



**Report on Allegations Concerning the Treatment of  
Children and Young People in Residential Care**

**30 August 2006**

**Parliamentary Commissioner for  
Administrative Investigations**



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## Ombudsman's Foreword

The care and protection of young people, whether by the Department for Community Development or otherwise, is an important responsibility that is shared by the whole community. The Western Australian community is entitled to expect that the very best and most effective care and protection is provided for young people who are vulnerable and whose circumstances require the provision of assistance by the State.

This report deals with a small number of young people who are particularly vulnerable, since many of them enter the care of the Department when there is no-one else in their family or the wider community who wants to, or is able to, care for them. They are the group of young persons residing at a small number of metropolitan residential care facilities, or hostels, operated by the Department.

Some of these young persons have a range of complex behavioural and psychological problems that make it extremely difficult to find a place for them anywhere else. The issues involved in their care and protection are both significant and challenging.

The investigation which is the subject of this report arose out of a disclosure made under the *Public Interest Disclosure Act 2003* to the Department. In my view, this report demonstrates the benefits that can potentially flow from a public interest disclosure being made.

The starting point for this investigation was the occurrence of a number of incidents in 2002 and 2003, the handling of which raised concerns about the administrative framework in the Department's residential care facilities, for the protection of young persons. The scope of this investigation was subsequently widened to include incidents and information about departmental hostels current up until early 2006.

These hostels were intended to provide temporary care and programs for a small group of young persons. However, over time, some of the programs developed for the hostels were undermined by a lack of alternative placement options. Many of the young persons in the hostels have now been living there for a far longer period than was originally envisaged.

These factors have added considerably to the pressured nature of the hostels environment and the numerous difficulties already faced by young persons in residential care and the Departmental staff who care for them.

The report shows that there is a lack of data about the characteristics of young persons in residential care, and I have recommended that such data be kept to assist the design and review of appropriate programs. I have also made a number of practical recommendations about the prevention and reporting of maltreatment in hostels, including recommendations that provide for:

- better information to be given to young persons about how they raise concerns and complaints;
- development of guidelines to improve the complaints handling system in the hostels and provide for the placement of staff while allegations of maltreatment against them are being investigated;
- review of the administrative forms for the recording of critical incidents in the hostels, as well as of relevant practice manuals;
- a gender balance among staff working in the hostel environment;

- ongoing training of staff in the management of young persons, in de-escalation techniques and in the use of restraints, together with a review of performance management programs;
- improvement of record management processes;
- the extension of a 24-hour on-call professional response team to assist residential care facilities;
- compilation of data on the use of restraints and consideration of an independent review of critical incidents in the hostels; and
- research into the use of brief periods of confinement of young persons in a 'time out' room as an alternative to physical restraint.

In terms of dealing with child maltreatment allegations against staff, I make recommendations for the development of guidelines about the responsibilities of managers and case workers in assessing the conduct of residential care workers; the rationalisation of policies and procedures on the handling of child maltreatment allegations against staff; and the provision of practical guidelines to be provided for the investigators of such allegations.

Some of the matters raised by this investigation potentially have a much broader application, of relevance to the protection of all young persons in the care of the State. These matters go beyond the jurisdiction of the Department and have been put forward in volume 2 of my report for consideration at a whole-of-government level. The recommendations made will, I hope, ensure that agencies involved in the care and protection of children are better placed to manage young persons in care, and to deal with allegations of maltreatment against staff. In summary, these recommendations are that Government:

- review the powers available to departmental officers for managing young persons in care who engage in extremely high-risk behaviours, including whether a 'secure welfare' option is necessary, or whether there are other and better alternatives;
- establish a mechanism to provide for the monitoring and evaluation of relevant government and non-government agencies' employee disciplinary processes where allegations of child maltreatment are involved;
- consider establishing an independent mechanism to monitor both Departmental and non-government residential care facilities; and
- consult with key stakeholders and relevant experts to develop an appropriate legislative, policy and administrative framework to allow for timely and effective management responses to allegations against staff in the area of child protection.

I am particularly pleased to acknowledge that the Department has responded positively to my recommendations, accepting all made about the Department's functions, and expressing support for the four whole-of-government recommendations. The Department's response to each recommendation is set out in the report and listed in Attachment 7.

I record my sincere appreciation to the Department, its senior executives and officers at all levels for their cooperation and assistance to my staff and me during the course of the investigation. I also wish to acknowledge and thank the children and young persons in residential care who had contact with my staff for their invaluable contribution to our investigation.

My thanks also go to all of my staff who were involved in the investigation and the preparation of this report, and in particular to Principal Investigating Officer Darryl Goodman and Senior Investigating Officer Dr Jeannine Purdy.

Deirdre O'Donnell

**OMBUDSMAN**

30 August 2006



## Report Summary

This report deals with an investigation conducted by my office into an allegation that the Department for Community Development (the Department) had failed to properly address institutionalised practices amongst its staff at a small number of metropolitan residential care facilities, or hostels, resulting, it was alleged, in the consistent abuse in care of the young persons residing there. Generally the children and young people in these Departmental facilities have had a number of previous placement breakdowns and are viewed as *'difficult to place'* for a range of reasons, including very difficult behaviours resulting from sometimes extreme histories of abuse and neglect.

This is a summary of the Ombudsman's investigation and recommendations.

### BACKGROUND TO INVESTIGATION

The matters examined in this report arose out of a disclosure made to my office under the *Public Interest Disclosure Act 2003* (the PID Act), in August 2003. The disclosure highlighted a number of incidents which occurred in 2002 and 2003, the handling of which raised concerns about the administrative framework in the Department's residential care facilities for the protection of children and young people from maltreatment. The disclosure raised further concerns about how the Department had responded to the informant's allegations; including the adequacy of the Department's own investigation into the informant's original disclosure to it under the PID Act.

### OMBUDSMAN'S INVESTIGATION

In response to the significance of the issues raised by the disclosure, this investigation was far more extensive than the general conduct of matters by my office. It not only included a detailed examination of the relevant files and policies associated with the incidents the subject of the initial disclosure, it also sought to build upon the insights from a substantial number of other agency inquiries and reviews. This enabled the issues raised by the disclosure to be placed within the broader context of current and historical trends in child protection and the management of children and young people in care.

Although the incidents which prompted this investigation are now some years old, the scope of the investigation has included incidents and information current up until early 2006. My officers visited each of the residential care facilities the subject of the disclosure in August and September 2005. In addition to two interviews with the informant, more than 25 meetings and interviews were held with a variety of Departmental officers including Direct Care Workers, Case Managers, Team Leaders in residential care facilities and in District Offices, professional staff and senior Departmental managers. Given that the focus of this investigation was on children and young people, it was also crucial that their perspectives of life in the Department's residential care facilities be obtained. There were informal discussions with young people during the visits to the residential care facilities, and CREATE Foundation staff co-facilitated, with my staff, a focus group of young people in Departmental residential care and also an interview with an ex-resident.

I acknowledge the cooperation of Departmental officers at all levels, and of those children and young people in residential care with whom my staff had contact, for their invaluable contribution to my investigation. I was particularly pleased too by the Department's response to my preliminary views on this investigation. As detailed in the report, the Department agreed to all of my recommendations relating to its functions and it is my understanding that the Department is already implementing measures to address these matters. I was also pleased that the Department has

expressed in principle support for recommendations that I have put forward for consideration at a whole-of-government level.

A summary of the matters considered in this investigation and my conclusions and recommendations follow.

## THE DEPARTMENT'S RESPONSE TO THE INFORMANT'S CONCERNS

While it is my view that there were inadequacies in the Department's response to the informant's concerns, this was the first disclosure received by the Department under the PID Act, and its investigation was affected by concerns about confidentiality and its understanding of the PID Act. It has now been nearly three years since the implementation of the PID Act. Agencies and their officers have a better understanding of the provisions of the Act and better resource materials and information are now available.

Nonetheless, at the time of the informant's original disclosure to the Department in 2003, the Department had not reviewed its hostel system as a whole, including its place in the provision of direct care to children and young persons, since its *Family and Children's Services' Accommodation Hostels: Report to the Minister for Community Development* in 2001. This was despite the acknowledgement in that report that the Department had lost the capacity to deal effectively with those high-risk children and young persons in its care,<sup>1</sup> and the indications that problems in the hostel environment had intensified, not the least being the problems caused by the lack of placement options.

The PID Act aims to ensure openness and accountability in government, and a Department receiving a disclosure has the opportunity to consider the matters raised by the disclosure and to take all reasonable action to prevent the matters to which a disclosure relates from continuing or occurring in the future. The informant in this matter has been subjected to additional inconvenience by having to repeat the disclosure to my office. I recommend:

1. The Department develop an appropriate apology which takes into account the inconvenience and anxiety caused to the informant as a result of the inadequacy of the Department's investigation of the original disclosure, as has been demonstrated by my investigation. (page 32)

## LEGAL AND ADMINISTRATIVE FRAMEWORK

For the purposes of this investigation, the primary legislation governing the Department's functions in relation to young people in care, and more generally, was the *Child Welfare Act 1947* (CW Act). Although the repealing of that Act and its replacement by the *Children and Community Services Act 2004* (C&CS Act) in March 2006 formally marked a new era in child protection, on the information before me, there has been significant '*cultural change*' in practice about these issues over the last 15 to 20 years. These changes appear to have been reflected more in Departmental policies than elsewhere, resulting in a proliferation of various policy instructions, manuals and protocols, which appears to have created difficulties.

It appears that the Department understands its statutory child protection mandate, whether under the CW Act or the C&CS Act, as restricting it from investigating allegations of abuse of children involving alleged perpetrators who are acting in their employment capacity. In these and other instances of extra-familial abuse, the Department states that its role is to assess that the family is taking adequate measures to ensure the safety of the child, and to provide post-trauma counselling and support for the child, their parents, and family assistance if requested. The Department's

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<sup>1</sup> Department of Family and Children's Services (now DCD), *Family and Children's Services' Accommodation Hostels: Report to the Minister for Community Development, Women's Interests, Seniors and Youth* (Hostels Report), 2001, p. 31.

primary investigative focus is upon alleged maltreatment by those who exercise parental responsibility for children and young people. Unless a person at work is considered to be exercising parental responsibilities for a child or young person in their care, the Department, if notified of alleged maltreatment, generally refers complainants to the Police for criminal matters or to the relevant employer to undertake internal disciplinary investigations.

In this regard, it appears that the Department classifies residential care workers (both Departmental and non-government) as exercising '*care responsibilities*'<sup>2</sup>, but not teachers, juvenile justice workers or others who arguably also may exercise significant power over children and young people in their care. As a result, the Department's own employees may be the subject of both Departmental child protection investigations as well as internal disciplinary investigations under the *Public Sector Management Act 1994* (PSM Act) (in addition to Police and Corruption and Crime Commission investigations if relevant). The Department has a difficult '*balancing act*' in trying to meet the potentially competing duty of care and legislative obligations which attach to it in these situations.

## THE HISTORY OF RESIDENTIAL CARE

Traditionally, children removed from their immediate families by the State (previously known as wards) were either placed in foster care, or, in significant numbers, were placed in residential (institutional) care which was largely outsourced to religious organisations.

The historical reasons for court intervention to remove children may be grouped into three categories: two relating to the conduct of children—'*delinquency*' (criminal conduct by those under the age of 18) and '*uncontrolled*' behaviour; the other, because the conduct, or absence, of others who were supposed to care for the children, left them '*destitute*' or '*neglected*'. There was a custodial approach to children in all of the institutions, but offenders and non-offenders were generally detained in separate facilities.

This changed, with increased provision of direct residential care to children and young people by the Department from the late 1950s. The model of care was based upon '*treatment*' rather than custody, although a number of the Departmental facilities were places of detention. Up until the early 1980s there was a proliferation of institutions and hostels run by the Department with a focus on the behaviour modification of children and young people. The distinction between offending and non-offending young people in the Department's care became blurred; particularly for those young people considered '*uncontrolled*' but who were not offenders.

The Edwards Report of 1982 which was said to have '*stopped the Department "in its tracks"*'<sup>3</sup> recommended that a clear distinction be made between a child's need for care and protection and the sanctions needed for the management of offending behaviour. Continuing changes from this time resulted in the Department ultimately losing its custodial capacity altogether in 1993 when the management of custodial juvenile facilities was transferred to the then Department of Justice. In a study of its residential facilities in 2001, referred to previously, the Department stated that with the loss of its custodial capacity its options for effectively managing very difficult young people were effectively closed.<sup>4</sup>

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<sup>2</sup> In its response to my preliminary report the Department stated that it would address concerns about a child in the CEO's care involving any Departmental officer regardless of their occupational group.

<sup>3</sup> Department for Community Services (now Department for Community Development 'DCD'), *Report on the Review of Departmental Juvenile Justice Systems (Juvenile Justice Systems)*, 1986, at p. 22.

<sup>4</sup> DCD, *Hostels Report*, p. 31.

## YOUNG PEOPLE IN CARE

It has been reported that the most notable change in the Department's policy in providing services to young people in care over the past few decades has been the move away from taking children into care and placing them in institutions. The number of young people who were wards declined from 4,907 in 1972 to just 711 in 1996 (although by 1996, there were more than another 1,000 children 'in care' without a formal court process). This dramatic decline in the number of children in care was the result of either keeping children with their families or returning them as soon as possible. If this was not possible, the preferred alternative was foster care. The decline in institutionalisation is referred to as a trend towards 'normalisation'.<sup>5</sup> However, in the five years to 2003-4, the number of children in care increased by some 45 per cent, and there continues to be a small group of children and young people whose difficult behaviours make placement with either their families or foster carers problematic.

## THE ADOLESCENT AND CHILDREN SUPPORT SERVICES

From the early 1990s a new vision was being developed for the Department's metropolitan hostels, which were to be part of the Department's new Adolescent and Children Support Services (ACSS). These were developed to take into account major changes in the Department's role in relation to the care of children and young people, most particularly the loss of custodial functions and the move to more 'normal' environments. It was also a time during which the long-term trends towards non-institutional care, and indeed away from taking children into care at all, were possibly at their peak. The ACSS hostels were to provide temporary care and programs for what the Department identified as a small group of young people in care whose high-level needs meant that alternative placements were scarce or non-existent.

The Department faced difficulties in the implementation of its vision for ACSS. It was unable to acquire a new site for an emergency and assessment centre, which was to be a cornerstone of the new hostels structure. Attempts to make cultural changes amongst its residential care workforce to provide direct care on an empathy-based as opposed to a behavioural model were affected by the continued reliance upon elements of behaviour modification programs and no clear articulation of alternatives. The program developed for each of the ACSS hostels was also undermined over time with the lack of placement options for young people, such that programs no longer matched the needs of many residents.

## YOUNG PEOPLE IN ACSS

An essential component in assessing the capacity of ACSS to prevent, detect and respond to abuse in care is an understanding of the young people in ACSS residential care. This is not only because these young people often appear to be atypical of those in care generally, but also because ACSS was developed to meet the needs of certain identified cohorts of young people in care as outlined above.

Research undertaken by my staff and more recent academic research that was brought to my attention by the Department has highlighted the lack of data about the children in residential care. I recommend:

2. The Department monitor data on the characteristics of the specific cohort of young people who reside in ACSS facilities to assist it design and review its programs to try to ensure, as far as practicable, that there is a match between its programs and those young people's needs. (page 70)

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<sup>5</sup> DCD, *Hostels Report*, p. 34.

## THE ROLE OF YOUNG PEOPLE IN PREVENTING MALTREATMENT

Young people can be the victims, witnesses or perpetrators of maltreatment in the Department's residential care facilities. Their role in the prevention of maltreatment is therefore crucial, and there are a number of systems in place to assist young people to fulfil this role. However, the information obtained as a result of this investigation supports the conclusion that:

- the contact and relationship between Case Managers and young people in the Department's residential care facilities, as with other external supports, varies;
- the Consumer Advocate was virtually unknown in the context of Departmental residential care; and
- there is variability in the availability and effectiveness of Departmental forms intended to ensure that carers are advised of young person's individual needs and to minimise risk.

The recent establishment of a dedicated Advocate for Children in Care by the Department is a positive initiative, and the Department has highlighted in response to my preliminary report the significant role of the Advocate in promoting dialogue with, and receiving complaints from, young people in residential and other care. However, with over 2,000 such children throughout the State, this new role will face the challenge of addressing the existing gaps in the systems available to young people in Departmental residential care to assist them avoid maltreatment and to minimise the risk some may pose to others.

## THE ROLE OF YOUNG PEOPLE IN REPORTING MALTREATMENT

Young people in residential care are not only important because of their role in ensuring that these facilities not develop into '*secret worlds*' where abuse can flourish, or as potential perpetrators of maltreatment. They can also play a crucial role in reporting maltreatment against themselves or others in care. There appears, however, to be a range of barriers to young people in residential care reporting maltreatment, including an apparent lack of information for young people about how to complain. I am pleased to note that recently the Department has made a concerted effort to address this, particularly in relation to providing information on complaining to the Advocate for Children in Care.

Other factors, however, can create the impression for young people (and others) that they are not listened to when they complain. There is also no requirement in existing administrative systems for young persons' version of critical incidents in the Department's hostels to be included in reports. I recommend:

3. In conjunction with the Charter of Children's Rights, the Department develop posters and other materials for distribution to its residential care facilities outlining the various avenues for children and young people to raise their concerns or complaints; and the Department ensure that this information is included in all induction materials and processes for residential care. (page 79)
4. The Department, in consultation with Direct Care Workers and other residential care staff, should develop mechanisms to give young people and others confidence in the complaint handling system in ACSS, for example, by developing guidelines which adhere to the principle of procedural fairness and relevant legislative protections for staff but which allow for feedback to young people and others raising concerns or complaints about a staff member. (page 80)
5. The Department develop guidelines to assist in determining the appropriate placement of staff while the subject of child maltreatment and/or standard of care allegations

and give consideration to the frequency of these incidents and impact on staffing requirements when calculating the workforce requirements for ACSS. (page 83)

6. The Department undertake a review of its ACSS Critical Incident Form so that it includes a section for the child or young person to complete about their version of events; or requiring a person not involved in the incident, such as a Team Leader, Case Manager or someone of the young person's choice, to speak with the child or young person about the incident and record their version of events. (page 84)

Although I have suggested improvements in these areas, there is reason to be cautious in relying too heavily upon children and young people with histories of abuse to identify and report maltreatment. Other systems for the prevention and reporting of maltreatment, which rely upon residential care staff, are of critical importance.

#### **OTHER ISSUES AFFECTING YOUNG PEOPLE**

Before turning to the role of residential care staff, there are two issues of significance to the young people consulted for the purposes of this investigation which, although not directly relating to maltreatment in the Department's residential facilities, warrant some attention.

First, access to keys for their own rooms may go some way in assisting the children and young people in residential care by giving them a greater sense of control over their environment and also by reducing the resemblance to a custodial setting. I suggest that the Department consider consulting residential care staff and young people about whether measures could be put in place to enable young people who elect to do so to be issued with keys to their own bedrooms.

Second, in situations where a young person in the Department's care is being investigated by Police because of allegations by a Departmental officer, there are particular difficulties for another Departmental officer to also be involved as the support for the young person; more so when it appears such Departmental officers do not, and are not trained to, view their role as an advocate for the young person in these circumstances. I suggest that the Department consider whether its field staff require training or guidelines on their role as the adult support for a young person in care who is attending a Police interview where there is a likelihood of charges being laid against the young person. At the very least, I suggest that the Department give consideration to ensuring that legal advice is available for such young people once a Police caution is issued and the potential charges relate to a Departmental officer.

#### **WHAT IS THE ROLE OF THE DIRECT CARE WORKERS?**

Paradoxically, the initial disclosure to my office identified Departmental residential care facilities as sites of the maltreatment of children and young people: maltreatment allegedly perpetrated not only by other residents, but also by Departmental staff. Allegations included that instead of contributing to the prevention and detection of maltreatment, some DCWs interacted poorly with young people; contributed to the maltreatment of young people by other young people in these facilities by not being vigilant of young people who were at risk of perpetrating, or being victims of, sexual offences; and were punitive.

