



**SPECIAL COMMISSION OF INQUIRY INTO
CHILD PROTECTION SERVICES IN NEW SOUTH WALES**

**PUBLIC FORUM
ROLE OF OVERSIGHT AGENCIES
28 MARCH 2008
FACTS SHEET**

1. Overview

- a. A number of organisations oversee various aspects of the child protection system in NSW. These organisations include the:
- i. Office of NSW Ombudsman
 - ii. Office of the Children's Guardian
 - iii. Commission for Children and Young People
 - iv. Official Community Visitors
 - v. Child Death Review Team
 - vi. Coroner's Court of NSW
 - vii. Department of Premier and Cabinet
 - viii. Department of Community Services ("DoCS") - internal review procedures.

2. NSW Ombudsman

- a. Broadly, the Ombudsman's role is to ensure that agencies fulfil their functions properly.¹ Over 7000 organisations providing services to children are scrutinised by the Ombudsman.² These include:
- i. NSW public sector agencies
 - ii. public and private sector agencies providing services for children including government and non-government schools,

¹ NSW Ombudsman website - <http://www.ombo.nsw.gov.au/> - as at 26 February 2008.

² NSW Ombudsman *Annual Report 2006-07*, 9.

child care centres and agencies providing substitute residential care

- iii. agencies providing community services that are funded, licensed or authorised by DoCS or the Department of Ageing, Disability and Home Care (“DADHC”).³
- b. The specific functions of the Ombudsman are detailed in the *Ombudsman Act 1974* (“*Ombudsman Act*”) and the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (“*CRAMA*”). The Ombudsman’s functions include:
 - i. monitoring, reviewing and making recommendations in relation to the delivery of community services⁴
 - ii. receiving, assessing, investigating and reviewing complaints about community service providers, and providing information and education in relation to the resolution of those complaints⁵
 - iii. reviewing the system for complaints handling of service providers⁶
 - iv. reviewing the situation of a child in care and providing report of the review to the Minister⁷
 - v. reviewing certain child deaths (“reviewable deaths” – discussed below) and formulating recommendations as to policies and practices to be implemented by service providers in order to prevent such deaths⁸
 - vi. maintaining a reviewable deaths register⁹
 - vii. scrutinising systems of government and certain non-government agencies for preventing conduct by employees that could be abusive to children (“reportable conduct”)¹⁰
 - viii. monitoring an agency’s handling and investigation of an allegation of reportable conduct¹¹
 - ix. determining that a class or kind of conduct of employees of an agency is exempt from being reportable¹²

³ NSW Ombudsman website, above n 1.

⁴ *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 11(1).

⁵ *Ibid.*

⁶ *Ibid* s 14.

⁷ *Ibid* s 13.

⁸ *Ibid* s 36.

⁹ *Ibid* s 36(1)(c).

¹⁰ *Ombudsman Act 1974* (NSW) s 25B.

¹¹ *Ibid* s 25G.

- x. investigating, reporting on and making recommendations in relation to certain conduct of public agencies.¹³
- c. The Ombudsman responds to reports, applications to review, and complaints, but also has the power act on his own initiative to:
- i. conduct investigations in relation to the handling of an allegation of reportable conduct¹⁴
 - ii. inquire into matters affecting service providers and visitable services and persons receiving, or eligible to receive, community services or services provided by visitable services¹⁵
 - iii. review the situation of a child in care or of a group of children in care.¹⁶
- d. In 2006-07, the Ombudsman received 560 formal complaints about community service agencies, over half of which were about DoCS.¹⁷ The most frequent complaints in relation to DoCS were about:
- i. Child protection services, including:
 - DoCS' response to risk of harm reports - either the lack of intervention or the type and adequacy of the intervention
 - communication between DoCS and families, DoCS and agencies, and DoCS and reporters
 - professional conduct of caseworkers
 - DoCS' work in relation to Children's Court processes
 - DoCS' own handling of complaints about its child protection activities.¹⁸
 - ii. Out-of-home care services, including:
 - contact arrangements between children in care and their families

¹² Ibid s 25CA.

