁸

Despite restoration being the preferred policy position, the Review is concerned about the way in which the PPPs are implemented in practice. The following section discusses the Review's data findings with respect to restoration rates and casework practice relating to restoration.

Data findings: Low restoration rates

FACS (Review Tool) data reveals that for the majority of children in the cohort, restoration was not seen as a possibility from early in proceedings. For most (90.5%) of the children in the cohort, a care plan was filed in the Children's Court (Figure 69). For almost half of the children in the cohort, the care plan was filed within 0 to 3 months after the child entered care (44.7%) and for a further 28.8% of children the care plan was filed within 4 to 6 months of the child entering care. Overall, almost three quarters of children in the cohort had their care plan filed within 6 months of entering care (Figure 68).

If appropriate casework had been undertaken with more families who had children removed, the successful restoration rate would have likely been far higher.

In the majority of cases where a child had a care plan filed, the plan did not identify restoration to the parents as a possibility (84.1%).⁹ As most children had care plans filed within six months of entering care, this highlights that decisions around the possibility of restoration were being made soon after children were removed. Of the cases that did identify restoration as a possibility, in over three quarters of these cases the child was restored (83%),¹⁰ indicating that in most cases where restoration was identified as a possibility, and most importantly work was undertaken to achieve this outcome, restoration was successful. While this could indicate that the department identified the 'right' cases in which to pursue restoration, the Review is of the perspective that restoration was a possibility in far more of the cases than those where it was deemed possible by the department. If appropriate casework had been undertaken with more families who had children removed, the successful restoration rate would have likely been far higher. All parents should have the opportunity to receive appropriate and targeted casework support when their children are removed, and the decision to withhold support and oppose restoration early is disempowering and should be avoided. Data also show that for the majority of children who had a care plan filed in the Children's Court, restoration was not considered a possibility after final orders were made (74.8%).¹¹

8 See, eg, Alan Campbell, 'I Wish the Views Were Clearer: Children's Wishes and Views in Australian Family Law' (2013) 38(4) *Children Australia*, 184.

9 Figure 67, Appendix A.

10 Figure 71, Appendix A.

11 Figure 70, Appendix A.



84.1%

In the majority of cases where a child had a care plan filed, the plan did not identify restoration to the parents as a possibility (84.1%)

34%

In the qualitative analysis, deficiencies in restoration goals provided to parents were specifically identified in 68 of the 200 cases (34% of cases in the sample).

35%

In 70 of the 200 cases (35% of cases in the sample), no casework was provided to parents to assist restoration.

Taken together, these data indicate that restoration was often opposed early (most care plans were filed at the Court within six months of the child entering care), and was opposed in the majority of cases. Where restoration was not viewed as a possibility, parents received no casework, which is deeply concerning. While these issues may be addressed at least in part through the new permanency reforms, the qualitative research suggests that restoration goals and casework also need to be improved in order to effectively support parents and families to address issues that affect their ability to safely parent their children. Qualitative findings around goals and casework are outlined below.

Data findings: Restoration goals

In the qualitative analysis, deficiencies in restoration goals provided to parents were specifically identified in 68 of the 200 cases (34% of cases in the sample). In 26 cases (13% of cases in the sample), it was specifically identified that no restoration goals were provided to parents after children entered care. This indicates that the parents were not provided with any structured plan outlining the criteria the department expected them to meet in order to have their children restored to their care. In a number of cases there was no safety assessment prior to the children entering care, meaning that parents had no clear understanding of what had preceded a child's entry into care, or what they would need to achieve in order to have their children restored.¹² The department's failure to provide parents with restoration goals is a disempowering practice that lacks transparency. It also reduces the likelihood of parents ever being able to achieve restoration—which is the priority after an Aboriginal child is removed and placed in OOHC.

In 42 cases (21% of cases in the sample) where restoration goals were provided to parents, there were deficiencies specifically identified with these goals. In some cases restoration goals were unachievable—such as requiring parents with entrenched substance use issues and addiction to be abstinent from substances long-term in order to get their children restored. In many cases the requirement of abstinence was also unsupported by casework (such as support to access detoxification or rehabilitation programs), where this was very clearly required for the parents

¹² Safety assessment is discussed in Chapter 12.

to manage their substance use issues. In some cases the only response to substance use issues was to require parents to undertake urinalysis, which was identified as a punitive mechanism to utilise when working with a parents with long-term addiction and substance use issues. It was common that restoration goals did not take a strengths-based approach to working with vulnerable parents. Other goals, such as prohibiting parents from being homeless in the future (such as in Case 29) appeared to punish parents for social disadvantage, especially when identified as a goal without any casework being provided to the parents to rectify underlying concerns.

In several cases restoration goals were not communicated clearly to parents—including parents with disability—and in some cases these goals did not appear to recognise parents disability or take this into account. This denied parents with disability natural justice and was discriminatory and disempowering. In other cases an unachievable number of goals were nominated for parents, and in some cases the goals stipulated would be impossible to achieve before final orders were sought from the Children’s Court (such as requiring parents to be abstinent for 12 months, or attend rehabilitation for 12 months). Other goals were time unlimited and vague, such as the goal that a mother not enter into a ‘violent relationship’ in the future.

Goals around domestic violence often raised serious concerns around the apparent disconnect between FACS’ understanding of domestic violence and the reality of coercive and controlling behaviour.¹³ Restoration goals which required mothers to not enter into ‘violent relationships’ appeared to misunderstand the insidious nature of domestic violence and to, in effect, punish future victimisation. Similarly, in several cases restoration goals required parents to undertake ‘couple’s counselling’ or ‘relationship therapy’, despite there being clear indicators of coercion and control by the male parent against the female parent, making these processes unsuitable. In these cases FACS effectively increased the risk to the vulnerable mother by exposing her to ongoing abuse. The department’s lack of expertise and knowledge around domestic and family violence is evident in reviewing the restoration goals provided to mothers in a number of domestic violence cases.

In other cases, while restoration goals were provided, they were not provided to parents in a formal way so as to enable them to structure any attempts to have their children restored to their care. The lack of clarity and certainty about restoration goals was concerning.

Data findings: Restoration casework

In over half of the cases in the qualitative sample there were issues identified with the restoration casework provided by the department (n=111, 55.5% of sample). This included casework in cases where there were no restoration goals provided, as well as cases where restoration goals were provided. This also included cases where restoration progressed, as well as cases where restoration was opposed.

In 70 of the 200 cases (35% of cases in the sample), no casework was provided to parents to promote restoration. In some cases, parents approached the department asking for help but caseworkers refused to provide any restoration goals or casework assistance to help them achieve restoration. In two cases (Case 70 and Case 155) it was specifically identified that the parents had attended FACS after their children were removed to ask what they needed to do to have them restored, only to be told by caseworkers that they were ‘not their clients’ (in one

13 This is discussed further in Chapter 9.



case the caseworker said that she was ‘not a solicitor’). This represents disempowering practice with motivated parents and is also contrary to FACS’ own policy around restoration. These cases occurred in different community service centres.

In a further 41 of the 200 cases (20.5% of cases in the sample), deficiencies were identified in the casework provided to parents to assist restoration. In many cases, ‘casework’ was limited to ‘cold referrals’¹⁴ or was identified by reviewers as being minimal or superficial. In other cases FACS’ casework was criticised as not being holistic—for instance, in Case 162 the casework lacked flexibility, as the mother was not able to meet some casework actions due to other commitments (that is, she was unable to enter rehabilitation as her housing became available). In Case 143 restoration casework did not appear committed to achieving the outcome of restoration. In this case, FACS was slow to progress payments for required services, did not amend restoration goals or casework approaches when key services were unavailable, and unfairly held the child’s parents accountable for failing to achieve some goals. This casework approach was identified as punitive and appeared designed put barriers in place to prevent the parents achieving restoration, despite their clear motivation to have their child returned.

Discussion

Children should be safe and it is important, in order to promote this safety, that Aboriginal families are provided with clear, achievable and strengths-based goals, accompanied by culturally sensitive and holistic casework, to make restoration the primary goal of permanency planning after children enter care. While restoration will not be achieved in all cases, strengths-based and supportive approaches to restoration are more likely to achieve this outcome for children who enter care and will give families the best chance of staying together.

It is important that further data be collected about restoration casework, including the number and nature of restoration goals provided to Aboriginal families, in order to inform practice and policy development in this area and to ensure that restoration is properly promoted as the primary casework goal in respect of children in OOHC.

The Review is also of the position that FACS must urgently increase the number of Aboriginal children being restored to their parents. This will increase the number of exits of Aboriginal children from OOHC, bringing the practice into alignment with the stated legal and policy position, and reducing state interference into the lives of Aboriginal children. Placing children in OOHC should generally be a temporary measure while parents are supported to make changes that will enable them to safely care for children at home. However, in the year when this cohort was reviewed, removal into OOHC was rarely used for the purpose of supporting and working with parents, and only a small percentage of children in the cohort were ultimately restored.

In 2017, the NSW Parliament General Purpose Standing Committee No. 2 made the following recommendation:

That the Department of Family and Community Services develop a specific strategy to improve opportunities for children and young people in out of home care to be restored to their families, where appropriate.¹⁵

14 A ‘cold’ referral describes the situation where a person is provided with a name and a number of a service or program to contact. This can be contrasted with ‘active’ or ‘warm’ referrals where a caseworker contacts a service or program on the behalf of a client and coordinates the client’s entry into, or access to, the service or program.

15 Legislative Council General Purpose Standing Committee No 2 *Child Protection* (2017), rec 27.

The Review endorses the earlier recommendation made by the NSW Parliamentary Inquiry and is of the view that FACS should develop a specific strategy to improve the rates of Aboriginal children and young people being restored to their families, where appropriate.

Recommendation 106: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community, design and implement a system for the collection, analysis and reporting of data about restoration goals and casework provided to support parents of children who enter out-of-home care, including what casework is provided to support parents to achieve restoration goals.

Recommendation 107: The Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community, develop and implement a specific strategy to promote the restoration of Aboriginal children to their parents. This strategy should take into account findings in this report.

Restoration best practice

The literature on best practices in restoration shows the importance of delivering adequate support services to parents both before and after the removal of a child.¹⁶ These support services must match the specific needs of the parents, for example, in relation to substance abuse, housing, domestic and family violence, financial needs and mental health services. Practical services such as childcare, health services, and financial assistance have been observed to be the most helpful in facilitating restoration in general.¹⁷ The Review addressed the importance of support services in Chapter 9.

Lower rates of restoration in Aboriginal families has been linked to historically inequitable access to resources.¹⁸ Therefore, for Aboriginal people, access to Aboriginal specific resources is also key in increasing restoration rates. This supports the position of stakeholders in our Review that there needs to be greater access to support services designed and delivered by Aboriginal people, specifically for Aboriginal families, which address the complex issues and dynamics associated with the impacts of colonisation. The Review discusses these topics in Chapter 9 this report and has made recommendations in that chapter.

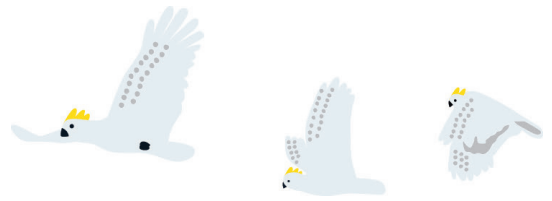
Intensive Reunification Programs have been evaluated in the U.S. with positive results. These types of programs typically involve parental visitation as a learning environment in which there is a chance to model positive behaviour.¹⁹ Other elements that have led to better restoration

16 See, eg, Neha Prasad and Marie Connolly, 'Factors that affect the Restoration of Children and Young People to their Birth Families: A Better Out-of-Home-Care System for NSW' (Transition Program Office, 2013); Elaine Farmer, 'Improving Reunification Practice: Pathways Home, Progress and Outcomes for Children Returning from Care to Their Parents' (2014) 44 *British Journal of Social Work* 348.

17 See, eg, Neha Prasad and Marie Connolly, 'Factors that affect the Restoration of Children and Young People to their Birth Families: A Better Out-of-Home-Care System for NSW' (Transition Program Office, 2013) citing Elizabeth Fernandez, *Accomplishing Permanency: Reunification Pathways and Outcomes Of Foster Children* (London: Springer 2013).

18 Neha Prasad and Marie Connolly, 'Factors that affect the Restoration of Children and Young People to their Birth Families: A Better Out-of-Home-Care System for NSW' (Transition Program Office, 2013) citing TC Cheng, 'Factors associated with reunification: a longitudinal analysis of long-term foster care' (2010) 32 *Children and Youth Services Review* 32, 1311.

19 Neha Prasad and Marie Connolly, 'Factors that affect the Restoration of Children and Young People to their Birth Families: A Better Out-of-Home-Care System for NSW' (Transition Program Office, 2013) citing M Berry, K McCauley and T Lansing, 'Permanency through group work: a pilot Intensive Reunification Program' (2007) 24 *Child Adolescent Social Work Journal*, 477 and BA Pine et al 'A better path to permanency for children in out-of-home-care' (2009) 31 *Children and Youth Services Review*, 1135.



rates in the U.S. include support services that are multi-systemic, skills-focused, and culturally competent; placement stability; meaningful engagement between the family and caseworkers; clarity in case planning; and clear restoration goals.²⁰ The Review has concluded that further exploration of intensive programs that include these elements would be helpful to promote higher restoration rates in NSW, with the important caveat that any such exploration of such programs must be done in partnership with Aboriginal communities to ensure that these are, indeed, designed in a way that they will be effective.

Similar themes were reflected in stakeholder input to the Review. For example, the Women's Legal Service NSW highlighted the importance of casework in supporting restoration, stating that:

... family restoration is facilitated by more frequent contact with the caseworker, particularly where that parent feels that their involvement in case planning and services is valued and respectful of their potential to keep their children safe, provides them with the information they need to successfully advocate for themselves and their children, and enables them to access the services and resources they need to achieve reunification.

Consistency of caseworker is also important. It is therefore important that caseworkers are well qualified and experienced and receive the necessary ongoing training, supervision and support to undertake their work and efforts be made to retain and support competent casework staff.²¹

Consultations with service providers also demonstrated the positive changes that could occur for families with the right support:

FACS has put a very compassionate and supportive caseworker in a restoration role if that's what they've called it ... (They've put someone in the role who) actually has the ability to speak and listen and get to know the families, I think his case load's a bit less. ... And he pushes a lot for the families to get restoration ... but that's only for one worker! They have to be thinking before removal, what the restoration will look like, and give that to the family. And so then it's like, 'Well we're removing your children, but it's only for a period of time. This is what we expect to change and this is what we gather in this time to happen, and these are our non-negotiables. This is what we're worried about.' And the family are like,

'Okay. What I need to do, I need to probably go to rehab, I need to get off drugs, and I need to start seeing a counsellor'.²²

On the other hand, according to this worker, what happens in practice usually is this:

'We're removing it because you're unsafe and you're neglectful'. That's the terminology they (FACS) use. That's the language, it's the process on how they're removed. It's still so daunting to talk about it and it's still a surprise to families.²³

20 U.S. Department of Health and Human Services, *Family Reunification: What the Evidence Shows* (BiblioGov, 2013) 2, citing J Corcoran, 'Family interventions with child physical abuse and neglect: A critical review' (2000) 22(7) *Children and Youth Services Review*, 563; G Macdonald, *Effective interventions for child abuse and neglect: An evidence-based approach to planning and evaluating interventions* (Chichester, England: John Wiley & Sons, 2001) 228-28; D DePanfilis, 'Intervening with families when children are neglected' in H Dubowitz (ed), *Neglected Children: Research, Practice, and Policy* (Thousand Oaks, CA: Sage Publications Inc., 1999) 211-236.

21 Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OHC in NSW*, December 2017, 12.

22 Confidential, *Consultation*, FIC 63.

23 Ibid.

It is the Review's perspective that the above 'lessons learnt' from literature and practice should guide a review of FACS relevant restoration policies and practice to ensure the embedding of best practice for Aboriginal families. For example, one obvious gap in the current policies and guidance is the promotion of access to relevant support services. Another gap in practice is the setting of clear, realistic and mutually established restoration goals.

The Review also notes that such an inquiry into restoration rates could also take into account the realities of domestic violence, substance use, poverty, intergenerational trauma, and other elements relating to the impact of colonisation. This would enable identification of the specific supports required by Aboriginal families who experience complex and dynamic issues that relate to systemic issues that cannot be solved through individual behavioural change.

Recommendation 108: To increase restoration rates, the Department of Communities and Justice should, in partnership with Aboriginal stakeholders and community, review its existing policies, guidance and practice relating to restoration to ensure that these all promote best practice in increasing restoration rates. This review should focus on providing sustained and suitable support services for Aboriginal families experiencing complex issues that cannot be solved simply through individual behavioural change.

Recommendation 109: The Department of Communities and Justice should fund an Aboriginal Community Controlled Organisation to design and pilot an Intensive Restoration Program designed specifically for Aboriginal families in NSW. Pilot funding must also include funding for evaluation based on measures designed in partnership with Aboriginal stakeholders and community.

General barriers to restoration

The Review identified several barriers that prevent restoration from occurring. The following sections provide an overview of potential issues with relevant law and policy. However, given that the key barrier appears to be the implementation of that law and policy, this section first outlines what stakeholders to the Review identified as key practical barriers.

Lack of support after removal

The Review heard from numerous stakeholders that a key issue preventing restoration was that once a child was removed, FACS withdrew its support of the parents. This is also identified and discussed above in the qualitative findings of the Review. Grandmothers Against Removal NSW submitted that:

All cases should be approached at all times with the attitude that there is a realistic possibility of restoration in order for parents to not simply be dismissed as lost causes, which happens all too often under the system currently. Parents are simply written off without being given real opportunities to heal their own trauma so that they can better



support their children. This approach is in the best interests of children because of the importance of maintaining family relationships.²⁴

In a confidential consultation, one stakeholder indicated that the proposed restoration plan is provided to the parents after the matter is established in the Children's Court. It lists all the restoration requirements, but there is no requirement for FACS to put in place the services to help the parent achieve these requirements. In this way, FACS 'sets the parent up to fail'.²⁵ This stakeholder noted that restoration casework must go beyond merely setting out recommendations for action.²⁶

A service provider stated that:

I think what FACS does really well is that they intervene and make decisions, and then because that decision or the child's been removed and it's in a care arrangement, they just abandon that family.
So it's them just being up to be like the parents to get this stuff together.²⁷

One mother informed the Review that she was in dire need of support after the removal of her children, after which she suffered depression and became suicidal.²⁸ A number of other stakeholders also indicated that they believed that the department should fund and support healing programs and services for families who have had their children removed.²⁹

Another service provider spoke bluntly to the Review about what FACS casework looks like:

And it's just like, 'Well when you can get up and get your sh*t together, when you can make these changes and you prove to us that you are a good parent, then come back and then we'll look to do restoration.'

And then they'll say, 'Well no, not much has changed because we still know that you're still using drugs.' Or, 'We're still not happy with your contact visits.' So they abandon ship all together of any thought of having a return to home plan. So guardianship's an easy option.³⁰

24 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 7.

25 Confidential, *Consultation*, FIC 63.

26 Ibid.

27 Ibid.

28 Confidential, *Consultation*, FIC 57.

29 Confidential, *Consultation*, FIC 61; Confidential, *Consultation*, FIC 69.

30 Confidential, *Consultation*, FIC 63.

The following case is illustrative of how a guardianship order may become a preferable option to restoration:

Study

In this case both parents indicated a desire to have K restored to their care and entered into a restoration plan with FACS. K's father agreed to an extensive list of undertakings that were filed with the Court in November 2016 and FACS also agreed to undertaking to support him with regular home visits, access to childcare, in-home care and transport support services. FACS also undertook to provide him with a housing support letter and referrals to family support, early intervention services and Link-Up.

FACS provided a housing support letter and referred K's father to two family support services but failed to fulfil (or even attempt to fulfil) any of the other undertakings. Neither referral resulted in a service being offered to K's father. Although FACS had committed to intensively supporting K's father to achieve restoration, casework tended to be more focused on assessing (and often re-assessing) K's father capacity to care for K as a single parent with two other high needs children in his care.

K's father demonstrated a willingness to work closely with FACS and he established open communication channels that were later used against him by FACS. For example, K's father informed FACS that he needed appropriate time to prepare himself and his family for the care of K and that there would be a steep adjustment required to care for K. FACS recorded this as K's father displaying "mixed sentiments". FACS did not attempt to work with K's father to alleviate his legitimate concerns. When his admissions were used against him in Court, K's father became fearful that he would lose custody of his two eldest children until case notes finally record him saying:

"[K's father] said it's not worth losing these two over K being placed here, just leave him where he is, as much as it breaks my heart. [K's father] said CS is always (sic) putting him down and he has had enough."³¹

This case could classify as an example of 'system abuse' in that a vulnerable father retreated from FACS out of fear that he would lose everything if he continued to pursue his rights in relation to one of his children. Had the Court been aware of the inconsistent and minimal casework support given to K during the restoration period or FACS' failure to follow through on their undertakings to support K's father, recommendations for guardianship may not have been accepted. It is clear when examining the twelve months K's father spent attempting to have K restored to his care that one of the major barriers to the restoration was FACS' withdrawal of support. Moreover, in this case it was evident that K's father's decision to support the guardianship application was made in defeat.

³¹ Family is Culture Case 375.