There appears to be a division of opinion within the Department over what care model should be adopted for young people in the Department's hostels. As a consequence of the lack of an agreed care model, there appears to be little guidance for DCWs about the specific measures they can implement to manage the difficult conduct of the young people in their care. I was pleased to be advised by the Department that it is now in the process of developing an agreed care model, which will also provide an overarching framework for behaviour management of children and young people within its hostels.

Discussions with residential care staff also indicated that the ACSS Procedures Manual was not of great assistance. It appears that ongoing consultation with, and the involvement of, DCWs in the

development and review of the manual may make it a more relevant and useful guide for practice. The ongoing review of the manual to ensure that there is consistency with broader Departmental policies and training on what constitutes best practice in the management and care of young people may also contribute to the development of a generally accepted and agreed vision of what it is that DCWs are to provide for those in their care. The Department has advised that it has taken steps to implement a program of review of the ACSS Manual, but this will need to be ongoing. I recommend:

7. The Department institute a program to regularly review the ACSS Manual in consultation with Direct Care Workers and other residential care staff with a view to developing a practical and relevant guide for staff working in that environment. (page 99)
8. The Department institute a program to regularly review the ACSS Manual to ensure that there is consistency in the articulation of applicable standards of care in all relevant Departmental documentation. (page 99)

### THE ROLE OF ACSS STAFF IN PREVENTING MALTREATMENT

Departmental staff at all levels who were interviewed during this investigation identified the following factors as assisting in the effectiveness of ACSS residential care workers' role in preventing maltreatment in the Department's hostels:

- a skilled and trained residential care staff;
- professional managers;
- specialised skills and techniques for dealing with crises; and
- access to professional support services for staff.

In developing ACSS the Department made significant efforts to improve the standard of care available for young people in its facilities. However, this investigation has identified a number of areas in which the systems available to residential care staff for preventing maltreatment may be improved. These include a greater focus on ensuring a gender balance of rostered staff, particularly in hostels which house both males and females; improved monitoring of, and access to, training for DCWs particularly in relation to de-escalation techniques and physical restraints; a review of the ACSS performance management program and more consistent records management. I recommend:

9. The Department increase its efforts to ensure a gender balance amongst Direct Care Workers and generally seek to have a balance in the staff rostered on shift; and a gender mix on shifts be a requirement in those Departmental residential care facilities which accept male and female residents. (page 101)
10. The Department set up a system for recording all training provided to its Direct Care Workers and monitoring their training needs, and take steps to ensure that ACSS has capacity to release Direct Care Workers from roster to access ongoing training on the same basis as other Departmental staff. (page 104)
11. The Department ensure that training on the management of children and young people suffering from mental health issues or intellectual disabilities, and good practice in the management and distribution of high-risk medications, be available for Direct Care Workers. (page 105)

12. ACSS review its performance management program to ensure it is achieving desired outcomes and monitor its ongoing implementation. (page 108)
13. In the interests of improving its records management processes, the Department review its policy on the retention of performance management records for its residential care staff to ensure that these are accessible to supervisors and that there is clear guidance to supervisors to ensure that these notes are retained in a consistent manner. (page 110)
14. The Department clearly elaborate for its residential care staff at all levels the various obligations which attach to the Department and in particular its ACSS Team Leaders, who are neither advocates for young people in care nor representatives of hostel staff, but must take into account the interests of both sides. (page 111)
15. The Department extend its 24-hour on-call professional response team, on a trial basis, to assist its residential care facilities, incorporating not only professional assistance and support but also including a role in on-the-job training of residential care staff. (page 114)
16. Given the recent authorisation of DCWs under the C&CS Act to apply restraints to children and young people, the Department undertake regular physical restraint training of all its DCWs to ensure that they are familiar with authorised techniques, restrictions relating to the use of physical restraints against abused young people, and contemporary notions of best practice in these matters. (page 116)

In addition to the above, there also appear to be some fundamental unresolved issues that are the legacy of the Department's historical role in providing direct care to children and young people. These concern what measures, if any, may legitimately be exercised in relation to young people in the Department's care which would not apply to adults. I have concluded that consideration can usefully be given to what alternatives could be available to the physical restraint of young people who are engaging in high-risk behaviours. I recommend:

17. The Department undertake research, incorporating the views of children and young people and residential care staff, on the use of brief periods of confinement in a 'time out' room as an alternative to physical restraint and to determine whether it has been successful in other jurisdictions. (page 118)

## THE ROLE OF ACSS STAFF IN REPORTING MALTREATMENT

Apparent impediments also exist which may limit the effectiveness of the systems available to residential care staff for the reporting of maltreatment. An underlying lack of confidence in, and trust of, management, was conveyed in interviews with my officers by many of these workers and this has the potential to inhibit them from divulging concerns about a staff member's interactions with young people to other Departmental officers. It appears, however, that other factors also contribute to DCW reticence to complain, and some staff alleged that officers had been subjected to intimidation and threats for reporting maltreatment. I was pleased to note that, prior to the completion of my preliminary report, the Department had taken action to make it clear to all staff that bullying was recognised as an occupational safety and health issue and was not acceptable behaviour. Subsequently and in response to my preliminary view, the Department outlined other measures it has implemented to ensure cultural change in ACSS, including the establishment of a Change Management Group with representatives from all levels of ACSS staff.



Impediments that were identified to the effectiveness of the reporting systems also included the limited nature of Critical Incident Report forms and the absence of systemic and independent review of those reports. From my perspective, however, perhaps the most significant impediment to residential care staff reporting maltreatment was embodied in the concerns expressed to my officers by DCWs about the fairness of the subsequent investigation process. The development of information for residential care staff about the assessment and investigation processes for Child Maltreatment Allegations (CMAs) (now '*Child Wellbeing Concerns*') may partially address this apprehension. However, as discussed in detail in Chapters 14 and 15 of this report, the concerns of residential care and other staff about investigative processes go further than this. I recommend:

18. The Department include information on how allegations, and the investigation of those allegations, are an integral part of working in residential care, what it means if an allegation is made for an employee, and an outline of the assessment and investigation processes in its induction training for residential care staff and on its intranet. (page 125)
19. The Department undertake a review of its ACSS Critical Incident Report form so that the forms accommodate a sufficient variety of critical incidents affecting children and young people in care and appropriately reflect the Children & Community Services regulation requirements relating to the recording and reporting of any incident in which an officer '*restrains*' a child. (page 126)
20. The Department maintain statistical data on the use of restraints in its residential care facilities; and consideration be given to the implementation of an independent review function which might, for example, be based on the Canadian model, involving an independent board consisting of community-based and professional members. (page 127)

## INVESTIGATING ALLEGATIONS OF CHILD MALTREATMENT

The informant's disclosure not only alleged that there was abuse of young people by residential care staff in the Department's hostels, it also alleged that the Department had failed to properly address the practices which led to that abuse. One aspect of the informant's allegation specifically concerned the adequacy of the Department's investigation of child maltreatment in its residential care facilities. The Department's response to child maltreatment in its hostels potentially involves two processes—Child Wellbeing Concern (previously CMA) investigations and disciplinary investigations under the PSM Act. Although the Department states that these two processes are independent, my enquiries have highlighted the degree to which each of these processes can impact on the effectiveness of the other as a means of responding to alleged child maltreatment occurring in the Department's hostels.

The CMA investigation process, with its focus on child protection and safety, has the scope to bring some very positive reforms to residential care settings. This potential is likely to be improved with the implementation of recommendations made in the Cant and Murray Reports, particularly those associated with establishing a specialist investigations capacity for dealing with allegations of abuse in care. However, the effectiveness of Case Workers in recognising the potential maltreatment of the children and young people they case-manage is significantly dependant upon their access to information. In contrast to foster care, Case Workers' access to information about the treatment of young people in residential care may be complicated by Departmental management structures, worker confidentiality and the absence of clear policies and guidelines on sharing information between work units.

Reconciling human resource management issues more generally with child protection imperatives is undeniably difficult. However, there are currently multiple policies applicable to this issue which appear at times to be inconsistent and in any event not to reflect actual Departmental practice.

This has the potential to leave Departmental staff without adequate guidance and vulnerable to allegations that they acted without authority. It is also important that in the highly sensitive context of child protection, the Department is in a position to readily and accurately advise external review and accountability agencies of its practice, and in particular, to have confidence that its policies indeed reflect its actual practice.

It appears there is currently some debate within the Department about whether the current dual child protection and Public Sector Management processes for dealing with allegations of maltreatment in its residential care facilities should continue. This is a question for the Department to determine. Should the Department decide to continue applying child protection processes in its residential care facilities, guidelines should be formulated on the appropriate limits on access to information by investigators, on the recording of investigation outcomes, on the feedback which can be provided to both staff and young people involved in these processes, and on the allocation of responsibility for the undertaking of tasks.

I recommend:

21. The Department, after consultation with direct care staff, field staff, relevant managers and Human Resource experts, develop guidelines about the responsibilities of Residential Care Managers and Case Managers in assessing the conduct of residential care workers. Based on those responsibilities, the Department provide guidelines on what information is to be passed on to field staff by Residential Care Managers about the conduct of individual hostel workers. (page 132)
22. The Department take steps as a priority to streamline and rationalise policies and procedures on the handling of child maltreatment allegations against Departmental staff and to ensure that its practice is consistent and is reflected in these documents. (page 145)
23. If the Department is to continue to apply child protection investigative processes within its residential care facilities, it should review its policies and processes so that there are practical guidelines for investigators articulating how child protection investigations and outcomes are to be managed in a workplace, and the clear allocation of responsibilities to specified officers. (page 146)

#### ***PUBLIC SECTOR MANAGEMENT ACT 1994 DISCIPLINARY PROCESSES***

In practice, human resources disciplinary processes significantly impact on how the child protection investigation process is implemented in the Department's residential care facilities. Investigators appear conscious of the potential for child protection investigative processes to compromise the employment-based processes contained within the PSM Act and relevant case law. The Department advises that its policies in this area are currently subject to review. From discussions with Departmental staff, it appears that one option is for child protection investigative processes not to be utilised in its residential care facilities, and instead reliance to be placed purely on PSM Act disciplinary processes.

However, existing disciplinary processes, according to the NSW Ombudsman, can lead to reduced capacity to manage risk, a restricted capacity to respond to individual employees' management needs appropriately, and a protracted process which impacts adversely upon both employees and those making the allegations. The capacity for the Department to make its disciplinary processes suitable for addressing child maltreatment concerns may depend upon the implementation of recommendations that would provide for the independent scrutiny of systems for handling child abuse allegations involving employees, and the review of the PSM Act to allow for timely and effective management responses to allegations against staff in the area of child protection. These issues are discussed further at Chapter 16.

If the Department should decide to retain both the disciplinary and child protection investigative processes, it should ensure that guidelines are available to investigators of allegations of child maltreatment against Departmental staff so that their conduct of the investigation does not compromise the opportunity for the Department to pursue disciplinary action if required. I recommend:

24. If the Department is to continue to apply child protection investigative processes within its residential care facilities, it should provide guidelines to investigators of allegations against Departmental staff so that their conduct of the investigation does not compromise the opportunity for the Department to pursue *Public Sector Management Act 1994* disciplinary action if required. (page 151)

## OTHER ISSUES ARISING

Other issues arose in the course of this investigation that go beyond the jurisdiction of the Department of Community Development, but that raise whole-of-government issues.

- **The future of Departmental residential care**

I am aware of earlier draft proposals to further limit the role of the Department in the provision of direct care to children and young people, although in its response to my preliminary view the Department stated that this is not its intention for the foreseeable future. Many of those who provided information for the purposes of this investigation, both ACSS and other Departmental staff, believed that given the complexity and variety of needs of young people in care, a broad range of placement options should be available. Should the Department continue to provide for the direct care of those children and young people it currently accommodates in the metropolitan area, it appears to me that there are a number of measures which could contribute to the effectiveness of this service, and these have been canvassed in my investigation report.

However, a broad issue remains: what should be done to manage high-risk behaviour by children and young people? In particular, I believe it would be timely for consideration to be given to whether it is appropriate to implement a '*secure welfare*' option for such children and young people, or whether there are other and better alternatives available. I should be clear that by '*secure welfare*' I am referring to a form of detention, which is regulated by legislation, can only be authorised by the courts for strictly limited periods, and is for therapeutic, generally assessment, purposes. It must be clear that this form of detention is not to be used for punitive purposes. I recommend to Government that:

25. A review be conducted of the adequacy of the existing powers available to Departmental officers for managing children and young people in care who engage in extremely high-risk behaviours affecting themselves and others. Such a review should include giving consideration to whether a '*secure welfare*' option is necessary, or whether there are other and better alternatives available. (page 155)

- **Investigating employment-related allegations of child abuse**

The Department's child protection investigations, previously conducted under section 10A of the CW Act, are generally limited to allegations of maltreatment of children if these allegations indicate abuse by parents or persons '*in loco parentis*'. The abuse may be direct, or indirect if there is an allegation that the child was being neglected because, for example, the parent had failed to deal appropriately with abuse of their children by others. The Department does not generally act directly to investigate allegations of abuse of children involving people in their employment capacity, nor does it monitor investigations conducted under disciplinary processes. This approach appears unlikely to have changed with the implementation of the C&CS Act.

I have outlined concerns arising from this investigation into the handling of allegations of child maltreatment within the framework of employment disciplinary processes. These concerns are reinforced by issues which were raised by previous investigations conducted by my office into the handling of allegations of child maltreatment within the framework of employment disciplinary

processes by a public sector agency other than the Department. Significantly, and in contrast to other jurisdictions such as New South Wales, there is no external systemic monitoring or evaluation of these disciplinary processes, even in relation to those government and non-government agencies that have substantial dealings with children. I recommend that:

26. Government establish a mechanism to provide for the monitoring and evaluation of relevant government and non-government agencies' employee disciplinary processes where allegations of child maltreatment are involved. (page 157)

- **An independent monitor**

The vulnerability of children and young people, and particularly those in the Department's residential care facilities, can limit their ability or willingness to recognise and report maltreatment. My officers found that it was Departmental officers who often were able and willing to raise concerns about maltreatment for examination as part of this investigation. As such, Departmental officers can play a crucial role in the prevention and detection of maltreatment in the Department's residential care facilities.

The lack of confidence in Departmental management expressed by Departmental staff during interviews with my officers, however, could inhibit them from divulging the same information to another Departmental officer. The value of an independent third party's access to residential care facilities for young people is demonstrated by the information my officers obtained during this investigation. I recommend that:

27. Government give consideration to externally allocating the function of monitoring both Departmental and non-governmental residential care facilities. (page 158)

- **Review of the *Public Sector Management Act 1994***

The NSW Ombudsman conducted an investigation of *Handling Child Abuse Allegations Against Employees* in 2000. According to the NSW Ombudsman, existing employment disciplinary processes can lead to reduced capacity to manage risk, a restricted capacity to respond to individual employees' management needs appropriately, and a protracted process which impacts adversely upon both employees and those making the allegations. This and other investigations by my office into the handling of allegations of child maltreatment under Public Sector agencies' current disciplinary processes have raised concerns similar to those identified in NSW. Moreover, it is not clear that there is capacity under disciplinary processes for consideration to be given to broader systemic issues which may be essential to address allegations of child maltreatment.

The PSM Act disciplinary processes, which essentially deal with issues between an employer and an employee, also appear to have difficulty accommodating the interests of '*third parties*' adversely affected by the conduct involving breach of discipline, particularly in light of the confidential nature of these investigations and outcomes. I recommend that:

28. Government consult with key stakeholders and relevant experts to develop an appropriate legislative, policy and administrative framework to allow for timely and effective management responses to allegations against staff in the area of child protection; and that departments with child protection responsibilities develop a comprehensive and consistent Public Sector response to allegations of child abuse against staff. (page 160)

## Explanation of Terms

**Abuse in care** - This term refers to the maltreatment of children who are in the care of the Department for Community Development (the Department), or in the terminology of the new legislation (see C&CS Act) a child in the CEO's care; it does not refer to the maltreatment of children and young people generally.

**ACSS (Adolescent and Child Support Services)** - The model for the Department's metropolitan residential care and intensive foster care services for children and young people in care, implemented since 1998. The focus of this investigation has been on the ACSS residential care facilities. At the time of writing, ACSS had been incorporated as one section of the new Placement Services, which also has responsibility for non-government residential care contract management. The term '*ACSS residential care*' or '*hostels*' is used in this report as a shorthand reference for those facilities which were the subject of this investigation.

**Behaviour modification** - Behaviour modification is a technique involving basic methods to alter human behaviour, such as reward and punishment, and can assume a behaviourist framework.

**Behaviourism** - A basic definition of behaviourism is '*the theory that human behaviour is determined by conditioning rather than by thoughts or feelings, and that psychological disorders are best treated by altering behaviours*'.<sup>6</sup>

**'Bennett principle'** - A legal principle whereby young people in the Department's care who suffer injury or harm may be entitled to independent legal advice about their potential legal claims against the Department, based on the 1992 High Court decision *Bennett v Minister of Community Welfare*. The Department advises that if this duty is not discharged and as a result the child or young person's potential claim against the Department or another party has become '*statute barred*' then the child or young person is likely to have a cause or right of action against the Department for the loss of this entitlement.

**Cant Report** - *The Final Report on the Quality Assurance of the Department for Community Development's Systems and Processes for Children in Care*, by consultants Rosemary Cant and Rick Downie of Social Systems & Evaluation. The Report refers to major inquiries and reviews relating to the safety of children in care in other jurisdictions in 2004, and states that the consultancy was initiated as part of the Department's ongoing quality assurance of its systems for children in care and for out of home care.<sup>7</sup>

**Case Manager/Case Worker** - Departmental staff whose duties include the exercise of the Director General's (CEO's) responsibilities for children in care on a day-to-day basis. The current title is Field Officer and the positions are located in Divisional offices. In the past the position had various titles, such as Family Welfare Officer, Social Worker and Graduate Welfare Officer.

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<sup>6</sup> *The Australian Concise Oxford Dictionary*, 4<sup>th</sup> edn, p. 121.

<sup>7</sup> R Cant & R Downie (Social Systems & Evaluation), *The Final Report on the Quality Assurance of the Department for Community Development's Systems and Processes for Children in Care*, p. i.

**C&CS Act** - The new *Children and Community Services Act 2004* which came into effect on 1 March 2006. It replaced the *Child Welfare Act 1947* (CW Act) which was the legislative basis for much of the Department's operations during the course of this investigation. This report refers primarily to arrangements which existed under the CW Act, with reference to variations to the Department's operations under the C&CS Act as relevant.

**Child in the CEO's Care:** See '*Children/young people in care*' below.

**Child maltreatment** - The term used by the Department to refer to physical, sexual or emotional harm or neglect of children generally by their parents or those *in loco parentis*. It can also refer to persistent actions or inactions, which may not be of a severe nature in any one instance, but where the cumulative effects result in significant harm to the child.<sup>8</sup>

**Child Maltreatment Allegation** - Allegations and incidents involving potential harm to children and young people assessed to determine whether these fall within the category of a '*Child Maltreatment Allegation*' (CMA); a distinction is made, for example, between child maltreatment and issues about the standard of care, such as inappropriate discipline. Under the C&CS Act, CMAs have been replaced by '*Child Wellbeing Concerns*', although at the time of writing, it does not appear from available Departmental information that the substance of these, as highlighting potential parental/carer abuse or neglect, has varied.

**Child Maltreatment Outcome Report** - if identified as a CMA, Departmental officers carry out an investigation and a '*Child Maltreatment Outcome Report*' is produced. Those reports may substantiate the allegation of abuse, identify perpetrators and include recommendations which focus on measures to ensure the safety and wellbeing of the child and others placed with the same parents/carers.

**Children/young people in care** - For the purposes of this report, the reference includes children and young people in care by virtue of a court order making them '*wards*' (children determined to be in need of care and protection), those placed under the control of the Department (whose parents continue to be their guardians)<sup>9</sup> and more recently children and young people in the care of the Department on the basis of '*consented placements*'; where there was no formal court order but an agreement with the parents that the Department care for the child or young person.