¹³ Ibid s 26.

¹⁴ Ibid s 25G.

¹⁵ *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 11(1)(e).

¹⁶ Ibid s 13(1).

¹⁷ Above n 2, 79.

¹⁸ Ibid, 79-82.

- the adequacy of support for maintaining placements, including foster placements
 - the adequacy of placements for meeting children's needs, including the standard of the physical environment of residential placements
 - communication with caseworkers about care arrangements
 - moving children between care placements and the adequacy of transition planning
 - decisions and administration issues about carer allowances and other payments
 - complaint-handling about problems arising with care placements.¹⁹
- e. The Ombudsman reviews the deaths of the following children:
- i. a child in care
 - ii. a child in respect of whom a report was made to DoCS, within the period of 3 years immediately preceding the child's death, about that child being at risk of harm
 - iii. a child who is a sibling of a child in respect of whom a report was made to DoCS, within the period of 3 years immediately preceding the child's death, about that child being at risk of harm
 - iv. a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances
 - v. a child who, at the time of the child's death, was an inmate of a children's detention centre, a correctional centre or a lock-up (or was temporarily absent from such a place)
 - vi. a child who, at the time of the child's death, was living in, or was temporarily absent from, residential care provided by a service provider and authorised or funded under the *Disability Services Act 1993* (NSW) or a residential centre for handicapped persons.²⁰
- f. The purpose of these reviews is to identify shortcomings in agency systems or practices that may have directly or indirectly contributed

¹⁹ Ibid.

²⁰ *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 35.

to the child's death, and to make recommendations to reduce the number of child deaths in the future.²¹

- g. The Ombudsman reviewed the deaths of 123 children who died in 2006.²² In relation to these 123 children:
- i. 114 were known to DoCS, of which:
 - 81 had been the subject of a risk of harm report in the three years prior to their death
 - 33 had not been the subject of a risk of harm report in the three years prior to their death, but they had a sibling who had been the subject of a risk of harm report in that period.
 - ii. 40 died as a result of abuse or neglect, or died in suspicious circumstances
 - iii. 73 were aged under 12 months when they died, and almost half of these were under 4 weeks old
 - iv. 25 were of Indigenous background.²³
- h. Public agencies and designated non-government agencies²⁴ are required to report the following categories of conduct of their employees²⁵ to the Ombudsman:
- i. any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offence)
 - ii. any assault, ill-treatment or neglect of a child
 - iii. any behaviour that causes psychological harm to a child.
- i. Reportable conduct does not extend to:
- i. conduct that is reasonable for the purposes of the discipline, management or care of children, having regard to the age, maturity, health or other characteristics of the children and to any relevant codes of conduct or professional standards

²¹ Above n 2, 92.

²² Ibid.

²³ NSW Ombudsman *Report of Reviewable Deaths in 2006 Volume 2: Child Deaths*, i.

²⁴ Above n 2, 136. Designated non-government agencies include all independent schools, agencies providing substitute residential care to children, licensed children's services and affiliated health corporations.

²⁵ Includes anyone engaged in providing services to children. See *Ombudsman Act 1974* (NSW) s 25A.

- ii. the use of physical force that, in all the circumstances, is trivial or negligible, but only if the matter is to be investigated and the result of the investigation recorded under workplace employment procedures
 - iii. conduct exempted from being reportable conduct by the Ombudsman (discussed below).²⁶
- j. The main purpose of the mandate to notify reportable conduct is to allow the Ombudsman to monitor and review the systems that agencies have in place for preventing reportable conduct, and for responding to allegations of reportable conduct.²⁷

3. The Children's Guardian

- a. The functions of the Children's Guardian are to:
- i. promote and safeguard the rights and best interests of all children and young persons in out-of-home care²⁸
 - ii. accredit designated agencies to provide out-of-home care services and to ensure these agencies fulfill their statutory responsibilities²⁹
 - iii. regulate the employment of children less than 15 years of age in:
 - entertainment
 - exhibition
 - door-to-door sales³⁰
 - iv. accredit and monitor non-government adoption service providers under the *Adoption Act 2000* and *Adoption Regulation 2003* (under delegation from the Director General of DoCS).³¹
- b. In relation to the accreditation of out-of-home care service providers, the Office of the Children's Guardian has developed an accreditation framework and a quality improvement program. As at 30 June 2007:

²⁶ *Ombudsman Act 1974* (NSW) s 25A.