Lack of investment in appropriate services

A number of stakeholders raised issues about lack of funding of Aboriginal restoration services or restoration services that have a deep understanding of the Aboriginal community. In their submission to the Review, Barnados noted that:

poor investment in well resourced and sustained restoration programming in OOHC programs have significantly contributed to the continuing problem of too many Aboriginal children entering and staying in OOHC.³²

In their submission to the Review, the Women's Legal Service NSW noted that guardianship and restoration were allocated the same base funding as adoption. They noted that if family preservation and restoration are genuinely the priorities of the NSW Government, this should be reflected in funding allocations.³³ AbSec also highlighted the need to focus funding on family preservation and restoration rather than OOHC and tertiary measures such as guardianship and adoption.³⁴ The Women's Legal Service NSW noted that restoration funding must also extend to parents who do not currently have children in their care.³⁵ In consultations it was noted that restoration is underfunded,³⁶ and there is 'no incentive to restore' as some agencies do not even have restoration policies.³⁷

The Review agrees that adequate allocation of funding to the levers that will promote Aboriginal families staying or returning together will reduce the numbers of Aboriginal children in OOHC in NSW. In light of these concerns, the Review makes the following recommendation:

Recommendation 110: The NSW Government should review funding allocations to ensure that these reflect the NSW Government legislative and policy position to prioritise restoration and family preservation. This funding should prioritise the restoration programs that are successfully delivered by Aboriginal Community Controlled Organisations and funding should be commensurate with the over-representation of Aboriginal children in the out-of-home care system.

Confusion about restoration process and goals

In addition to a lack of support, the Law Society of NSW noted poor communication around the restoration process and restoration goals, leading to confusion on the part of the parents. This was also reflected above in the Review's qualitative data findings (discussed above). According to the Law Society of NSW:

some individuals feel that they were expected to make significant changes to get their children restored, but were not advised of what these changes were, nor were they supported during the process by the Department in any way.³⁸

32 Barnados Australia, Submission No 2 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 2.

33 Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 19.

34 Ibid 20.

35 Ibid.

36 Confidential, *Consultation*, FIC 41; Confidential, *Consultation*, FIC 42.

37 Ibid.

38 The Law Society of New South Wales, Submission No 3 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 49.

The Benevolent Society submitted that parents were often confused about how restoration might occur, and that parents experiencing financial hardship experienced unique challenges. It submitted:

[The parents] feel a lot of shame and guilt that this is happening, especially when it is not explained to them why this is happening. They feel angry like any other family. Some people don't have mobiles so FACS can't call them and tell this is happening. No one talks to them about restoration and how that works. FACS don't go to the house and say do you need help to get to this appointment, they don't offer them an Opal card, nothing. And that's a huge problem, basic things that would help, are just missed or not done.³⁹

Women's Legal Service NSW recommended that there be better promotion of restoration as a permanency pathway, and that specialist teams be established within FACS to provide further information about restoration—for example, though a hotline that parents could call to receive information about restoration policies and requirements.

In consultations, the Review was also informed that FACS did not always tell parents why their children had been removed, and what they needed to do to 'better themselves'.⁴⁰ One stakeholder noted that caseworkers did not 'check in' with parents, or help them devise an action plan, but instead expected them to meet goals unassisted.⁴¹

The Review encountered several cases where the parents were confused about what needed to occur in order for restoration to take place and were not supported by FACS in their restoration efforts. For example,

- In Case 134, both parents sought restoration and the Court Clinician's report in July 2016 recommended that restoration to the mother was a realistic possibility. The mother asking FACS to get a copy of the Summary of Proposed Plan so she could know what she needed to do to have her children restored. However, the plan provided no goals to the parents and indicated that FACS was not supporting restoration. There is no evidence about FACS ever giving either parent clear goals to have the children restored to their care; particularly as FACS went against the Clinician's report in making the recommendation against restoration. No casework was ever provided by FACS to assist restoration. Despite FACS' lack of assistance and goal-setting for the parents, the mother has demonstrated some change—having moved and having referred herself to sexual assault and family support services. The father has also demonstrated some change. Both parents have continued to seek restoration and a restoration assessment was to be completed in August 2018, suggesting that restoration may now be a possibility.

In the following case, also mentioned above in the qualitative data findings, it seems that FACS actively deterred restoration:

- In Case 70, A attended a meeting with FACS and asked FACS for assistance and advice on what she needed to do to satisfy the department that she could safely care for her two children. The FACS caseworker told A that her children were their 'clients' and she would need to seek her own support to help make changes. Since this discussion, A has apparently

39 The Benevolent Society, Submission No 7 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 10.

40 Confidential, *Consultation*, FIC 14–15.

41 Confidential, *Consultation*, FIC 63.



disconnected from FACS and has continued with her drug use. Restoration conditions included abstinence from alcohol and drug use and the requirement that the parents undertake counselling for substance abuse. No similar requirements had been encouraged in pre-entry into care casework. FACS did not complete casework with either parent to promote restoration.

Clear communication about restoration goals is fundamental to a parents ability to achieve restoration, and it is incumbent on FACS to effect this and to provide supportive casework aimed towards fostering and promoting restoration.

Impossible goal setting

The Review identified that FACS would often set impossible goals for parents, goals that were not realistic or achievable, or that goals would be linked to outcomes that would have been impossible for parents to achieve without support.

One of the key examples of impossible goal setting was around domestic violence. The lack of knowledge and specialisation around domestic and family violence within the department is evident through all stages of the system—from early intervention and pre-entry into care casework, through to casework and restoration goal setting.⁴² The Review identified in a number of cases that restoration goals would include that a mother was to desist from being subjected to domestic violence. This is grossly unfair, demonstrates little knowledge of how domestic and family violence affects women, and is illustrative of victim blaming in the system. The following cases provide examples of restoration goal setting from the case file review:

- FACS initially provided goals to F which required her to address her drug use, domestic violence, parenting skills, ensure a safe home environment and engage with FACS. F advised her caseworker she wanted her daughter returned and asked what was required. She demonstrated action and progress towards meeting these requirements, for example, the case file documents how F was making positive changes around the home so her daughter would be returned. It appears that little casework, other than organising contact, occurred to support restoration. FACS decided there was no realistic possibility of restoration for reasons including the F's 'inability to secure the house' from her abusive partner.⁴³ This was identified as placing a heavy burden on a woman subjected to domestic violence, evincing a lack of specialisation and knowledge around domestic violence, and being inappropriate practice with a long-term domestic violence victim.
- In Case 310, FACS provided restoration goals to J's parents, including for both parents to attend drug rehabilitation and to 'demonstrate the capacity to lead a lifestyle free from domestic violence and other violence over a period of twelve months.' His mother had further goals to attend domestic violence counselling and to undergo mental health assessment and treatment. His father was required to attend an anger management program.
- In Case 390, even though there was no immediate risk to B, she was removed from a formal event at school. While the restoration goals set by FACS were clear and concise, they included a requirement for her parents to stop using drugs. There had never been any concerns about the parents using drugs so it is not clear why FACS required them to undergo urine drug tests as a restoration condition.

⁴² This is discussed further in Chapter 12.

⁴³ Family is Culture Case 330.

Women's Legal Service NSW also highlighted the complex realities faced by women and how restoration goals were not always realistic, particularly without support:

Women with children who are experiencing family violence are often in a difficult position. Women who stay in violent relationships often do so to protect their children from the perpetrator rather than leaving their children alone with the perpetrator. Yet children who are exposed to family violence are at risk of being removed by FACS. If women leave violent homes with their children, children are also at risk of removal as a result of homelessness. Once children are removed, inappropriate housing can be a barrier to restoration due to a lack of safe and affordable housing options.⁴⁴

Some stakeholders consulted during the Review noted that there was a sense that FACS was 'always moving goals posts',⁴⁵ and made Aboriginal parents 'jump through hoops' to prove their children should be returned.⁴⁶ The Review was informed that this burden was particularly placed on women, who were required to attend appointments with doctors, therapists, parenting groups and other services, whilst men were not typically required to also attend.⁴⁷ One stakeholder believed there was a higher threshold for Aboriginal families seeking restoration than for non-Aboriginal families.⁴⁸

The Review also identified in the case files that parents were expected to juggle complex and competing goals, and FACS did not demonstrate any awareness or understanding of the challenging choices parents would have to make, including in situations of poverty. For instance:

- In Case 350, FACS set a number of goals for J's parents, including to attend anger management course and violence counselling and to cease violence against J. The case file indicates that the only casework to progress restoration included organising contact. Initially, J's parents worked with FACS, however, they withdrew on the basis that FACS was not willing to work with them outside of the hours of their full-time jobs; they were concerned about losing their jobs. FACS was unwilling to work with the parents outside the hours 9–5pm.
- Similarly, in Case 37, M's parents sought restoration. FACS set a number of goals for the parents, including requiring them to attend a rehabilitation centre for at least one month. One practical barrier was that M's mother was concerned she would lose her home if she went to the rehabilitation centre.
- Case 360 highlighted the sheer volume of goals that some parents would be expected to achieve and highlighted also that some goals were often not evidence-based or tailored to the issues facing the parents. In this case, B complied with all of the provisions of a care plan which required him to complete urine testing (3 times a week for 8 weeks then randomly as requested by FACS), secure stable accommodation and stay in this accommodation for a minimum of 12 months (must be free from rent arrears, police involvement and intelligence, complaints and tenancy tribunal proceedings) and undergo a parenting capacity assessment. In addition to this, B engaged with FACS to support his child's learning. B also broke his current lease so that he could move into a property that would meet the

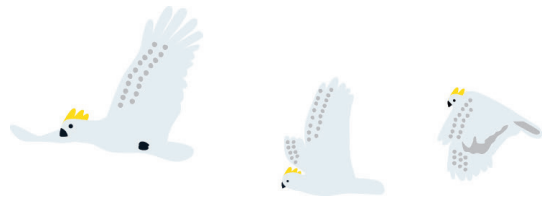
44 Women's Legal Service NSW, Submission No 20 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 17.

45 Confidential, *Consultation*, FIC 12.

46 Confidential, *Consultation*, FIC 63.

47 Ibid.

48 Confidential, *Consultation*, FIC 56.



requirements of FACS. B was living with family members who may have had the capacity to support him. The conditions of this care plan were extreme and disproportionately onerous (even punitive) given that there is no information to suggest that B was a drug user or that his accommodation with family members was unstable. The child was restored to the care of his father and he sees his mother in supervised visits each month by telephone while his mother is in residential rehabilitation.

These cases highlight the importance of realistic, achievable and supported goal setting, taking into account a family's issues, what needs to change, and supportively working with families to effect these necessary changes.

Dignity of risk

Dignity of risk approaches, which accept and attempt to manage a particular level of risk in any parenting approach or behaviour, particularly seem to fall away at the point of restoration goals. As illustrated in the case file examples above, many of the restoration goals are extremely strict and often unachievable in practice. This, coupled with a lack of casework support, appears to be one of the key barriers to restoration occurring from a practice perspective.

Conditions in restoration plans often prohibit non-illegal behaviour, such as consuming alcohol. This could be considered paternalistic and interventionist. Other conditions, such as requiring abstinence and taking approaches to casework which use urinalysis (an invasive 'pass/fail' or 'clean/dirty' can be disempowering to parents with addiction issues, are very time and resource intensive, and can set up parents to fail. They can also be demotivating and create barriers to restoration:

- In Case 103, FACS set restoration goals for C and R which required them to attend detox and rehabilitation, demonstrate that they could stay off drugs for 6 months, have 'no adverse police or FACS involvement', maintain secure and permanent housing, complete parenting programs, complete mental health care plans, and not to associate with anyone who would hurt their child. R was also required to undergo a specialist psychological assessment to assess his risk to his child in relation to his history of being confirmed as a person causing sexual harm to a child. FACS provided insufficient casework to help the parents to meet these goals, and none of the goals responded effectively to R's domestic violence against C. Casework assistance was limited to FACS booking R and C into urinalysis and organising for them to attend parenting programs. Neither parent met these goals and restoration has not been considered post final orders.

Housing

The Review is also concerned that a lack of appropriate housing may act as an impediment to restoration, and that department-wide policies may compound the difficulties faced by families attempting to satisfy restoration requirements.⁴⁹ For example, Housing policy provides that families seeking restoration of children from OOH, and families experiencing domestic and family violence, may be eligible for priority housing assistance.⁵⁰ This acknowledges the importance of secure housing to vulnerable families. However, the requirements imposed on parents seeking to access this policy provide an unnecessary barrier to families who are already in crisis. The policy requires individuals to provide:

49 The issue of housing is also discussed in Chapter 9.

50 Department of Family and Community Services (NSW), 'Eligibility for priority housing—urgent housing needs', *Social Housing Eligibility and Allocations Policy Supplement* (Web Page, 22 October 2018) <<https://www.facs.nsw.gov.au/housing/policies/social-housing-eligibility-allocations-policy-supplement/chapters/urgent-housing-needs>>.

- Evidence of current risk of homelessness;
- Evidence that the lack of appropriate accommodation is impacting their ability to have children restored;
- Associated medical assessments;
- Referrals from support providers;
- Supporting legal documentation such as Family Court papers, a Warrant of Possession or Apprehended Violence Order; and
- Evidence of an inability to resolve their housing need in the private market.⁵¹

Much of this information would already be held by caseworkers. In circumstances where housing is required for restoration to progress, caseworkers should provide this information to the housing division directly to reduce the burden on the family. The perpetuation of silos within the department places an unnecessary strain on vulnerable families. The free flow of information within FACS could create a less onerous process for families experiencing or facing imminent homelessness and reduce the amount of time that children remain in OOHC.

Recommendation 111: The Department of Communities and Justice should develop a memorandum of understanding (MOU) between Housing and Community Services that allows for the sharing of information held by Community Services when it is required by Housing before parents can access Housing services. This should include information needed to satisfy housing eligibility requirements, to be given 'priority status', or to access programs such as Staying Home, Leaving Violence.

Potential legal barriers

Section 83: Realistic possibility of restoration

Section 83(1) of the *Care Act* requires that, when the Secretary applies to the Children's Court for a care order for the removal of a child or young person, the Secretary must assess whether there is a realistic possibility that the child or young person could be restored. Section 83(1) was amended in the most recent reforms to the *Care Act* in November 2018 to include the words 'within a reasonable period'.

In March 2019, the meaning of this amendment was considered by Judge Johnstone, President of the NSW Children's Court.⁵² In *DFaCS and the Steward Children*, Johnstone J held that the amendment reversed a view previously expressed by Justice Slattery of the NSW Court Appeal, that is, that there needed to be a realistic possibility of restoration at the current hearing date.⁵³ Rather, Johnstone J indicated that the amendment indicated that there should be a realistic possibility of restoration within 'such period to be determined according to the facts of each individual case but no longer than a period of two years by virtue of the other limiting sections

51 Department of Family and Community Services (NSW), 'Priority housing: child protection caseworker factsheet' (Web Page) <<https://www.FACS.nsw.gov.au/housing/factsheets/priority-housing-child-protection-caseworker>>.

52 *DFaCS and the Steward Children* [2019] NSWChC 1.

53 *In the matter of Campbell* [2011] NSWSC 761.



in the Act.⁵⁴ This approach represents a new and positive development that will potentially promote higher rates of restoration.

Section 83(2) of the *Care Act* further provides that, if the Secretary assesses that there is a realistic possibility of restoration within a reasonable period, the Secretary is to create a permanency plan to this effect and submit it to the Children's Court. On the other hand, s 83(3) and (4) provide that, if the Secretary assesses that restoration is not a reasonable possibility, the Secretary must create a permanency plan for an alternative long-term placement, in which he or she must consider whether adoption as a preferred option, and submit that permanency plan to the Children's Court. Section 79A(3)(a) of the *Care Act* requires that the Children's Court must not make a guardianship order unless it has assessed that there is no realistic possibility of restoration.

When the Children's Court receives a care plan, the Court must determine whether to accept the Secretary's assessment within a reasonable period (6–12 months after the making of an interim order, depending on the age of the child).⁵⁵ In making this assessment, the *Care Act* requires the Children's Court to consider whether the permanency planning has been adequately addressed.⁵⁶ The *Care Act* also requires that, prior to making a final order approving a permanency plan that involves restoration, the Children's Court must also assess the evidence that the child's parents are likely to be able to satisfactorily address the issues that led to the initial removal of their child or young person.⁵⁷

Section 83(7A) clarifies that permanency plans, which may include placement anywhere, do not need to provide details as to the exact placement in the long term, prior to the Children's Court making final orders, but simply need to provide further and better particulars so the Court has a 'reasonably clear plan' of the needs of the child or young person, and how those needs may be met.

The Children's Court can play a valuable oversight role in promoting the implementation of the preferred placement hierarchy set out in s 10A of the *Care Act*. However, it is questionable whether the current framing of s 83 allows the Children's Court to adequately promote the preferred position of restoration, rather than approving permanent placement elsewhere. The cohort showed a very low number of cases in which the Secretary assessed that there was a 'realistic possibility' of restoration in the care plan. This does not sit easily alongside restoration as the preferred position after removal.

The NSW Government should review s 83 of the *Care Act* to ensure that what is required of the Children's Court in this section aligns with 10A of the *Care Act*. For example, if restoration is not recommended, a revised s 83 could also direct the Children's Court to query directly why the preferred placement is not recommended. It could also empower the Children's Court to enquire more directly about the specific actions that FACS has, or could, take to support restoration becoming a realistic possibility. A revised s 83 that empowers the Children's Court to actively encourage restoration could be an important mechanism to promote higher restoration rates.

Further, Legal Aid NSW in its submission to our Review noted that:

54 *DFaCS and the Steward Children* [2019] NSWChC 1, [33].

55 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 83(5).

56 *Ibid* s 83(7)(a).

57 *Ibid* s 83(7)(b).

Section 83 could be amended to expressly require consideration of placement with family and kin once the Court had determined there is no realistic possibility of restoration to parents. This is in effect what currently happens and would enshrine the section 10A principles by requiring the Court to actively consider extended family, kin or other suitable persons. [we] would see an amendment of this kind as consistent with the FACS Family Finding model, and may increase the emphasis on the importance of this aspect of casework to outcomes for children.

For example, section 83(3) could be amended to provide that where the Secretary assesses that there is no realistic possibility of restoration of a child or young person to their parents, the Secretary must prepare a permanency plan either: recommending placement with a relative, member of kin or community or other suitable person(s), or indicating that there is no suitable person, and submit that plan to the Children's Court for consideration.⁵⁸

This amendment would be suitable in achieving compliance with s 10A principles for cases where restoration to parents would not be in the best interests of the child.

Recommendation 112: The NSW Government should amend s 83 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to allow the Children's Court of NSW a more active role in ensuring restoration is a preferred placement.

Recommendation 113: The NSW Government should amend s 83 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to expressly require the Children's Court of NSW to consider the placement of an Aboriginal child with a relative, member of kin or community, or other suitable person, if it determines that there is no realistic possibility of restoration within a reasonable period.

In *DFaCS and the Steward Children*, Johnstone J also discussed what is meant by a 'realistic possibility' of restoration. He noted this is not such a high bar as 'probability' but that it goes beyond 'mere hope' that the parents' situation may improve. He indicated that a child's parents would need to lead evidence that they:

have already commenced a process of improving the deficiencies in their parenting identified at the time of removal or in the Summary of Proposed Plan, or in the Care Plan, such that there has been progress towards success in ameliorating their poor behaviour and that continuing success can confidently be predicted.⁵⁹

The sector, Aboriginal stakeholders and FACS, acknowledge that Aboriginal parents are subject to complex, overlapping challenges relating to intergenerational trauma, institutional racism, domestic violence and mental health issues. To ensure best practice decision making of Magistrates dealing with issues of placement of Aboriginal children and young people, the Review would welcome further education for Magistrates on these topics.

58 Legal Aid NSW, Submission No 6 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 4.

59 *DFaCS and the Steward Children* [2019] NSWChC 1, [29].



Recommendation 114: The NSW Judicial Commission should, in partnership with Aboriginal educators, provide opportunities for further education to Children’s Court of NSW Magistrates and staff regarding the research on intergenerational trauma, the effects of colonisation, domestic violence, poverty, substance abuse and mental health issues that may affect Aboriginal parents’ interactions with the Court.

Section 85: Provision of services

The Review notes that s 85 of the *Care Act* requires a government department or agency, or a funded non-government agency, that is requested by the Children’s Court to provide services to a child or young person (or the child or young person’s family) to facilitate restoration, to use its best endeavours to provide those services. The Review recognises the valuable role that the Children’s Court could play in supporting such service provision through utilising s 85.

The Department of Communities and Justice should monitor the use of s 85 in care and protection proceedings. Detailed data about the way in which s 85 is used—for example, information about the number of times a particular service is utilised by the Court, or information about variations in service provision needs in different geographic areas—will enable the department to better inform policy and practice around service provision to support restoration. The Review notes, however, that data about the use of s 85 by Magistrates will not capture instances where orders are not made for the provision of restoration services (if, for example, the Magistrate is unaware that no suitable services exist in the area, or is unaware of the existence of a particular service).

Recommendation 115: The Children’s Court of NSW should develop a practice directive for Magistrates to utilise powers under s 85 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to direct service provision in restoration cases. The Department of Communities and Justice is to collect and report data around the use of this section in care and protection proceedings.

Section 90: Restoration after final orders

If a child is placed in permanent care according to final orders, it is possible for a parent to make an application under s 90 of the *Care Act* to rescind or vary the final orders and have the child restored. This type of application can only be made with leave granted by the Children’s Court. There is a high bar for this application. The Children’s Court may only grant leave for such an application if the applicant can show that there has been a significant change in circumstances since the order was made or varied.