With the new C&CS Act, children and young people in the care of the Department<sup>10</sup> are no longer to be referred to as wards. Children and young people in care may be the subject of a protection order from the courts (other than in interim urgent situations), or a '*negotiated placement*' where a child cannot be cared for by the parents. This negotiated placement option is not available if the child is in need of protection, as occurred in the past in relation to '*consented placements*'. It appears that this was altered in the new legislation to prevent there being any perception of duress being applied when the Department took a child into care without court direction. Note, however, there is also provision made under the new Act for children to be in the CEO's care if they are in receipt of '*placement services*' (s. 30(d)). This term is not defined under the Act. Departmental staff advise that it is intended to refer to homeless young people who are estranged from their parents and are in receipt of accommodation from the Department, and that its use will be limited under Departmental policy. The Minister stated that this definition was included to ensure that such young people can receive services under the new Act.<sup>11</sup>

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<sup>8</sup> Family and Children's Services (now DCD), *New Directions in child protection and family support*, 1996, p. 19.

<sup>9</sup> Previously children under the age of six in the care of foster carers (both wards and non-wards) also had to be the subject of a licence granted by the Department (Cant Report, p. 1). There is no equivalent provision in the C&CS Act.

<sup>10</sup> Under the C&CS Act the terminology is '*child in the CEO's care*', the CEO being the Chief Executive Officer of the Department.

<sup>11</sup> Western Australia, Legislative Assembly, *Debates*, 11 March 2004, pp. 865-866.

**Child Wellbeing Concerns** - With the C&CS Act coming into effect, '*Child Wellbeing Concerns*' have replaced '*Child Maltreatment Allegations*'. These concerns need not be limited to abuse or neglect, although investigations of Child Wellbeing Concerns are restricted to when parents are unable to care for a child or the child has been neglected or abused and the parents are unable or unwilling to protect the child. It is of note that under this C&CS Act '*parent*' is defined as anyone, other than the Department's CEO, who has responsibility for the long-term or day-to-day care, welfare and development of the child.

**CW Act** - The *Child Welfare Act 1947* which was the legislative basis for much of the Department's operations during the course of this investigation. It was replaced by the C&CS Act on 1 March 2006, while the report on this investigation was being finalised. This report refers primarily to arrangements which existed under the CW Act with reference to variations to the Department's operations under the C&CS Act as relevant.

**CCSS (Client Community Services System)** - The Department's client data base which currently '*tracks*' information on parents, carers and children and has recently been modified so that it provides a means to track incidents occurring at the same facility, for example the same hostel or child-care agency. Originally it was only a record of children, as they were the only clients of the Department, but this has been extended to care-providers who now also receive assistance from the Department as it has become increasingly family-focussed. The CCSS also records CMAs, the outcomes of Departmental Child Maltreatment Investigations and has a search facility to locate the names of perpetrators of child maltreatment identified as a result of the Department's investigations. Generally, the only perpetrators who are recorded on CCSS are parents or those *in loco parentis*.

**Crisis Care Management (CCM)** - This was the training package for Direct Care Workers on how to respond to critical incidents including risks of violence at the time of this investigation. The course was run by the Department's Learning and Development Unit and training included de-escalation skills such as the ability to redirect and prevent a behavioural crisis or violent situation occurring. It provided a range of low-risk physical intervention techniques, including evasive self-defence and physical restraint. Physical restraint was not permitted to be used in ACSS facilities unless staff had been accredited in the CCM course. Subsequent to this investigation, CCM has been replaced by a different training package, Therapeutic Crisis Intervention (TCI).

**Critical Incident Report** - An ACSS form for use in its hostels. The ACSS Procedures Manual states that these reports are to be completed for '*an event, which involves an injury or potential for injury, and/or a strong stress reaction in a young person or staff*'.<sup>12</sup> At the time of the investigation, these recorded a staff member's version of a critical incident involving a young person resident at the hostel.

**Direct Care Workers (DCWs)** - Departmental staff, previously known as '*Group Workers*', who provide direct care to the children and young people in Departmental residential care facilities. DCWs are level 2 or 3 workers who currently are required to have a minimum Certificate 3 and 4 in Human Services at entry level. DCWs are rostered and work varying shift times, with additional pay and leave entitlements as a result. A selection criterion for Level 2 DCWs is that they have the '*Capacity to take physical control of young people in a safe and caring manner, in accordance with specified standards*.'

**Duty of care** - Refers to a general duty at law to take reasonable care to prevent or minimise harm to others. The scope of that duty is difficult to define precisely, but liability for a failure to exercise the appropriate standard of care can extend to harm which occurs to others because of a failure to act with the attention and caution that a reasonable person in the circumstances would use, generally referred to as '*negligence*'.

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<sup>12</sup> ACSS Procedures Manual [undated], p. 6.

**Duty of Care Unit and Register** - The Department's Duty of Care Unit and the Duty of Care Register have been in place since February 2004. The Duty of Care Register is an '*integrated module*' of the CCSS, with more restricted staff access, and it relates only to children and young people in care. It has been used to record the incidents involving children and young people in the Department's care described in Director General's Instruction 59, and including deaths, serious injuries, critical incidents and allegations of abuse in care. It was developed, amongst other things, to assist the Unit to monitor the timeliness and adequacy of Departmental investigations and responses to abuse in care, and to address the Department's obligations resulting from the '*Bennett principle*'. The Duty of Care Unit and related procedures were commended in the Cant Report as '*best practice*' in meeting the Department's obligations under the '*Bennett principle*'.<sup>13</sup>

**Edwards Report** - The 1982 report of Professor Eric Edwards on *The treatment of juvenile offenders: a study of the treatment of juvenile offenders in Western Australia as part of an overall review of the Child Welfare Act 1947*. The report identified a number of concerns including the indeterminate sentences and lack of due process associated with juvenile offending. Professor Edwards recommended that child welfare issues should be kept separate from those issues relating to young offenders and that a clear distinction should be made between a child's need for care and protection and the sanctions needed for the management of offending behaviour.

**Group Workers** - The former job title of the Departmental officers now known as Direct Care Workers. The change in title was to mark the division between the role in the secure juvenile justice facilities which were operated by the Department until 1993, and the non-custodial role of workers in the Department's '*open*' residential care facilities. The title continues to be used for juvenile justice officers working in the secure or '*closed*' juvenile justice facilities now operated by the Department of Corrective Services.

**Individual Care Plan** - These are plans developed by Case Workers that outline the individual care needs for each child or young person in residential care, and include details about school or workplace attendances, contact with family and guidance to staff about issues such as the use of physical restraints for those with abuse histories, or other specific management strategies. Care plans are now required to be prepared and implemented under the new C&CS Act, section 89(2).

***In loco parentis*** - Persons acting in the place of parents, for example foster carers and legal guardians.

**Looking After Children (LAC) Form** - A form completed by Case Workers to provide information to carers about children and young people to be placed in their care at the time of placement or as soon as possible afterwards. (Now known as Assessment and Planning System forms.)

**Maltreatment** - See '*Child maltreatment*'.

**Murray Report** - *A duty of care to children and young people in Western Australia: Report on the quality assurance and review of substantiated allegations of abuse in care, 1 April 2004 to 12 September 2005*, by Gwenn Murray, a Queensland child protection expert. The report states that '*As part of the Department's ongoing review and quality assurance work, the Director General sought to have recent substantiated cases of abuse in care independently reviewed*'.<sup>14</sup> Fifty-nine instances of substantiated abuse in care were reviewed.

**Out-of-home care** - This is available for children and young people aged under 18 years who are placed away from their parents and family home, either voluntarily or as a result of a care and protection order, for reasons of safety and family crisis, including abuse, neglect, parental illness or incapacity. The form of care may be home-based (foster and relative care) or facility-based (for

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<sup>13</sup> At p. 51.

<sup>14</sup> At p. v.



example, residential care). Across Australia there has been a shift towards foster care and other forms of home-based care and intensive family support services are increasingly used as an alternative to the removing of children from home.<sup>15</sup>

**Placement Services** - A division of the Department, recently restructured, to include both Departmental metropolitan and country residential care, contract management for non-government residential care, and other out-of-home care services. The Department's metropolitan residential care services were known as ACSS during the time of this investigation and I have retained that term for the purposes of this report.

**Residential Care Facility** - Residential buildings where children and young people in care are placed and supervised by paid staff. These may be operated by government or non-government agencies and are also referred to as hostels.

**Safety Plan** - Initiated as part of the Department's Director General's Instruction 62 in response to the Cant Report recommendation to review the policies on the placement of children and young people considered a risk to others;<sup>16</sup> safety plans are to identify risks posed by the child or young person and specific strategies to overcome these.

**'Secure welfare'** - A term used in this report to refer to a form of detention, which is regulated by legislation, can only be authorised by the courts for strictly limited periods, and is for therapeutic, generally assessment, purposes. It is to be distinguished from detention for punitive purposes.

**'Time-out'** - A term used in this report to refer to the securing of children and young people into a room for brief periods. It is suggested in this report as an alternative to the physical restraint techniques currently employed in Departmental residential care. As the legal authority for residential care staff to make use of a 'time-out' form of restraint would be the same as applies to physical restraint, it would also be unlawful if used for improper purposes such as punishment.

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<sup>15</sup> Productivity Commission, *Report on Government Services 2006*, Commonwealth of Australia, 2006, 15.3.

<sup>16</sup> Cant Report, p. iii.

## Volume 1 - Department for Community Development

# Part I Investigating This Complaint

## Chapter 1 Introduction

### 1.1 What is this report about?

This report deals with an investigation conducted by my office into an allegation that the Department for Community Development (the Department) had failed to properly address institutionalised practices amongst its staff at a small number of metropolitan residential care facilities, or hostels, resulting it was alleged in the consistent abuse in care of the young persons residing there.<sup>17</sup> Generally the children and young people in these facilities, known at the time of my investigation as the Adolescent and Child Support Services (ACSS)<sup>18</sup> hostels, had a number of previous placement breakdowns and were viewed as *'difficult to place'* for a range of reasons, including very difficult behaviours resulting from sometimes extreme histories of abuse and neglect.

The children and young people in these residential care facilities constitute only a very small proportion of those in the Department's care. This itself proved to be an important factor in the investigation. In recent years issues concerning children and young people in care generally, and in particular abuse in care,<sup>19</sup> have been the subject of many government reviews and inquiries. It is of note, however, that few reviews or inquiries have undertaken a detailed consideration of how the administration of residential care facilities might be improved.

In undertaking this investigation the focus has been on assessing potential shortfalls and areas for improvement in the Department's residential care facilities. As a consequence, the investigation tends to have a focus on the negative—evidence of maladministration; systems which fail at times of stress; inconsistencies and deficiencies in policy and procedure. A number of negatives were highlighted by the investigation, as will be seen in the remainder of this report. However, a number of positives were also highlighted by the investigation, and it is important that these be acknowledged. These include:

- those children and young people who generally liked residential care staff, who were reasonably happy in the environment and who had good relations with Direct Care Workers<sup>20</sup> (DCWs) and their Case Managers<sup>21</sup>;

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<sup>17</sup> For the purposes of this report, this reference includes children and young people in care by virtue of a court order making them *'wards'* (children determined to be in need of care and protection), those placed under the control of the Department (whose parents continue to be their guardians) and more recently children and young people in the care of the Department on the basis of *'consented placements'*; where there was no formal court order but an agreement with the parents that the Department care for the child or young person. Under the new *Children & Community Services Act 2004* children and young people in the care are no longer *'wards'* and they cannot be placed under the control of the Department or be the subject of *'negotiated placements'*; instead they are referred to as children *'in the CEO's care'*.

<sup>18</sup> ACSS comprises the Department's metropolitan residential care and intensive foster care services for children and young people in care, implemented since 1998.

<sup>19</sup> This is a reference to the maltreatment of children and young people who are in the care of the Department; it does not refer to the maltreatment of children and young people generally.

<sup>20</sup> Departmental staff who provide direct care to the children and young people in Departmental residential care facilities. DCWs are level 2 or 3 workers who currently are required to have a minimum Certificate 3 and 4 in Human Services at entry level.

- the young people who had left care and spoke positively of the opportunity to participate in programs at the residential care facilities which had allowed them to '*turn their lives around*'; and
- the staff who spoke of the cyclical nature of working in residential care—with the good and the bad times, and the satisfaction they found in assisting children and young people, sometimes, to overcome their past to become valued members of the community, or simply because they had a good day with '*the kids*'.

## 1.2 Why did the Ombudsman investigate?

The matters examined in this report arose out of a disclosure which was made to my office under the *Public Interest Disclosure Act 2003* (the PID Act), in August 2003. The disclosure highlighted a number of incidents which occurred in 2002 and 2003, the handling of which raised concerns about the administrative framework in the Department's ACSS residential care facilities for the protection of children and young people from maltreatment. The disclosure raised further concerns about how the Department had responded to the informant's allegations, including the Department's own investigation into the informant's original disclosure to it under the PID Act.

I was satisfied that the information given to me amounted to an appropriate disclosure of '*public interest information*' under the PID Act. '*Public interest information*' is defined under the PID Act as:

'information that tends to show that, in relation to its performance of a public function (either before or after the commencement of this Act), a public authority, a public officer, or a public sector contractor is, has been, or proposes to be, involved in:

- (a) improper conduct;
- (b) an act or omission that constitutes an offence under a written law;
- (c) a substantial unauthorised or irregular use of, or substantial mismanagement of, public resources;
- (d) an act done or omission that involves a substantial and specific risk of:
  - (i) injury to public health;
  - (ii) prejudice to public safety; or
  - (iii) harm to the environment;

or

- (e) a matter of administration that can be investigated under section 14 of the *Parliamentary Commissioner Act 1971*.'

Although the incidents which prompted this investigation are now some years old, the scope of my investigation, which is discussed in more detail below, has included incidents and information current up until early 2006. These incidents indicate that many of the concerns raised by the initial disclosure continue to be relevant to what has been occurring in the Department's facilities, in spite of changes to policies and procedures made in the interim. They also accentuate the continuing public interest in seeking to address the difficult challenges posed by these settings.

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<sup>21</sup> Departmental staff whose duties include the exercise the Director General's responsibilities for children in care on a day-to-day basis. The current title is Field Officer and the positions are located in Divisional offices. In the past the position had various titles, such as Family Welfare Officer, Social Worker and Graduate Welfare Officer.

### 1.3 Scope of investigation

This investigation was prompted by a disclosure made to my office under the PID Act. Compared to legislation such as my own *Parliamentary Commissioner Act 1971* (PC Act), for example, the PID Act provides for substantially increased penalties for the victimisation of persons making a disclosure under that Act (known as ‘*informants*’) and also provides specific penalties for the release of information identifying the informant and the persons the subject of the disclosure. The PID Act, however, does not grant any different or additional investigative powers to the authority receiving a disclosure. The PID Act only requires that a proper authority ‘*investigate or cause to be investigated*’ the information disclosed to it. As a result my office relies upon the powers available under the PC Act. These powers are extensive, being ‘*all the powers, rights and privileges that are specified in the Royal Commissions Act 1968, as appertaining to a Royal Commission and the Chairman thereof*’.<sup>22</sup>

The PC Act also provides that I ‘*may obtain information from such persons and in such manner, and make such inquiries*’ as I think fit.<sup>23</sup> Generally, I find it useful not to rely on the formal exercise of the powers under the PC Act and, in most instances, conduct my investigations on a less formal basis. This investigation, reflecting the significance of the issues raised by the disclosure, was far more extensive than the general conduct of matters by my office. However, it was also conducted on an informal basis, and I acknowledge the cooperation of Departmental officers at all levels, and of those children and young people in residential care with whom my staff had contact.

Although I rely on my investigative powers under the PC Act to conduct investigations into disclosures made to me under the PID Act, my jurisdiction under the PID Act is broader than the PC Act. The scope of my investigations under the PC Act is limited to investigations relating ‘*to a matter of administration [that] affects any person or body of persons [complaining] in his or its personal capacity*’.<sup>24</sup> The same jurisdiction is replicated in one of the provisions empowering me as ‘*a proper authority*’ to receive public interest disclosures under the PID Act.<sup>25</sup> However, a second provision empowers me as a proper authority, together with the Public Sector Standards Commissioner, to receive and investigate any disclosure of public interest information about ‘*public officers*’ (other than a member of Parliament, a Minister, judicial officer or other officer referred to in Schedule 1 of the PC Act).<sup>26</sup> This head of power is not restricted to matters of administration, nor to matters affecting complainants in their personal capacity, and may include, for example, an investigation into alleged ‘*improper conduct*’ that has had no impact on the informant personally.<sup>27</sup> It is also of note that in responding to a public interest disclosure, I must take such action as is ‘*necessary, reasonable and within the limits of my powers and functions*’, to prevent the matter disclosed from continuing or occurring again.<sup>28</sup>

#### 1.3.1 Issues arising

The disclosure raised numerous concerns and involved substantial documentation. Some of the concerns clearly fell within the category of matters of administration affecting the informant in a personal capacity; others perhaps more readily could be classified as raising concerns about ‘*public officers*’ in the performance of their ‘*public function*’.

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<sup>22</sup> PC Act, s. 20(1)(a)

<sup>23</sup> PC Act, s. 19(3).

<sup>24</sup> PC Act, s. 14(1).

<sup>25</sup> PID Act, s. 5(3)(c).

<sup>26</sup> PID Act, s. 5(3)(g).

<sup>27</sup> PID Act, s. 3 (‘*public interest disclosure*’).

<sup>28</sup> PID Act, s. 9(1)(a).

At the initial stage, the extensive documentation provided by the informant was reviewed, additional relevant materials were obtained from the Department and other sources, and two lengthy informal interviews were held with the informant. It was decided that the matters raised would be investigated under three broad issues:

- the adequacy of systems relating to the prevention and detection of maltreatment in the ACSS hostels;
- the adequacy of measures used to deal with and respond to maltreatment in the hostels; and
- the adequacy of the Department's response to the concerns about the ACSS hostels raised by the informant.

## 1.4 Methodology

This investigation commenced with a comprehensive review and summary of relevant Departmental records in relation to the initial incidents in 2002 and 2003 (the subject of the disclosure), of the Department's own investigation of those matters, and also of the multiplicity of Departmental policies and procedures relevant to those incidents.<sup>29</sup>

Given the length of time this involved, and particularly given the dynamic area of child protection policy and practice,<sup>30</sup> it became apparent that the investigation should extend beyond those incidents raised by the initial disclosure. Accordingly, my officers approached the Department in July 2005 to arrange for visits to each of the ACSS residential care facilities, with the intention of gaining a contemporary understanding of these environments and to engage in informal discussions with facility staff and the children and young people resident there.

Those visits proved not only to be invaluable of themselves, but prompted a number of interested parties to subsequently approach my officers with their concerns. This greatly assisted my officers in their understanding of the issues arising in the complex environment of residential care facilities and also helped ensure that the investigation continued to be relevant to current concerns.

Subsequently, various Departmental officers were interviewed, including Direct Care Workers, Case Managers, Team Leaders in residential care facilities and in District Offices, professional staff and senior managers.

Given that the focus of this investigation was on children and young people in care it was crucial that their perspectives of life in the Department's residential care facilities were obtained. In addition to informal discussions with young people during the visits to the residential care facilities, my officers were also able to explore the views and concerns of young people with the assistance of the CREATE Foundation,<sup>31</sup> which contributed its expertise in consulting with children and young people to this investigation. CREATE staff co-facilitated, with my staff, a focus group of young people in Departmental residential care and an interview with an ex-resident.

As can be seen from the extensive use of quotes throughout this report, the informal visits, meetings, focus group and interviews proved to be of invaluable assistance in understanding the Department's residential care facilities. To appreciate these quotes, there is a need for some background information on the individuals quoted. To assist readers to make an informed

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<sup>29</sup> See, for example, 3.4 below.

<sup>30</sup> Refer, for example, to the reports and reviews referred to in 1.5.