²⁷ Above n 2, 137.

²⁸ *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 181(1)(b) & (c).

²⁹ *Ibid* s 181(1)(e).

³⁰ NSW Office for Children *Annual Report 2006-07*, 92. See also *Children and Young Persons (Care and Protection) Act 1998* (NSW), chapter 13 and schedule 2.

³¹ NSW Office for Children *Annual Report 2006-07*, 92.

- i. 30 designated agencies had been accredited
 - ii. 2 agencies were applying for accreditation
 - iii. 27 agencies were in the quality improvement program.³²
- c. The Children’s Guardian monitors the compliance of out-of-home care service providers with the accreditation criteria and legislative obligations using case file audits.³³
- d. The 2006-07 case file audit examined 2,335 files from 51 agencies.³⁴ The key areas of casework practice assessed in the 2006-07 audit were:
- i. file content and structure
 - ii. participation in case plans and review
 - iii. review of case plans
 - iv. compliance with Aboriginal and Torres Strait Islander (“ATSI”) placement principles.³⁵
- e. The results of the 2006-07 audit included the following:
- i. overall, children and young people placed with non-government designated agencies that had sole case management responsibility were most likely to have current and comprehensive essential information recorded on their files, and accredited agencies were more likely to comply in the key areas of file content and structure than agencies in the quality improvement program
 - ii. overall, accredited agencies were generally better than quality improvement program agencies at supporting participation in decision making
 - iii. accredited agencies were more likely than agencies in the quality improvement program to comply with guidelines in relation to conducting reviews of case plans
 - iv. 74 per cent of relevant files documented placement decisions that were based on the ATSI placement principles.³⁶

³² Ibid, 95.

³³ Ibid, 89.

³⁴ Ibid.

³⁵ Ibid, 103-104.

³⁶ Ibid.

- f. There are some provisions of the *Children and Young Persons (Care and Protection) Act 1998* (“*Care Act*”) relevant to the Children’s Guardian that have not yet been proclaimed. These provisions include:
 - i. allowing the Children’s Guardian to carry out a review of an out-of-home care placement at any time (s 150(6))
 - ii. stipulating that an agency supervising a voluntary out-of-home placement notify the Children’s Guardian of the care arrangements for a child or young person who has been in voluntary out-of-home care for more than 21 days (s 155(2)(b)(i))
 - iii. stipulating the Children’s Guardian be notified of the death of a child in out-of-home care (s 172(b))
 - iv. allowing the Children’s Guardian to exercise the parental responsibilities of the Minister (s 181(1)(a))
 - v. stipulating that the Children’s Guardian examine a copy of the case plan, including a copy of each file review, for each child or young person in out-of-home care (s 181(d))
 - vi. giving the Children’s Guardian the power to remove the responsibility for the daily care and control of a child or young person from an authorised carer (s 182)
 - vii. giving the Children’s Guardian standing to apply to the Children’s Court to have an order in relation to the care of a child varied or rescinded (s 184).