Section 90 orders appear to be rare. Such orders were not the focus of extensive stakeholder input to our Review. The Review notes that the NSW Parliamentary Committee heard evidence that ‘Aboriginal families who are under resourced and beaten down by a harsh and unsympathetic system they don’t understand, have no hope of raising a section 90’.⁶⁰

60 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017) [354].

The President of the Children's Court of NSW, Judge Johnstone, has noted that grants of Legal Aid are only provided in NSW for s 90 applications when they have a very real prospect of success.⁶¹ Without the provision of Legal Aid, there is a significant practical barrier for Aboriginal parents experiencing poverty and seeing return of their children. As noted in one consultation, many Aboriginal families simply don't have the money to pay any legal fees.⁶² The Law Society of NSW noted that FACS' practice is to cease supporting families after final orders are made. It argued that under s 113 of the *Care Act*, it is possible for FACS to continue to support families, and that this was an important pathway to future restoration.⁶³

The Review acknowledges that permanency is the focus for children. However, given the specific barriers to restoration that are experienced by Aboriginal families, and the desires for Aboriginal families to be reunited, the Review supports that families should receive continued support when requested.

Recommendation 116: The Department of Communities and Justice should provide further support to Aboriginal families who seek to progress a s 90 application after final orders have been made. This should be done by way of FACS developing a support strategy in partnership with Aboriginal stakeholders and community, designed specifically for this purpose.

Section 79: Abbreviated timeframes for restoration

The 2018 amendments to the *Care Act* also added a timeframe within which restoration or an alternative permanency arrangement must occur. When a permanency plan has been approved that allows for restoration, guardianship or adoption, s 79(9) of the *Care Act* provides that the maximum period that an order may be made allocating all elements of parental responsibility to the Minister is 24 months.

The Law Society of NSW was one of many stakeholders who noted how challenging it was for parents to have their child restored. One of the reasons for this is that permanent orders may be made before the parents have an appropriate amount of time to make changes.⁶⁴

Grandmothers Against Removal NSW noted that:

The ongoing push toward 'permanency planning' is deeply troubling because of GMAR Sydney members' lived experience of the child protection system as an institution that already removes extremely high numbers of First Nations children from their families. Changing legislation to strengthen the ability of the system to remove more children, for longer time periods, will cause more damage to children, not less, because the system itself is extremely traumatising.⁶⁵

The Review recognises that remaining indefinitely in care is not beneficial for children. However,

61 Evidence, Judge Johnstone, 27 September 2016 cited in Ibid 75.

62 Confidential, *Consultation*, FIC 63.

63 The Law Society of New South Wales, Submission No 3 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 74-75.

64 Ibid.

65 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 1.



it also recognises that rigid timeframes are problematic, in part because there are lengthy waiting lists for the services that are generally linked to restoration goals and restoration work is often limited to un-coordinated and cold referrals.⁶⁶ For example, one of the goals for restoration may be for the parent to secure permanent housing or complete a period of treatment for mental health or substance abuse. However, the waiting list for these government or non-government services may be more than 24 months. At 30 June 2018, the waiting time for most types of social housing in most areas of Sydney was 5-10 years.⁶⁷ This means that the restoration period may expire prior to services being made available, and a permanent order such as guardianship or adoption may be made for Aboriginal children as a result, which may not be in the best interests of the child.

The Review notes that s 79(10) of the *Care Act* states that s 79(9) does not apply if the Children's Court is satisfied that there are special circumstances that warrant the extension of this 24 month maximum period. The Review identifies that further clarification is needed in regards to s 79(10), for example, requiring that Aboriginal parents are provided services linked to restoration goals.

The Review agrees that parents should have a longer period to address complex issues, and that this should be accompanied by support services delivered by ACCOs.

Recommendation 117: The NSW Government should amend s 79(10) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) to ensure that it is linked to service provision that would support Aboriginal parents to have their children restored to their care.

Restoration policies

The Review heard from stakeholders that the pathway to restoration was confusing. The Review itself experienced the challenging nature of navigating relevant policies and practice guidance and ascertaining how the different elements fit with the relevant legislation. For example, some information relating to restoration is contained in the restoration guidance on the public FACS website and additional information about restoration is contained in a separate drug and alcohol policy. Moreover, not all information is publicly available online. It is important that the department be more transparent about what restoration assessments entail.

In 2017 the Legislative Council General Purpose Standing Committee No 2 recommended that FACS publish a plain English policy position on how parents and carers can work towards restoration of their children, including a clear internal review process for parents and carers who have been denied restoration.⁶⁸ At the time of the Review, the FACS website provides the following information on a website titled 'Bringing Your Child Home':⁶⁹

66 A 'cold' referral describes the situation where a person is provided with a name and a number of a service or program to contact. This can be contrasted with 'active' or 'warm' referrals where a caseworker contacts a service or program on the behalf of a client and coordinates the client's entry into, or access to, the service or program.

67 FACS Statistics Department of Family and Community Services, *Guide to Waiting Times for Social Housing* (30 June 2018) <https://public.tableau.com/profile/facs.statistics#!/vizhome/FACSSocialHousingExpectedWaitingTimes/EWT2_018>.

68 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017), rec 26.

69 Department of Family and Community Services (NSW), *Bringing Your Child Home* (online) <<https://www.facs.nsw.gov.au/families/out-of-home-care/parents-with-kids-in-oohc/bringing-your-child-home>>.

A restoration plan is required in the following circumstances:

1. When the Children's Court is involved, and the Court or FACS is of the view that restoration may be possible;
2. Where FACS has arranged for a temporary placement of the child;
3. Where a parent arranges care for their child through a non-government fostering agency for four weeks or more and the plan is for the child to return home; or
4. Where the Court has allocated parental responsibility for a child to FACS or another carer, but restoration is to be considered at a later time.

In the event that a Restoration Plan is created, the *Care Act* requires that it include the following:

- Restoration goals (namely, what needs to change before a child is restored);
- Services that can be arranged by FACS or the Children's Court to support restoration; and
- The duration of time that a parent will be assisted to work towards restoration.⁷⁰

If a parent is seeking restoration of their child, then the parent must:

- Be provided with a copy of the restoration plan;
- Understand what is required to be done under the restoration plan; and
- Have had their views considered when the restoration plan was developed.

Further information from the FACS public website is extracted below:

What can I do to give my children the best chance of getting home?

Hang in there, even if it's tough. Tell yourself you can get there in the end.

Know what is in the Restoration Plan. If you are confused, or worried about the plan, talk to a caseworker or another worker you trust about your concerns.

Do what you say you are going to do. That shows your child, and other people, that you can be trusted. Children grow up fast, so the time to get started is now.

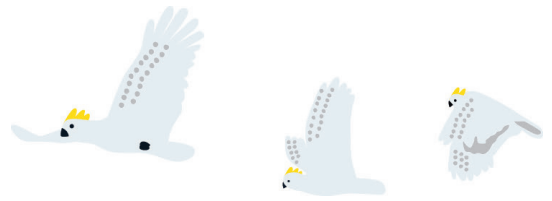
You don't have to do it on your own. There are people out there who can help you, even if you don't find them straight away.

When you see your children, try to do things that you'll be able to keep doing with them when they go home. Remember that presents and expensive outings don't count as much as your child having a good time with you.

What should I tell my child?

Tell your child that you love them.

⁷⁰ Children and Young Persons (Care and Protection) Act 1998 (NSW) s 84.



Let your child know that they have not been placed away from you as a punishment.

Be realistic and honest. Don't make promises you may not be able to keep.

If there are workers who are helping you, let your child know that you and your child are part of a team.⁷¹

The online guide is vague in terms of what support is available for parents. For example, it states 'You don't have to do it on your own. There are people out there who can help you, even if you don't find them straight away'. This direction is not as helpful as pointing towards relevant services or providing a script on how to ask a caseworker for help. This guide does not contain information about the kinds of services or that may be provided as part of restoration. Similarly, it does not provide information tailored towards Aboriginal parents, which is an oversight given the high numbers of Aboriginal children in care. The online guide also does not contain detailed information about what could happen in cases where the parent and children have been denied restoration.

Whilst the Review acknowledges that this guide is a positive start, resources such as the guide should provide parents with practical and clear information. For example, the guide should include information regarding what parents can expect from the restoration process, information as to how parents could seek support and services, practical advice around how to manage the experience of child removal, information on the factors that are considered by caseworkers in the decision-making process around restoration and what the parents could do when restoration is not deemed to be a 'realistic possibility'. As noted above, this is the case for the majority of children in our cohort, and many parents would likely need this support.

Given the challenges in navigating the material around restoration, it would be helpful for Aboriginal parents to be able to access a hotline run by a funded Aboriginal organisation to receive greater support in understanding better what is required to successfully achieve restoration.

Recommendation 118: The Department of Communities and Justice should review and update the restoration information that is publicly available on its website in line with issues raised in this report. The department should also provide online information to improve guidance for parents in relation to restoration practices and processes and further information about what parents can do when restoration is not deemed to be a 'realistic possibility'

Recommendation 119: The NSW Government should provide funding to enable a restoration hotline to be established by an Aboriginal organisation in order to provide parents and families of Aboriginal children in out-of-home care more detailed information about the restoration process and what is required to successfully achieve restoration.

⁷¹ Department of Family and Community Services (NSW), 'Restoration: Bringing your child home' (website) <<https://www.facs.nsw.gov.au/families/out-of-home-care/parents-with-kids-in-oohc/bringing-your-child-home>>.

Permanency Planning Case Management Policy

As noted above, the Permanent Placement Principles (PPPs) were added to the *Care Act* in 2014. In 2018, the Permanency Support Program came into effect to support the implementation of these principles. The Permanency Planning Case Management Policy supports the implementation of the Permanency Support Program. This policy addresses the PPPs for children in NSW.⁷² Practice guidance located on the FACS intranet operationalises this policy. This policy is not dealt with in depth here for the reason that the policy itself notes that casework with Aboriginal children is guided by the *Aboriginal Case Management Policy*.

Aboriginal Case Management Policy

The *Aboriginal Case Management Policy* is most relevant for understanding guidelines around casework with Aboriginal children and families. This policy is available online.⁷³ It came into effect in October 2018. It is intended to support:

Aboriginal families and communities to overcome key barriers and obstacles including poverty, intergenerational trauma, disadvantage and marginalisation that negatively impact on the development of Aboriginal children and young people.⁷⁴

The implementation of the policy aims to achieve a number of positive outcomes, such as 'Aboriginal children are ... safe at home with relatives and kin—they are supported to live with their own family and community to grow up strong and in culturally rich environments'.⁷⁵

The *Aboriginal Case Management Policy* is operationalised by *The Aboriginal Case Management Rules and Practice Guidance*, developed by FACS in partnership with AbSec in 2018. The Rules and Practice Guidance addresses the expectations, roles and responsibilities for practitioners across the continuum of support. These include services, family preservation, restoration, OOHC and after care in relation to Aboriginal Community Response, Aboriginal Family Strengthening, and Aboriginal Child Safety. The Rules and Practice Guidance are available in full on the FACS intranet.

The Rules and Practice Guidance have been developed in partnership with an Aboriginal peak body and in Chapter 16 the Review recommends that they be implemented as a matter of priority.

While the Review recognises this is a step in the right direction, it is important that the *Aboriginal Case Management Policy* contains measurable outcomes. Ideally, these outcomes will be publicly reported against, to ensure that this policy (and its guidance) is in fact having the desired impact. If this is not undertaken, policies will continue to give the appearance of best practice without having any practical effect on issues such as disproportionate numbers of removals and low levels of restoration.

72 Department of Family and Community Services (NSW), *Permanency Case Management Policy* (online) <<https://www.facs.nsw.gov.au/families/permanency-support-program/permanency-case-management-policy/case-management-policy>>.

73 Department of Family and Community Services (NSW), *Aboriginal Case Management Policy* (online) <<https://www.facs.nsw.gov.au/providers/children-families/deliver-ppsp/aboriginal-case-management-policy>>.

74 Ibid.

75 Ibid.



Restoration policy

The restoration policy and associated practice guidance, such as a goal scaling tool, are located on the FACS intranet. This restoration policy is provided to caseworkers and includes a list of factors that could be considered by the caseworker and their team in determining whether restoration is a realistic possibility. For example, these factors include the views of the child, the strengths of the family, and a consideration of whether FACS has been flexible and creative in their engagement of the family. The restoration policy notes that any casework must be ‘culturally sensitive’ and that consultation must occur with Aboriginal people when an Aboriginal child has been removed. The restoration policy notes that restoration is a process and that families need support to work towards it.

In the event that restoration is identified as a realistic possibility in the case plan, the restoration policy includes guidance around identifying restoration goals, such as using words and language that make sense to the family and identifying steps that could be taken to help meet the goals, including who will be responsible for each step. The restoration policy suggests that caseworkers make tasks fair, achievable and measurable, that being identify any barriers, and consider how families could be supported to achieve the identified goals. These are positive elements which the Review encourages FACS to ensure are carried through in practice.

However, the restoration policy is lacking in key elements. For example, it lacks an emphasis on directing caseworkers towards services to support the family to work towards restoration. The policy also does not contain guidance about the realities of domestic violence, drug and alcohol use, nor relevant information relating to Aboriginal children. Given the unrealistic restoration goals in case files, the Review recommends that the restoration policy be reviewed to ensure that the most up-to-date information about current best practice in drug and alcohol use, and domestic violence, is made available to caseworkers. It is repeatedly demonstrated in the case files that caseworkers do not understand complex practice considerations around particular presenting issues for families. For example, setting a restoration goal for an abused woman to ‘stop being abused’ to have her child returned does not acknowledge that it is not her fault that she is being abused, does not recognise that she may rely upon the abuser for financial support, and does not take into account that separation is a dangerous period for women. She will need support to implement this restoration goal. In Chapter 9, the Review recommends that specialist training be provided to caseworkers in this area.

Further, at least at the time of the Review, the restoration policy did not contain reference to the recent amendments to s 83 of the *Care Act* outlined above or clarifying information from President Johnstone from the Children’s Court. As noted above, Judge Johnstone interpreted this reasonable period to be two years, as opposed to the date the plan was submitted to the Court. It is important that these legal changes flow through to relevant policy and guidance as they influence practice.

Overall, the Review notes that many elements of the restoration policy are positive. The Review notes that it had only limited data made available to it, and that a further review of data in recent years—for both Aboriginal children and for comparative purposes, non-Aboriginal children to track relevant differences in restoration and non-restoration rates—would be helpful in building the fuller picture around current restoration rates. It is also necessary that FACS design, in partnership with Aboriginal community and stakeholders, enhanced data collection and reporting around measures relevant to the issue of restoration.

The Review recommends that restoration policy and practice advice is reviewed as per the above, to ensure that it aligns with best practice and relevant law in all areas. Further, given that relatively positive law and policy in this area is coupled with extremely low numbers of restoration, the Review is of the opinion that FACS should conduct an internal investigation into the implementation of relevant policies and practice, as this appears to be the weakest link in the restoration chain.

Of course, further training and internal reviews will only ever go so far in the landscape of the general lack of accountability. FACS policies have a strong emphasis on self-assessment on the part of the caseworker, or the managing caseworker. Again, given the very low numbers of restoration, in contrast to the legislative aims, there must be greater oversight of what is happening in practice in this area. The Review draws attention to the recommendations on accountability made in Chapter 8 and reinforces the importance of these recommendations in the context of low restoration rates.

Recommendation 120: The Department of Communities and Justice should conduct an internal review examining caseworkers' non-compliance with existing restoration policy and guidance and use the findings of this Review to improve restoration casework practice and policy in the department.



22. Adoption of Aboriginal children in OOHC

What is adoption?

Adoption involves the permanent transfer (by court order) of parental legal rights and responsibilities from a child's biological parents to his or her adoptive parents. When a child is adopted, he or she obtains a new birth certificate and gains rights of inheritance from the adopting parents (while losing rights of inheritance from the birth parents).⁷⁶ The 'classic distinction' between adoption and out-of-home care (OOHC) is that adoption is a permanent arrangement and OOHC 'is a form of temporary caretakership'.⁷⁷ However, it is arguable that the introduction of 'open adoption', which encourages contact between a child and a natural parent, and long-term care orders that provide carers with all of the legal rights and responsibilities of a parent (such as guardianship orders), have blurred the distinction between adoption and foster care.

Aboriginal views on adoption

The concept of legal adoption (first introduced in Australia in 1896)⁷⁸ is 'alien to Aboriginal philosophies'⁷⁹ and has never been recognised in Aboriginal communities. Traditional Aboriginal child-rearing practices may see children looked after by members of their extended family, often for prolonged periods of time, without there ever being a severing of the parent-child relationship.⁸⁰ In addition, people other than the child's parents, such as members of the child's extended family or community, often play an important role in raising Aboriginal children.⁸¹ Torres Strait Islander communities, on the other hand, have a system of customary adoption which involves the permanent transfer of care of a child to an adoptive parent and 'makes the child fully a member of the adoptive family'.⁸²

The cruel, unjust and inhumane policies of separating Aboriginal children from their families in Australia are now well known.⁸³ In the late nineteenth and twentieth centuries, Australian Government officials forcibly removed thousands of young Aboriginal children from their families, sending them to training institutes or to work for white families (in the hope that they would 'assimilate' with the white population). After 1940 in NSW, these child removals were conducted under child welfare law, where children were removed 'in bulk' by court order after

76 New South Wales Law Reform Commission, *Review of the Adoption of Children Act 1965* (Issues Paper No 9, 1993) [2.1].

77 J Neville Turner, 'Adoption or anti-adoption? Time for a National Review of Australian Law' (1995) 2 *JCULR* 43, 43.

78 *Ibid.*

79 Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997) ch 22, 424, citing Lorraine Randall, 'Aboriginal Placement', in R Oxenberry (ed) *Proceedings of Third Australian Conference on Adoption* (Department of Continuing Education, University of Adelaide) pages 342, 346.

80 Australian Law Reform Commission, *Recognition of Aboriginal Customary Law* (ALRC Report 31, 12 June 1986) [383].

81 *Ibid.*

82 Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997) ch 22, 404 citing Paul Ban, 'The Quest for Legal Recognition of Torres Strait Islander Customary Adoption Practice' 1993 2(60) *Aboriginal Law Bulletin* 4, 4.

83 These policies are discussed further in Chapter 1.

it had been determined they were 'neglected' or 'uncontrollable'.⁸⁴ Some of these children were adopted by white families, while others were 'fostered out' or placed in institutions. As noted in Chapter I, the psychological, physical and emotional consequences of this trauma are still being suffered by Aboriginal communities today.

The alien nature of adoption to Aboriginal culture, the horrors endured by the members of the Stolen Generation and the enduring impact of the trauma and loss of connection to culture caused by forced removals of Aboriginal children, have all led to the wider Aboriginal community to conclude that adoption is not a suitable option for Aboriginal children involved with the child protection system.⁸⁵

The NSW Government appears to have accepted this position in the past. In a 2012 consultation report, for example, FACS acknowledged that 'adoption is not considered a culturally accepted practice for Aboriginal children' and that decisions about the placement of Aboriginal children in OOHC would continue to be made according to the Aboriginal Child Placement Principle (ACPP) (as opposed to the permanent placement principles).⁸⁶ The report noted that:

the terrible and destructive impacts of the Stolen Generation continue to impact the community deeply and the submissions received were clear on this issue ... The Government is not seeking to impose adoption on the Aboriginal and Torres Strait Islander community.⁸⁷

Aboriginal communities remain strongly opposed to the adoption of their children, which undermines their rights to family, community, culture and identity, and potentially breaches their rights under the *United Nations Declaration on the Rights of Indigenous Peoples* and the *United Nations Convention on the Rights of the Child*.⁸⁸ AbSec has observed that it sees

permanent care orders such as guardianship and adoption, administered 'on' Aboriginal communities (rather than by communities through their own robust governance structures) as a return to past practices broadly referred to as the Stolen Generations. That is, it represents the ongoing permanent removal of Aboriginal children from their families, communities, culture and Country by non-Aboriginal systems in the name of providing better outcomes for our children. As with the Stolen Generations, there is no evidence that outcomes for Aboriginal children are promoted through these approaches.⁸⁹

84 Human Rights and Equal Opportunity Commission, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* (1997) ch 22, 404 citing Paul Ban, 'The Quest for Legal Recognition of Torres Strait Islander Customary Adoption Practice' 1993 2(60) *Aboriginal Law Bulletin* 4, 4.

85 Department of Family and Community Services (NSW), 'Open adoption now a reality in NSW' (Media Release, 10 November 2014); Department of Family and Community Services (NSW), 'New law helps ease adoption delays and red tape' (Media Release, 29 September 2016).

86 Department of Family and Community Services (NSW), *Report on the Outcomes of Public Consultation on the Child Protection Legislative Reforms Discussion Paper 2012 (Safe Home for Life Consultation Report)* (Report, November 2013) 2.

87 *Ibid.*

88 *United Nations Declaration on the Rights of Indigenous Peoples*, GA September 2007) art 7(2), (8); See Absec Submission to Family & Community Services, *Shaping a Better Child Protection System* (November 2017) 12; Wendy Caccetta, 'Adoptions threaten culture: peak body', *National Indigenous Times* (online, March 21, 2018) <<https://nit.com.au/adoptions-threaten-culture-peak-body/>>.