<sup>31</sup> CREATE Foundation is a not-for-profit organisation run 'for and by children and young people in out of home care ... [it] exists to improve life opportunities for children and young people ... who are unable to live with their parents' (CREATE Foundation, *Do No Harm: Towards good practice in protecting children and young people in out of home care from abuse and neglect*, p.2).

assessment of the views expressed, while also protecting participants' confidentiality, I have cited the comments of individuals according to their position within the Department's structure, in the categories outlined below:

- *'Direct Care Workers'* (Level 2 and 3 Direct Care Workers, past and present);
- *'Residential Care Managers'* (ACSS Team Leaders Level 5 & 6, Social Workers, Placement Officer and Clinical Psychologist, past and present);
- *'Senior Managers'* (Placement Services Manager, Director of Placement Services, Director East Division<sup>32</sup>, Executive Director Community Development and Statewide Services and other senior Departmental Managers, past and present); and
- *'Field Officers'* (Case Managers, Team Leaders and other staff in the District Offices, past and present).<sup>33</sup>

To ensure anonymity, only a sample of those who filled the positions referred to in the above Departmental structure were consulted.

Other relevant parties, of course, include the children and young persons in residential care, whose comments are attributed to *'Young Persons'*. I would like to particularly thank all those who participated in the informal visits and meetings, interviews, and the young people's focus group.

I acknowledge that the Department views many of the quotes used in this report as highly emotive, as not necessarily factually accurate nor as relevant to the circumstances in its hostels by the time this report was finalised. However, the Department was prepared to accept these quotes as subjective assessments of people's lived experiences at the time these views were expressed. I appreciate the Department's comments, and believe this final report is enriched by the inclusion of these many *'voices'*.

My officers were also able to research a number of relevant inquiries and reviews for the purposes of this investigation. This enabled the issues raised by the disclosure to be placed within the broader context of current and historical trends in child protection and the management of children and young people in care.

Finally, in May 2006 and in accordance with my obligations under section 23 of the PC Act, I provided my preliminary views on this investigation to the Department, and extracts to relevant individuals, for their consideration and comment. The Department and relevant individuals have provided written responses and/or had meetings with my staff. I considered their submissions and formed a final view on the matter. That final view is published in this report, together with a fair representation of the submissions of relevant parties. The full text of the Department's response to the various recommendations can be found at Attachment 7 to this report.

I would like to add that I am particularly pleased by the Department's response to my preliminary views on this investigation. As detailed throughout this report, the Department has agreed to all my recommendations relating to its functions, and it is my understanding that the Department is already implementing measures to rectify the deficits identified. I was also pleased that the Department has expressed its in principle support for recommendations that I have put forward for consideration at a whole-of-government level.

Specific details of the different aspects of the methodology employed in this investigation are provided at Attachment 2.

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<sup>32</sup> A new Executive Director (Special Projects) assumed responsibility for projects relating to residential care and abuse in care in April 2006.

<sup>33</sup> The formal structure of ACSS is outlined at Attachment 1. Note that not all of the positions referred to above have been interviewed; these have been included only as indicative of the categories used to identify the general status of participants.

### 1.4.1 Report structure

Part I of the first volume of this report provides the background to the investigation of this complaint, both by my own office and by the Department. The broader context of current and historical trends in child protection and the management of children and young people in care, set out in Parts II and III of this report, provide the framework against which the roles of young people and residential care staff in the prevention and reporting of maltreatment is assessed (Parts IV and V). The Department's processes for the investigation of maltreatment are examined in Part VI.

The second volume of this report addresses those significant issues raised by this investigation which are put forward for consideration and response at a whole-of-government level.

## 1.5 Parallel inquiries

During the course of my investigation, a very large number of parallel inquiries by or on behalf of governments across Australia have occurred, highlighting the current level of concern over child protection.<sup>34</sup>

The reports produced during this time include:

- R Layton, *Our best investment. A state plan to protect and advance the interests of children*, SA Department of Human Services, 2003;
- Queensland Ombudsman, *Report of the Queensland Ombudsman: An investigation into the adequacy of the actions of certain government agencies in relation to the safety, well being and care of the late baby Kate, who died aged 10 weeks*, 2003;
- Gwenn Murray, '*Towards child-focussed safe and stable foster care*': *Final Report on phase one of the audit of foster carers subject to child protection notifications: External Review Report*, 2003;
- Gwenn Murray, '*The Territory's Children*'. *Ensuring safety and quality care for children and young people. Report on the audit and case review*, 2004;
- Crime and Misconduct Commission, '*Protecting Children*': *An inquiry into abuse of children in foster care*, Brisbane, 2004;
- C Vardon, '*The Territory as Parent*': *Review of the safety of children in care in the ACT and of ACT child protection management*, 2004;
- CREATE Foundation, *Do No Harm: Towards good practice in protecting children and young people in out of home care from abuse and neglect* [undated];
- Ministerial Advisory Council on Child Protection, *Caring Well - Protecting Well: Investing in systemic responses to protect children in WA*, 2004;
- The Senate Community Affairs References Committee, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as a child*, 2004; and
- The Senate Community Affairs References Committee, *Protecting vulnerable children: A national challenge*, 2005.

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<sup>34</sup> Also reflected in the present level of recurrent expenditure on child protection and out-of-home care services: at least \$1230.8 million across Australia in 2004-05 (WA ranks third highest in expenditure per child in out-of-home care, but second lowest in per capita expenditure based on the total population of children) (Productivity Commission, Report on Government Services 2006, 15.10, 15.34).



In addition, there are national statistics and other data compiled and published annually by the Australian Institute on Health and Welfare in its series on *Child Protection Australia*, and by the Productivity Commission on children's services as part of its *Report on Government Services*.

A number of additional Western Australian inquiries and reviews had a particular relevance to this investigation, and these have been considered in some detail for the purposes of this investigation:

- Auditor General (WA), *Accommodation and Support Services provided to Young People unable to live at home* (Report No 11), 1998;
- Department of Family and Children's Services,<sup>35</sup> *Family and Children's Services' Accommodation Hostels: Report to the Minister for Community Development, Women's Interests, Seniors and Youth*, 2001;
- Social Systems & Evaluation (Rosemary Cant and Rick Downie), *The Final Report on the Quality Assurance of the Department for Community Development's Systems and Processes for Children in Care*, 2004, (the Cant Report);
- Judi Anderson, (Draft and Confidential) *Care Responses into the Future 2006 - 2010*, 2005;<sup>36</sup> and
- Gwenn Murray, *A duty of care to children and young people in Western Australia: Report on the quality assurance and review of substantiated allegations of abuse in care, 1 April 2004 to 12 September 2005*, 2005, (the Murray Report).

A Legislative Council Select Committee on the Adequacy of Foster Care Assessment Procedures by the Department for Community Development was established on 21 September 2005 and is due to report by 24 August 2006. The degree to which the issues raised by my investigation will overlap with the Committee's work remains unclear at the time of writing.<sup>37</sup>

As can be seen, the Department's 2001 report is the only one of the numerous recent reports and reviews concerned specifically with Departmental residential care facilities.<sup>38</sup> The draft and confidential *Care Responses into the Future* was reportedly originally intended to focus solely on the Department's facilities, but eventually came to encompass all forms of out-of-home care. The Department advises that the draft report was commissioned in 2004, therefore subsequent to the PID disclosure being made to my office, and describes the report as an internal project to explore the significant changes occurring in services to children in care. The Department states that the intent of the project was to look at the full spectrum of placements and other services offered to children in care, although a particular focus was Departmental placements including residential care.<sup>39</sup>

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<sup>35</sup> As the Department was previously known.

<sup>36</sup> As referred to in the Cant Report, at pp. 11-12, and the Murray Report, at p. 36. The draft and confidential Report as provided to my office was described as '*a deliberative document only*'.

<sup>37</sup> Although the Committee is examining the adequacy of foster care assessment procedures, a term of reference is to examine the circumstances surrounding the 42 cases of abuse of children in care that are alleged to have taken place between April 2004 and September 2005, some of which include abuse in residential care. Other terms of reference also appear relevant to this investigation, including the adequacy of funding, training, supervision and support of Department for Community Development Case Workers and any other related matter.

<sup>38</sup> Unlike this investigation, the Department's Report also includes an examination of the Department's country hostels.

<sup>39</sup> The project considered statistical data, interviewed stakeholders within the Department and the non-government sector and obtained information on other Australian and international trends and concluded in June 2005. The Department advises that it provided valuable information about the costs of providing placements and services for children in care which it was able to use to support the budget process which resulted in improved funding for children in care in the 2006/07 Budget. The Department states that the draft report also highlighted that reforms were required to a number of key areas of services to children in care and that separate projects have been formed to address particular areas. However, it also advises that as many of the strategies recommended in the report have been superseded by other developments, the Department's Executive has not endorsed this report and it remains in a confidential draft form. This report, like all of the above Western

It should be noted, finally, that in January 2006 while this investigation was in its final stages, the Department appointed a consultant, Terry Simpson, to undertake a confidential review of its Placement Services (Hostels)<sup>40</sup>.

The terms of reference for this review were:

- To examine the over-arching programmatic focus in the hostel system and make comment on its implementation in each individual hostel. Make recommendations as to how the programs can be strengthened to improve outcomes for children in the hostel system;
- Flowing from the above examine the current skill requirements and training of the workers in the hostel system and make recommendations as to whether this is adequate and what else is required to improve the skills of staff to implement the programs to deliver better outcomes for children in the hostel system; and
- Examine the management systems and comment on their adequacy, make recommendations for improvement, with a particular focus on how critical incidents are reported, recorded, investigated, monitored and staff and children supported.

That review included the five hostels the subject of my investigation and the Canowindra Hostel in Bunbury, which was not managed by ACSS but is one of a number of regional hostels for children and young people managed by various Departmental District Offices. Simpson reviewed Departmental documentation, visited each hostel and consulted Departmental officers and external agencies, including my officers, and the review was completed in March 2006. The review was part of a positive initiative by the Department to appoint an Executive Director (Special Projects) on a 12-month term, with responsibility for the Department's residential care facilities and abuse in care, amongst other projects.<sup>41</sup> The Department states that the Executive Director's appointment was to ensure that many reforms which were already underway prior to receipt of my preliminary report would be fully implemented and states that the Simpson report<sup>42</sup> is assisting the Executive Director to guide the reforms occurring in Placement Services during the next 12 months.

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Australian inquiries and reviews referred to as having a particular relevance to the investigation, do include very useful, but more limited, examinations of the ACSS facilities than can be found in the Department's 2001 Report.

<sup>40</sup> ACSS has now been incorporated as one aspect of the new Placement Services, which also has responsibilities for non-government residential care management. I have continued to use the term ACSS residential care or hostels as a shorthand reference for those facilities which were the subject of my investigation.

<sup>41</sup> Previously ACSS had been within the jurisdiction of the Director of the East.

<sup>42</sup> T Simpson, *'Review of Placement Services (Hostels) on behalf of the Department for Community Development'*, 2006.

## Chapter 2 The Department's Response to the Informant's Concerns

### 2.1 Background

The disclosure which prompted this investigation was the first made to the Department under the PID Act. It highlighted incidents which occurred in 2002 and 2003 and outlined the informant's concerns about the treatment of certain young persons in the Department's residential care facilities.

In the months before lodging the disclosure, the informant had been dealing with Departmental managers in relation to issues the informant raised about the incidents and treatment of young persons in the hostels. The informant was not happy with the way in which those issues were dealt with and made the decision to lodge a disclosure with the Department. Apparently because of concerns about the way in which the issues raised had been previously dealt with, the informant did not give consent to the disclosure of information that might identify them as the person who made the disclosure.

The disclosure made to the Department mentioned '*the abuse of children in DCD hostels ... over a period of years*' and alleged '*punitive treatment of young persons in care*'. The disclosure was accompanied by a large number of documents consisting of copies of notes, e-mails, reports, correspondence and a list of persons who could be spoken to about some of the incidents and behaviours mentioned. In addition, a case example relating to one named young person was given, with details of the alleged punitive action taken.

The allegations made by the informant to the Department may be summarised as follows:

- attempts had been made by the informant to bring issues about the culture prevailing in the hostels, the performance management of certain hostel staff and the lack of leadership support, to the attention of managers at the Department. However, there had been no satisfactory investigation of the concerns raised;
- there were unacceptable practices in the hostels which breached the United Nations Charter of Human Rights. These included the use of punitive measures by staff, such as the denial of water and meals, the improper use of restraints, improperly locking young persons out of the hostel, improper methods used to wake up young persons, and threatening behaviour towards them;
- the provocation and assault of a young person by a member of staff; and
- the inadequate and unnecessarily delayed investigation of the incident involving the assault and the improper charging of the young person.

### 2.2 The Department's investigation

The informant approached the Department about making a disclosure on 4 July 2003 and the Department's investigation took place over a period of three weeks in late July and early August 2003. In relation to the issues raised, the informant was told that:

- there was insufficient evidence to support the claim that the specific case in question involved denial of meals or drinks and certainly not in terms of the United Nations Office of the High Commissioner Convention on the Rights of the Child;
- in relation to the allegation of assault, the evidence indicated that appropriate investigations were conducted by the Department and that the young person had the opportunity to give their account and to make a statement to investigating police;
- systems are not necessarily perfect and cannot always meet the specific needs of every individual who comes into the program or care situation. There must be a balance between

the needs of the individual, the needs of other individual clients in care, the statutory requirement to provide a safe working place and the general requirements and constraints, including budget, of any program provided by the State. What might seem to be the most desirable option is not always a practicable reality and at times is indeed a difficult balancing act;

- there are very conflicting views on how programs should be administered in the hostels and how issues should be resolved, but these are within the confines of the program provided by the State and as such are not matters that come within the parameters of the PID Act, other than for purposes of clarification of the issue;
- the case study did not support the view of symptomatic, wider or more prevalent issues existing within ACSS;
- a number of persons in the list provided by the informant could not be contacted and spoken to because to do so would reveal the informant's identity and put the confidentiality of inquiries at risk; and
- the general evidence provided by persons contacted did not effectively support or further the core issue that was raised.

The informant was also told that other matters raised, including management issues, personnel conflicts and staff disciplinary issues, did not come within the parameters of the PID Act. The informant subsequently approached my office and lodged a separate disclosure about the matter.

## 2.3 Analysis

Although my officers interviewed the informant and Departmental officers about the adequacy of the Department's investigation of the disclosure, the confidentiality provisions of the PID Act restrict discussion of individual accounts. Section 16(3) of the Act prevents the '*... disclosure of information that might identify or tend to identify anyone as a person in respect of whom a disclosure of public interest information has been made under this Act ...*' (my emphasis) unless certain circumstances apply. As one of the informant's allegations to my office was that the Department did not adequately examine the original disclosure, it seems to me that the phrasing used in this section is wide enough to include any Departmental officer involved in dealing with or investigating the informant's disclosure.

This disclosure was the first received by the Department. The Department's obligation was to investigate the disclosure or cause it to be investigated if the disclosure related to the Department's functions and otherwise met the definition of '*public interest information*' under the Act. Although the Department investigated the disclosure it appears to me that its ability to do so was affected by several factors, including the following:

- The Public Interest Disclosure Bill was passed by Parliament in early May 2003 and the PID Act came into force on 1 July 2003. There was very limited time to plan its implementation and to produce the Code of Conduct and Integrity and the Guidelines required by the PID Act before this disclosure was received. Although the Guidelines on Internal Procedures, for use by government agencies and public authorities, were sent out to agencies by the Office of the Public Sector Standards Commissioner on 1 July 2003 the investigation of disclosures under the Act was new to all of those involved. In this regard the Department has commented that the process of conducting a PID was very new for the Western Australian Public Sector at the time of this disclosure and no training was then available to Departmental staff about the new legislation and consequently no guidance in how to conduct such an investigation. In these circumstances the Department states that it did its best to provide its officers involved in the matter with all necessary information, support and links to other relevant agencies;
- The large amount of documentation provided by the informant at the time of the disclosure to support allegations about incidents and behaviours that had occurred in the hostels. The documents consisted of notes, e-mails, reports, correspondence and other documents. It was not an easy task to identify from the documents all the issues of concern to the

informant and make an assessment whether the information provided amounted to '*public interest information*' that could be investigated under the PID Act. In addition, a number of the matters raised had been the subject of separate processes within the Department initiated by the informant and this may well have influenced the decision whether to examine them as part of the disclosure; and

- Concerns about confidentiality. The Act provides serious penalties for disclosing the identity of an informant in circumstances other than those provided by the Act. The informant in this case did not give consent to the disclosure of information that might identify them at the time of making the disclosure to the Department. The issue of whether the informant gave consent at a later stage, when the matter could be further investigated by the Department cannot be resolved because of a conflict in accounts. In this respect, however, I note that section 16(1)(c) of the PID Act allows a person to disclose information that might identify the informant if '*it is necessary to do so to enable the matter to be investigated effectively.*' Before exercising the authority to disclose a name under section 16(1)(c), however, the person must give reasonable notice to the person whose identity is to be disclosed, that the disclosure is to be made and the reasons for it.

The same information provided to the Department by the informant was given to my office when the informant made the disclosure. My officers held two lengthy interviews with the informant to discuss the information given and to identify the matters to be investigated. As a result, a number of the concerns expressed by the informant and not dealt with by the Department were identified as being appropriate disclosures requiring investigation. Some of those matters, including management and staff disciplinary issues, the level of care prevailing in the hostels, inconsistency about the approach to care and a lack of guidance available to DCWs about what measures could be implemented to manage the behaviour of the young persons in their care, are dealt with in this report.

## 2.4 Conclusion

Having reviewed the investigation of the informant's disclosure by the Department, I formed the view that it did not adequately address the concerns expressed about the consistency and standard of care provided to young persons in the hostels. I believe that this is not the fault of any individual officer or officers, but rather is an observation made following all the work subsequently undertaken by my office.

On the information before me, it seems that at the time of the informant's original disclosure to the Department in 2003, the Department had not reviewed its hostel system as a whole, including its place in the provision of direct care to children and young persons, since its *Family and Children's Services' Accommodation Hostels: Report to the Minister for Community Development* in 2001. This was despite the acknowledgement in that report that the Department had lost the capacity to deal effectively with the high-risk children and young persons in its residential care,<sup>43</sup> and the indications that problems in the hostel environment had intensified, not the least being the problems caused by the lack of placement options. In response to this observation, the Department has referred to subsequent extensive work it has undertaken in relation to its residential care services, including the draft and confidential report, *Care Responses into the Future*, the *Review of Placement Services*<sup>44</sup> and the appointment of Executive Director of Special Projects, referred to previously. I appreciate the positive outcomes of this work by the Department, in particular the additional funding the Department has now secured for the residential care sector. I note these efforts were subsequent to the commencement of my own investigations into the Department's hostels.

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<sup>43</sup> *Hostels Report*, p.31.

<sup>44</sup> T Simpson, '*Review of Placement Services (Hostels) on behalf of the Department for Community Development*', 2006.

In terms of assisting the Department to undertake future PID investigations, given the circumstances I have described, I do not consider that there is any recommendation I need make. It has now been nearly three years since the implementation of the PID Act. Agencies and their officers have a better understanding of the provisions of the Act and the criteria they must take into account in deciding whether to investigate a public interest disclosure. Better resource materials and information are now available for Public Interest Disclosure officers conducting an investigation, and the Office of the Public Sector Standards Commissioner is conducting workshops for officers involved. The Department has requested that I note that this investigation occurred over a lengthy period and the Department's practice has continued to evolve. The description of the investigation in this report, in the Department's view, is not clearly representative of its evolving practice in relation to PID investigations. I believe that the extensive dialogue between my officers and staff of the Department during our investigation has contributed to a greater understanding by the Department of its responsibilities under the PID Act. It has also highlighted some issues that may be raised in the context of a review of the legislation.

However, the PID Act aims to ensure openness and accountability in government by encouraging people to make disclosures and protecting them when they do so. Consistent with that aim a Department receiving a disclosure has the opportunity to fully examine the information given, to investigate any matter concerning its operations and to take all reasonable action to prevent the matter to which the disclosure relates from continuing or occurring in the future. In my view, given the intent of the PID legislation and in particular, the Department's stated desire to improve its residential care facilities, the Department's investigation of the informant's disclosure should have reasonably explored the concerns about the consistency and standard of care provide in the hostels.