4. The Commission for Children and Young People

- a. The principal functions of the NSW Commission for Children and Young People (“the Commission”) are outlined in s 11 the *Commission for Children and Young People Act 1998* (“*CCYP Act*”). Those functions are (in summary):
 - i. to promote and monitor the safety, welfare and well-being of children, and to promote the participation of children in decision-making
 - ii. to participate in, and monitor background checking for, child-related employment, and to intervene in review applications concerning prohibited persons
 - iii. to provide and promote information, awareness and training on issues affecting children

- iv. to make recommendations to government and non-government agencies on legislation, policies, practices and services affecting children, and to conduct special inquiries into issues affecting children
 - v. to develop and administer a voluntary accreditation scheme for programs for persons who have committed sexual offences against children
 - vi. to support and assist the Child Death Review Team in the exercise of its functions.
- b. The Commission (along with 4 other approved agencies³⁷) conducts Working With Children Checks (“background checks”) in order to provide employers with information to assist them select staff in child-related employment. The background check process includes checking for relevant criminal records, relevant apprehended violence orders, child protection prohibition orders, and relevant employment proceedings.³⁸ The Commission then carries out a risk assessment based on information obtained as a result of the check.³⁹
- c. In the 2006-07 financial year, a total of 226,212 background checks were conducted in NSW, with 75,592 of these conducted by the Commission.⁴⁰ In the same period, 607 risk assessments were undertaken.⁴¹
- d. Under the *CCYP Act*, a person who:
- i. has been convicted of a serious sex offence;
 - ii. has been convicted of a child-related personal violence offence or the murder of a child; or
 - iii. is registered under the *Child Protection (Offenders Registration) Act 2000*

is forbidden from working in, or seeking to work in, child-related employment, unless he or she successfully applies for a declaration that their “prohibited status” no longer applies.⁴² The Commission (as well as the Industrial Relations Commission and the Administrative Decisions Tribunal) has the power to make such a declaration.⁴³

³⁷ The Department of Education and Training, the Department of Arts, Sport and Recreation, the Department of Health, and the Catholic Commission for Employment Relations.

³⁸ *Commission for Children and Young People Act 1998* (NSW) s 34.

³⁹ *Ibid.*

⁴⁰ Above n 31, 45.

⁴¹ *Ibid.*

⁴² *Commission for Children and Young People Act 1998* (NSW) ss 33B & 33C.

⁴³ *Ibid* ss 33H & 33I.

5. Child Death Review Team

- a. The Child Death Review Team (“the Team”) is convened by the Commissioner for Children and Young People. The purpose of the Team is to collect and provide information about the deaths of all children aged 0 -17 years in NSW, in order that such information can be used to reduce the numbers of deaths in this age group.⁴⁴
- b. The functions of the Team are detailed in s 45N of the *CCYP Act*, and can be summarised as follows:
 - i. to maintain a Child Death Register
 - ii. to classify deaths according to cause, demographic criteria and other relevant factors
 - iii. to identify patterns and trends
 - iv. to undertake research that aims to help prevent or reduce the likelihood of child deaths
 - v. to make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths
 - vi. to monitor the implementation of recommendations made to prevent child deaths
 - vii. to identify areas requiring further research by the Team or other agencies.
- c. Pursuant to s 45N(2), the Team can not undertake a review of a “reviewable death” (as defined in the *CRAMA* and referred to above).
- d. The Team keeps a Child Death Register (“the Register”), in which deaths are classified according to cause of death, demographic criteria and other relevant factors.⁴⁵ The Team analyses the data in the Register, identifies patterns in relation to the deaths, and makes recommendations to government and to non-government agencies for the prevention of future child deaths.⁴⁶
- e. From data collected in 2006, the Team established that:

⁴⁴ NSW Commission for Children website <http://www.kids.nsw.gov.au/> - as at 26 February 2008.

⁴⁵ Above n 31, 63.

⁴⁶ NSW Child Death Review Team *Summary Report 2006*, 1.