89 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 6.



Can Aboriginal children be adopted?

The *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*) and the *Adoption Act 2000* (NSW) permit Aboriginal children to be adopted. However, it is an option of last resort or, to use the language of the *Care Act*, the ‘last preference’.⁹⁰ The *Care Act* contains several pre-requisites that must be satisfied before an Aboriginal child who has been removed from his or her family can be adopted by a non-Aboriginal person. For example, FACS must demonstrate that no suitable placement of the child or young person can be made in accordance with the placement principles in s 13 of the Act. Further, a local, relevant and community-based Aboriginal or Torres Strait Islander organisation must be consulted, as well as the local Aboriginal or Torres Strait Islander community. Finally, the placement must be culturally appropriate, and both the Minister for FACS and the Minister for Aboriginal Affairs must agree to the adoption.⁹¹

Under the *Adoption Act 2000* (NSW), the court must not make an adoption order unless the Aboriginal placement principles in that Act have been properly applied.⁹² Further an Aboriginal child should not be adopted unless the Secretary is satisfied that it ‘is clearly preferable in the best interests of the child to any other action that could be taken by law in relation to the care of the child’.⁹³ Further, an Aboriginal child cannot be placed with a non-Aboriginal adoptive parent unless the parent ‘has the capacity to assist the child to develop a healthy and positive cultural identity’.⁹⁴ There must also be a preliminary hearing before the adoption of an Aboriginal child by a non-Aboriginal adoptive parent,⁹⁵ and before consent is given, the person giving consent must be given the opportunity for adoption counselling.⁹⁶ Section 75(b) of the *Adoption Regulation 2015* (NSW) provides that an adoption plan must contain ‘details of the ways in which the child is to be assisted to develop a healthy and positive cultural identity and of ways in which links with the child’s cultural heritage are to be fostered’.

The *Adoption Act 2000* (NSW) recognises that the concept of adoption is ‘absent in customary Aboriginal child care arrangements’.⁹⁷

The push for more adoptions of children in OOHC

In 2012, the NSW Government embarked upon a campaign to increase the adoption of children and young people in OOHC.⁹⁸ In 2014, it introduced a hierarchy of placement options into the *Care Act*. This hierarchy (known as the permanency planning principles)⁹⁹ ranked adoption above the option of providing parental responsibility of a child to the Minister, thereby

90 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 10A.

91 *Ibid* s 78A.

92 The Aboriginal placement principles in order of preference are (i) adoption by a person belonging to the Aboriginal community or one of the communities to which the birth parent or parents belong; (ii) adoption by a person from another Aboriginal community, and (iii) adoption by a non-Aboriginal parent: *Adoption Act 2000* (NSW) s 35.

93 *Adoption Act 2000* (NSW) s 36.

94 *Ibid* s 35(3).

95 *Ibid* s 80.

96 *Ibid* s 64.

97 *Ibid* s 35(1).

98 Note that part of the Liberal/Coalition election platform in 2011 included a promise to focus on permanency in the care arrangements of children and young people in the child protection system.

99 *Children and Young Person (Care and Protection) Act 1998* (NSW) s 10A.

legislating for the first time that adoption was preferred to long-term foster care of children in OOHC. The *Adoption Act* was amended to provide that the Secretary could invite an authorised carer of a child in OOHC to submit an application to adopt the child.¹⁰⁰ In addition to this legislative change, other changes were introduced to facilitate the greater adoption of children and young people from OOHC. For example, allowances for foster carers wishing to adopt a child were improved¹⁰¹ and the Institute for Open Adoption Studies was established.¹⁰² In addition, funding was provided ‘to progress existing adoption applications’ and improve the rate of adoptions.¹⁰³

Funding to increase the rate of adoptions from OOHC was also increased. In 2017, the NSW Government pledged \$24 million over four years for the ‘Adoptions Transformation’ program, which included the establishment of an Adoptions Taskforce. This Taskforce has worked with the Supreme Court to ‘halve the average time of the adoption order process’.¹⁰⁴ In May 2018, the ‘My Forever Family’ program was launched¹⁰⁵ to match children in OOHC with families that support their needs (including the needs for restoration, guardianship or adoption).

The NSW Government also indicated that it is committed to decreasing the time taken to complete adoptions. In 2016–17, adoption orders took an average of 4.2 years to be completed, and the Government has noted its commitment to halving this number in the future.¹⁰⁶ In fact, in all child protection cases, the NSW Government has stated that it wishes to ‘have permanency within two years’ of coming into contact with the child protection system. To achieve this goal, the Government has legislated timeframes around restoration, guardianship and open adoption (see discussion below).¹⁰⁷

While the NSW Government has been largely silent on the impact of its push for adoptions on the Aboriginal community, the national discourse on the issue has been tarnished by controversy. In early 2018, the issue of the adoption of Aboriginal children attracted national media attention. After reports about the sexual assault of a toddler in kinship care in Tennant Creek in the Northern Territory, the federal Children’s Minister, David Gillespie, stated that he would push states and territories to consider more adoptions of Indigenous children, although he stated that it would never be ‘forced’.¹⁰⁸ Several emotive opinion pieces published in national newspapers painted a picture of white Australians ‘tearing their hair out’ over Aboriginal child sexual abuse and neglect while ‘culturally informed bureaucrats’ continued to pursue kinship care for Aboriginal children.¹⁰⁹ These reports culminated in a segment on the Channel

100 *Adoption Act 2000* (nsw) s 45D.

101 NSW Government, ‘A Forever Home for Our Most Vulnerable Children’ (Media Release, 29 March 2017).

102 Department of Family and Community Services (NSW), ‘Open Adoption Research Legislation Introduced into Parliament’ (Media Release, 24 June 2016).

103 Department of Family and Community Services (NSW), ‘NSW Budget—Reforms for Kids Needing Care’ (Media Release, NSW Government, 18 June 2016); NSW Government, ‘New Institute Puts Focus On Adoption’ (Media Release, NSW Government, 16 March 2016).

104 Department of Family and Community Services (NSW), ‘NSW achieves record number of out-of-home care open adoptions’ (Media Release, NSW Government, 3 July 2017).

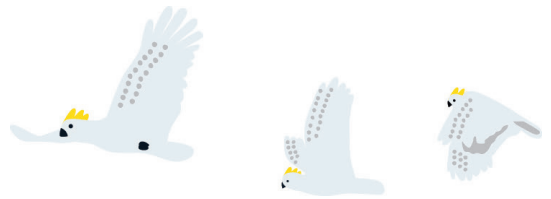
105 This commenced operation on 1 July 2018.

106 Department of Family and Community Services (NSW) *Shaping a Better Child Protection System* (Discussion Paper, October 2017) 31.

107 NSW Government, ‘NSW Adopts Change for Foster Care’ (Media Release, NSW Government, 22 May 2018).

108 Bridget Brennan, ‘Adoptions for more Indigenous children should be an option, Minister says’ *ABC News* (online, 13 March 2018) <<http://www.abc.net.au/news/2018-03-13/adoption-for-more-indigenous-foster-kids-david-gillespie-says/9543448>>.

109 Angela Shanahan, ‘Adoption Can Save Aboriginal Kids from Chaos’ *The Australian* (online, 17 March 2018 <<https://www.theaustralian.com.au/news/inquirer/adoption-can-save-aboriginal-kids-from-chaos/news-story/2a232dace188bdd2619ffd280b815887>>); Jeremy Sammut, ‘White Adoptions Won’t Create New Stolen Generation’ *The Daily Telegraph* (online, March 15 2018) <<https://www.dailytelegraph.com.au/rendezview/white-adoptions-wont-create-new-stolen-generation/news-story/4a531d4ea541003d44cdff71633448e4>>.



7 breakfast show *Sunrise* in which one ‘panellist’ suggested that ‘just like the first Stolen Generation, where a lot of children were taken because it was for their wellbeing, we need to do it again, perhaps’.¹¹⁰ This segment was later to be found by the Australian Communications and Media Authority to be in breach of clause 3.3.1 because of its inaccuracy and in breach of clause 2.6.2 for causing intense dislike, serious contempt or severe ridicule on the basis of race.

Throughout 2018, the advocacy organisation, Adopt Change, also featured in the media, agitating for reform of adoption laws to reduce ‘red tape’ and change attitudes towards adoption as a solution for children in OOHC.¹¹¹

The 2018 legislative reforms

In its October 2017 Discussion Paper, *Shaping a Better Child Protection System*, FACS proposed a number of changes to the legislation governing adoption in NSW to ‘streamline’ adoption orders in order to ensure that children and young people have a ‘forever family’ when they are unable to be restored to their parents. It noted that proposals to facilitate ‘easier and quicker’ adoptions were opposed by stakeholders in 2012, but relied on several arguments to justify raising the proposals again, including: (i) the fact that it was necessary to reduce pressure on the OOHC system; (ii) that it had removed the ‘economic barrier’ to adoption by providing a ‘means test adoption allowance to foster parents who adopt children from OOHC’; and (iii) the fact that adoption provides children with a greater sense of belonging than long term foster care.¹¹²

Given the number of Aboriginal children in OOHC, and the strong and lengthy opposition of the Aboriginal community to the adoption of Aboriginal children, it is surprising the Discussion Paper did not examine the application of the proposed changes to adoption laws to Aboriginal children. There was no discussion of whether the proposed reforms were intended to apply to Aboriginal children and young people, nor any mention of the Stolen Generation or of evidence about the impact of child removals on Aboriginal communities and culture. There was no discussion of the way in which adoption laws would apply unequally to Aboriginal children and young people (by virtue of their over-representation in the child protection system) and no mention of Aboriginal community views on adoption. This failure to properly countenance the Aboriginal objection to these laws and the anxiety it animated in the Aboriginal community is concerning. The failure to recognise or discuss these issues is symptomatic of the continued failure, despite numerous policy pronouncements, to engage or partner meaningfully with the Aboriginal community around important child protection issues. It reflects a departmental preference ‘for “mainstreaming” of a dominant socio-cultural perspective’.¹¹³

Ultimately, the NSW Government did not proceed with several of its proposed changes to streamline adoption law. For example, it did not proceed with its proposal to transfer the jurisdiction for OOHC adoptions from the Supreme Court to the Children’s Court. It also did not

110 Emma Reynolds, ‘You should know better, Sunrise’ *The Morning Bulletin* (online, 14 March 2018) < <https://www.themorningbulletin.com.au/news/you-should-know-better-sunrise-breakfast-show-slam/3360362/>>.

111 Bridget Brennan, ‘Adoptions for more Indigenous children should be an option, Minister says’ *ABC News* (online, 13 March 2018) <<http://www.abc.net.au/news/2018-03-13/adoption-for-more-indigenous-foster-kids-david-gillespie-says/9543448>>.

112 See Department of Family and Community Services (NSW) *Shaping a Better Child Protection System* (Discussion Paper, October 2017) 29–30.

113 Kylie Cripps and Julian Laurens, ‘The protection of cultural identity in Aboriginal and Torres Strait Islander children exiting from statutory out of home care via permanent care orders: Further observations on the risk of cultural disconnection to inform a policy and legislative reform framework’ (2015/2016) 19(1) *AILR* 70, 75.

proceed with its proposal to specify a time period in which a parent was required to be located prior to an adoption. It noted that none of its proposed reforms to streamline adoption law had been widely supported by stakeholders.¹¹⁴

However, it did proceed with several significant and controversial reforms. In October 2018, the NSW Government introduced the *Children and Young Persons (Care and Protection) Amendment Bill 2018*. The Bill was said to build on the introduction of the permanent placement principles in 2014.¹¹⁵ In particular, it was stated that it would take ‘permanency solutions a step further by emphasising the permanent placement principles—the central pillars of placement—in a fresh way.’¹¹⁶ This ‘flagship’ reform¹¹⁷ of this Bill was a change to the legislation to prevent the Children’s Court from making an order allocating parental responsibility to the Minister for more than two years in circumstances where the ‘permanency plan’ was restoration, guardianship or adoption.¹¹⁸ Further, prior to making a care order, the Children’s Court was required to find whether there is a possibility of restoration ‘within a reasonable period’ not exceeding 24 months. Finally, the Bill permitted the making of guardianship orders by consent. No draft exposure Bill was released for consultation, and the Bill was introduced late in the sitting year. The Bill was opposed by the NSW Opposition.¹¹⁹

Again, during the second reading speech, the NSW Government failed to address in detail the possible effect of these reforms on Aboriginal children and families, or the Aboriginal community more widely, instead noting that the Supreme Court was ‘unlikely to make an adoption order’ without being satisfied that the Aboriginal child would have family contact and cultural connection. It did not acknowledge widespread public opposition from Aboriginal community groups to the changes in the legislation. It did not note opposition from the NSW peak advocacy body, AbSec, which took out full page newspaper advertisements pleading for the Government to change its approach, and which pointed out that ‘Aboriginal children already have a forever family—their extended family, kinship network and community back home’¹²⁰ It also did not note concern from the National Aboriginal and Torres Strait Islander Social Justice Commissioner,¹²¹ nor the open letter signed by 79 organisations working in the child protection sector (including multiple Aboriginal organisations) and over 2000 individuals that opposed the introduction of the reforms.¹²² As one key stakeholder conveyed to the Review during consultations, ‘we will lose an entire generation of our jarjums’.

Instead, during debate on the introduction of the Bill, the Minister argued that those who opposed the Bill were ‘hell-bent on painting a picture that Aboriginal people do not support this

114 Department of Family and Community Services (NSW), *Shaping a Better Child Protection System Report on the Outcome of Consultations* (Report, October 2018) 13-15.

115 New South Wales, *Parliamentary Debates*, Legislative Council, 14 October 2018, 53.

116 Ibid.

117 Ibid 55.

118 This provision would not apply in ‘exceptional circumstances’: see *Children and Young Persons (Care and Protection) Amendment Bill 2018* (NSW) cl 20.

119 New South Wales, *Parliamentary Debates*, Legislative Assembly, 15 November 2018, 2.

120 Lorena Allam ‘Fears of ‘another stolen generation’ after New South Wales’ move on foster care’ *The Guardian* (online, 27 October 2018) <<https://www.theguardian.com/australia-news/2018/oct/27/fears-of-another-stolen-generation-after-new-south-wales-move-on-foster-care>>.

121 Lorena Allam, ‘Aboriginal Groups Beg NSW to Back Down on Adoption Changes’ *The Guardian* (online, 19 November 2018) <<https://www.theguardian.com/australia-news/2018/nov/19/aboriginal-groups-beg-nsw-to-back-down-on-adoption-changes>>.

122 Community Legal Centres Delivering Access to Justice, ‘NSW Forced Adoptions Open Letter’ (online, 23 November 2018) <<https://www.clcnsw.org.au/nsw-forced-adoptions-open-letter>>.



Bill'¹²³ and noted that she had received support for the provisions of the Bill.¹²⁴

Ultimately, the Bill was passed, with the reforms commencing on 4 February 2019. Concerns about the new provisions of the *Care Act* raised by stakeholders, including the Law Society and Community Legal Centres, centre around the fact that it limits the time period for restoration to two years (after which adoption may be pursued). In many cases, a longer timeframe will be needed by a family to make the necessary changes, particularly in light of a lack of effective service provision for a range of social issues, such as housing, substance abuse and mental health problems, particularly in rural areas.¹²⁵ For example, as was noted in the debate on the Bill:

We know that the waiting list for housing is five to 10 years. When those families are told that they need to have a stable home—a two-bedroom or three-bedroom house—what is the waiting time for that? It is 10 years in most parts of Sydney and regional New South Wales.¹²⁶

Why increase adoption?

The revived pro-adoption discourse in NSW is not unique to this jurisdiction. As Tregeagle et al note, 'in order to move children out of the welfare system, policy-makers in western welfare systems have become increasingly pro-adoption'.¹²⁷ The pro-adoption developments in Australia mirror those in the USA and the UK in the early 2000s, and appear to be premised on the approach that 'if permanence is good for children, and adoption offers permanence, adoption must be good for children'.¹²⁸ As Ross and Cashmore note, Australia is a 'late and slow entrant'¹²⁹ into the field in which adoption has changed from a private law construct to 'an integral part of the State's child protection machinery'.¹³⁰ As Cripps and Laurens note, permanent care orders, such as adoption, are appealing 'from a neoliberal costs saving and organisational "efficiency" perspective'.¹³¹

However, while the NSW Government is promoting its reforms in the context of an overburdened child protection system in which multiple child placements are common—as evidenced by the use of language such as 'forever families'—it is important to recognise the possible shortcomings of adoption. For example it has been noted that, 'an overemphasis on adoption could mean that other strategies to improve outcomes for children are neglected',¹³² and that attempts to increase adoptions are essentially a mechanism for the NSW Government to absolve itself of all but a small financial responsibility to children who have come into

123 New South Wales, *Parliamentary Debates*, Legislative Assembly, 22 Nov 2018, 7.

124 Ibid 7.

125 New South Wales, *Parliamentary Debates*, Legislative Assembly, 15 November 2018, 4.

126 Ibid.

127 Susan Tregeagle et al, 'A Pathway From Long Term Care to Adoption: Findings from an Australian Permanency Programme' (2014) 38(2) *Adoption & Fostering* 115, 117.

128 K Murphy, M Quartly and D Cuthbert, 'In the best interests of the child": Mapping the (re) emergence of pro-adoption politics in contemporary Australia' (2009) 55(2) *Australian Journal of Politics and History* 201.

129 Nicola Ross and Judy Cashmore, *Adoption reforms New South Wales Style: A comparative look* (2016) 30 *Australian Journal Family Law* 51.

130 Ibid, citing S Harris-Short, 'Holding onto the Past? Adoption, Birth Parents and the Law in the Twenty-First Century' in R Probert and C Barton (eds), *Fifty Years in Family Law: Essays for Stephen Cretney* (Intersentia, Cambridge, 2012) 148, 152.

131 Kylie Cripps and Julian Laurens, 'The protection of cultural identity in Aboriginal and Torres Strait Islander children exiting from statutory out of home care via permanent care orders: Further observations on the risk of cultural disconnection to inform a policy and legislative reform framework' (2015/2016) 19(1) *AILR* 70, 71.

132 The Conversation, 'Adoption has a role in child protection but it's no panacea' *The Conversation* (online, 17 April 2015) <<https://theconversation.com/adoption-has-a-role-in-child-protection-but-its-no-panacea-40151>>

contact with the child protection system.¹³³ The 2015 review of adoption law in South Australia concluded that adoption should be a ‘last resort’, noting that it was ‘not always the preferred solution to the issue of the needs of children in the care system for safety, for stability and belonging and for long-term identity formation’.¹³⁴ In fact, some commentators argue that a child’s need for permanency and individual attachments ‘can be met without the formality of adoption’.¹³⁵

Further, the drive to expedite adoptions must be viewed cautiously, as ‘adoption takes time to do, as it should. It’s not something and nor should it ever be a quick five minute rubber stamp’.¹³⁶ Prior to the introduction of its 2018 reforms, the NSW Government did not analyse in any depth whether the streamlining of adoption cases would result in better outcomes for children and young people in the long-term. The Discussion Paper, the report on the outcome of consultations and the second reading speech did not address existing debates in the academic literature—for example, the debate about whether adoption is more stable than long-term foster care¹³⁷—and did not analyse any relevant overseas literature (such as literature discussing adoption breakdown rates in countries with higher adoption rates such as the UK and the USA). However, despite this, the Government has committed to a target of more than 1,000 open adoptions from OOHC over a four-year period.¹³⁸

Submissions and consultations

Several stakeholders expressed concern to the Review about permanency planning and the adoption of Aboriginal children. For example, AbSec noted that the ‘fundamental rights of Aboriginal children to their family, community and culture must not be “traded” for legal permanency as a solution to reduce the OOHC population’.¹³⁹ It expressed the view that it was opposed to legal permanent care orders ‘given the lack of meaningful safeguards for Aboriginal children and young people’.¹⁴⁰

Grandmothers Against Removal NSW submitted that the current permanency policy reflected a narrow understanding of permanency, particularly in light of the fact that many children and young people leaving OOHC seek to reconnect with their families and cultures and that true permanency planning is supporting families to stay together.¹⁴¹

Four family violence prevention legal services submitted that court orders should be made on an interim basis for two years, after which they should be reviewed again by the Court. In that

133 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 12.

134 Lorna Hallahan, *Adoption Act 1988 (SA) Review*, (Report, September 2015) 62.

135 Rachel Hodgkin and Peter Newell, ‘Implementation Handbook for the United Nations Convention on the Rights of the Child’ 2000 27(2) *Journal of Government Information* 294.

136 Lisa Vihtonen, Barnados Adoption Manager, cited in Emily Blatchford, ‘Adoption in Australia: Everything you Need to Know’ *Huffpost* (Online, 14 September 2017) <https://www.huffingtonpost.com.au/2017/09/11/adoption-in-australia-everything-you-need-to-know_a_23203810/>.

137 See, eg, J Triseliotis, ‘Long-term foster care or adoption? The evidence examined’ (2002) 7(1) *Child & Family Social Work* 23; D Quinton and J Selwyn ‘Adoption as a solution to intractable parenting problems: evidence from two English studies. *Children and Youth Services Review*’ (2009) 31(10) 1119.

138 Lorena Allam, ‘Aboriginal groups beg NSW to back down on adoption changes’ *The Guardian* Monday (online, 19 November 2018, <<https://www.theguardian.com/australia-news/2018/nov/19/aboriginal-groups-beg-nsw-to-back-down-on-adoption-changes>>.