The informant has been subjected to additional inconvenience by having to repeat the disclosure to my office. I also acknowledge that the inconvenience experienced by both the informant and any Departmental officers involved in the matter has been heightened by the length of the process involved in this investigation.

The Department has stated that on the information and support that was available at the time in relation to carrying out PID investigations, it worked diligently to investigate the matter in an expeditious manner. In my view, however, the issue is not solely one of the practical difficulties that confronted the Department and its staff in dealing with new legislation. I recommend that:

1. The Department develop an appropriate apology which takes into account the inconvenience and anxiety caused to the informant as a result of the inadequacy of the Department's investigation of the original disclosure, as has been demonstrated by my investigation.

I am pleased that the Department accepts this recommendation.

## Chapter 3 Legal and Administrative Framework

For the purposes of this investigation, the primary legislation governing the Department's functions in relation to young people in care and more generally was the *Child Welfare Act 1947*.<sup>45</sup> Although the repealing of that Act and its replacement by the *Children and Community Services Act 2004* (C&CS Act), formally marked a new era in child protection, on the information before me, there has been significant '*cultural change*' in practice about these issues over the last 15 to 20 years.

It appears these changes had not been captured so much in the CW Act's provisions, which in key respects remained unaltered over this time, but were driven by broader changes in societal attitudes to children and young people and issues of child abuse. Change appears to have been more likely to be reflected in Departmental policy; the administrative framework relating to young people in the Department's care is therefore also very significant.

### 3.1 *Child Welfare Act 1947*

A key provision of the CW Act that authorised the Department to intervene in the lives of children and young people was section 10A which stated:

'10A. General function of the Director-General

The Director-General may take such action or cause such action to be taken, not inconsistent with the provisions of this Act, as may be reasonably or probably necessary for promoting the welfare of a child, whether that child is a ward or placed under the control of the Department or not, and the Director-General and any officer of the Department authorised by the Director-General in that behalf has all such powers as may be reasonably necessary to enable such action to be taken.'

That provision, inserted in the CW Act in 1976, gave the Director General (now the Chief Executive Officer '*CEO*') extensive powers provided these were exercised for promoting the welfare of a child,<sup>46</sup> whether the child was a ward, was in the Department's control, or was not.

The C&CS Act contains a very similar provision, namely 21 (1) (b) which states:

'21. Functions of CEO

(1) The Functions of the CEO include

(a) .....

(b) to take, or cause to be taken, any action, not consistent with this Act, in respect of a child or a class or group of children that the CEO considers reasonably necessary for the purpose of safeguarding or promoting the wellbeing of the child of children concerned.'

It appears however, that primarily reliance has been placed on the power of the Department under section 30 of the CW Act to make application to the court to have children and young people committed to its care or placed under its control.<sup>47</sup> Although the powers to act to promote the welfare of children under section 10A were on the face of it almost unlimited, it appears that the

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<sup>45</sup> The long title to the CW Act states: '*An Act to consolidate and amend the law relating to the protection, guidance and maintenance of children in need of care and protection and for other purposes connected therewith.*'

<sup>46</sup> In any event s. 3A of the CW Act (inserted in 2002) requires that in performing a function or exercising a power under that Act in relation to a child, the best interests of the child is the paramount consideration.

<sup>47</sup> The CW Act, '*Children in Need of Care and Protection and Uncontrolled Children*', ss. 29-32.

Department had largely restricted the scope of its responsibilities (other than when specifically required to do otherwise<sup>48</sup>) to only those concerns about child welfare which might require removing children from the care of their parents or legal guardians.

This approach is of considerable significance with reference to the Department's operations generally, and had specific implications for this investigation, as indicated below.

The Department's child protection investigations, presumably conducted pursuant to section 10A, as there was no specific conferral of investigative powers under the CW Act,<sup>49</sup> can be summarised as follows. These investigations were initiated in response to what was referred to as '*Child Maltreatment Allegations*'. '*Child maltreatment*' was the term used by the Department to refer to physical, sexual or emotional harm or neglect of children. It could also refer to persistent actions or inactions, which may not be of a severe nature in any one instance, but where the cumulative effects result in significant harm to the child. A distinction was made, however, between child maltreatment and issues about the standard of care, such as inappropriate discipline.

Under the CW Act, the Department would generally only act to investigate allegations of mistreatment of children if these allegations indicated abuse by parents, persons '*in loco parentis*' (in the place of parents), or someone exercising care responsibilities for the child.<sup>50</sup> The Department has stated that:

'The Department has a statutory responsibility to receive and assess reports of children and young people being maltreated through the actions, in-actions or inability of people who have parental responsibility to protect and care for them...'<sup>51</sup>

Relevantly, the Department does not investigate allegations of abuse of children involving people acting in their employment capacity. Unless that role is interpreted as also including the exercise of parental responsibilities for the child or young person, the Department, if notified, generally refers complainants to the Police for criminal matters or to the relevant employer to undertake internal disciplinary investigations. Significantly for this investigation, it appears that the Department classifies residential care workers (both Departmental and non-government) as exercising '*care responsibilities*',<sup>52</sup> but not teachers, juvenile justice workers or others who arguably also may exercise significant power over children and young people in their care. As a result its own employees may be subject to both Departmental child protection and disciplinary investigations (in addition to Police and Corruption and Crime Commission proceedings if relevant).

The limited jurisdiction that the Department has had in investigating allegations of abuse is not explicit in all its publications.<sup>53</sup> It appears that a number of stakeholders, and even some staff members within the Department, are unaware that the Department does not have a direct role in

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<sup>48</sup> For example, the Department has specific functions to regulate child-care facilities; in the absence of these legislative obligations it appears that the Department would not investigate allegations of abuse perpetrated by child-care staff.

<sup>49</sup> There is, however, a power under s. 146A of the CW Act to apply for a warrant to enter premises and '*there investigate and inquire into the information*' raising suspicions about a child's care and apprehend any such child.

<sup>50</sup> Case Practice Manual 4.3.1. It also states '*Cases where a child is assaulted by a "stranger" or by someone with no "care" responsibilities, and where there are no apparent protection issues within the family, are generally dealt with by the Police.*'

<sup>51</sup> DCD, *Statutory Child Protection: A Policy for the Wellbeing and Safety of the Maltreated Child* (2004), p. 4.

<sup>52</sup> In its response to my preliminary report the Department stated that it would address concerns about a child in the CEO's care involving any Departmental officer regardless of their occupational group.

<sup>53</sup> See, for example, the Department's website page '*The Role of DCD*', where it states that the Department '*has a statutory responsibility to ensure children are protected from abuse and neglect by promoting the wellbeing of children... [and] assessing and responding to concerns for the wellbeing of children ... and families... The recently passed new Children and Community Services Act 2004 has strengthened the powers of the Department to receive and assess allegations of child abuse and neglect and take action to protect children*'. ([www.community.wa.gov.au/Resources/Child+Protection/The+Role+of+DCD.htm](http://www.community.wa.gov.au/Resources/Child+Protection/The+Role+of+DCD.htm) as at 17 May 2006)



investigating allegations which do not involve abuse or neglect by those with parental responsibilities. The Department states that it has addressed this problem through ongoing staff training, which commenced prior to the implementation of the C&CS Act in March 2006 when it replaced the CW Act, and which clearly explains the Department's legislative responsibility to ensure a child's wellbeing, including the extent of its investigative powers.

Allegations about maltreatment and abuse perpetrated by people other than those acting in a parental capacity are not generally recorded on the Department's databases. Any investigations of these maltreatment allegations by employers are not subject to a systemic monitoring or other follow up by the Department:

'The Department may also receive reports concerning the maltreatment of children and young people by people who do not have parental responsibility for them. In such cases the Department has a responsibility to ensure an assessment of the report occurs and appropriate action is taken. In most cases this will be through referral to the Western Australian Police Services and/or advice and support to those with parental responsibility.'<sup>54</sup>

In spite of changes in this area as a result of C&CS Act, it appears unlikely that this understanding of the Department's role will change. The Department has changed the terminology used to represent the action it takes under the C&CS Act but the practice remains unchanged for matters that are about allegations that a child has been maltreated. If it is alleged that a third party maltreats a child, the Department advises that, consistent with its policy and practice, it will assure itself that the parent is protective. Should a child remain at risk, the Department may initiate intervention action under the C&CS Act or take other steps to ensure the safety of the child.

The C&CS Act provides specifically for the CEO, under section 32(1)(d), to '*cause an investigation to be conducted*' but only to '*ascertain whether the child may be in need of protection*'. Because investigations are tied to determining the need for care and protection, these can only occur in circumstances where:

- the child's parents are not available or able to care for the child; or
- the child has been or is likely to be harmed as a result of physical, sexual, emotional and psychological abuse and '*the child's parent's have not, or are unlikely or unable to protect the child from harm, or from further harm*'.<sup>55</sup>

Parents are defined as anyone, other than the Department's CEO, who has responsibility for the long-term or day-to-day care, welfare and development of the child.

However, the Department advises that this does not preclude the investigation of allegations of abuse in respect of children in the CEO's care which can occur by virtue of section 21(1)(b) or the fact that the CEO has parental responsibility or the child is otherwise in the CEO's care.

There is nothing on the face of these changes which would indicate that the Department intends to take a broader role in investigating child abuse than it did under the CW Act. As a result the limited jurisdiction exercised by the Department appears unlikely to be expanded by the new legislation.

Concerns have arisen from this investigation<sup>56</sup> and others conducted by my office into another public sector agency about the handling of allegations of child maltreatment within the framework of employment disciplinary processes. For example, these processes focus on the relationship between employee and employer; they do not appear to provide for information to be available to third parties affected by employee misconduct; or to make specific provision for investigative or

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<sup>54</sup> DCD, *Statutory Child Protection*, p. 4.

<sup>55</sup> Section 28(2).

<sup>56</sup> Described in detail at 15.3.

evidentiary rules to accommodate child witnesses. Because of the high standard of proof required, these processes can also limit the capacity of the employer to take appropriate risk management measures, in some instances to the detriment of both the employee and children. Significantly, and in contrast to other jurisdictions such as New South Wales,<sup>57</sup> there is no external systemic monitoring or evaluation of these processes, even in relation to those government and non-government agencies that have substantial dealings with children. I deal with this issue in more detail at 16.1.

In its response to my preliminary report, the Department requested that I note that its internal investigative capacity has been substantially enhanced with an additional six full time equivalent positions being allocated to the Duty of Care Unit to centralise the investigations of allegations of abuse in care, including allegations concerning Departmental staff.<sup>58</sup> I welcome this enhancement.

### 3.2 Specific *Child Welfare Act 1947* provisions concerning residential care

There were a number of specific provisions in the CW Act concerning residential care. These included a power for the Director General to be the guardian of wards, to have the supervision of children in the Department's control,<sup>59</sup> and to place any such children in '*suitable facilities*'.<sup>60</sup> Those facilities might have been Departmental facilities, which could be inspected by judges or magistrates; and subsidised or voluntary facilities, which could be inspected by Departmental officers.<sup>61</sup> There was also a requirement that a Departmental officer visit all wards or those under the control of the Department who '*have been placed out*' at least once every six months.<sup>62</sup> The benefits available to a ward could also be extended to children with '*absent parents*'.<sup>63</sup>

A number of provisions under the CW Act until 2006 gave considerable powers to the Department to apprehend children. There was a power for police or Departmental officers to apprehend a child appearing or suspected to be in need of care and protection, a power to apprehend '*absconders*' from facilities without a warrant; and a power to apprehend children without parental supervision where a responsible person could not be located.

The Department comments that the CW Act, after the changes of the 1980s and 1990s, did not provide any clear legal power for it to detain children against their will. While some provisions, such as section 31, appeared to give a power to detain, the Department states that a close reading of the actual provision reveals no such power. It states that the 'detention' power in section 138B only relates to the placement of a child or until the child could be returned to a parent or responsible person or made the subject of a care and protection application.

The new C&CS Act provides for the apprehension of children in need of protection with or without a warrant, to 'move [children] to safe place', but not for their 'detention'. Unlike the CW Act, however, it does authorise the restraint of a child by a Departmental or police officer, but that term is not defined.

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<sup>57</sup> See *Ombudsman Act 1974* (NSW), Part 3A '*Child Protection*', and NSW Ombudsman, *Annual Report 2004/5*, pp. 80-85.

<sup>58</sup> Message from the Acting Director General to DCD staff, 11 May 2006.

<sup>59</sup> Section 10(1).

<sup>60</sup> Section 10(2).

<sup>61</sup> Part III '*Facilities*'.

<sup>62</sup> Section 64(1).

<sup>63</sup> Section 66C.

### 3.3 Public Sector Management Act 1994

One of the complexities of this investigation was that there was no neat delineation of issues relating to the investigation of allegations of child maltreatment. Indeed the conflicting obligations of managing a workplace the function of which is child protection is in many respects central to the issues examined in this report. As a result, although there is clear guidance under the CW Act making the interests of the child paramount (introduced by amendment in 2002) in the exercise of functions under that Act (as elaborated in more detail in the new legislation), other legislative obligations are applicable as well. In examining the Department's residential facilities, and in particular the interaction between young people and Departmental staff in those environments, the *Public Sector Management Act 1994* (PSM Act) is an equally significant piece of legislation.

That legislation establishes a clear and strict process by which concerns and allegations involving disciplinary breaches by public officers are to be handled and is set out in more detail in Chapter 15 of this report. It is of note that the disciplinary process provided for in the PSM Act is, like other employment disciplinary processes, generally highly confidential. The Department of the Premier and Cabinet notes that this process is to be:

'applied independently of any other criminal or civil action and should not be confused with these. The disciplinary process is concerned with the relationship between employer and employee.'<sup>64</sup>

The prescriptive nature of the above process is based on the significance of fair process in matters which potentially involve the loss of livelihood and other serious consequences for employees, amplified by the need to ensure that public officers are able to undertake their work without fear or favour.

The Department of the Premier and Cabinet's *Disciplinary Procedures Guide* provides examples of what may be minor and serious breaches under the PSM Act. Minor infractions potentially include disregarding a non-smoking policy; making excessive personal phone calls; or being repeatedly late. Serious infractions potentially involve misappropriation of funds; behaving aggressively or offensively with colleagues; or releasing agency records to the media without approval.<sup>65</sup> As indicated previously, one of the questions raised by this and other investigations by my office, particularly in the context of allegations of employee mistreatment of children, is how well adapted such disciplinary processes are for dealing with matters where there is a third party 'victim' who has no or limited recourse to other avenues, criminal or civil; and who moreover, as a child in a criminal or civil proceedings, would have the benefit of particular investigative and evidentiary rules.

### 3.4 Policies and administrative framework

The recent Murray Report stated:

'It would seem that departmental standards, procedures and practice are observing the findings of previous reviews and the changing approaches of child protection practice in Australia.

The continuum of service delivery and child protection thinking in Australia has changed considerably in recent times. Practice is improving across the jurisdictions as recommendations

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<sup>64</sup> Department of Premier and Cabinet (DP&C), *Disciplinary Procedures Guide: A comprehensive guide to the disciplinary procedures contained in the Public Sector Management Act 1994*, 2005, p. 8.

<sup>65</sup> DP&C, p. 8

from various reviews are implemented, resources and support are increased and further studies continue to focus on how to provide optimum care and practice.’<sup>66</sup>

As indicated previously at 3.2, the primary piece of legislation applicable to the protection of children until March 2006, the CW Act, was widely accepted as not having, in significant ways, kept up with important changes in broader community attitudes.<sup>67</sup> This was understandable in the rapidly changing and responsive environment described by Murray. However, the result was that changes were reflected more in Departmental policies than anywhere else. This resulted in a proliferation of various policy instructions, manuals and protocols, and appears to have created difficulties.

In undertaking this investigation some considerable time was spent in trying to determine the relevant Departmental policies applying in residential care. This policy included:

- Director General’s Instructions;
- Administrative Instructions;
- Administrative Procedures and Approvals in Casework;
- Best Practice Manual;
- Field Worker Guidelines;
- Case Practice Manual;
- Child Protection - A Guide to Practice;
- Various published policy statements;
- Staff circulars and various e-mails;
- Police protocol;<sup>68</sup>
- Training materials; and
- The ACSS Manual.

An example of the problem posed by the variety of policy sources can be seen in the Department’s response to a request from my office seeking information on any applicable policies and procedures indicating the timeframe for the conduct of child maltreatment investigations, where the allegations involved Departmental employees.<sup>69</sup> In responding, the Department elaborated upon the timeframe and upon further details associated with the investigation of Departmental employees, providing copies of 22 various policies, forms, flowcharts and reports all relevant to such an investigation. Murray recommended the Department streamline its policies and processes associated with responding to abuse in care,<sup>70</sup> and I support that recommendation. The Department has advised that it is currently working on implementing the Murray recommendation as a matter of priority. In its response to my preliminary views on this matter, the Department acknowledged the confusion caused by the number of different policy and procedural documents within the

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<sup>66</sup> Murray Report, p. x.

<sup>67</sup> The Department identifies the background to the current C&CS Act as commencing almost 20 years ago, in 1987, with the Legislative Review Committee’s review of legislation administered by the Department. This resulted in the 1991 report ‘*Laws for People*’. (J Wilkinson, Power point presentation, ‘*Children and Community Services Act 2004 - Overview*’, 30 March 2006, (p. 2).)

<sup>68</sup> Protocol between the Western Australia Police Service and the Department for Community Development’s Adolescent and Child Support Service, 2001.

<sup>69</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 22).

<sup>70</sup> Murray Report, p. xiii. Recommendation 9.1: ‘*It is recommended that the wide ranging policy and procedural documents in response to allegations of abuse in care, be streamlined for ease of use and incorporated into training.*’

Department. It advised that work has been occurring on an ongoing basis since early 2005 to streamline the number of policy, procedural and practice documents used within the Department. The Department states that the Field Worker Guidelines is an online manual which has replaced and consolidated a range of policy and practice guidelines and that a corporate Electronic Document and Records Management System, part of the '*Assist-D Project*', is expected to make it much easier to ensure historical documentation such as old procedures and manuals are electronically stored but not generally accessible when the information is superseded.

The confusion over policy directives is not only the result of the proliferation of documentation. For example, in its response to the request for information about the timeframe for the conduct of child maltreatment investigations involving Departmental employees, the Department did not include reference to the Administrative Instruction 522 - the topic of which is '*Procedures to deal with allegations of child maltreatment against Departmental employees and foster carers*'. It seems that this Instruction is under review, and indeed has been for some years,<sup>71</sup> but according to Departmental Instructions it remains in force.<sup>72</sup> That policy requires, among other things, that the outcome of substantiated and unsubstantiated child maltreatment allegations against Departmental staff and the relevant documentation be retained on the officers' personal files. One policy document, Case Practice Manual 4.10, supports the retention of the outcome of substantiated and unsubstantiated allegations, but at least one other, Best Practice Manual 1.4.10, directly contradicts the Instruction and states no outcome is to be recorded on the personal files if an allegation is unsubstantiated. On the basis of a number of discussions with various Departmental officers, discussed further in 14.8.3, it appears that the Department's actual practice may not be consistent with any written policy, with the outcome of neither substantiated nor unsubstantiated allegations being retained on the officers' files.

The Department's policies and manuals are discussed again later in this report.

### 3.5 Duty of care

'*Duty of care*' refers to a general duty, at law, to take reasonable care to prevent or minimise harm to others. The scope of that duty is difficult to define precisely, but liability for a failure to exercise the appropriate standard of care can extend to harm which occurs to others because of a failure to act with the attention and caution that a reasonable person in the circumstances would use, generally referred to as '*negligence*'. The obligations associated with a '*duty of care*' can be made more precise through legislation, which may include or exclude certain responsibilities, for example with reference to employers' responsibilities for the safety and well-being of their employees. Legislation may also give guidance about which duties are most important, for example in the case of the Department exercising power under the CW Act and now the C&CS Act, that the interests of the child are to be paramount. However, it is generally accepted that duty of care obligations extend more broadly.