- i. there was an increase in the overall death rate (as compared to 2005 numbers)
- ii. there was an increase in the number of infant deaths (as compared to 2005 numbers)
- iii. the death rate was higher for males than for females
- iv. the rates of death for 1-17 year olds had remained steady (as compared to 2005 numbers)
- v. males were more likely to die from external causes than females
- vi. amongst those who died from external causes, vulnerable children were over-represented
- vii. amongst the total number of child deaths, Aboriginal and Torres Strait Islander children and young people were over-represented
- viii. there was an increase in the rate of transport-related child fatalities (as compared to 2005 numbers)
- ix. Aboriginal children and young people were over-represented in transport fatalities
- x. there was a decrease in the number of house fire-related child fatalities (as compared to 2005 numbers)
- xi. there was an increase in drowning fatalities
- xii. the number of fatal assaults had remained steady (as compared to 2005 numbers)
- xiii. remote areas had higher rates of child death
- xiv. amongst the total number of child deaths, children in areas of greatest socio-economic disadvantage were over-represented
- xv. the distribution of child death varied across NSW
- xvi. age and gender patterns were evident.⁴⁷

⁴⁷ Ibid 2-4.

6. State Coroner

- a. The role of the Coroner is to determine the identity of the deceased and the date, place, manner and medical cause of death of the deceased.⁴⁸
- b. Under s 22A of the *Coroner's Act 1980* ("the *Coroner's Act*"), the Coroner can make recommendations in relation to any matter connected with the death with which an inquest or inquiry is concerned.
- c. Pursuant to s 12A(1)(a) of the *Coroners Act* it is mandatory to report to the State Coroner or Deputy State Coroner the deaths of:
 - i. a child in care
 - ii. a child in respect of whom a report was made to DoCS, within the period of 3 years immediately preceding the child's death, about that child being at risk of harm
 - iii. a child who is a sibling of a child in respect of whom a report was made to DoCS, within the period of 3 years immediately preceding the child's death, about that child being at risk of harm
 - iv. a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances.
- d. There is generally no obligation to conduct an inquest in relation to these deaths, unless it appears to the Coroner that the death resulted from homicide or unless the Minister or the State Coroner directs that an inquest must be carried out in a particular case.⁴⁹

7. Official Community Visitors

- a. Official Community Visitors ("Visitors") visit accommodation services for children and young people that are operated, funded or licensed by DoCS or DADHC, and where residents are in full-time care ("visitable services").⁵⁰
- b. The functions of the Visitors are to:
 - i. inform the Minister and the Ombudsman about the quality of accommodation services
 - ii. promote the legal and human rights of residents

⁴⁸ NSW Coroner's Court website <http://www.lawlink.nsw.gov.au/coroners> - as at 12 March 2008.

⁴⁹ *Coroner's Act 1980* (NSW) ss 14, 14A & 14B.

⁵⁰ Official Community Visitors *Annual Report 2005-06*, 9.

- iii. act on issues raised by residents
- iv. provide information
- v. help resolve complaints.⁵¹

8. Department of Premier and Cabinet

- a. The Department of Premier and Cabinet oversees the implementation of the NSW State Plan. The two State Plan priorities for which DoCS has lead responsibility are “F6 – Increased proportion of children with skills for life and learning at school entry” and “F7 – Reduced rates of child abuse and neglect”.
- b. DoCS is required to report against a set of performance measures for F6 and F7 on a quarterly basis.

9. DoCS internal review systems

- a. DoCS has a Child Deaths and Critical Reports Unit (the “Unit”), which examines DoCS’ involvement with children and young people who have died. The Unit’s focus is on identifying where changes to systems and processes might lead to better outcomes, and to make achievable and context-specific recommendations accordingly.⁵²
- b. In 2006-07 the Unit conducted 96 initial reviews and 18 detailed reviews, which included interviews with staff and reviews of policies and procedures.⁵³
- c. As a designated agency under the *Ombudsman Act*, DoCS is obliged to notify the Ombudsman of any reportable allegation or reportable conviction relating to a DoCS employee.⁵⁴ In this context, DoCS employees includes not only DoCS salaried staff, but also authorised carers (including authorised relative carers).
- d. DoCS also has its own response procedure in relation to allegations of reportable conduct of employees, which is coordinated through its Allegations Against Employee Unit (AAE Unit).
- e. The functions of the AAE Unit include:
 - i. co-ordinating and investigating allegations of reportable conduct made against employees, including allegations of sexual abuse and serious physical or psychological abuse

⁵¹ *Community Services (Complaints, Reviews and Monitoring) Regulation 2004* (NSW) reg 4.