139 Aboriginal Child, Family and Community Care State Secretariat (AbSec), Submission No 13 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 12.

140 Ibid.

141 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 2.



submission, the legal services argued that parents often needed more than two years to address complex and long-standing issues, and that this approach could result in better outcomes for families, particularly those with children under the age of five in OOHC.¹⁴²

SNAICC submitted that permanency for Aboriginal children was ‘tied to existing identity, kinship relationships, and connections to culture and country’, and that it was important not to permanently deprive children of these connections through the application of ‘inflexible permanency planning measures’.¹⁴³

It noted in its attached analysis of implementation of the ACPP that

the push towards expedited permanency in the context of limited Aboriginal and Torres Strait Islander-led prevention, early intervention, and restoration/reconnection programs, and where Aboriginal and Torres Strait Islander children, families, and communities are not effectively enabled to participate in decision-making is unfair, inappropriate, and alarming.¹⁴⁴

One stakeholder submitted that legislation should be enacted to ensure that Aboriginal children could not be adopted.¹⁴⁵

Data findings

While the most recent available data (pre-dating the recent reforms) show that adoption of Aboriginal children is occurring at low rates (Figure 79) the Review encountered several cases in its file review that raised the issue of adoption for the children in question. For example:

- In Case 214, the child’s grandparents were affected by the stolen generation and FACS identified and de-identified the child at different stages in the care process before finally agreeing to identify him. The child was placed with non-Aboriginal foster carers in a placement managed by a non-government OOHC provider. Casework notes indicate that the placement is meeting all of the child’s needs despite the child not having a cultural plan, there being no evidence that he has contact with other Aboriginal family members, there being no evidence that the child engages in cultural activities, and there being no evidence that his non-Aboriginal carer has received cultural competency training (or been introduced to Aboriginal services). The child’s mother seeks restoration and appears to have complied with the restoration requirements detailed for her by FACS. However, the non-government OOHC provider opposed the restoration, preferring for the child to be adopted by his current carers.
- In Case 155, a family of six children were removed from their mother following an incident that was questionably labelled as neglect. The family was affected by the Stolen Generation

142 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018.

143 Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 1.

144 Secretariat of National Aboriginal and Islander Child Care *Baseline Analysis of Best Practice Implementation of the Aboriginal and Torres Strait Islander Child Placement Principle in New South Wales* (2017); Secretariat of National Aboriginal and Islander Child Care (SNAICC), Submission No 5 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, December 2017, 3–4.

145 Confidential, *Consultation*, FIC 71.

and two of the children were later de-identified as Aboriginal by FACS on the basis that their mother had been unable to provide sufficient proof of her Aboriginality. The children were separated in care and three of the children were placed with non-Aboriginal carers. The placements are managed by different non-government providers. The carers of the two de-identified children have expressed a desire to adopt them. Their mother seeks restoration and has constantly sought this since the children entered care. She met with caseworkers at the CSC soon after removal to ascertain what was required of her to have the children restored to her care and she was not provided any information, instead being told by the caseworker that the caseworker was 'not a solicitor' and couldn't provide advice.

- In Case 216, long term Aboriginal foster carers wish to explore adoption. The file did not contain any further relevant details.

Discussion

The changes in law and policy relating to adoption have led to an increase in adoption rates for non-Aboriginal children. In 2016-17, there were 'a record 129 adoptions in NSW of children who had been living in foster care, up from 67 in the previous year'.¹⁴⁶ Of these children, two were Aboriginal.¹⁴⁷ In 2017-2018, 140 children were adopted (six of whom were Aboriginal).¹⁴⁸ While rates of Aboriginal adoption have not significantly changed, there is little guarantee that this will remain the case in light of the comprehensive framework that has been established to expedite adoptions from OOH in NSW.

In light of widespread opposition from the Aboriginal community to the practice of adoption for Aboriginal children; the fact that adoption is not a culturally accepted practice; the history of the forced removal of Aboriginal children; the damaging consequences of loss of connection to culture and sense of identity that may accompany adoption; the fact that 'permanency' should be perceived as more than legal permanency (and should incorporate cultural permanency); and the evidence uncovered in this Review that at least one OOH provider is opposing restoration based on a view that the child would be better off being adopted by his foster carers, the Review has concluded that legislation should provide that adoption cannot not be pursued for Aboriginal children.

Recommendation 121 The NSW Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and the *Adoption Act 2000* (NSW) to ensure that adoption is not an option for Aboriginal children in OOH.

¹⁴⁶ NSW Government, *Shaping a Better Child Protection System* (Discussion Paper, October 2017) 31.

¹⁴⁷ New South Wales, *Budget Estimates Hearing*, Portfolio Committee No 2, Wednesday 5 September 2018, 18.

¹⁴⁸ Ibid.



23. Reforming the Children’s Court

Introduction

In Chapter 8, the Review made several recommendations aimed at ensuring the Children’s Court operates with more transparency. These recommendations, when implemented, will help to improve access to justice by those involved in child protection proceedings. Parents and young people will be able to read judgments of the Children’s Court online, and in this way, gain an understanding of how the court operates and the way the law has been applied to cases with similar facts to their own. Legal practitioners will also have a readily available source of up-to-date information about the jurisdiction and will have a greater ability to use precedents in their legal arguments. However, our file review and research has raised other concerns about the operation of the Children’s Court jurisdiction which, if resolved, will also help to reduce the number of Aboriginal children in out-of-home care (OOHC). This section deals with these additional issues.

Improving the quality of evidence presented to the Children’s Court

The Review was aware, while conducting its file reviews, that a number of individuals had previously alleged in stakeholder engagements and in various public fora, that FACS had provided false or misleading information to the Children’s Court in care and protection proceedings. For example, in its 2014 submission to the Senate Inquiry into Out of Home Care, Allecom stated that three quarters of the 151 participants in its survey (including 71 participants from NSW) had reported that caseworkers had made false and misleading statements in legal proceedings.¹⁴⁹ In its final report, the Senate Inquiry noted that ‘a number of submissions which were accepted in-confidence contained allegations that child protection authorities and courts had acted improperly and the justification for removal was either inaccurate or misleading’.¹⁵⁰ Further, at least six submissions to the 2017 Legislative Council inquiry into child protection alleged that FACS had included false or misleading information in its documents and evidence,¹⁵¹ and similar allegations were made in the 2017 documentary file, *After the Apology*.¹⁵² A study of the Children’s Court, conducted by UNSW, also raised this issue, noting that:

The statutory department’s authority to influence the information that is presented in Court was noted by some research participants ... As there are no rules of evidence in the Children’s Court for ‘care and protection’ matters, the interpretations of statutory department caseworkers were perceived by participants to be highly influential, and not always critically evaluated. This was seen by participants in this study to be at times problematic, as the statutory department can exclude information that is inconsistent with their version of events and recommendations. A number of the research

149 Australian Legislative Ethics Commission, Submission No 91 to Community Affairs References Committee, *Senate Inquiry to Out of Home Care* (November 2014).

150 Senate Community Affairs References Committee, *Out of Home Care* (Report, 2015) [5.92].

151 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017), [8.64]; Alliance for Family Preservation and Restoration, Submission No 44 to Legislative Council General Purpose Standing Committee No 2, *NSW Parliament Inquiry into Child Protection* (1 July 2016).

152 See *After the Apology* (website) <<http://aftertheapology.com/press>>.

participants raised the issue that they have had statements from their mandatory reports taken out of context, and that often the perspectives of support workers who spend the most time with families are not represented in Departmental reports to the Children's Court.¹⁵³

Grandmothers Against Removal NSW (GMAR NSW) submitted to this Review, that FACS caseworkers regularly lied to the Court and that caseworkers often informed the Children's Court that they had attempted to prevent removal 'when no real effort was made'.¹⁵⁴ GMAR NSW expressed the view that lying to the Court should be treated as a criminal offence and that FACS should be legally required to act as a model litigant.¹⁵⁵ Further, it argued that caseworkers should be required to provide the Court with detailed evidence of their efforts to keep families together, and that this should go beyond affidavits by caseworkers to include evidence from other individuals or organisations who have been involved with working with the family.¹⁵⁶

During consultations, several stakeholders suggested that court documents were falsified, or highlighted irrelevant or biased information (while disregarding the strengths of the family).¹⁵⁷ For example, court documents could include allegations that were of no fault of the parents,¹⁵⁸ allegations that were contrary to other witness accounts,¹⁵⁹ or use exaggerated language (such as stating that a parent 'acted with aggression and violence', as opposed to 'spoke with a raised voice').¹⁶⁰

It is clear that the provision of false or misleading evidence to a court is unethical and potentially unlawful. The department has frameworks, policies and guidelines in place that, if adhered to, would ensure that this did not occur. First, the department and its lawyers (from FACS Legal or an approved external legal services provider) are required to comply with the NSW Government's *Model Litigant Policy*. The policy sets high standards for the behaviour of agencies of the state, requiring them to act 'with complete propriety, fairly and in accordance with the highest professional standards'.¹⁶¹ While the Model Litigant Policy does not mention the issue of evidence specifically, the Secretary's Guidelines on the policy stated that legal officer must 'promptly gather and consider any relevant information to the proceedings which is available to the Department'.¹⁶²

Second, lawyers for the department are required to comply with professional ethical obligations.¹⁶³ The paramount duty of any solicitor is to the court and the administration of justice.¹⁶⁴ A solicitor must not 'act as a mere mouthpiece of the client'¹⁶⁵, and must not 'deceive or knowingly or recklessly mislead the court'.¹⁶⁶ In particular, a solicitor must ensure that advice

153 Elizabeth Fernandez et al, *A Study of the Children's Court of New South Wales* (UNSW, 2014) [6.2.1].

154 Grandmothers Against Removals NSW, Submission No 8 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOH in NSW*, December 2017, 5.

155 Ibid 5, 3.

156 Ibid 5, 6.

157 Confidential, *Consultation*, FIC 61; Confidential, *Consultation*, FIC 23; Confidential, *Consultation*, FIC 54; Confidential, *Consultation*, FIC 80.

158 Confidential, *Consultation*, FIC 54.

159 Confidential, *Consultation*, FIC 23.

160 Confidential, *Consultation*, FIC 23.

161 NSW Government, *Model Litigation Policy*, [3.1].

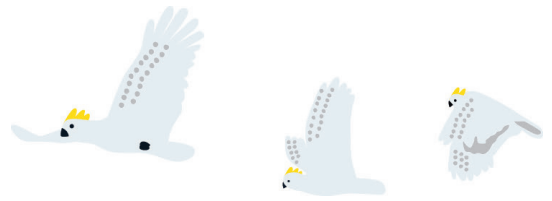
162 Department of Family and Community Services (NSW), *FACS Policy Directive for Management of Legal Matters*, Appendix B, [7].

163 *Legal Profession Uniform Law Australian Solicitors' Conduct Rules 2015*.

164 Ibid r 3.

165 Ibid r 17.

166 Ibid r 19.



about invoking the powers of a court ‘is reasonably justified by the material then available to the solicitor’ and must not allege any matter of fact in litigation unless he or she ‘believes on reasonably grounds that the factual material already available provides a proper basis to do so’.¹⁶⁷ If a solicitor becomes aware that a their client, in this case a FACS employee, has lied to the court, or suppressed material evidence, the solicitor must refuse to take any further part in the case unless the client authorises the solicitor to inform the court of the lie or suppression.¹⁶⁸ Breach of any of these rules can give rise to disciplinary action by the Legal Services Commissioner.

Legal practitioners representing FACS in the care and protection jurisdiction are also required to comply with the *Code of Conduct for Legal Representatives in Care and Protection Proceedings in the Children’s Court of New South Wales*.¹⁶⁹ This code of conduct requires legal practitioners for FACS to,

in accordance with the obligation to fully and frankly disclose to the Court and all other parties in a timely manner all information relevant to the case, including information that relates to the safety, welfare and well-being of a subject child or young person, provide to the Court all relevant material known to the legal practitioner in a complete, fair and impartial manner whether that material is supportive of the Director-General’s case or otherwise.¹⁷⁰

Caseworker training also includes a module on ‘legal matters’, which notes the importance of caseworkers providing fair and balanced evidence to the court, and not omitting any relevant information. Evidence prepared by caseworkers is checked with the casework manager and the FACS legal representative to ensure it is accurate, truthful and not misleading.

In addition to providing false or misleading evidence, it appears that in some cases FACS may fail to provide relevant evidence entirely. For example, in one Children’s Court case, the judge noted that FACS had not informed the Court that the children in question had been harmed while in care. It noted that the mother’s solicitor

cross-examined the principal caseworker who disclosed that the children had been mistreated by the foster carers arranged by Life Without Barriers, and that they had recently been relocated. This mistreatment included assaults and being locked inside their rooms for extended periods, with locks on the outside of the doors. There was nothing in the affidavit material by Departmental officers to indicate these dreadful occurrences.¹⁷¹

FACS may also fail to provide ‘strength-based’ evidence—that is, ‘evidence about the strengths of the family or positive steps that [have] been taken to reduce risks to the child’.¹⁷² In 2017, the Legislative Council’s General Purpose Standing Committee No. 2 noted concerns about the lack of strengths-based evidence provided to the Children’s Court and recommended that the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (*Care Act*) be amended ‘to include a specific provision requiring the Department of Family and Community

167 Ibid r 21.

168 Ibid r 20.

169 This Code of Conduct was prepared by the Children’s Court of NSW Advisory Committee.

170 Children’s Court of NSW, *Code of Conduct for Legal Representatives in Care and Protection Proceedings in the Children’s Court of New South Wales* [2.4].

171 *Re Mr Donaghy (Costs)* [2012] NSWChC 11.

172 Legislative COunc General Purpose Standing Committee No 2, *Child Protection* (2017), [4.23].

Services to provide strength based evidence when presenting its case in care and protection proceedings.¹⁷³ It also recommended that the NSW Ombudsman have oversight of the department's obligations in this regard.¹⁷⁴ The NSW Government did not support these recommendations, stating that it was of the view that the legislative provisions were adequate to ensure that all the relevant evidence was being presented to the Court.¹⁷⁵

The Review's file review

In light of the sheer number of policy documents, codes of conduct, legislative instruments and training materials that address the issue of the standard of evidence to be supplied to the Children's Court, the Review was perplexed to discover that FACS provided the Children's Court with misleading or untrue evidence in a significant proportion of the case files that were reviewed. The gravity of the occurrence varied on a case by case basis. While it is possible that some of the mistakes and omissions could be attributed to human error, in some cases it was difficult to understand how the error could have occurred during the normal course of events.

Broadly, the files reveal that on a number of occasions factually incorrect information was presented to the Court, while many files contained information that the Review classified as 'misleading'. These were identified as being not placed in its correct context, overstated or exaggerated the factual evidence, minimised shortcomings in FACS casework, failed to identify relevant 'strengths' of the parents, or concealed the 'full picture' from the Court. The following provides a brief overview of the types of issues identified by the Review in relation to evidence provided by FACS to the Children's Court.

- In Case 5, despite being aware that a child was Aboriginal for some time, FACS informed the Court that it had 'only recently' become aware of her Aboriginality.
- In Case 14, FACS informed the Court that it had referred the child's parents to drug and alcohol counsellors, when no referral had in fact taken place.
- In Case 81, FACS informed the Court that it was concerned about the 'transience' of the children's mother and the children's exposure to domestic violence. However, the mother had been in stable accommodation provided by the Department of Housing for a period of three years and was not in a violent relationship.
- In Case 230, FACS informed the Court that there was no parent available to care for the child, when in fact the child's father was available to care for him.
- In Case 16, FACS informed the Court that Barnados refused to work with the child's father, when in fact Barnados had closed its file with the family because there were no ongoing child protection issues.
- In Case 50, FACS informed the Court that in a consultation with the children's parents, the parents had 'ignored child protection concerns', when in fact the children's parents' concerns largely mirrored those possessed by FACS.
- In Case 228, FACS filed a s 82 report which stated that the children's placement was

173 Ibid rec 7.

174 Ibid rec 8.

175 NSW Government, *NSW Government Response to Report 46 of the Legislative Council Portfolio Committee No. 2—Health and Community Services—Child Protection* (Report, September 2017) 12.



progressing well and that the children had been referred to a counselling service. However, the children were in fact exhibiting significant behavioural issues (thus precipitating their referral to counselling).

- In Case 397, FACS informed the Court (in a care application, a care plan and an affidavit) that an Aboriginal child had been placed with Aboriginal foster carers, when in fact the foster carers were not Aboriginal (and this was clearly recorded on the FACS KiDS system).
- In Case 201, FACS informed the Court of its concerns about the child’s mother’s mental health, but did not inform the Court that the child’s mother was consistently responsive and attentive to her child’s needs, demonstrated affection towards her child, and had never harmed her child (and in fact did not use any form of physical discipline).

Case Study—‘Kylie’ and her newborn baby¹⁷⁶

While in prison, a pregnant Aboriginal woman (‘Kylie’), applied to be accepted into the Mother and Baby program at Jacaranda Cottage. If accepted, she would have been able to continue to care for her baby while incarcerated. She was eligible for entry into the program (which had a rigorous assessment process), but only if her baby was not to be assumed into care by FACS.

At a meeting with social workers from the correctional centre, FACS stated that it needed to complete a full assessment of the situation before Kylie could enter the Mother and Baby program. However, FACS did not complete a safety and risk assessment prior to the baby’s birth. Instead, FACS assumed Kylie’s baby into care when she was one day old, after which Kylie was no longer eligible for the program. The reasons for the assumption were historical (that is, FACS noted that Kyle had three other children who had been removed from her care in the past and a history of drug use). Kylie was not informed or consulted about the assumption of her newborn child, and in fact believed that she had been accepted into Jacaranda Cottage with her baby up until the point in time that her baby was assumed into care.

In the care application, FACS informed the Children’s Court that Kylie had been denied access to the Mother and Baby program. FACS did not inform the Court that she had been denied access because FACS had assumed her child into care. This omission made it appear as though Kylie’s baby did not have a parent available to care for her (as the baby’s father was also in prison), when in fact, Kylie was willing and able to care for her newborn child in a safe, supervised environment.

A new, independent statutory body to conduct care and protection litigation

Concerns about the quality of evidence presented by the statutory child protection authority to the relevant court exists in other jurisdictions. In 2013, the Carmody Inquiry into child protection in Queensland heard concerns about the adequacy of legal advice provided to the Department of Child Safety and the quality of the evidence filed by the department in legal proceedings.¹⁷⁷ In light of ‘widespread mistrust and concern’ about the department’s handling of child protection litigation, it recommended that a new independent statutory office be established to make applications for care and protection orders on behalf of the department. This body would operate in a similar manner to an independent prosecuting service, and would receive briefs of evidence from the department, at which point it would decide what, if any, order would be sought from the Children’s Court. The department would retain the capacity to apply for certain interim orders where necessary.¹⁷⁸ The Queensland Government accepted this recommendation¹⁷⁹ and the new Director of Child Protection Litigation was appointed in mid-2016.¹⁸⁰ The Office of the Director of Child Protection Litigation states that it

will improve outcomes for children and their families by providing greater accountability and oversight for child protection order applications that are being proposed by the DCCSDS, by ensuring that the applications filed in court are supported by good quality evidence, promoting efficiency and evidence-based decision making.¹⁸¹

Thus, Queensland is the first and only jurisdiction in Australia ‘to create a professional separation between the decision to apply for a child protection order and the related frontline child safety casework’.¹⁸² The Director of Child Protection Litigation makes an independent decision about whether or not an application for a child protection order should be made and the type of order that should be sought. If an application for a child protection order is made, the DCPL will be responsible for conducting the proceedings in the Children’s Court of Queensland.¹⁸³

The Director has issued detailed *Director’s Guidelines* to encourage best practice, transparency and consistency in care and protection litigation, and publishes an annual report, which contains detailed information about the conduct of child protection proceedings in the State in the preceding financial year.

The Review has concluded that it is highly desirable for an independent statutory body to conduct care and protection litigation in NSW. For years stakeholders have expressed concern about the nature and quality of the evidence that FACS provides to the Children’s Court. While these concerns have been mentioned in previous reports, no recommendations have been made to address them comprehensively. The Review’s file review has revealed that these concerns

177 Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection*, (June 2013) 476–477.

178 Ibid 481–483, rec 13.17.

179 Queensland Government, *Queensland Government Response to the Queensland Child Protection Commission of Inquiry Final Report* (Report, December 2013) 29.

180 *Director of Child Protection Litigation Act 2016* (Qld).

181 Queensland Government, *About us* (online 30 June 2019) Director Child Protection Litigation <<https://www.dcpl.qld.gov.au/about-us>>.

182 Director of Child Protection Litigation, *Director of Child Protection Litigation Annual Report 2016-17* (Report 2016–17) 6.