In the context of the Department's residential facilities, the Department's duty of care obligations, depending upon the particular circumstances, may extend to a range of people including the young people in its care and their families; its employees; and possibly residents in the vicinity of its facilities. The limits of those duties are not precisely defined and are likely to change over time and as a result of court judgments and legislative reform.

At this point I wish to note a recent initiative by the Department to develop a '*Duty of Care Register*', administered by the Department's Duty of Care Unit. The Duty of Care Register is an '*integrated module*' of the CCSS, the Department's client database. The Duty of Care Unit and Register deal solely with those Departmental clients who are, or were, children and young people in

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<sup>71</sup> Cant Report, p. 49.

<sup>72</sup> See Director General's Instruction No. 1 which states that Administrative Instructions '*will remain in force*' until these are reviewed and reissued as Director General's Instructions.

care. Since February 2004, the Register has been used to record those incidents involving young people in the Department's care described in Director General's Instruction 59, including deaths, serious injuries, critical incidents and allegations of abuse. It was developed, among other things, to assist the Unit to monitor the timelines and adequacy of Departmental investigations and responses to abuse in care, and to address the Department's obligations resulting from the '*Bennett principle*', a legal principle whereby young people in its care may be entitled to independent legal advice about their potential legal claims against the Department.

The Cant Report assessed aspects of the Duty of Care Unit relating to meeting the Department's obligations under the '*Bennett principle*' as best practice.<sup>73</sup> It is important to be aware, however, that the Unit and Register only deal with one particular aspect of the Department's duty of care - that owed to those children and young people in its care who have been abused.

Because the Department's duty of care obligations extend to a range of people, in my view there is a difficult '*balancing act*' of potentially competing obligations which the Department aims to try and meet. A relevant example in the instance of residential care concerns young people in the Department's care whose difficult histories have resulted in them being both vulnerable to, and perpetrators of, sexual abuse, as well as prone to violent acting out. As indicated, a primary responsibility of the Department in performing its functions under the CW Act, and now the C&CS Act, has been to act in the interests of '*the child*' in accordance with its legislative obligations. However, where those young persons are resident in the Department's facilities, this requires not only that adequate measures are in place to protect a young person from him or herself, but also from each other. At the same time the Department is also subject to other obligations; for example, to ensure that there are measures in place to reasonably protect other young people and members of the public in the vicinity of the residential care facility from risk and nuisance; and that staff have the skills and capacity to manage difficult young people appropriately and without undue risk to themselves.

As mentioned earlier, in this investigation I have primarily examined three broad issues:

- the adequacy of systems relating to the prevention and detection of maltreatment;
- the adequacy of measures used to deal with maltreatment; and
- the adequacy of the Department's response to the informant's disclosure.

Although these issues are examined against the background of the Department's overall duty of care, I recognise that the Department has a complex and difficult task in managing its responsibilities.

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<sup>73</sup> At p. 51.

## Part II Background

### Chapter 4 The History of Residential Care

The allegation which prompted this investigation was that the Department had failed to properly address institutionalised practices amongst staff in its metropolitan facilities, resulting, it was alleged, in the consistent abuse in care of young persons. The history of the care of children and young people removed from their families in this State, as detailed below, assists in understanding both the nature of the concerns raised and how these may be addressed.

#### 4.1 Out-of-home care in WA

In its 2003 submission to the Senate Community Affairs References Committee Inquiry into Children in Institutional Care,<sup>74</sup> the Department highlighted the traditional view in WA that:

‘A basic theme for government officials and legislators has been that the care of children should be left in the hands of ordinary citizens and religious bodies’.<sup>75</sup>

It was said that, as a result:

‘The history of out-of-home care in Western Australia is ... largely one of a state sponsored system with more facilities run by private than the public sector.’<sup>76</sup>

This history was ‘state sponsored’ because, other than the Indigenous children removed under racially specific laws<sup>77</sup> and British child migrants (both of which are outside the scope of this investigation), children and young people were removed from the guardianship of their parents by the courts and ‘committed to the care of the Department’. The historical reasons for court intervention may be grouped into three categories: two relating to the conduct of children - ‘delinquency’ (criminal conduct by those under the age of 18) and ‘uncontrolled’ behaviour; the other, because the conduct, or absence, of others who were supposed to care for the children, left them ‘destitute’ or ‘neglected’. As indicated above, however, traditionally the provision of direct

<sup>74</sup> The Report of that Inquiry was referred to at 1.5 above, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as a child*.

<sup>75</sup> *Annual Report for the Department of Community Welfare, June 30 1979* quoted in Western Australian Department for Community Development (DCD), *Submission to Senate Community Affairs References Committee Inquiry into Children in Institutional Care*, 2003, at p. 4. For example, the Department’s *Signposts* contains information and contact details for more than 200 facilities that provided some sort of residential, out-of-home care in Western Australia from 1920, sometimes even earlier. The Department and its predecessors had an active role in managing 78 of these facilities, with the remainder being the responsibility of non-government organisations (DCD, *Signposts – A Guide for Children and Young People in Care in WA from 1920* [undated - released 2 November, 2004], p. 17.)

<sup>76</sup> DCD, *Submission to the Senate Community Affairs References Committee Inquiry into Children in Institutional Care*, p. 4.

<sup>77</sup> In addition to the ‘Aboriginal missions’ and ‘Children’s homes’, there were also a large number of hostels for Indigenous children and young people accessing education and employment away from their homes which were operated by, or in association with, the Native Welfare Department (DCD, *Signposts*, p. 34). The Department assumed responsibility for these hostels from 1972. Although the legal status of the ‘Aboriginal Protector’ prior to that time was as the guardian of many Indigenous children, who presumably then would also fall within the category of children in the care of the State, these hostels have not been considered for the purposes of this report.

care to these children, who were known until recently as wards,<sup>78</sup> was either through foster care or was outsourced to private, generally religious, organisations, which were often subsidised by government to provide this care.

Up to the 1950s, other than foster care, out-of-home care was generally provided through 'Traditional Institutions' with 'dormitories, large dining halls and separated from the local community by a physical barrier such as a fence, sometimes even with a school on the premises', some with hundreds of resident children and young people.<sup>79</sup> At the same time, an emphasis on the State's role in the placement, inspection, licensing and regulation, rather than as itself a primary caregiver,<sup>80</sup> meant that children within public sector institutions consistently represented only a small minority of those in the Department's care.

In 1947 when the CW Act was passed, the Department ran only one of the 'institutions' for children listed in the Schedule to the Act, the Walcott Receiving Centre.<sup>81</sup> Generally once the non-offending wards, 'neglected', 'destitute', 'incorrigible' or 'uncontrolled' children, were placed in the care of the Department by the courts, they could be committed either to this Centre or any of the other religious institutions, either by specific court order or at the discretion of the Department.<sup>82</sup> However, if a child was found guilty of an offence punishable by imprisonment, the Children's Court could order that child to be detained at an 'industrial school' rather than be sent to an adult prison, but not to any other of the scheduled institutions.<sup>83</sup> The industrial schools for both males and females at that time were run by religious organisations.

The industrial schools and the other institutions for children, at this time, were all places of detention regardless of which agency managed their operations. The thinking may be characterised as:

'a child, unlike an adult, has a right "not to liberty but to custody". He can be made to return to his parents, to go to school, etc. If his parents default in effectively performing their custodial functions ... the state may intervene. In doing so it does not deprive the child of any rights because he has none. It merely provides the "custody" to which the child is entitled.'<sup>84</sup>

Until the late 1950s, the Department oversaw this system, but provided little direct residential care to children, including the child offenders who were known as 'delinquents'.<sup>85</sup>

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<sup>78</sup> Later, in 1976, the Department could have control of children, but was not their guardian, and as such these children were not wards. More recently some children were in the care of the Department on an informal basis, and they were referred to as 'non-wards'. Under the C&CS Act, children in care are no longer referred to as wards in any circumstance.

<sup>79</sup> DCD, *Signposts*, p. 26.

<sup>80</sup> DCD, *Submission*, p. 5.

<sup>81</sup> CW Act, Schedule 2 (1947 version). The Government Reception Home (or Depot) opened in 1894 to receive and hold children until they could be either returned home or placed elsewhere. Throughout its history, the Walcott Centre, as it became known, accommodated children who came there for all sorts of reasons - country children who came for medical treatment in Perth, children who were destitute or whose families were temporarily unable to care for them, and children who had been referred by the Police or Courts. Its functions did not change considerably until the 1970s (DCD, *Signposts*, p.534).

<sup>82</sup> CW Act, ss. 30(b), 31 (1947 version).

<sup>83</sup> 1947 version of the CW Act, ss. 34(a), 41. There was some discretion in special circumstances determined by a court, or in instances of misconduct where it was approved by the Minister, to transfer an 'inmate' of an institution to an industrial school, and to transfer, also with approval of the Minister, an inmate of an industrial school to a different institution for good conduct (s. 41(2)).

<sup>84</sup> Justice Forstas, Gault Case (US), quoted in DCD, *Juvenile Justice Systems*, at p. 23. Although there were fundamental differences between the juvenile justice processes in the US and Australia, this point appears applicable to the operation of the CW Act provisions relating to both offending and non-offending juveniles at least in the first half of the 20<sup>th</sup> Century.

<sup>85</sup> Other than the Walcott Reception Centre, Tudor Lodge was the only other Departmental run-facility up until the 1960s, and it provided accommodation for male wards and immigrant children working in the city from 1952 (DCD, *Signposts*, pp. 521, 523). Stoneville (later Hillston), described as 'the only residential reformative institution for boys in the State' was



A significant departure from the '*basic theme*' of leaving '*the care of children ... in the hands of ordinary citizens and religious bodies*'<sup>86</sup> occurred in 1958 when the Department purchased land for the development of a '*closed reformatory*' for boys at Caversham (later known as Riverbank).<sup>87</sup> This was the same year that the Premier established a committee to report on juvenile delinquency in WA, consisting of the departmental heads of Child Welfare, Health and Education and the Commissioner of Police. The appointment of the committee appears to have been in response to '*a group of people*' who came together after a series of lectures on juvenile delinquency which had been run by the Adult Education Board.<sup>88</sup> They had written to the Minister requesting '*the appointment of a widely representative committee to enquire into the prevention of Juvenile Delinquency and associated problems*'.<sup>89</sup> The report's recommendations, which were not published until 1962, were largely consistent with the views of the original '*group of people*' who had prompted the inquiry, and included:

- the establishment of a residential corrective hostel to be operated by the Department for the '*most difficult boys so that no boy thereafter be placed in the adult gaol*';
- the establishment of a small closed reformatory for '*the most difficult girls*' (similar to the Riverbank facility);
- the establishment of a separate remand home for the short-term care, diagnosis and treatment of '*disturbed children*' referred by the courts or the Department;
- the strengthening of psychological staff employed within the Department by '*the progressive appointment of clinical psychologists*'; and
- the provision of additional family-type hostels for older aged boys and girls who had difficulty accessing private accommodation '*because of their records and characteristics*'.<sup>90</sup>

These recommendations for the marked expansion in the direct care role of the Department had been augmented by legislative changes to the CW Act in 1959. Those changes included removing the court's capacity to commit offending children to industrial schools, instead allowing the court only to commit offending children to '*the care of the Department for treatment, discipline and training*', and removing the prohibition from placing offending children in institutions other than industrial schools.<sup>91</sup> The Attorney-General, in the second reading speech delivered in August 1959, stated:

'the main purpose of the Bill is to enable the Child Welfare Department... to have greater control of the treatment of children who are committed to the care of the department; and to limit to some degree the power of the children's courts to make such orders as they now can make,

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managed by the Anglican Church on behalf of the Department from 1955, when the Salvation Army Seaforth Industrial School closed. (The management committee consisted of a majority of members appointed by the Anglican Archbishop and some Departmental representatives: J McCall, TL Robertson, D Moynagh & J O'Brien, *Report on Juvenile Delinquency in Western Australia*, 1962, p. 26.) Hillston did not come under the control of the Department until 1969 (DCD, *Signposts*, pp. 237-239, 498).

<sup>86</sup> *Annual Report for the Department of Community Welfare, June 30 1979* quoted in DCD *Submission to Senate Community Affairs References Committee Inquiry into Children in Institutional Care*, at p. 4.

<sup>87</sup> DCD, *Signposts*, p. 437.

<sup>88</sup> Those most involved included Erica Underwood, who had recently resigned from the Children's Court Bench, Professor Arthur Fox (Philosophy), Professor Eric Saint (Medicine), Malcolm Uren, journalist, George Bagration, child welfare worker, and interestingly given his later role, Eric Edwards, senior law lecturer (McCall et al, *Report on Juvenile Delinquency in Western Australia*, p. 5, and attachment by M Uren '*Delinquency*', p. 53).

<sup>89</sup> McCall et al, *Report on Juvenile Delinquency in Western Australia*, p. 5.

<sup>90</sup> McCall et al, *Report on Juvenile Delinquency in Western Australia*, pp. 28, 58.

<sup>91</sup> *Child Welfare Act Amendment Act 1959*, ss. 7, 10.

which can, or could, have the effect of undermining the treatment and discipline that the Child Welfare Department is able to provide.’<sup>92</sup>

Further changes to the CW Act in 1965 continued the trend towards giving the Department an unfettered discretion in managing wards. Courts lost the capacity to order the detention of non-offending wards (the neglected, destitute, uncontrolled and incorrigible children) in specific institutions, and instead could simply commit them to the care of the Department. The ‘*committal*’ of all such wards to institutions was now purely within the Department’s discretion.<sup>93</sup> This was said to be associated with the modernisation of the Act so that the majority of these children could be placed with foster carers or returned to their families.<sup>94</sup> Significantly too, the provision which had required that non-offending children not be sent to industrial schools was repealed.<sup>95</sup> Whatever the intention of these changes, one significant result was to significantly reduce the legal demarcation between offending and non-offending wards.

A significant expansion of direct residential care by the Department followed, apparently related to the Department’s role as a ‘*treatment agency*’ for the young offenders and other children committed to its care by the Children’s Courts,<sup>96</sup> although other Departmental facilities also provided assessment of non-offending wards, or temporary accommodation for those of working age.<sup>97</sup> The Department established a growing range of treatment (secure or ‘*closed*’) institutions, and treatment and training (‘*open*’) community based hostels, some of which later were attached to closed institutions, as in the case of Nyandi and Riverbank.<sup>98</sup> The treatment model adopted at that time appears to have been that of behaviour modification, with the treatment institutions and hostels focused on, but not confined to, the provision of services to juvenile offenders.<sup>99</sup>

This trend towards ‘*treatment*’ expanded when, in the early 1970s, the programs for juvenile offenders were extended to the new Departmental facility, the McCall Centre, which was ‘*aimed at primary school age children who were “behaviourally disturbed”*’.<sup>100</sup> A description of how the Department understood its operations at that time states:

‘The developing view of treatment is that, before a child can live a responsible life (that is, attend school or work regularly, remain reasonably stable in employment and residence, not offend, and so on), a number of periods may be spent in the institution’s buildings – security or open sections. These periods may include daily school attendance or work away from the institution. The different periods spent at the institution are regarded as part of a continuing process of treatment, interspersed with further treatment while living in the community. This further treatment is carried out by, or under the supervision of, institution staff. Increasingly, the child participates in planning his or her own programme is given more responsibility for carrying it out.’<sup>101</sup>

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<sup>92</sup> Western Australia, Legislative Assembly, *Debates*, 25 August 1959, pp. 1175-1176.

<sup>93</sup> *Child Welfare Act Amendment Act 1965*.

<sup>94</sup> Western Australia, Legislative Assembly, *Debates*, 17 November 1965, p. 2511.

<sup>95</sup> *Child Welfare Act Amendment Act 1965*, s. 19.

<sup>96</sup> CW Act, s. 34(a) (prior to 1976).

<sup>97</sup> From 1969, Bridgewater provided assessment for ‘*neglected or otherwise needy children who are not delinquent*’ (non-offending) children (DCD, *Signposts*, p. 121). In the 1970s, the Mt Lawley Reception Home (as the Government Reception Centre was then known) shifted from being mainly a holding centre to one with a greater emphasis on assessment and planning for the child’s future (DCD, *Signposts*, p. 534). Tudor and Stuart Lodges also provided temporary accommodation for wards of working age at this time.

<sup>98</sup> DCD, *Signposts*, pp. 27-28.

<sup>99</sup> DCD, *Hostels Report*, p. 31.

<sup>100</sup> *Annual Report of the Department for Community Welfare, June 30th 1973* referred to in DCD, *Signposts*, p. 28.

<sup>101</sup> *Annual Report of the Department for Community Welfare, June 30th 1973* as quoted in DCD, *Signposts*, pp. 27-28.

During this era, the Department also assumed control of all the Native Welfare Department's Education and Employment Hostels, and subsequently expanded its residential care services to include group homes in the metropolitan and regional areas. It appears that the group homes may also have been influenced to a degree by the behaviour modification models applied in the treatment and training hostels, with an emphasis on *'a more specialised type of family care' in a 'skilled and stabilising environment'*.<sup>102</sup>

There were further significant changes to the CW Act in 1976, with an intention of continuing the guardianship of parents over their *'delinquent'* children after they offended.<sup>103</sup> According to the second reading speech, the proposal was that, in contrast to children who were placed in the care of the Department on the basis of being *'in need of care and protection'*;<sup>104</sup> offending children would only be *'placed under the control'* of the Department. The intention was described as ensuring that while the Department had *'virtually the same control over an offending child under the new proposal it will have the very important effect of demonstrating that parents still are basically responsible for their children'*.<sup>105</sup> The proposal was also that in relation to *'uncontrolled'* children, being *'a "grey area" bridging offenders and innocent children'*, the courts would have an option as to whether to place them under the care or in the control of the Department *'depending on the circumstances in each particular case'* - with an emphasis upon older children who were *'out of control lean[ing] towards the provisions for offenders while the younger child is seen more appropriately as being in need of care and protection'*.<sup>106</sup>

When the amendments were made to the Act, however, an option to place children in need of care and protection and *'uncontrolled children'* either under the control, or in the care, of the Department had been included; whereas offending children could only be placed under the control of the Department.<sup>107</sup> As a result there continued to be no clear legislative delineation between offending, *'uncontrolled'* and non-offending wards, although it appears that in practice the status of being under the control of the Department was viewed as significant and perhaps was associated with misconduct by juveniles rather than default by those supposed to be caring for them.

The merging of the management of offending and non-offending wards was such that by the late 1970s, a Departmental description of residents in the *'closed'* institutions such as Riverbank, Hillston, Longmore Remand and Assessment Centre, and particularly Nyandi, was as follows:

*'Most of the children catered for in these centres have problems arising from a particular set of family or socio-economic circumstances. Such children may exhibit behavioural problems, be subject to emotional disturbances, have committed offences, or may simply require residential care as a result of family breakdown'*.<sup>108</sup>

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<sup>102</sup> Group Homes were established by the Department *'for children who need a more specialised type of family care than can be provided in a normal foster home or boarding placement. The children placed in these facilities are not necessarily problem children, but because of their circumstances they would find it difficult to settle into a private family. The Departmental group home can provide a skilled and stabilising environment as a stepping stone to future return home or foster placement'* (Annual Report of the Department for Community Welfare, June 30th 1974 quoted in DCD, *Signposts*, at p. 35).

<sup>103</sup> Western Australia, Legislative Assembly, *Debates*, 26 August 1976, pp. 2193-2195.

<sup>104</sup> The same 1976 amending Act changed the terminology from children who were *'neglected'* or *'destitute'* to children who were in need of care and protection.

<sup>105</sup> Western Australia, Legislative Assembly, *Debates*, 26 August 1976, p. 2194.

<sup>106</sup> Western Australia, Legislative Assembly, *Debates*, 26 August 1976, p. 2194.

<sup>107</sup> CW Act, s. 30(1).

<sup>108</sup> *Annual Report of the Department for Community Welfare, June 30th 1979* quoted in DCD, *Signposts*, p. 28. There is some dispute about the number of children and young people who were initially placed in these institutions solely for the purposes of residential care and it appears this option was used rarely, if ever, from the 1970s.