⁵² NSW Department of Community Services Child Death & Critical Report Unit *Child Deaths Report 2006*, 6 & 9.

⁵³ NSW Department of Community Services *Annual Report 2006-07*, 89.

⁵⁴ *Ombudsman Act 1974* (NSW) s 25C.

- ii. maintaining a database of allegations made against employees, monitoring resolution and analysing trends
 - iii. ensuring allegations are dealt with fairly and confidentially.⁵⁵
- f. Upon receipt of an allegation, the AAE Unit makes a determination as to whether or not the matter constitutes “reportable conduct”.
 - g. If a matter is found not to constitute reportable conduct, it is referred to the relevant DoCS Region to be treated as a child protection risk of harm report.
 - h. In relation to matters that *are* found to constitute reportable conduct, the AAE Unit makes a determination as to whether or not they are “serious”. Serious matters are then investigated by the AAE Unit. Matters that are considered “less serious” are investigated by the relevant DoCS Region (in each of the DoCS Regions there is a team of DoCS officers who have been trained by the AAE Unit to conduct investigations into these allegations of “less serious” reportable conduct).
 - i. Serious matters include (but are not limited to) any allegations against salaried staff, any matters where the Police or JIRT are taking action, and any allegation of:
 - i. sexual assault, sexual misconduct or sexual offence committed against, with or in the presence of a child
 - ii. serious physical assault or neglect where there is an apparent injury
 - iii. physical assault where there are multiple victims, multiple incidents or the employee has a significant history of allegations of reportable conduct.
 - j. Regardless of whether the investigation is conducted by the AAE Unit or is referred back to the Region, the same investigative procedures are followed. Investigations generally involve:
 - i. evidence gathering, including interviewing all relevant people and collecting relevant documentation
 - ii. giving the DoCS employee an opportunity to respond to the allegations
 - iii. completion of an Outcome Report which includes a judgement as to whether on the balance of probabilities the employee has committed the alleged conduct / behaviour.

⁵⁵ NSW Department of Community Services *Managing Allegations Against Employees - Policy and Procedures*, 2005, 10.

- k. Following an investigation, one of the following results is recorded on the employee's file:
- i. Sustained (on the balance of probabilities, there is sufficient evidence that the alleged conduct did occur)
 - ii. Not sustained – insufficient evidence (ie. where there is insufficient evidence available to establish that the alleged conduct did or did not occur)
 - iii. Not sustained – false (conduct did not occur)
 - iv. Not sustained – vexatious (without substance and with malicious intent to cause distress to the accused person)
 - v. Not sustained – misconceived (was found that even though the allegation was made in good faith, it was based on a misunderstanding of what actually occurred)
 - vi. Unable to determine (where it was not possible to complete an investigation and reach a conclusion)
 - vii. Not reportable conduct.
- l. Recommendations can then be made based on the findings. In the case of a salaried officer where the allegation is sustained, the range of recommendations could include dismissal, caution, warning, other disciplinary action or remedial action. In the case of an authorised carer (including an authorised relative carer) where an allegation is sustained, the range of recommendations could include de-authorisation.
- m. These recommendations are made to the Regional Director or delegate and either approved or not accepted. If accepted they are then monitored by the AAE Unit. If the recommendations are not accepted, the Regional Director must provide written reasons, and the AAE Unit may refer the matter to the Deputy Director-General (Operations) for review.
- n. DoCS has informed the Inquiry that there has been a 500 per cent increase since 2003 in the number of reports received by the AAE Unit concerning allegations against employees (in 2003 there were 170 reports received, and in 2007 there were 848 reports received).⁵⁶ DoCS has said that most of the reports concern foster carers.⁵⁷

⁵⁶ Information provided by DoCS to the Inquiry on 18 March 2008.

⁵⁷ Ibid.