183 Queensland Government, *The role of the ODCPL* (online 30 June 2019) Director Child Protection Litigation <<https://www.dcpl.qld.gov.au/about-us/the-role-of-the-odcpl>>.



are legitimate and that FACS regularly provides evidence to the Children’s Court that is false or misleading. In addition, it appears that FACS may regularly omit evidence such as evidence of a parent’s ‘strengths’, the effort a parent has made to address substance abuse issues, or the positive parenting approach of the parent. This has occurred despite there being numerous policy documents that indicate that this approach is not permitted, including the Model Litigant Policy. This is despite the fact that evidence provided by caseworkers is screened by lawyers, both internal and external. In addition, it appears from an adverse judicial comment that lawyers representing FACS may not always act with the requisite degree of independence, but instead may adopt unreasonable and inflexible approaches to litigation.¹⁸⁴

In these circumstances, the preferable solution is to establish an independent body to conduct care and protection litigation. After almost three years of operation, the Queensland model—which was adopted to address similar concerns to those which currently exist in NSW—has proven to be workable and has been well-received by stakeholders. It provides a sound template upon which to base the new NSW approach. While it is outside the scope of this Review to determine where the new statutory body should be located, it appears the co-location of the Queensland Office of the Director of Child Protection Litigation with Crown Law, to enable both to share support services, has proven effective and resulted in cost savings. In NSW, it may be possible to co-locate the new independent statutory body with either the Office of the Director of Public Prosecutions, the Crown Solicitor’s Office or a specialist Children’s Court (such as the Parramatta Children’ Court, located within the Parramatta Justice Precinct).

Recommendation 122: The NSW Government should establish an independent statutory agency to make decisions about the commencement of child protection proceedings (including decisions about what orders are to be sought in the proceedings), and to conduct litigation on behalf of the Secretary of the Department of Communities and Justice in the Children’s Court of NSW care and protection jurisdiction.

Application of the rules of evidence

The Children’s Court is an informal jurisdiction. As noted in Chapter 6, the rules of evidence do not generally apply in the Court (unless the Court orders otherwise).¹⁸⁵ In practice, this means that the exclusionary evidential rules designed to ensure that a court does not rely on unreliable or undesirable evidence—such as certain kinds of hearsay evidence, opinion evidence and credibility evidence—do not apply in care and protection proceedings. A similar approach is taken in other legal proceedings in NSW, such as sentencing proceedings.¹⁸⁶ The exclusion of the rules of evidence is designed to ensure that proceedings can be run efficiently and expeditiously, and that the Court has access to all information that may be useful to the determination of the proceedings. However, it also means that the quality of the evidence presented to the Court needs to be carefully scrutinised to ensure that it is sufficiently reliable to form the basis of factual findings.

¹⁸⁴ See *Alice Mason and Reece Mason (No 2)* (Children’s Court (Care), Magistrate Sheedy, 30 July 2018), 19; *The Secretary, Department of Family and Community Services and Tyson Tanner (Costs)* [2017] NSWChC 1.

¹⁸⁵ *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 93(3).

¹⁸⁶ See *Evidence Act 1995* (NSW) s 4(1).

In the 2017 inquiry into child protection in NSW, a number of stakeholders submitted that the rules of evidence should apply to care and protection proceedings.¹⁸⁷ This would ensure that the evidence presented by FACS was ‘tested’, in the sense that it was adequately screened for accuracy and truthfulness.

Section 93(3) of the *Care Act* provides that a court is not bound by the rules of evidence unless it determines that the rules, or some of the rules, apply to the proceedings (in whole or in part). There is no further legislative guidance about when the court should decide that the rules of evidence should apply to the proceedings. This can be contrasted with s 4(2) of the *Evidence Act 1995* (NSW) and other evidence Acts that are of a uniform nature, which provides as follows:

- 4(2) If such a proceeding relates to sentencing:
 - (a) this Act applies only if the court directs that the law of evidence applies in the proceeding, and
 - (b) if the court specifies in the direction that the law of evidence applies only in relation to specified matters--the direction has effect accordingly.
- (3) The court must make a direction if:
 - (a) a party to the proceeding applies for such a direction in relation to the proof of a fact, and
 - (b) in the court’s opinion, the proceeding involves proof of that fact, and that fact is or will be significant in determining a sentence to be imposed in the proceeding.
- (4) The court must make a direction if the court considers it appropriate to make such a direction in the interests of justice.

The Review considers it would be useful to amend the *Care Act* along these lines, to ensure that parents and young people are aware that they may request that the laws of evidence apply to important facts in circumstances where the truthfulness or reliability of a caseworker or any other person’s evidence is disputed. Such an amendment would also provide greater clarity to judicial officers about the circumstances in which the rules of evidence apply to care and protection proceedings, highlighting that they should apply if it is in the ‘interests of justice’.

Recommendation 123: The NSW Government should amend the *Children and Young Persons (Care and Protection) Act 1998* (NSW) so that, as in s 4(2) of the Uniform Evidence Acts, the rules of evidence do not apply unless: (i) a party to the proceeding requests that they apply in relation to the proof of a fact and the court is of the view that proof of that fact is or will be significant to the determination of the proceedings; or (ii) the court is of the view that it is in the interests of justice to direct that the laws of evidence apply to the proceedings.

187 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017), [4.18]–[4.22].



Only specialist magistrates to hear care and protection matters

The vast majority of proceedings under the *Care Act* are heard by specialist Children's Magistrates—usually in a dedicated Children's Court, although in regional areas other court complexes may be utilised by travelling Children's Magistrates.¹⁸⁸ Currently, the Children's Court sits in nine permanent locations in NSW¹⁸⁹ and has 16 specialist Children's Magistrates.¹⁹⁰ However, care proceedings may also be heard by a local court Magistrate exercising the jurisdiction of a Children's Court.¹⁹¹ This is more likely to be the case in rural or regional areas.¹⁹²

In 2017, the Legislative Council's inquiry into child protection expressed the view that it was 'critically important' for specialist magistrates to oversee all care and protection matters.¹⁹³ To achieve this, it recommended that the NSW Government provide the Children's Court with funding for at least three additional Children's Magistrates in order to ensure that all care and protection matters in NSW were heard by a specialist Children's Magistrate.¹⁹⁴ The NSW Government indicated it would 'give this recommendation further consideration', noting that to implement it 'would require additional resourcing'.¹⁹⁵ This recommendation does not appear to have been implemented, as the number of specialist Children's Magistrates has not increased since the release of the Legislative Council's report.

The President of the Children's Court, Judge Peter Johnstone, has requested that the Children's Court be sufficiently resourced to enable specialist magistrates to hear all matters under the *Care Act* 'across the totality of the state'.¹⁹⁶

The Review agrees that it is important that all care and protection matters are heard by specialist Children's Magistrates. Although local court magistrates deal with a wide variety of legal subject matter, the *Care Act* is complex, is amended regularly, and deals with important human rights. Further the informal and non-adversarial approach of the Children's Court means that its practice and procedure is sufficiently different to require a degree of specialisation. While the appointment of additional magistrates will require additional resources, the benefits to be achieved from the change, including more informed and consistent judicial decision-making, as well as more efficient case management, justify the costs of the reform.

188 Children's Magistrates hear approximately 90% of cases in NSW: see Children's Court, Submission No 19 to the Legislative Assembly Committee on Law and Safety, *Inquiry into the Adequacy of Youth Diversionary Programs in NSW* (8 February 2018). Children's Magistrates are appointed by the Chief Magistrate of the Local Court: *Children's Court Act 1987* (NSW) s 7.

189 Locations include Parramatta, Surry Hills, Broadmeadow, Campbelltown, Port Kembla, Sutherland, Nowra, Woy Woy and Wyong: see NSW Government: Justice, *Court Structure*, (13 April 2018) Children's Court <http://www.childrenscourt.justice.nsw.gov.au/Pages/childrenscourt_aboutus/structure.aspx>.

190 Note that Children's Magistrates are Local Court magistrates who are selected having regard to their knowledge and experience dealing with children, young people and their families.

191 See *Children's Court Act 1987* (NSW) s 13.

192 NSW Government: Justice, *Court Structure*, (13 April 2018) Children's Court <http://www.childrenscourt.justice.nsw.gov.au/Pages/childrenscourt_aboutus/structure.aspx>.

193 Legislative Council General Purpose Standing Committee No 2, *Child Protection* (2017), [4.85].

194 *Ibid* 11.

195 NSW Government, *NSW Government Response to Report 46 of the Legislative Council Portfolio Committee No. 2—Health and Community Services—Child Protection* (Report, September 2017), 14.

196 Children's Court of New South Wales, Submission No 18 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, November 2017, 7.

Recommendation 124: The NSW Government should appoint a sufficient number of new magistrates to ensure that all proceedings under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) are dealt with by specialist Children’s Magistrates.

A separate court list for Aboriginal children and their families

Throughout this report, the Review has noted how FACS practice and procedure routinely disregards Aboriginal cultural considerations. For example, this report discusses how cultural planning for Aboriginal children is often non-existent or tokenistic in nature, how FACS does not always make an effort to identify and locate Aboriginal kin of children involved in the child protection system, and how FACS narrowly and incorrectly interprets and applies the Aboriginal Child Placement Principle. In many cases, the failure of the department to adequately respect and address Aboriginal cultural issues could be identified and remedied (at least in part) by the Children’s Court of NSW. Specialist Magistrates could carefully review cultural plans, explore genograms, and investigate culturally important contact arrangements. However, this approach would require the Children’s Court to be ‘culturally competent’, or to acknowledge and incorporate

the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaption of services to meet culturally-unique needs.¹⁹⁷

In his submission to this Review, the President of the Children’s Court of New South Wales noted that the Youth Koori Court that operates in the criminal jurisdiction in Parramatta ‘has demonstrated the ability of the court process to operate in a way that recognises the importance of cultural connection for Aboriginal young people, with positive outcomes’. He submitted that consideration be given to

establishing a dedicated, separate court list for Aboriginal and Torres Strait Islander families, with a dedicated Children’s Magistrate trained in Aboriginal and Torres Strait Islander cultural identity and issues.¹⁹⁸

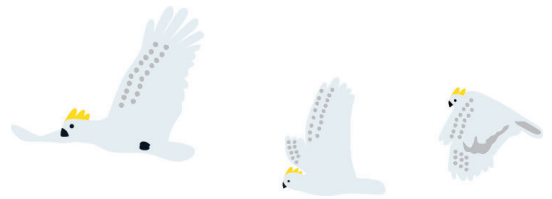
A dedicated list for Aboriginal families would ensure that the court process was more meaningful and culturally appropriate, and would ‘signal a positive and refocused degree of care and sensitivity on the part of the court to those navigating the care and protection system’.¹⁹⁹ Four family violence prevention legal services also made a joint submission which recommended that NSW pilot a program based on the Victorian Koori Children Protection Court.²⁰⁰

197 Terry L Cross et al, *Towards a Culturally Competent System of Care: A Monograph of Effective Services for Minority Children who are Severely Emotionally Disturbed* (Report, March 1989) iv, 7.

198 Children’s Court of New South Wales, Submission No 18 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, November 2017.

199 Ibid.

200 Family Violence Prevention Legal Services (Joint Submission), Submission No 11 to *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*, January 2018.



The Review agrees that a separate, dedicated court list for Aboriginal and Torres Strait Islander children and families is desirable and may operate to reduce, over time, the number of Aboriginal children and young people in OOHC. It may also help to rectify to some degree the deeply entrenched mistrust of the care and protection system among Aboriginal communities. An Aboriginal magistrate, or less preferably a magistrate with specialised knowledge of Aboriginal culture and a proven ability to communicate and work with Aboriginal families, would help to ensure the best outcomes for Aboriginal children in the OOHC system. A dedicated list for Aboriginal children and their families would also enable Aboriginal and Torres Strait Islander Elders or other respected community members, to participate more in decision-making regarding Aboriginal children and could be supported by Aboriginal court staff and service agencies. Proceedings in the court could also be conducted in a more culturally appropriate manner.

Recommendation 125: The NSW Government should, in consultation with the Children’s Court of NSW and other relevant stakeholders, such as the NSW Child, Family and Community Peak Aboriginal Corporation (AbSec) and the Aboriginal Legal Service, design and implement a pilot project establishing a dedicated court list for proceedings under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) involving Aboriginal children.

APPENDIX

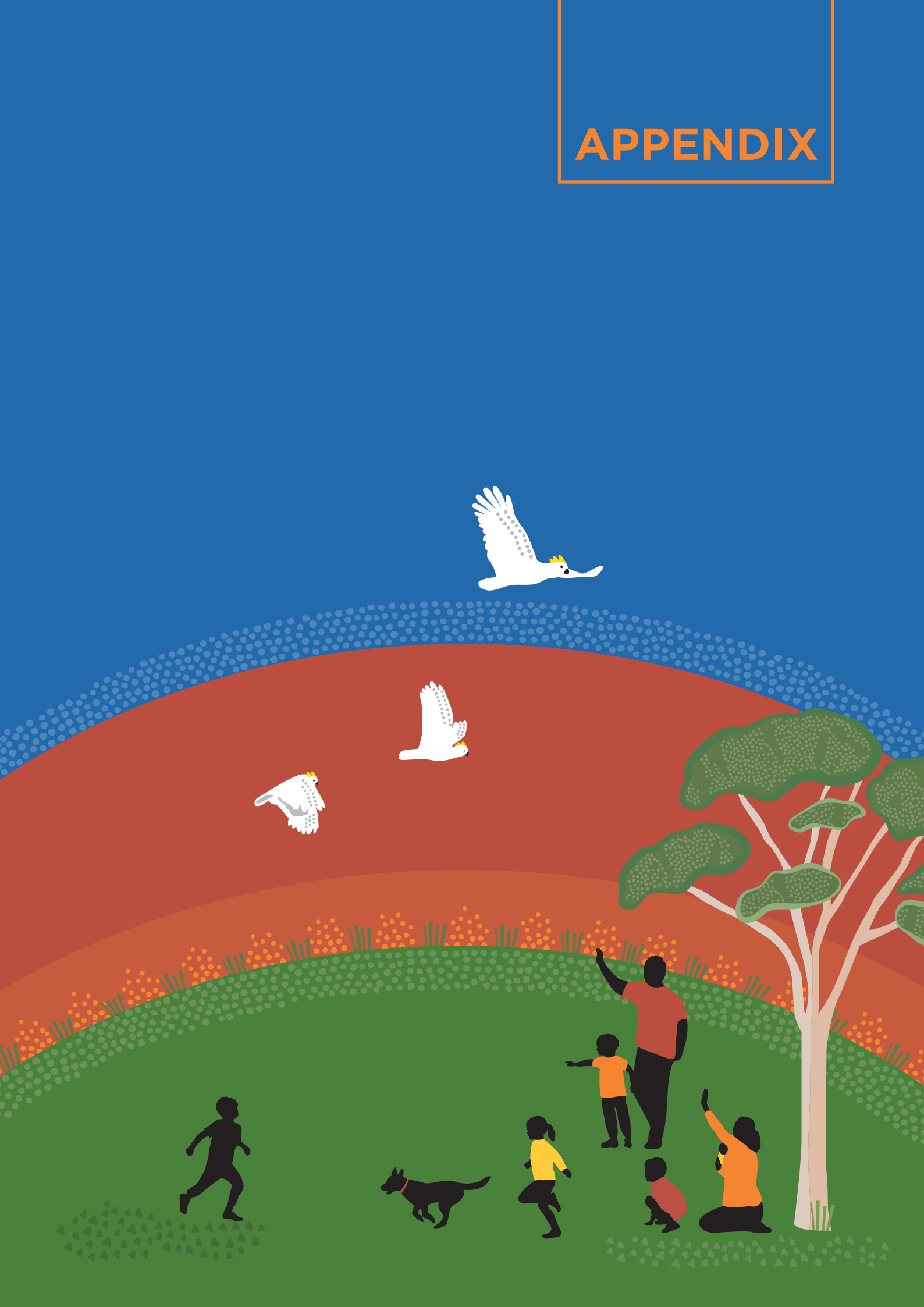


Figure 1 Number and proportion of children and young people entering OOHC between 2011/12 and 2017/18 by Aboriginality, NSW

Financial Year	Aboriginal			Non-Aboriginal			Total	
	Number	%	% change	Number	%	% change	Number	% change
2011/12	1,147	32.0	*	2,438	68.0	*	3,585	*
2012/13	1,037	32.3	-9.6	2,173	67.7	-10.9	3,210	-10.5
2013/14	1,182	34.6	14.0	2,236	65.4	2.9	3,418	6.5
2014/15	1,363	37.5	15.3	2,276	62.5	1.8	3,639	6.5
2015/16	1,318	34.5	-3.3	2,503	65.5	10.0	3,821	5.0
2016/17	1,058	36.3	-19.7	1,856	63.7	-25.8	2,914	-23.7
2017/18	817	37.9	-22.8	1,340	62.1	-27.8	2,157	-26.0

Source: KIDS and ChildStory - CIW Annual data



Figure 2 Number of children and young people with ROSH reports in 2011/12 and the proportion who entered OOHC between 2011/12 and 2016/17 by district of their first ROSH report in 2011/12, NSW

District (first ROSH report during 2011/12)	Aboriginal		Non-Aboriginal		Total	
	Number	% entering OOHC	Number	% entering OOHC	Number	% entering OOHC
Sydney	372	28.8	1,670	11.8	2,042	14.9
Western Sydney	607	24.1	4,853	9.7	5,460	11.3
South Eastern Sydney	212	23.1	2,501	9.0	2,713	10.1
South Western Sydney	802	26.7	6,840	10.1	7,642	11.9
Northern Sydney	39	30.8	1,721	7.1	1,760	7.6
Central Coast	507	24.1	2,904	10.9	3,411	12.9
Far West	298	16.1	289	9.7	587	12.9
Hunter New England	2,713	21.4	8,000	12.6	10,713	14.8
Illawarra Shoalhaven	813	22.1	2,852	14.0	3,665	15.8
Mid North Coast	688	18.8	1,786	10.5	2,474	12.8
Murrumbidgee	683	18.9	2,455	11.3	3,138	12.9
Nepean Blue Mountains	623	20.9	3,589	10.2	4,212	11.8
Northern NSW	898	15.3	2,480	8.1	3,378	10.0
Southern NSW	482	12.7	1,625	9.0	2,107	9.9
Western NSW	2,258	19.5	2,678	9.9	4,936	14.3
Statewide Services	540	12.8	2,520	4.2	3,060	5.7
*Total children	12,536	20.4	48,772	10.3	61,308	12.3

Source: KIDS – CIW Annual data

*Total includes where district is missing/not stated.

Figure 3 Proportion of children and young people with ROSH reports in 2015/16 by primary reported issue and age groups, NSW

Primary reported issue	Proportion of children by age groups (years)				Total children
	<5 %	5-9 %	10-14 %	15-17 %	
Aboriginal					
Carer drug/alcohol issues	45.4	27.3	21.5	5.7	3,124
Child/young person drug/alcohol issues	9.4	17.8	46.5	25.8	523
Domestic violence	49.2	26.9	17.4	6.3	3,592
Physical abuse	37.0	29.6	25.0	8.2	4,856
Sexual abuse	24.4	29.4	31.6	13.9	3,675
Emotional abuse	31.9	32.2	28.5	7.1	1,024
Neglect	32.5	29.6	27.5	10.0	6,253
Carer mental health	48.0	25.6	20.9	5.3	733
Suicide risk for child	11.7	17.5	42.9	27.9	240
Child inappropriate sexual behaviour	20.2	31.7	34.6	13.1	609
Prenatal	83.0	7.5	4.3	3.6	784
Child or young person is a danger to self/others	10.2	22.1	44.4	23.0	1,102
Non-Aboriginal					
Carer drug/alcohol issues	38.0	30.4	23.5	7.4	6,363
Child/young person drug/alcohol issues	10.3	18.1	38.8	31.8	913
Domestic violence	41.3	29.4	21.1	7.6	11,226
Physical abuse	28.1	30.4	28.6	11.5	18,703
Sexual abuse	18.1	27.1	32.1	18.1	14,852
Emotional abuse	22.7	32.0	33.5	10.9	4,440
Neglect	29.2	29.2	28.6	12.0	14,469
Carer mental health	41.1	28.9	23.2	6.5	2,753
Suicide risk for child	8.4	17.1	47.8	26.5	981
Child inappropriate sexual behaviour	17.5	36.4	29.9	14.5	2,611
Prenatal	80.1	6.5	4.5	4.9	1,610
Child or young person is a danger to self/others	9.2	21.2	41.8	27.1	3,343

Source: KIDS - CIW Annual data

Total number of children reported for the issue includes children with missing age groups, so the sum total of proportions in a reported issue may not add up to 100



Figure 4 Number and proportion of children and young people in OOHC as at 30 June 2012 to 2018 by Aboriginality, NSW

At 30 June	Aboriginal		Non-Aboriginal		Total
	Number	%	Number	%	Number
2012	6,287	34.6	11,882	65.4	18,169
2013	6,487	35.4	11,813	64.6	18,300
2014	6,793	35.8	12,157	64.2	18,950
2015	6,472	36.8	11,113	63.2	17,585
2016	6,968	37.3	11,691	62.7	18,659
2017	7,152	38.1	11,628	61.9	18,780
2018	6,766	38.9	10,621	61.1	17,387

Source: KIDS and ChildStory - CIW Annual data

Figure 5 Number and proportion of children and young people who entered OOHC in 2015/16 by the placement exit reason of their last non-respite placement before 30 June 2018, NSW