These institutions had become significantly smaller than the *'traditional institutions'* referred to previously, and held between 20 and 40 young people, with Hillston and Longmore having capacity for up to 60.

During this era, children were managed by the Department with a focus on child protection and, generally, criminal offences as well as other inappropriate behaviours by children and young people, were viewed as a symptom of dysfunction or abuse that needed treatment.<sup>109</sup> As a result children and young people deemed at risk, such as those with substance abuse issues, those likely to commit self-harm, promiscuous behaviour, truants or run-aways, were dealt with in the same way as those committing criminal offences.<sup>110</sup> It appears that the Department invoked a broad discretion to act in young people's *'own good'*, as it saw it, irrespective of those young people's legal status as offenders or otherwise. This enabled staff to place non-offending young people who were regarded as difficult to manage, as well as those who were offenders, in secure custody for an indeterminate period, to be released when their Case Managers believed they were ready to be returned to the community.

The Department reports that, by the early 1980s, it:

'operated an extensive network of residential programs for children in care. [In addition to custodial placements the] available beds included those provided by "*halfway hostel*" ... which were [linked to] high-security ... or semi-secure ... institutions which nonetheless provided some beds in the community and after care services [as well].

... adolescents whose behaviour could not be controlled were generally catered for in the juvenile justice [detention] system.'<sup>111</sup>

## 4.2 The Edwards Report and its aftermath

In 1982 Professor Eric Edwards of the Faculty of Law, University of WA, conducted a milestone inquiry into the treatment of juvenile offenders in WA, and it was said that *'his report stopped the Department "in its tracks"'*.<sup>112</sup> The Edwards Report identified a number of concerns including the indeterminate sentences and lack of due process associated with juvenile offending.<sup>113</sup> Noting that WA had the highest rate of juvenile detention in the country, Edwards recommended that child welfare issues should be kept separate from those of young offenders and that a clear distinction should be made between a child's need for care and protection and the sanctions needed for the management of offending behaviour:<sup>114</sup>

'The non-offenders may suffer from association with offenders and from the stigma which goes with that association... [For offenders] the offence may be a symptom of a personal problem but a minor offence should not be used as an excuse to introduce the child to an extended treatment program because it was thought this would do the child good.'<sup>115</sup>

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<sup>109</sup> A Wells, *'Juvenile Justice in Western Australia'*, paper presented to the Children and Crime: Victims and Offenders Conference convened by the Australian Institute of Criminology, Brisbane, 17-18 June 1999, p. 2.

<sup>110</sup> Wells, *'Juvenile Justice in Western Australia'*, p. 2. It is of note, however, that some facilities such as the Department's Bridgewater Care and Assessment Centre were only used for non-offending or *'non-delinquent'* children and young people (DCD, *Signposts*, p. 121).

<sup>111</sup> DCD, *Hostels Report*, p. 31.

<sup>112</sup> DCD, *Juvenile Justice Systems*, at p. 22.

<sup>113</sup> Wells, *'Juvenile Justice in Western Australia'*, p. 2.

<sup>114</sup> Wells, *'Juvenile Justice in Western Australia'*, p. 2. By 1993 the role of detaining juvenile offenders was taken completely from the Department and transferred to the newly formed Department of Justice (DCD, *Submission*, p. 8.)

<sup>115</sup> Edwards Report quoted in DCD, *Juvenile Justice Systems*, at p. 23.

Edwards also recommended that detention was to be a last resort for juvenile offending.<sup>116</sup> Also noting the detention of non-offending children and young people in institutions such as Longmore and Nyandi,<sup>117</sup> Edwards, in his discussion of '*uncontrolled children*', stated that these should be simply children in need of care and protection; that applications should only be able to be made by the Department (and not Police or relatives); and that '*“Children in need of care” should not be detained in institutions in which offenders were detained, unless ... the Court so orders*'.<sup>118</sup> This was consistent with the justice model, according to which children and young people should be entitled to the same procedural protections as adults before being detained.

A subsequent report by Jan Carter, an internationally recognised social worker at that time, *The Wellbeing of People: The Final Report on the Welfare and Community Services Review in Western* (the Carter Report),<sup>119</sup> was to continue the impetus for the profound changes to the Department's residential care which were to take place over the next decade.<sup>120</sup> While the Edwards Report called for the separation of juvenile welfare and offending issues, the Carter Report promoted the policy that welfare issues were best dealt with by retaining children within '*normal*' communities and '*normal*' family life, and recommended:

'progressive closure of present hostels with a view to diverting resources to assist in the development of family support services.'<sup>121</sup>

The Carter Report, however, also noted that there would be a continuing need for some institutions to '*protect the extreme casualties and the most vulnerable*' children and young people.<sup>122</sup>

Those hostels which had been attached to the secure institutions closed following these reviews,<sup>123</sup> and the Departmental '*assessment*' and '*treatment*' hostels were supplanted by '*Community Support Hostels*' in 1984. The overriding focus of these was to be '*that of care*' as opposed to justice concerns;<sup>124</sup> and the '*basic aim*' was to:

'identify and understand problems being experienced [by the children admitted to them], then to provide support and direction towards re-establishing routine involvement in community activities... [At the same time, the hostel staff emphasized] behavioural stabilisation and training to increase the chances of success in activities involvement and subsequent placements.'<sup>125</sup>

In 1985 there were approximately 250 places in the metropolitan-based Community Support Hostels.<sup>126</sup> What had by this time come to be referred to as the '*McCall System*', comprising the

<sup>116</sup> DCD, *Submission*, p. 8. (WA then, as now, had the highest per capita rate of juvenile incarceration - DCD, *Signposts*, p. 29; Crime Research Centre, *Crime and Justice Statistics for Western Australia 2004, 2005*, p. 114.)

<sup>117</sup> For example, for the various years between 1975 to 1980, the proportion of girls detained at Nyandi who had not committed an offence were reported as follows: 24 per cent, 30 per cent, 38 per cent, 46 per cent, 35 per cent, and 30 per cent. In 1980/81 the rate was 56 per cent. However Edwards also notes that these admissions were not necessarily to the maximum-security section of Nyandi. (EJ Edwards, *The treatment of juvenile offenders : a study of the treatment of juvenile offenders in Western Australia as part of an overall review of the Child Welfare Act 1947* (Edwards Report), vol. 2, 1982, p. 27.)

<sup>118</sup> Edwards Report, vol. 3, p. 210.

<sup>119</sup> Welfare and Community Services Review (WA), *The wellbeing of the people: the final report of the Welfare and Community Services Review in Western Australia*, Western Australian Government Printer, 1984.

<sup>120</sup> DCD, *Hostels Report*, p. 20.

<sup>121</sup> DCD, *Hostels Report*, p. 20.

<sup>122</sup> DCD, *Hostels Report*, p. 20.

<sup>123</sup> DCD, *Hostels Report*, p. 31.

<sup>124</sup> DCD, *Signposts*, p. 30.

<sup>125</sup> *Annual Report of the Department for Community Welfare, June 30th 1985* quoted in DCD *Signposts*, p. 30.

<sup>126</sup> DCD, *Hostels Report*, p. 20.

McCall Centre Residential Unit, Community Support and a Kindergarten, continued to have a distinct role for 'particularly difficult children who could not fit into the normal placement alternatives of home, foster care or residential care',<sup>127</sup> but with a reduced number of placements. The Department states that although there was a reduction in its hostel bed numbers at this time, there was an expansion in other types of foster and non-government care with a focus on strengthening the range of placement options available for children in care. The Department has been unable to provide specific numerical data on alternative placement options, but referred to historical research which highlighted the expansion of the non-government sector generally in Western Australia since the 1970s.<sup>128</sup>

The Department's hostels continued to rely upon behaviour modification principles to assist the children and young people resident there to make the transition to independent living, or to enable them to return to family or foster care. A significant feature of these programs was that they were highly structured; this was seen as a very positive development in the hostels at the time:

'Treatment and training programs were based on stabilisation or behaviour modification, and social skilling. You would work with the young person to get them into jobs, to become independent. The hostel programs were based on similar psychological principles to the treatment institutions - behaviour and response. There were incentive programs; these were positive. For example it might target a particular behaviour which was worked out with the young person. You would develop a program for that issue - it was based on verbal encouragement to reinforce positive behaviour and a points system. Young people would progress through various stages, based on conformity etc. There were also basic life skills - training young people about how to function in the mainstream and to live independently.

The programs were a positive and constructive way of indicating the "rules of the game". These were intended to lead to stabilisation and behaviour change. I say there was a need for kids to be aware of the "rules of the game" because there needed to be consistency ... there had been massive inconsistencies between shifts and various staff members before. Because these were institutions there needed to be order. The kids were unsettled and highly destructive. Depending on the shifts there could be anything from punitive to useless responses. The programs provided a framework which was fair and reasonable and allowed for therapeutic intervention ... the programs included records for residents based on the points system and this took away any discretion by individual workers, making the system accountable.'

Senior Manager

It appears that at this time there was no legislative prohibition against the detention of non-offending young people in secure institutions. The emphasis of the programs, according to staff, was on positive interaction and incentives, but it appears there remained at least the potential for persistent non-compliance with institutional programs to result in the brief detention of young people.<sup>129</sup> Staff recollection is that this occurred infrequently, particularly after the Edwards Report.<sup>130</sup>

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<sup>127</sup> DCD, *Signposts*, p. 324.

<sup>128</sup> DCD, *From Crisis to Prevention: The Community Services Industry Study* (1994), pp. 2-10.

<sup>129</sup> My officers were told there were 'heaps of hoops to be jumped' before young people could be admitted to these secure facilities but it was an option, particularly for those who were on remand for assessment under s. 28 of the CW Act.

<sup>130</sup> The Edwards Report (vol. 2, pp. 102, 107) recorded that girls in Nyandi held in 'Time Out' (for 'serious anti-social behaviour') were given a cabin, where the girl was held 'virtually in solitary confinement, at night in her cabin, during the day seated upright at a small bare desk in a corridor. She is not allowed to read or do anything, or even to slouch or lay her head on the table.' In an analysis conducted by Professor Edwards, the legal status of girls held in these circumstances were approximately 70 per cent offenders (under the Department's control), but also included 15 per cent care and protection wards ('in the care' of the Department) and 13 per cent who were considered as 'Control Care and Protection' or declared 'Uncontrollable'.

Nonetheless the option of such a placement may have been a factor in the effectiveness of these programs, at least for some of the children and young people at particular risk who were in the Department's care. The apparent absence of a system anchoring the current programs in Departmental residential care is considered in more detail in Chapter 11.

Another report written in 1986, the Department's *Report on the Review of Departmental Juvenile Justice Systems*, found:

'Until quite recently unruly children without an offence history, or only a minor one, were treated in exactly the same way as the State's most serious offenders. The Act did not distinguish between children in need of care and protection and offenders until 1976, and even now children in need of care and uncontrolled children can be placed under control by the Court and locked-up in the same institutions as offenders if that is the Department's decision.'<sup>131</sup>

The report states that as a consequence of the Edwards Report, amongst other things, there had been '*recognition in policy that deprivation of liberty is a serious matter of justice which the Courts should decide*'.<sup>132</sup> This appears to have been a reference to Departmental policy that only young people placed under its control with a recommendation for detention were admitted to secure facilities.<sup>133</sup> The report goes on to note, however, the concerns expressed by '*some staff that welfare will be forgotten and children will be treated to all intents and purposes as if they were adults*', but denies this stating that '*It is not a matter of welfare or justice being mutually exclusive alternatives, but rather a question of what balance should be struck between the two.*'<sup>134</sup>

Interestingly, the report also referred positively to the welfare support system of institutions such as Nyandi, which included hostels, annexes, after-care and community activity centres. It stated that:

'The welfare support system has highly skilled staff and well developed programs which could be used to provide specialised service to adolescents of both sexes who require more than average support to achieve family re-integration or independence.'<sup>135</sup>

As mentioned earlier, however, it appears to some degree, that the success of those programs had relied upon at least the availability of a '*brief intervention*' in the maximum security facilities of Longmore or Nyandi, for those young people who were '*out of control*' because of significant offending, running away or placing themselves at risk.<sup>136</sup>

In 1988, legislation was enacted which meant that children and young people could not be admitted to gazetted detention facilities unless they had offended against the law or were the subject of a court order for their detention under the CW Act.<sup>137</sup> At the same time, the capacity of the Department and the Police to seek to have a child declared '*uncontrolled*' and placed in the care or control of the Department was revoked.<sup>138</sup> The Department states that the:

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<sup>131</sup> DCD, *Juvenile Justice Systems*, p. 24.

<sup>132</sup> DCD, *Juvenile Justice Systems*, p. 26.

<sup>133</sup> DCD, *Juvenile Justice Systems*, p. 116.

<sup>134</sup> DCD, *Juvenile Justice Systems*, p. 27.

<sup>135</sup> DCD, *Juvenile Justice Systems*, p. 118.

<sup>136</sup> The Nyandi program, '*Community Time Out*', which was '*used as a consequence for aggressive behaviour in hostels and running away*' ceased in 1984/5. However, it was replaced by a '*Brief Secure Detention*' program for '*uncontrolled runaway girls*'. (DCD, *Signposts*, p. 394)

<sup>137</sup> DCD, *Hostels Report*, p. 32.

<sup>138</sup> *Acts Amendment (Children's Court) Act 1988*, s. 12.

'options the Department had for effectively managing very difficult young people who did not require detention or were not on a justice order were effectively closed.'<sup>139</sup>

This amendment was part of the Act which brought the Children's Court under the jurisdiction of the Attorney General and away from the Department, with the appointment of a President (equivalent to a District Court Judge), rather than a Special Magistrate as head of the Court.<sup>140</sup> The changes marked a significant step in the separation of juvenile justice from the Department's welfare role and meant that those high-risk young people who had previously been detained in gazetted detention facilities, briefly or otherwise, had to be placed in other forms of Departmental residential care or fostered out.

The Department responded to my preliminary view about its legislative powers to apprehend and detain young people by saying that in its opinion that view was not accurate, and stressing that in fact it sought to maintain the division between managing the welfare of children and young people in need of care and protection, and the requirements of justice for young offenders. This approach culminated in the transfer of the young offender facilities to the Department of Justice (now the Department of Corrective Services) in 1993.<sup>141</sup>

In spite of the formal division of justice and welfare functions, it is also significant that the intake of young people into the Community Support Hostels as a result of offending continued, including those on arrest or remand who could not return home. By 1987 a recommendation was made that admission to those hostels '*solely on the basis of the Justice process [were] inappropriate*'.<sup>142</sup> Nonetheless, justice system-related admissions (at 77 per cent) comprised the majority of admissions into these hostels in 1989.<sup>143</sup>

#### 4.2.1 Further review

Another Departmental review, the '*Review of Service Delivery & Management Structures of McCall Centre & Community Support Hostels*', was conducted in 1991 with a view to, amongst other things, developing a suitable organisational structure.<sup>144</sup> The result was the amalgamation of the McCall system with the metropolitan Community Support Hostels and the closing of more metropolitan hostels.<sup>145</sup> Resources were instead directed towards support services and alternative models such as foster care and one-on-one intensive foster places.<sup>146</sup>

The Department staffed those hostels that remained with employees who lived in. The hostels, at that time known as '*McCall hostels*' continued to focus on '*behaviourally difficult children*' and provide '*a behavioural change and management program*' but now provided just 28 beds in the metropolitan area.<sup>147</sup> By 1994, Bedford Hostel, which was to play a pivotal role in the subsequent development of ACSS, had become the Crisis Assessment Centre for the McCall Hostel network.<sup>148</sup>

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<sup>139</sup> DCD, *Hostels Report*, p. 31.

<sup>140</sup> *Acts Amendment (Children's Court) Act 1988*.

<sup>141</sup> Wells, '*Juvenile Justice in Western Australia*', p. 4.

<sup>142</sup> DCD, *Signposts*, p. 32.

<sup>143</sup> DCD, *Signposts*, p. 32.

<sup>144</sup> DCD, *Signposts*, p. 33.

<sup>145</sup> DCD, *Hostels Report*, p. 32.

<sup>146</sup> DCD, *Hostels Report*, p. 32.

<sup>147</sup> DCD, *Hostels Report*, pp. 20, 33. The places were at McCall itself, Kyewong, Tudor Lodge and Darlington Lodge (DCD, *Signposts*, p. 33).

<sup>148</sup> DCD, *Signposts*, p. 99.



Placements for children and young people in metropolitan Departmental residential care facilities had declined from 250 to approximately one tenth of that number in ten years.<sup>149</sup>

### 4.3 The historical legacy

A number of observations arise from the history of residential care in WA and have particular relevance to this investigation.

- **The move to ‘family-like’ arrangements**

As elsewhere, residential care facilities in WA, which began as large, campus-based institutions, moved over time to smaller units, styled on what was supposed to be more ‘family like’ arrangements.<sup>150</sup>

- **Minimal government role in the provision of direct care for young people**

The government stance in WA, apart from what appears to be an exception in the 1960s and 70s, was ‘*that the care of children should be left in the hands of ordinary citizens and religious bodies*’.<sup>151</sup> The consistent decline in the provision of direct government care, at least for welfare purposes, from the 1980s is consistent with what the Department has more recently identified as one of the ‘*themes for continuous improvement*’ for out-of-home care - the move from ‘*institutionalised care and practice to “normalised” care environments through family and community based placements*’ (my emphasis).<sup>152</sup> The Department states, however, that in whatever form, it has always provided care for children and young people who are unable to live with their families.

- **Inseparability of justice and welfare issues for some young people**

In spite of the formal separation of justice and welfare functions which has characterised this area since the 1980s, research has highlighted that many of the factors which put young people at risk of involvement in the juvenile justice system are characteristics shared by those in the child protection areas - family conflict, unstable accommodation or homelessness, low socio-economic status, problems with school-work and attendance, parents/relatives who are offenders, and substance abuse and violence within the family.<sup>153</sup> A study by the Auditor General found that there was a high degree of contact between the young people in care and the criminal justice system,<sup>154</sup> and these links were most recently referred to in research for the new WA low-security women’s prison,<sup>155</sup> Boronia, and in the Murray Report.<sup>156</sup>

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<sup>149</sup> DCD, *Hostels Report*, p. 20.

<sup>150</sup> DCD, *Signposts*, p. 24.

<sup>151</sup> *Annual Report for the Department of Community Welfare, June 30 1979* quoted in DCD *Submission to Senate Community Affairs References Committee Inquiry into Children in Institutional Care*, at p. 4.

<sup>152</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 19).

<sup>153</sup> Wells, ‘*Juvenile Justice in Western Australia*’, p. 5.

<sup>154</sup> Auditor General Western Australia, *Accommodation and Support Services provided to Young People unable to live at home* (Report No 11), Office of the Auditor General Western Australia, 1998, p. 3; with 18 per cent of the AG’s sample group being arrested and charged by Police within two years of leaving care compared to 8.6 per cent of the general population of that age group.

<sup>155</sup> A survey of women prisoners in WA in 2002 found that one in five female prisoners had been wards at some time in their childhood: J Salome, *Towards Best Practice in Women’s Corrections: The Western Australian Low Security Prison for Women*, [circa 2004], p. 4.

<sup>156</sup> Murray Report, p. 6.

- Perceptions about workplace culture

Departmental documents assess the success of ACSS with reference to how complete had been the movement away from the 'McCall System' and the 'McCall Hostels', which are described as being based on a 'correctional model' and 'negative', towards the 'caring', 'non-punitive' or 'child focussed' contemporary model with its approach of engaging with the young people in the Department's residential care facilities.<sup>157</sup> Although the Department is of the view that 'correctional' and the contemporary Departmental 'treatment' models for the care of young people are now distinct,<sup>158</sup> it seems to me that this correctional model characterisation, referred to above, is based in part on the continuity of the 'treatment' model of behavioural change and management adopted at McCall and its associated hostels, and the approach to the management (and rehabilitation) of young people in the secure juvenile justice institutions and hostels at the time these were in the Department's jurisdiction.<sup>159</sup>

The perception that this same approach continues to be endemic in the ACSS facilities proved significant to some of the witnesses interviewed during this investigation:

'Many of the people working in the hostels have a detention centre background. Their focus is on control. In my view nurturing, caring skills and self-esteem should be the focus. The reward systems used in hostels are tokenistic and outdated. The management style is based on behaviourist models from the 1970s and 80s. Direct Care Workers should be listening and talking to young people, using verbal skills.'