Placement exit reason of last non-respite placement by 30 June 2018	Aboriginal		Non-Aboriginal	
	Number	%	Number	%
Allegation against carer	*	*	*	*
Carer circumstances changed	13	2.7	26	2.4
Court Order	15	3.1	40	3.7
Child/young person died	0	0	*	*
Child/young person exits out-of-home care	41	8.4	118	10.8
Child/young person incarcerated	6	1.2	*	*
Child/young person missing	6	1.2	9	0.8
Disruption	18	3.7	30	2.7
Planned Move	75	15.4	144	13.2
Restoration Breakdown	*	*	5	0.5
Transfer of Order	7	1.4	8	0.7
Child/young person has self restored	12	2.5	47	4.3
Move to independent living	12	2.5	22	2.0
Restored to parents	230	47.3	542	49.5
Court Order - Adopted	0	0	*	*
Court Order - Parental Responsibility to Relative	0	0	8	0.7
Disruption involving child/young person	*	*	*	*
Move to independent living 18 years & over	*	*	*	*
Move to independent living under 18 years	*	*	*	*
Other - planned move, In-care	6	1.2	8	0.7
Other - planned OOHC Exit	9	1.9	11	1.0
Placement breakdown	0	0	*	*
System missing	16	5.1	46	5.4
Total	486	100	1,095	100

Source: KiDS and ChildStory - CIW Annual data

System missing means that an exit reason was not recorded on KiDS/ChildStory



Figure 6 Number and proportion of children and young people entering OOHC in 2015/16 by Aboriginality and age, NSW

Age Group (at entry during 2015/16)	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
0-4 years	684	51.9	1,223	48.9	1,907	49.9
5-9 years	345	26.2	653	26.1	998	26.1
10-14 years	229	17.4	503	20.1	732	19.2
15-17 years	60	4.6	124	5.0	184	4.8
Total children	1,318	100	2,503	100	3,821	100

Source: KIDS - CIW Annual data

Figure 7 Number and proportion of children and young people who entered OOHC in 2015/16 by whether the child had been in OOHC previously and Aboriginality, NSW

Previously in OOHC	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Yes	232	17.6	316	12.6	548	14.3
No	1086	82.4	2187	87.4	3273	85.7
Total children	1,318	100	2,503	100	3,821	100

Source: KIDS - CIW Annual data

Figure 8 Number and proportion of children and young people who entered OOHC in 2015/16 by time between their first ROSH report and first entry into OOHC and Aboriginality, NSW

Time between first ROSH report and first entry into OOHC for children and young people	Aboriginal		Non-Aboriginal	
	Number	%	Number	%
No ROSH prior to entry	27	2.0	52	2.1
Less than a year	423	32.1	953	38.1
1-4 years	486	36.9	749	29.9
5-9 years	281	21.3	553	22.1
10+ years	101	7.7	196	7.8
Total children	1,318	100	2,503	100

Source: KIDS - CIW Annual data

Figure 9 Number and proportion of children and young people who entered OOHC in 2015/16 by the number of ROSH reports in the 2 years prior to entry and Aboriginality, NSW

Number of ROSH reports in the 2 years prior to entry into OOHC in 2015/16	Aboriginal		Non-Aboriginal	
	Number	%	Number	%
< 5	664	50.4	1,552	62
5-9	467	35.4	712	28.4
10-14	130	9.9	154	6.2
15+	57	4.3	85	3.4
Total children	1,318	100	2,503	100

Source: KIDS - CIW Annual data

Figure 10 Statistics for the number of ROSH reports in the 2 years prior to entry into OOHC in 2015/16 by Aboriginality, NSW

Statistics for the number of ROSH reports in the 2 years prior to entry into OOHC in 2015/16	Aboriginal	Non-Aboriginal
Mean	5.5	4.5
Median	4.0	3.0
Standard Deviation	4.9	4.0
Minimum	0.0	0.0
Maximum	46.0	30.0

Source: KIDS - CIW Annual data



Figure 11 Number and percentage of children who entered OOHC during 2015/16 who were reported at ROSH with the specified issues prior to their entry into OOHC by Aboriginality, NSW

Reported issue (primary and secondary)	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Carer drug/alcohol issues	1,027	77.9	1,565	62.5	2,592	67.8
Child/young person drug/alcohol issues	151	11.5	168	6.7	319	8.3
Domestic violence	846	64.2	1,404	56.1	2,250	58.9
Physical abuse	940	71.3	1,742	69.6	2,682	70.2
Sexual abuse	465	35.3	776	31.0	1,241	32.5
Emotional abuse	688	52.2	1,238	49.5	1,926	50.4
Neglect	999	75.8	1,773	70.8	2,772	72.5
Carer mental health	541	41.0	1,070	42.7	1,611	42.2
Carer other issues	236	17.9	381	15.2	617	16.1
Runaway	51	3.9	78	3.1	129	3.4
Suicide risk for child	66	5.0	171	6.8	237	6.2
Child inappropriate sexual behaviour	123	9.3	197	7.9	320	8.4
Prenatal	481	36.5	581	23.2	1,062	27.8
Child is danger to self/others	165	12.5	279	11.1	444	11.6
Other	*	*	23	0.9	*	*
Total children	1,318		2,503		3,821	

Source: KIDS - CIW Annual data

Percentage totals for reported issues will be greater than 100 as each child can have more than one reported issue.

*Cells with value less than 5 have been suppressed.

Figure 12 Number and proportion of children and young people in the review cohort who had a care application filed by the grounds for care outlined in the care application, NSW

Grounds for care	Number	%
71(1)(a)	110	11.5
71(1)(b)	79	8.3
71(1)(c)	443	46.3
71(1)(d)	844	88.3
71(1)(e)	750	78.5
71(1)(f)	*	*
71(1)(g)	0	0.0
71(1)(h)	*	*
Not stated	11	1.2
Total children who had a care application filed	956	

Source: Review Tool

*Cells with value less than 5 have been suppressed

Percentage totals will be greater than 100 as each child can have more than one grounds for care in the care application.

See Table 45.2 for a description of the grounds for care.

Figure 13 Number and proportion of children and young people in the review cohort by whether a care application was filed, NSW

Care application filed	Number	%
Yes	956	83.6
No	188	16.4
Total children	1,144	100

Source: Review Tool



Figure 14 Number and proportion of children and young people in the review cohort by the legislative basis of entry into OOHC in 2015/16, NSW

Legislative basis	Number	%
Assumption (s 44)	501	43.8
Order pursuant to Family Law	7	0.6
Removal (s 43)	311	27.2
Removal pursuant to Children's Court Order (s 48)	33	2.9
Search Warrant (s 233)	94	8.2
Temporary Care Arrangement (s 151)	151	13.2
Other Children's Court order not described above (e.g. Interim Orders only)	39	3.4
Other**	8	0.7
Total children	1,144	100

Source: Review Tool

**Includes 'Not stated'

Figure 15 Proportion of children and young people in the review cohort by the legislative basis of entry into OOHC and the authority approving the entry into OOHC in 2015/16, NSW

Legislative basis	Entry into OOHC authorised by			
	Manager Casework	Manager Client Services	Other^	Total
	%	%	%	%
Assumption (s 44)	71.3	27.3	1.4	100
Order pursuant to Family Law	*	0.0	*	100
Removal (s 43)	47.3	38.3	14.5	100
Removal pursuant to Children's Court Order (s 48)	63.6	*	*	100
Search Warrant (s 233)	46.8	38.3	14.9	100
Temporary Care Arrangement (s 151)	91.4	*	*	100
Other Children's Court order not described above (e.g. Interim Orders only)	82.1	*	*	100
Other**	*	*	*	100
Total children	747	307	90	1,144

Source: Review Tool

N/A: Cells with value less than 5 have been suppressed

**Includes 'Not stated'

^Includes 'Caseworker', 'Director Community Services', 'District Director', 'Helpline Team Leader', 'No' and 'Not stated'

Figure 16 Number and proportion of children and young people in the review cohort by whether practice issues were identified in the way the children came into OOHC in 2015/16, NSW

Practice issues identified	Number	%
Yes	538	47.0
No	596	52.1
Not stated	10	0.9
Total children	1,144	100

Source: Review Tool

Figure 17 Care arrangement at entry into OOHC for children and young people who entered OOHC during 2015/16 by Aboriginality, NSW

Care Type	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Care Responsibility to the DG: Other than Temporary Care	43	3.3	106	4.2	149	3.9
Care Responsibility to the DG: Temporary Care	146	11.1	306	12.2	452	11.8
Other Relative / Kinship Care: No Order	90	6.8	105	4.2	195	5.1
Other Voluntary Care	10	0.8	52	2.1	62	1.6
Parental Responsibility Order to Relative	43	3.2	72	2.9	115	3.0
Parental Responsibility to the Minister / DG	965	73.2	1,787	71.4	2,752	72.0
Other/Not stated*	21	1.6	75	3.0	96	2.5
Total	1,318	100	2,503	100	3,821	100

Source: KIDS - CIW Annual data

*Other includes adoption and detached refugees



Figure 18 Number and proportion of children and young people in the review cohort by sector case managing the child at the time of the review, NSW

Case management sector	Number	%
Aboriginal OOHC NGO	122	10.7
FACS	565	49.4
PR to relative	49	4.3
OOHC NGO	118	10.3
Aboriginal partnership with mainstream NGO	10	0.9
Other	*	*
Not applicable	15	1.3
Not stated	*	*
Not in OOHC	261	22.8
Total children	1,144	100

Source: Review Tool

*Cells with value less than 5 have been suppressed

**Includes 'Other'

Figure 19 Number and proportion of children and young people in the review cohort who were in care by whether the the current carer is Aboriginal at the time of the review, NSW

Aboriginal carer	Number	%
Yes	469	53.1
No	407	46.1
Not stated	7	0.8
Total children in care	883	100

Source: Review Tool

Figure 20 Number and proportion of children and young people in the review cohort who were in care by the current placement type at the time of the review, NSW

Current placement type	Number	%
Foster Care - DOCS - non-Aboriginal	34	3.9
Foster Care - DOCS - Aboriginal	40	4.5
Kinship - Aboriginal - DOCS	263	29.8
Kinship - non-Aboriginal - DOCS	194	22.0
Non-Related Person	*	*
Independent Living	*	*
Motel	*	*
Residential Agency	25	2.8
Parent/s	47	5.3
Foster Care - Agency - non-Aboriginal	107	12.1
Foster Care - Agency - Aboriginal	77	8.7
Kinship - Aboriginal - Agency	46	5.2
Juvenile Justice	*	*
Other	22	2.5
Not stated	18	2.0
Total children in care	883	100

Source: Review Tool

*Cells with value less than 5 have been suppressed.

Figure 21 Number and proportion of children and young people in the review cohort by the people involved in decision making for the current placement at the time of the review, NSW

People involved in decision making	Number	%
Child (as appropriate)	272	23.8
Aboriginal families	726	63.5
Aboriginal kinship groups	150	13.1
Aboriginal communities	23	2.0
Aboriginal representative organisations	154	13.5
None of the above	250	21.9
Not stated	28	2.4
Total children	1,144	

Source: Review Tool

Percentage totals will be greater than 100 as each child can have more than one group involved in decision making.



Figure 22 Number and proportion of children and young people in the review cohort who had a care application filed by whether the care application identified the child as Aboriginal, NSW

Care application identified the child as Aboriginal	Number	%
Yes	906	94.8
No	39	4.1
Not stated	11	1.2
Total children who had a care application filed	956	100

Source: Review Tool

Figure 23 Number and proportion of children and young people in the review cohort who had a care application filed by whether the care application noted that the Aboriginal Child Placement Principles (ACPP) were being considered in the application or placement, NSW

ACPP considered	Number	%
Yes	862	90.2
No	82	8.6
Not stated	12	1.3
Total children who had a care application filed	956	100

Source: Review Tool

Figure 24 Number and proportion of children and young people who entered OOHC during 2015/16 by their OOHC status at 30 June 2018 and Aboriginality, NSW

OOHC status at 30 June 2018	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Exited OOHC	486	36.9	1,095	43.7	1,581	41.4
Remained in OOHC	832	63.1	1,408	56.3	2,240	58.6
Total children	1,318	100	2,503	100	3,821	100

Source: KIDS and ChildStory - CIW Annual data

Figure 25 Number and proportion of children and young people who entered OOHC in 2015/16 and exited by 30 June 2018 aged less than 17 years by re-entry status at 30 June 2018 and Aboriginality, NSW

OOHC status at 30 June 2018 of children who exited OOHC at <17 years old	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Did not re-enter	355	78.4	914	86.9	1269	84.3
Re-entered	98	21.6	138	13.1	236	15.7
Total	453	100	1,052	100	1,505	100

Source: KIDS and ChildStory - CIW Annual data

Figure 26 Number and proportion of children and young people in the review cohort by the age of the mother at the time of entry into OOHC in 2015/16, NSW

Age group	Number	%
<18 years	22	1.9
18-24 years	249	21.8
25-34 years	549	48.0
35-44 years	298	26.0
45-54 years	26	2.3
Total children	1,144	100

Source: Review Tool

Figure 27 Summary statistics on the age of the mother at the time of entry into OOHC in 2015/16 for the children and young people in the review cohort, NSW

Age	Number
Mean	30.3
Median	30.0
Minimum	14
Maximum	51

Source: Review Tool



Figure 28 Number and proportion of children and young people in the review cohort by the Aboriginal status of the mother, NSW

Aboriginal status	Number	%
Aboriginal and/or Torres Strait Islander	843	73.7
Not Indigenous	282	24.7
Other**	19	1.7
Total children	1,144	100

Source: Review Tool

**Includes 'Not stated' and missing

Figure 29 Number and proportion of children and young people in the review cohort by whether the child's mother has child protection history in NSW

Child protection history	Number	%
Yes	781	68.3
No	363	31.7
Total children	1,144	100

Source: Review Tool

Figure 30 Number and proportion of children and young people in the review cohort by whether the child's mother has OOHC history in NSW

OOHC history	Number	%
Yes - Parental Responsibility to the Minister	146	12.8
Yes - Supported Care	30	2.6
Yes - Temporary Care Arrangement	74	6.5
Yes - Voluntary Care	42	3.7
No	845	73.9
Not stated	7	0.6
Total children	1,144	100

Source: Review Tool

Figure 31 Number and proportion of children and young people in the review cohort by the age of the father at the time of entry into OOHC in 2015/16, NSW

Age group	Number	%
<18 years	12	1.0
18-24 years	140	12.2
25-34 years	467	40.8
35-44 years	365	31.9
45-54 years	116	10.1
>54 years	16	1.4
Not stated	28	2.4
Total children	1,144	100

Source: Review Tool

Figure 32 Summary statistics on the age of the father at the time of entry into OOHC in 2015/16 for the children and young people in the review cohort, NSW

Age	Number
Mean	33.7
Median	33.0
Minimum	15
Maximum	68

Source: Review Tool

Figure 33 Number and proportion of children and young people in the review cohort by the Aboriginal status of the father, NSW

Aboriginal status	Number	%
Aboriginal and/or Torres Strait Islander	665	58.1
Not Indigenous	388	33.9
Other [^]	91	8.0
Total children	1,144	100

Source: Review Tool

[^]Includes 'Not stated' and missing



Figure 34 Number and proportion of children and young people in the review cohort by whether the child's father has child protection history in NSW

Child protection history	Number	%
Yes	475	41.5
No	628	54.9
Not stated	41	3.6
Total children	1,144	100

Source: Review Tool

Figure 35 Number and proportion of children and young people in the review cohort by whether the child's father has OOHC history in NSW

OOHC history	Number	%
Yes - Parental Responsibility to the Minister	80	7.0
Yes - Supported Care	32	2.8
Yes - Temporary Care Arrangement	44	3.8
Yes - Voluntary Care	11	1.0
No	923	80.7
Not stated	54	4.7
Total children	1,144	100

Source: Review Tool

Figure 36 Number and proportion of children and young people in the review cohort by whether the parents have child protection history in NSW

Parents with child protection history	Number	%
Both parents	371	32.4
One parent	489	42.7
Neither parent	243	21.2
Not stated	41	3.6
Total children	1,144	100

Source: Review Tool

Figure 37 Children and young people who received Intensive Family Support (IFS) in the 2 years prior to entry into OOHC in 2015/16 by Aboriginality, NSW

Received IFS in the 2 years prior to entering OOHC in 2015/16	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Yes	86	6.5	176	7.0	262	6.9
No	1,232	93.5	2,327	93.0	3,559	93.1
Total children	1,318	100	2,503	100	3,821	100

Source: KIDS - CIW Annual data

The Intensive Family Support program is not universally available and there would be many communities where access to the program is limited or there is a waiting list.

Figure 38 Closure status of the program at the time of entry into OOHC for children and young people who received Intensive Family Support (IFS) in the 2 years prior to entry into OOHC in 2015/16 by Aboriginality, NSW

Closure status at the time of entering OOHC in 2015/16	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Case plan goal achieved	17	19.8	33	18.8	50	19.1
Program ongoing	43	50.0	78	44.3	121	46.2
Family withdrew/declined/not located/relocated/not engaging in services	9	10.5	28	15.9	37	14.1
Eligibility criteria no longer met	10	11.6	6	3.4	16	6.1
Other*	7	8.1	31	17.6	38	14.5
Total children	86	100	176	100	262	100

Source: KIDS - CIW Annual data

The Intensive Family Support program is not universally available and there would be many communities where access to the program is limited or there is a waiting list.

*Other includes unsuitable to program and any missing information.



Figure 39 Children and young people who received Brighter Futures (BF) in the 2 years prior to entry into OOHC in 2015/16 by Aboriginality, NSW

Received Brighter Future Service (BF) in the 2 years prior to entering OOHC in 2015/16	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Yes	264	20.0	453	18.1	717	18.8
No	1,054	80.0	2,050	81.9	3,104	81.2
Total children	1,318	100	2,503	100	3,821	100

Source: KIDS - CIW Annual data

The Brighter Futures program is not universally available and there would be many communities where access to the program is limited or there is a waiting list.

Figure 40 Closure status of the program at the time of entry into OOHC for children and young people who received Brighter Futures (BF) in the 2 years prior to entry into OOHC in 2015/16 by Aboriginality, NSW

Closure Status at the time of entering OOHC in 2015/16	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Case plan goal achieved	*	*	*	*	23	3.2
Program ongoing	66	25.0	170	37.5	236	32.9
Family withdrew/declined/not located/relocated/not engaging in services	116	43.9	169	37.3	285	39.7
Eligibility criteria no longer met	62	23.5	75	16.6	137	19.1
Other**	*	*	*	*	36	5.0
Total children	264	100	453	100	717	100

Source: KIDS - CIW Annual data

The Brighter Futures program is not universally available and there would be many communities where access to the program is limited or there is a waiting list.

*Cells with value less than 5 have been suppressed.

**Other includes 3 month period exceeded, assessed as unsuitable and missing status.

Figure 41 Number and proportion of children and young people in the review cohort by whether the family was referred to Intensive Family Based Services (IFBS), NSW

Referred to IFBS	Number	%
Yes, 1-2 years prior to entry into care	60	5.2
Yes, <12 months prior to entry into care	126	11.0
Yes, during current assessment period	62	5.4
No**	896	78.3
Total children	1,144	100

Source: Review Tool

**Includes 'Not stated'

The IFBS program is not universally available and there would be many communities where access to the program is limited or there is a waiting list.



Figure 42 Number and proportion of children and young people in the review cohort referred to IFBS by whether the referral was accepted, NSW

Referral to IFBS accepted	Number	%
Yes	199	80.2
No - family uncontactable	*	*
No - family chose not to engage with service	19	7.7
No - risk was deemed to be too high	11	4.4
N/A - not applicable	14	5.6
Not stated	*	*
Total children referred to IFBS	248	100

Source: Review Tool

*Cells with value less than 5 have been suppressed

The IFBS program is not universally available and there would be many communities where access to the program is limited or there is a waiting list.

Figure 43 Number and proportion of children and young people in the review cohort by whether the family was referred to Intensive Family Preservation Services (IFPS), NSW

Referred to IFPS	Number	%
Yes, 1-2 years prior to entry into care	34	3.0
Yes, <12 months prior to entry into care	23	2.0
Yes, during current assessment period	28	2.4
No**	1059	92.6
Total children	1,144	100

Source: Review Tool

**Includes 'Not stated'

The IFPS program is not universally available and there would be many communities where access to the program is limited or there is a waiting list.

Figure 44 Number and proportion of children and young people in the review cohort referred to IFPS by whether the referral was accepted, NSW

Referral to IFPS accepted	Number	%
Yes	65	76.5
No - family uncontactable	*	*
No - family chose not to engage with service	11	12.9
No - risk was deemed to be too high	5	5.9
N/A - not applicable	*	*
Total children referred to IFPS	85	100

Source: Review Tool

*Cells with value less than 5 have been suppressed

The IFPS program is not universally available and there would be many communities where access to the program is limited or there is a waiting list.

Figure 45 Number and proportion of children and young people in the review cohort by type of secondary assessment completed, NSW

Secondary assessment completed	Number	%
Safety and risk assessment	990	86.5
Secondary risk of harm	32	2.8
No safety assessment located	117	10.2
Not stated	5	0.4
Total children	1,144	100

Source: Review Tool

Figure 46 Number and proportion of children and young people in the review cohort who had a SARA assessment by whether a risk assessment was completed, NSW

Risk assessment completed	Number	%
Yes	959	96.9
No	31	3.1
Total children who had a SARA assessment	990	100

Source: Review Tool



Figure 47 Number and proportion of children and young people in the review cohort who had a risk assessment by age group at the time of the risk assessment and whether the child was interviewed for the risk assessment, NSW

Age group	Interviewed for the risk assessment					
	Yes		No**		Total	
	Number	%	Number	%	Number	%
<6 years	51	8.4	555	91.6	606	100
6-12 years	159	52.0	147	48.0	306	100
13-17 years*	26	55.3	21	44.7	47	100
Total children who had a risk assessment	236	24.6	723	75.4	959	100

Source: Review Tool

*Includes missing age

**Includes 'Not stated'

Figure 48 Number and proportion of children and young people in the review cohort who had a risk assessment by whether the child was observed during the risk assessment, NSW

Observed during risk assessment	Number	%
Yes	889	92.7
No**	70	7.3
Total children who had a risk assessment	959	100

Source: Review Tool

**Includes 'Not stated'

Figure 49 Number and proportion of children and young people in the review cohort who had a risk assessment by whether a risk re-assessment was completed, NSW

Risk re-assessment completed	Number	%
Yes	78	8.1
No**	243	25.3
N/A - child is no longer in the original assessed household	96	10.0
N/A - child is in OOHC	542	56.5
Total children who had a risk assessment	959	100

Source: Review Tool

**Includes 'Not stated'

Figure 50 Number and proportion of children and young people in the review cohort who had a SARA assessment by the safety assessment outcome, NSW

Safety assessment outcome	Number	%
Safe	50	5.1
Safe with plan	230	23.2
Unsafe**	710	71.7
Total children who had a SARA assessment	990	100

Source: Review Tool

**Includes 'Not stated'

Figure 51 Number and proportion of children and young people in the review cohort with a safety plan by whether the safety plan addresses the identified dangers, NSW

Safety plan addresses the dangers identified	Number	%
Yes	98	46.9
Partially	83	39.7
No**	28	13.4
Total children with a safety plan	209	100

Source: Review Tool

**Includes 'N/A - not applicable'

Figure 52 Number and proportion of children and young people who entered OOHC during 2015/16 with a substantiated ROSH report made between 2015/16 and 2016/17 with substantiated risk or harm while in OOHC where they were the victim, NSW

Experienced substantiated actual or risk of harm while in OOHC	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Yes	114	8.6	131	5.2	245	6.4
No	1,204	91.4	2,372	94.8	3,576	93.6
Total children	1,318	100	2,503	100	3,821	100

Source: KIDS - CIW Annual data



Figure 53 Children and young people who entered OOHC during 2015/16 and had a substantiated ROSH report made between 2015/16 and 2016/17 with substantiated risk or harm while in OOHC where they were the victim by their relationship with the perpetrator, NSW

Relationship with perpetrator	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Current carer	46	40.4	43	32.8	89	36.3
Past carer	10	8.8	15	11.5	25	10.2
Parent	12	10.5	21	16.0	33	13.5
Child household member/sibling	8	7.0	18	13.7	26	10.6
Adult household member	8	7.0	7	5.3	15	6.1
Carers friend/relative18+	14	12.3	5	3.8	19	7.8
Other child or young person	8	7.0	11	8.4	19	7.8
Residential care worker	*	*	*	*	11	10.2
Others	12	10.5	18	13.7	30	12.2
Total children	114		131		245	

Source: KIDS - CIW Annual data

Percentage totals add up to more than 100 as children can have more than one substantiated report which may provide more than one perpetrator.

*Cells with value less than 5 have been suppressed.

Figure 54 Children and young people who entered OOHC during 2015/16 and had a substantiated ROSH report made between 2015/16 and 2016/17 which substantiated risk or harm while in OOHC where they were the victim by the care setting in which the abuse occurred, NSW

Care setting in which the abuse in care occurred	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Authorised FACS foster care	8	7.0	19	14.5	27	11.0
Authorised FACS relative care	75	65.8	59	45.0	134	54.7
Authorised NGO foster care	13	11.4	21	16.0	34	13.9
Authorised NGO relative care	*	*	*	*	*	*
Independent living	*	*	*	*	*	*
Non-related person	*	*	*	*	*	*
Other	6	5.3	13	9.9	19	7.8
Residential care	14	12.3	19	14.5	33	13.5
Self placed-not authorised	*	*	*	*	*	*
Total children	114		131		245	

Source: KIDS - CIW Annual data

Percentage totals add up to more than 100 as one child may have more than one substantiated report.

*Cells with value less than 5 have been suppressed.

Figure 55 Children and young people who entered OOHC during 2015/16 and had a substantiated ROSH report made between 2015/16 and 2016/17 which substantiated risk or harm while in OOHC where they were the victim by whether they remained in the placement where the harm or risk occurred, NSW

Remained in the placement where substantiated harm/risk occurred immediately after assessment	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
Yes	60	52.6	83	63.4	143	58.4
No	54	47.4	48	36.6	102	41.6
Total children	114	100	131	100	245	100

Source: KIDS - CIW Annual data



Figure 56 Number and proportion of children and young people in the review cohort by whether Aboriginal consultation occurred at each key stage of case management, NSW

Stage of OOH case management	Aboriginal consultation		No Aboriginal consultation		Total	
	Number	%	Number	%	Number	%
Helpline	35	3.1	1,109	96.9	1,144	100
CSC Triage	5	0.4	1,139	99.6	1,144	100
Pre Assessment Consultation	47	4.1	1,097	95.9	1,144	100
Assessment consultation	56	4.9	1,088	95.1	1,144	100
Safety Assessment	61	5.3	1,083	94.7	1,144	100
Safety Assessment Review	10	0.9	1,134	99.1	1,144	100
Risk Assessment	28	2.4	1,116	97.6	1,144	100
Child Protection Case Plan	86	7.5	1,058	92.5	1,144	100
Risk Reassessment	8	0.7	1,136	99.3	1,144	100
Pre-entry into care	218	19.1	926	80.9	1,144	100
Post entry into care	374	32.7	770	67.3	1,144	100
Initial Placement	164	14.3	980	85.7	1,144	100
Long Term Care consideration	474	41.4	670	58.6	1,144	100
Placement change	166	14.5	978	85.5	1,144	100
OOHC Case Plan	286	25.0	858	75.0	1,144	100
Cultural Plan	398	34.8	746	65.2	1,144	100
Other	114	10.0	1,030	90.0	1,144	100

Source: Review Tool

Figure 57 Proportion of children and young people in the review cohort who had Aboriginal consultation by the Aboriginal people consulted at each key stage of case management, NSW

Stage of OOHC case management	Single internal FACS Aboriginal staff member %	Multiple internal FACS Aboriginal staff members %	Internal FACS Aboriginal staff members participating in structured panel process %	Panel comprising Internal Aboriginal staff and external Aboriginal staff representing agencies (16A) %	Panel comprising internal Aboriginal staff, external Aboriginal staff and Aboriginal community members %	Other %	Total Aboriginal consultation	
							Number	%
Helpline	94.3	*	0.0	0.0	0.0	*	35	100
CSC Triage	*	*	0.0	0.0	0.0	*	5	100
Pre Assessment Consultation	48.9	*	*	0.0	0.0	44.7	47	100
Assessment consultation	55.4	0.0	*	*	*	33.9	56	100
Safety Assessment	42.6	8.2	8.2	*	*	39.3	61	100
Safety Assessment Review	30.0	0.0	0.0	0.0	0.0	70.0	10	100
Risk Assessment	28.6	*	17.9	0.0	0.0	42.9	28	100
Child Protection Case Plan	26.7	7.0	15.1	*	*	50.0	86	100
Risk Reassessment	*	*	0.0	0.0	0.0	62.5	8	100
Pre-entry into care	37.6	20.2	12.4	6.4	0.0	23.4	218	100
Post entry into care	26.2	27.3	18.2	4.5	2.4	21.4	374	100
Initial Placement	27.4	14.6	13.4	4.3	*	39.6	164	100
Long Term Care consideration	13.3	21.3	34.4	4.6	4.2	22.2	474	100
Placement change	9.6	19.3	29.5	4.2	4.8	32.5	166	100
OOHC Case Plan	29.7	5.9	14.7	3.1	3.5	43.0	286	100
Cultural Plan	23.9	16.6	17.8	2.5	2.0	37.2	398	100
Other	33.3	16.7	14.9	*	0.0	34.2	114	100

Source: Review Tool; N/A: Cells with value less than 5 have been suppressed.



Figure 58 Number and proportion of children and young people in the review cohort by the people involved in decision making for the first placement in 2015/16, NSW

People involved in decision-making	Number	%
Child (as appropriate)	151	13.2
Aboriginal families	498	43.5
Aboriginal kinship groups	69	6.0
Aboriginal communities	19	1.7
Aboriginal representative organisations	59	5.2
None of the above	543	47.5
Not stated	23	2.0
Total children	1,144	

Source: Review Tool

Percentage totals will be greater than 100 as each child can have more than one group involved in decision making.

Figure 59 Number and proportion of children and young people in the review cohort by the placement type for the first placement in 2015/16, NSW

First placement type	Number	%
Foster Care - DOCS - non-Aboriginal	192	16.8
Foster Care - DOCS - Aboriginal	50	4.4
Kinship - Aboriginal - DOCS	268	23.4
Kinship - non-Aboriginal - DOCS	191	16.7
Non-Related Person	9	0.8
Independent Living	*	*
Motel	95	8.3
Residential Agency	28	2.4
Parent/s	35	3.1
Foster Care - Agency - Non-Aboriginal	114	10.0
Foster Care - Agency - Aboriginal	44	3.8
Kinship - Agency - Aboriginal	*	*
Other	109	9.5
Not stated	*	*
Total children	1,144	100

Source: Review Tool

*Cells with value less than 5 have been suppressed

Figure 60 Number and proportion of children and young people in the review cohort by whether the first placement in 2015/16 was with an Aboriginal carer, NSW

Aboriginal carer	Number	%
Yes	401	35.1
No	727	63.5
Not stated	16	1.4
Total children	1,144	100

Source: Review Tool

Figure 61 Number and proportion of children and young people in the review cohort by whether Aboriginal family or kin was assessed or authorised to care for the child, NSW

Carer assessment of Aboriginal family or kin	Number	%
Yes, assessed and authorised	543	47.5
Yes, assessed but not authorised	100	8.7
Not assessed**	501	43.8
Total children	1,144	100

Source: Review Tool

**Includes 'Not stated'

Figure 62 Number and proportion of children and young people in the review cohort by whether non-Aboriginal family or kin was assessed or authorised to care for the child, NSW

Carer assessment of non-Aboriginal family or kin	Number	%
Yes, assessed and authorised	366	32.0
Yes, assessed but not authorised	48	4.2
Not assessed	718	62.8
Not stated	12	1.0
Total children	1,144	100

Source: Review Tool



Figure 63 Number and proportion of children and young people in the review cohort who were in care by whether the child has a cultural plan at the time of the review, NSW

Cultural Plan	Number	%
Yes	598	67.7
No	285	32.3
Total children in care	883	100

Source: Review Tool

Figure 64 Number and proportion of children and young people in the review cohort who were in care and have a cultural plan at the time of the review by whether there is evidence of connection to country in the cultural plan, NSW

Connection to country	Number	%
Yes	321	53.7
No	277	46.3
Total children with a cultural plan	598	100

Source: Review Tool

Figure 65 Number and proportion of children and young people in the review cohort who were in care and have a cultural plan at the time of the review by whether there is evidence of age appropriate exposure to cultural elements in the cultural plan, NSW

Age appropriate exposure to cultural elements	Number	%
Yes	403	67.4
No**	195	32.6
Total children with a cultural plan	598	100

Source: Review Tool

**Includes 'Not stated'

Figure 66 Number and proportion of children and young people in the review cohort who were in care and have a cultural plan at the time of the review by whether there is evidence of engagement with Aboriginal services, NSW

Engagement with Aboriginal services	Number	%
Yes	360	60.2
No**	238	39.8
Total children with a cultural plan	598	100

Source: Review Tool

**Includes 'Not stated'

Figure 67 Number and proportion of children and young people in the review cohort who had a care plan filed by whether the care plan identified restoration to parent/s as a possibility, NSW

Identify restoration as a possibility	Number	%
Yes	153	14.8
No	870	84.1
Not stated	12	1.2
Total children who had a care plan filed	1,035	100

Source: Review Tool

Figure 68 Number and proportion of children and young people in the review cohort who had a care plan filed by duration between entry into OOHC in 2015/16 and filing the care plan, NSW

Duration	Number	%
More than 6 months prior to entry into care	10	1.0
6 months or less prior to entry into care	6	0.6
0 to 3 months after entry into care	463	44.7
4 to 6 months after entry into care	298	28.8
7 to 9 months after entry into care	136	13.1
10 to 12 months after entry into care	49	4.7
More than 1 year after entry into care	61	5.9
Not stated	12	1.2
Total children who had a care plan filed	1,035	100

Source: Review Tool



Figure 69 Number and proportion of children and young people in the review cohort by whether a care plan was filed, NSW

Care plan filed	Number	%
Yes	1,035	90.5
No	109	9.5
Total children	1,144	100

Source: Review Tool

Figure 70 Number and proportion of children and young people in the review cohort who had a care plan filed by whether restoration to the parents was ever considered a possibility after final orders, NSW

Restoration considered as a possibility after final orders	Number	%
Yes	192	18.6
No	774	74.8
Unclear	30	2.9
Not stated	39	3.8
Total children who had a care plan filed	1,035	100

Source: Review Tool

Figure 71 Number and proportion of children and young people in the review cohort who had restoration identified in the care plan by whether the child was restored, NSW

Child was restored	Number	%
Yes	127	83.0
No	26	17.0
Total children who had restoration identified in the care plan	153	100

Source: Review Tool

Figure 72 Number and proportion of children and young people in the review cohort who were in care by whether the child has contact with their mother at the time of the review, NSW

Contact with mother	Number	%
Yes	720	81.5
No**	163	18.5
Total children in care	883	100

Source: Review Tool

**Includes 'Not stated'

Figure 73 Number and proportion of children and young people in the review cohort who were in care and have contact with their mother by whether the frequency of the contact at the time of the review, NSW

Frequency of contact	Number	%
Placed with mother	33	4.6
Daily	9	1.3
Weekly	56	7.8
Fortnightly	39	5.4
Monthly	186	25.8
< 2 months	128	17.8
< 6 months	37	5.1
< 12 months	5	0.7
Unclear**	227	31.5
Total children who have contact with their mother	720	100

Source: Review Tool

*Cells with value less than 5 have been suppressed

**Includes 'Not stated'



Figure 74 Number and proportion of children and young people in the review cohort who were in care and have contact with their mother by whether the contact is supervised at the time of the review, NSW

Contact is supervised	Number	%
Yes	564	78.3
No	120	16.7
Not stated	36	5.0
Total children who have contact with their mother	720	100

Source: Review Tool

Figure 75 Number and proportion of children and young people in the review cohort who were in care by whether the child has contact with their father at the time of the review, NSW

Contact with father	Number	%
Yes	479	54.2
No	397	45.0
Not stated	7	0.8
Total children in care	883	100

Source: Review Tool

Figure 76 Number and proportion of children and young people in the review cohort who were in care and have contact with their father by the frequency of the contact at the time of the review, NSW

Frequency of contact	Number	%
Placed with father	16	3.3
Daily	5	1.0
Weekly	26	5.4
Fortnightly	40	8.4
Monthly	116	24.2
< 2 months	75	15.7
< 6 months	26	5.4
< 12 months	*	*
Unclear	173	36.1
Not stated	*	*
Total children who have contact with their father	479	100

Source: Review Tool

*Cells with value less than 5 have been suppressed

Figure 77 Number and proportion of children and young people in the review cohort who were in care and have contact with their father by whether the contact is supervised at the time of the review, NSW

Contact is supervised	Number	%
Yes	365	76.2
No	87	18.2
Not stated	27	5.6
Total children who have contact with their father	479	100

Source: Review Tool

Figure 78 Number and proportion of children and young people in the review cohort by the number of placements the child had during the 24 months since entering OOHC in 2015/16, NSW

Number of placements	Number	%
1	583	60.0
2	228	23.5
3	92	9.5
4	40	4.1
5 or more	29	3.0
Total children*	972	100

Source: KIDS and ChildStory - CIW Annual data and Review Tool

*Non-permanent placements of less than 7 days in duration are excluded from the count.

**Excludes 166 children who only had non-permanent placements of less than 7 days in duration or transferred to guardianship during the 24 month period since entering care in 2015/16 and a small number of children who could not be matched to FACS administrative data.



Figure 79 Number of children and young people adopted between 2011/12 and 2016/17, NSW

Financial Year	Total number of children adopted
2011/12	64
2012/13	77
2013/14	82
2014/15	87
2015/16	67
2016/17	129

Source: Adoption Services records

Key results:

- A total of 10 Aboriginal children and 496 non-Aboriginal children were adopted
- between 2011/12 and 2016/17.
- In 2016/17, 129 children were adopted from OOHC which was around double
- the number adopted in 2011/12 (64).
- Less than five Aboriginal children were adopted in each of the financial years.
- Due to the small numbers, the breakdown by Aboriginality is not shown in Table 5.1.
-

Figure 80 Table S13 Number and proportion of children and young people entering OOHC in 2015/16 by Aboriginality and age breakdown, NSW

Age group (at entry during 2015/16)	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
2 weeks or under	138	10.5	246	9.8	384	10.0
2 weeks - 6 months	99	7.5	170	6.8	269	7.0
7 months - 12 months	63	4.8	89	3.6	152	4.0
13 months - 24 months	114	8.6	204	8.2	318	8.3
25 months - 4 years old	270	20.5	514	20.5	784	20.5
over 4 years old	634	48.1	1280	51.1	1914	50.1
Total	1,318	100	2,503	100	3,821	100

Source: KIDS - CIW Annual data

Figure 81 Number and proportion of children and young people in the review cohort who had a risk assessment by age group at the time of the risk assessment and whether the child was interviewed for the risk assessment, NSW

Age group	Interviewed for the risk assessment					
	Aboriginal		Non-Aboriginal		Total	
	Number	%	Number	%	Number	%
<3 years	8	1.9	417	98.1	425	100
3 years	10	14.7	58	85.3	68	100
4 years	17	25.4	50	74.6	67	100
5 years	16	34.8	30	65.2	46	100
<u>6 years</u>	<u>29</u>	<u>51.8</u>	<u>27</u>	<u>48.2</u>	<u>56</u>	<u>100</u>
7 to 12 years	130	52.0	120	48.0	250	100
>12 years**	26	55.3	21	44.7	47	100
Total children who had a risk assessment	236	24.6	723	75.4	959	100

Source: Review Tool

** Includes 'Not stated'

Note: There are 31 children who had a SARA assessment but did not have a risk assessment.



Figure 82 Number of ROSH reports by age and Aboriginality, 2016/17

Age at contact	Aboriginal		Non-Aboriginal		Total ROSH reports	
	Number	%	Number	%	Number	%
Unborn	1,497	3.6	3,043	2.6	4,540	2.9
<1	2,738	6.6	6,034	5.1	8,772	5.5
1	2,384	5.8	5,277	4.5	7,661	4.8
2	2,421	5.9	5,526	4.7	7,947	5.0
3	2,467	6.0	6,014	5.1	8,481	5.3
4	2,430	5.9	6,281	5.3	8,711	5.5
5	2,255	5.5	6,227	5.3	8,482	5.3
6	2,183	5.3	6,560	5.6	8,743	5.5
7	2,252	5.5	6,849	5.8	9,101	5.7
8	2,273	5.5	6,926	5.9	9,199	5.8
9	2,279	5.5	7,010	6.0	9,289	5.8
10	2,364	5.7	6,649	5.6	9,013	5.7
11	2,203	5.3	6,527	5.5	8,730	5.5
12	2,217	5.4	6,702	5.7	8,919	5.6
13	2,297	5.6	6,933	5.9	9,230	5.8
14	2,408	5.8	7,780	6.6	10,188	6.4
15	2,145	5.2	7,363	6.3	9,508	6.0
16	1,412	3.4	5,224	4.4	6,636	4.2
17	1,005	2.4	3,356	2.9	4,361	2.7
Not stated	40	0.1	1,410	1.2	1,450	0.9
Total	41,270	100.0	117,691	100.0	158,961	100.0

Source: KIDS - CIW Annual data

Figure 83

Table S23.1 Number of children involved in ROSH reports by age and Aboriginality, 2016/17

Age at first contact during 2016/17	Aboriginal		Non-Aboriginal		Total children in ROSH reports	
	Number	%	Number	%	Number	%
Unborn	847	4.7	2,106	3.1	2,953	3.4
< 1	1,147	6.3	3,265	4.8	4,412	5.1
1	1,020	5.6	2,927	4.3	3,947	4.6
2	1,068	5.9	3,189	4.7	4,257	4.9
3	1,082	5.9	3,439	5.0	4,521	5.2
4	1,037	5.7	3,668	5.4	4,705	5.4
5	1,041	5.7	3,723	5.5	4,764	5.5
6	947	5.2	3,839	5.6	4,786	5.5
7	1,033	5.7	3,922	5.7	4,955	5.7
8	1,023	5.6	3,991	5.8	5,014	5.8
9	1,016	5.6	3,990	5.8	5,006	5.8
10	1,031	5.7	3,841	5.6	4,872	5.6
11	927	5.1	3,713	5.4	4,640	5.4
12	889	4.9	3,763	5.5	4,652	5.4
13	954	5.2	3,804	5.6	4,758	5.5
14	970	5.3	4,187	6.1	5,157	6.0
15	924	5.1	4,042	5.9	4,966	5.7
16	694	3.8	3,195	4.7	3,889	4.5
17	519	2.9	2,268	3.3	2,787	3.2
Not Stated	31	0.2	1,354	2.0	1,385	1.6
Total	18,200	100.0	68,226	100.0	86,426	100.0

Source: KIDS - CIW Annual data

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