Direct Care Worker

'[The work place culture of DCD hostels] is an old culture. It is an old detention centre type culture more than anything. There is a lot of staff that have been in the hostel systems for a long, long time and the hostel systems sort of evolved from basically just being a place where kids were able to be put and there was no real program being run out of them. They were just basically accommodation for young people. So a lot of the staff came out of that, when ACSS was introduced which would have been in 1998, there was a move to change it from just being accommodation to it being more of a treatment model so there were programs like EQUIP started up in Como, the assessment centre was a new centre built up in Kath French up in Stoneville and there was a model or plan about how that was going to work and part of that model was also looking at introducing new staff into the system and spreading some of the expertise around so not just having, I guess, the old Direct Care Worker mentality within the system they wanted to get some social workers or some psych students or some sort of more, I say more professional not saying those workers aren't professional, but more professional based qualifications into that system. It didn't happen ...'

Residential Care Manager

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<sup>157</sup> 'Update: Adolescent and Child Support Service' [circa 2000, 2003] provided in file of Departmental materials, 24 September 2004, marked "A".

<sup>158</sup> The Department states that it has a developmental holistic ecological approach to deal with young people in its residential care to ensure their best interests are met. Services include psychological, social work, medical, intensive residential care, social integration, educational stabilisation, housing options, employment opportunities, family therapy and family reunification, community development and reintegration, mental health support and mentoring. The Department states that its work with these young people takes into account their developmental requirements and determines the best interests of the child through a discussion with the young person, parents, family community and Departmental support personnel. The Department states that there is some interaction between the two treatment services, however it contends that its treatment model focuses on the holistic needs of the young person in the current, medium and long term contexts while the Department of Corrective Services' model is generally aimed at the prevention of re-offending and or the predisposing condition that led to the offence (e.g. violent assault, substance abuse etc). The Department states that as a rule this work does not take into account the issues relating to family of origin although recently Corrective Services has implemented Multi Systemic Therapy (MST) which does address these issues, but does not focus on children in the residential care of DCD as they need to be part of the family system to be involved.

<sup>159</sup> DCD, *Signposts*, p. 28; DCD, *Hostels Report*, p. 33.

'... I think the reason for that culture, and I have thought about it a lot, one is that it is an old culture. The Department used to operate the Juvenile Detention centres and staff moved between them and I think it comes originally from there; I think that that culture, try and we might, we haven't shifted it. What we have done, if we have done anything, is to send it further underground, but it is still there and it is a very strong group. There is a mistrust of management by the Direct Care Workers. I don't know how much of that is fair, maybe some of it, but ... there is a culture of "*the kids are the enemy*" and so if anyone sees it any other way then they are the enemy.'

#### Residential Care Manager

It is difficult to assess the validity of perceptions of the entrenched culture amongst many DCWs as being based on a punitive and out-dated model for dealing with the young people in their care. It appears that a substantial number of long-term DCWs would have experience from the time when the Department operated young offender detention facilities. However, within a broader historical context this does not necessarily imply a correctional or punitive approach; the emphasis historically, at least since the development of a form of '*justice*' specifically for juveniles that was differentiated from that which applied to adults, was towards a welfare model, even if the practice often was substantially different.<sup>160</sup>

On a local level, the perceptions about the workplace culture being based on a punitive and out-dated approach is not supported when we consider the range of hostels traditionally operated by the Department. Although the Department and its Direct Care Workers (then referred to as Group Workers) did operate secure facilities for juveniles, there were a range of other Departmental hostels which operated quite specifically for non-offending children and young people in care.

Naffine states that little account was taken of the differences between the US and Australian systems, although she also notes:

'And yet in other ways there was legitimate concern about the due process of Australian juvenile justice. In particular, there was good reason to question the considerable powers vested in courts to deal with children they deemed to come within the vague charge of uncontrollable.'<sup>161</sup>

As indicated below, it may be in fact that what underlies the concerns about a '*Direct Care Worker culture*' is more specific - the treatment of children and young people who previously would have been charged through formal court processes as '*uncontrollable*' or who may have been regarded by the Department as such. It appears that many of the children and young people currently resident in the ACSS facilities may well have fallen within the category of '*uncontrollable*' which in the past would have seen them held in secure detention, subject to behaviour modification programs based on incentives and trained via '*reward*' systems.

Academic work highlights how the option for the courts to determine that children and young people were '*uncontrollable*' or for the Department to deem them as such provided a capacity to the courts and welfare agencies to impose '*moral censure*', particularly against young women for what was seen as sexual misbehaviour.<sup>162</sup> However, there was also perhaps some margin within this category to include children and young people at risk, who had a history of failed placements, who could no longer be placed with their families or foster carers, and who engaged in high-risk behaviours.

<sup>160</sup> It should be noted, too, that unlike the United States courts where juveniles could be deemed delinquent in view of their social background, the Australian courts never dispensed with the need to establish specific criminal charges or to show the court that the child had been neglected within the terms of the legislation (Cunneen & White, *Juvenile justice*, p. 20; N Naffine, '*Philosophies of juvenile justice*', in F Gale, N Naffine & J Wundersitz, *Juvenile Justice: debating the issues*, Allen & Unwin, St Leonards NSW, 1993, p. 6.)

<sup>161</sup> Naffine, '*Philosophies of juvenile justice*', p. 7.

<sup>162</sup> Naffine, '*Philosophies of juvenile justice*', p. 6; Cunneen & White, *Juvenile Justice*, p. 22.

In the Department's 2001 report, it highlighted that young people coming into its care because of psychological problems and conduct disorders might be extremely aggressive and engage in extreme behaviours.<sup>163</sup> It also highlighted another particular concern that *'the most fundamental harm caused by carer abuse or neglect'* is the *'destruction of a child's trust in those people who are supposed to care for and nurture them'*.<sup>164</sup> It went on to emphasise that it was not uncommon for these young people to direct their anger at those who tried to care for them.

- Management of young people at risk

Prior to the 1980s, the Department managed certain at risk young people within its juvenile justice facilities, although they were not subject to any detention or justice order. With the separation of justice and welfare functions, and although the Department appeared to continue to have significant legislative powers to apprehend and detain young people, the Department stated that its *'options ... for effectively managing very difficult young people ... were effectively closed'*<sup>165</sup>. The Department's residential care facilities became responsible for managing these young people. A key issue in this investigation, examined in more detail below, has been how effective that management has been with reference to the prevention and detection of maltreatment.

It is clear that on a justice model, which seeks to place juveniles in the position of adults before the courts, there is no place for detaining juveniles on the basis of *'uncontrollability'*. At the same time, however, it is also broadly accepted that special measures are required to protect children and young people which do and should not apply to adults. The question that arises is what should be done to manage high-risk behaviour by children and young people.

This report is not the avenue for resolving the above question. But the issue is very real and needs to be addressed: what is to be done about children and young people who engage in what is viewed as very high-risk, but not necessarily criminal, behaviours and for whom family or community-based placements are no longer available? It creates problems that are often interpreted as being the result of a punitive and out-dated Direct Care Worker culture. However, it is clearly not only some DCWs who see an advantage in behaviour modification styles of management for the difficult children and young people in their care; for example current ACSS materials endorse the use of a *'McCall behaviour modification program'* at Darlington House<sup>166</sup> (Attachment 3); the Equip program includes a very basic reward system (Attachment 4), with small amounts of money being allocated to young people who achieve mundane tasks such as getting up on time in the morning; Preparation for Placement (PFP) focuses on basic life skills training and has a rewards based system where positive participation is rewarded by privileges, such as group outings, or payment.<sup>167</sup>

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<sup>163</sup> DCD, *Hostels Report*, p. 11.

<sup>164</sup> DCD, *Hostels Report*, p. 12.

<sup>165</sup> DCD, *Hostels Report*, p. 31.

<sup>166</sup> *'Darlington: Proposals for Service Delivery Approaches'* [undated] provided in file of Departmental materials, 24 September 2004, marked "E", p. 2. The description continues that this is to be *'combined with a deliberate use of nurturing relationships between carers and the boys'*. Attachment 3 outlines the *'program'* for chores at Darlington.

<sup>167</sup> These appear very similar to those described in the 1981 Edwards Report which says the *'treatment programs'* then employed in the secure facilities of the Department were as follows:

*'the treatment programs vary considerably in detail, but each is based on principles of behaviour modification with two main thrusts - the teaching of basic skills with an emphasis on the "concept of relevance" to give the children choices they may not have had before and to enable them to cope more successfully in society; and a motivation system, either in a form of a "token economy" system (Riverbank) or a system based on crediting and debiting of points for good and bad behaviour. These programs are continued as far as practicable in the hostels.*

*The skills programs include social interaction skills (following instructions, social greetings, punctuality, appearance, table manners, etc.) and practical skills which are divided into three groups - community (calendar, shopping, first aid, newspaper, street directory, to name a few); pre-vocational (job hunting and job applications, use of telephone, unemployment benefits, banking, taxation and the like); and academic (reading, spelling, maths, letter-writing among others.)'* (vol. 2, pp. 90-91)

Further complicating the issue is an apparent underlying academic disciplinary tension between certain schools in social work and psychology and the degree to which people outside these residential care environments are able to comprehend the inherent difficulties faced by DCWs. Reference has been made to the previous Departmental structure where young people who were resident in 'the institutions' were managed within those institutions, in particular under the supervision of psychologists who were on-site. Subsequently it was Case Managers located in District Offices who made the significant decisions about children and young people resident in the hostels:

'The organisation for young people in residential care now is based on decisions made by Social Workers [the Case Workers] in Divisional Offices about kids, and the hostels look after the young people. Now there isn't much advice from psychs - it's more social workers who give advice. They are supposed to be managing the young people's behaviour but they don't know how to handle them.'

Direct Care Worker

'... they wouldn't have a bloody clue what it's like to restrain a kid... Wouldn't have a clue. And you know the Field Officers won't restrain. We've got Case Workers coming to us now. They won't see a kid on their own. They won't transport a kid on their own and yet we do it all. ... I've had a lot of calls from the field. We've got problems. Can you come in and restrain. ... they phoned me. [A young girl] was going through the roof... She was eight or nine at the time. And they said look you know .... There was a couple of Directors in town and someone else and everybody was so frantic. And I said tell me again, I said where's this kid? And they said at the Police Station. I said who's in the room with her? There's two Police Officers and two Case Workers. And I said we're talking about an eight year old? I said take control for God's sake. You know. I couldn't believe it. They said what do you mean take control? I said go and sit next to the kid, one on either side and take control. Outlast her. And they did and she ended up with us [in ACSS] (laugh). Interesting point.'

Senior Manager

In addressing the issue it is evident that those who work closely with the children and young people in residential care would have much to contribute. So too, would those children and young people themselves. When asked about how they were being managed in the residential care facility, one young person responded:

'What I hate the most is when they say, "I know how you feel". They don't. They haven't been through what I've been through.'

Young Person

## 4.4 Conclusions

During the more than half a century that the CW Act was in force, the practice in the direct residential care of children changed markedly. Historically, direct residential care had largely been outsourced to religious organisations; there was a custodial approach, but one which separated offending and non-offending wards. This changed with the provision of direct residential care by the Department, based upon a 'treatment' rather than a custodial model. The distinction between offending and non-offending wards, however, became blurred. Later changes resulted in the Department ultimately losing its custodial capacity altogether.

With changes to the Department's role, the expectations on Departmental staff providing the direct care of children also changed, from an emphasis on a behavioural modification to an empathy-based model (although the Department states that empathy has always been a core part of all of its work with its clients). The potential for conflict between the Department's responsibility to the young people in its care and to manage its direct care staff in accordance with applicable Public Sector Management principles further complicates these direct care environments.

It appears to me that the concerns expressed about what is referred to as '*Direct Care Worker culture*' and '*institutionalised practices*' raise more issues about how the hostels operate. I have attempted to respond to those issues, at least to the degree that these might be addressed by administrative remedies, throughout this report.

## Chapter 5 Young People in Care

Chapter 4 outlined the history of the care of children and young people removed from their families in this State, particularly focussing on the more recent history of Departmental direct care of children. This was done to assist in understanding both the nature of the concerns raised and the potential remedies to the apparently straightforward allegation which prompted this investigation, of whether children and young people are being maltreated in the Departmental facilities. As part of the context of my investigation, it is also important to understand the children and young people who find themselves in care.

### 5.1 Characteristics of young people in care

The Department describes the children and young people in its residential care facilities as follows:

‘Children and young people in the Department’s residential care system have experienced severe trauma in their lives including dysfunctional families and multiple failed placements. Children also have fragile or broken relationships with their families and with other people who are important in their lives.

Not surprisingly children and young people in residential care are often angry, vulnerable and have extremely difficult behaviours to manage. They are frequently disadvantaged in terms of their health, education and social development and increasingly are entering residential care with mental health or substance abuse problems.

It is common for children to be verbally and physically violent to other children and workers in residential care. They are regularly non compliant, have anger management problems, destroy property, run away and attempt to harm themselves.

The combination of their circumstances and behaviours has resulted in children experiencing rejection by family, carers and other service providers and ultimately an admission to Departmental residential care is the only placement option available for them. Not surprisingly this can further negatively affect the child’s already low self-esteem.

Many of the children and young people in residential care have “Attachment Disorders” which refers to being so traumatized by a range of experiences such as abuse, multiple placements and the failure of significant relationships that they are extremely sensitized to the potential for future failure and do not want to form any close relationships like those involved in a “traditional” family or foster type placement.<sup>168</sup>

One explanation of how it is that the Department’s residential care has come to accommodate this particular group of children and young people is provided below.

‘... back in 1996 we had 700 kids in care, today we have 2,200 and it’s been driven by drugs, mental health as a result of drugs, and domestic violence is the other underlying factor there and you just saw it in late 95, the numbers just started to go and they’ve been going at about between seven per cent and 12 per cent a year since then and it’s harder to get foster carers. Our traditional market of the mums that stayed at home, they don’t stay at home any more, they’re out working getting their own careers, families have got to have two incomes to survive so we are finding it increasingly difficult to get foster carers ... so the big shift has been to relative carers ... something like 40 per cent odd of children in care now are with relative carers and Gwenn Murray’s pointed out that we’ve got particular problems with relatives so ... you get shoved into a response, but you don’t actually change the processes quick enough to keep up with that. So that’s the context we’re working in and just a group of kids whose behaviours are - we haven’t seen ... [the likes of] them before, the kids we’re getting in the last four or five

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<sup>168</sup> Correspondence from the Department, 3 August 2006. A more detailed profile of the young people in its residential care, provided by the Department, is found at Attachment 6.

years. When you get seven and eight year olds who can't use a knife and fork, eat with their fingers, no boundaries you know, just been let run loose; so that's the dilemma we are facing.'

Senior Manager

When the Auditor General reported in 1998 on young people unable to live at home he commented that the most notable change in the Department's policy in providing services to young people in care over the past few decades had been '*the move away from making children wards and then accommodating them in Children's homes*'. The number of young people who were wards declined from 4,907 in 1972 to just 711 in 1996.<sup>169</sup> As indicated in the previous chapter, this dramatic shift was the result of either keeping children with their families or returning them as soon as possible,<sup>170</sup> referred to as a trend towards '*normalisation*'.<sup>171</sup>

At the same time, however, the Department appeared to have an increasing number of young people in its care on the basis of '*consented placements*': being in the physical care of the Department although the young persons' parents continued to be their guardians.<sup>172</sup> These so-called '*non-wards*' generally entered care at a much older age than wards, and while abuse was the primary reason for wards entering care, parental conflict was the major reason for non-wards being in a placement.<sup>173</sup>

Although WA continues to have one of the lowest rates for placing children in out-of-home care,<sup>174</sup> in the ten years from 1996, the number of wards more than doubled to 1,539.<sup>175</sup> To some extent this increase was balanced by a decline in the number of '*non-wards*', from over 1,000 in 1996 to 561 in 2005.<sup>176</sup> Overall however, during the five years to 2003/4, there was an increase of 43.2 per cent in the number of children and young people in out-of-home care in WA.<sup>177</sup> It needs to be acknowledged nonetheless that there were still less than half as many young people in the Department's care in 2005 than there were in 1972.<sup>178</sup>

Paradoxically the recent increase in the number of children in care has coincided with a decline in the number of children entering care each year.<sup>179</sup> This was attributed to fewer young people

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<sup>169</sup> Auditor General, *Accommodation and Support Services*, p. 8.

<sup>170</sup> Auditor General, *Accommodation and Support Services*, p. 8.

<sup>171</sup> DCD, *Hostels Report*, p. 34

<sup>172</sup> Auditor General, *Accommodation and Support Services*, p. 8. Unlike the current C&CS Act provisions relating to negotiated placements, it appears these consented placement could occur in circumstances where the child or young person may otherwise be subject to a care and protection order. It appears that this was altered in the new legislation to prevent there being any perception of duress being applied when the Department took a child into care without court direction. Note, however, the provision made under the new Act for children to be in the CEO's care if they are in receipt of '*placement services*' (s. 30(d)). This term is not defined under the Act. Departmental staff advise that its use will be limited under Departmental policy.

<sup>173</sup> Auditor General, *Accommodation and Support Services*, p. 14.

<sup>174</sup> Australian Institute of Health and Welfare (AIHW), *Child protection Australia 2004-05*, AIHW, Canberra, 2006, p. 50.

<sup>175</sup> DCD, *Annual Report 2004-05*, p. 55.

<sup>176</sup> DCD, *Annual Report 2004-05*, p. 56. The new legislation, the C&CS Act, creates a new range of protection orders (all administered by the courts) and removes the option of placing young people in the Department's care by consent if there are reasonable grounds to believe the young person needs protection (s. 75(5)).

<sup>177</sup> Anderson, (Draft and Confidential) *Care Responses into the Future*, p. 10. This is consistent with national trends - see Murray Report, p. 8 (an increase of 56% from 1996 to 2004). Between 30 June 2000 and 30 June 2005 the total number of young people in care increased from 1, 486 to 2,100 (DCD, *Annual Report 2004-05*, p. 56).

<sup>178</sup> There were 4,907 young people in care in 1972 and 2,100 in 2005 (Auditor General, *Accommodation and Support Services*, p. 8 and DCD, *Annual Report 2004-05*, p. 56).

<sup>179</sup> In 2005, the '*long trend of decreasing numbers of children and young people entering care*' reversed, with more entering care than the previous year (DCD, *Annual Report 2004-05*, p. 55).



leaving than entering care each year. The younger age of the children first entering care<sup>180</sup> and other factors delaying a return to family,<sup>181</sup> mean that children are simply spending longer in care. This is consistent with data which show that in 1997 less than 40 per cent of young people in care had been in continuous placement for two years and more,<sup>182</sup> whereas by 2005, 64 per cent of children in care had been in continuous placement for two years and more.<sup>183</sup>

Approximately equal numbers of male and female children and young people are in care. However, although they constitute only six per cent of the WA population of persons 17 years old and younger,<sup>184</sup> over a third of those in care on 30 June 2005 were Indigenous.<sup>185</sup> The rate at which Indigenous children are taken into care is almost ten times the rate of other children in WA.<sup>186</sup> Many are placed in 'relative care'.<sup>187</sup> This is related to 'The Aboriginal Child Placement Principle' which outlines a preference for the placement of Indigenous children with Indigenous people when they are placed outside their nuclear family.<sup>188</sup> Both the recent Cant and Murray Reports highlight the deficiencies in assessment of suitable placements and support for carers associated with relative care in WA.<sup>189</sup>

## 5.2 Facility-based care<sup>190</sup>

Consistent with Australia-wide trends towards 'normalised' home-based placements, the proportion of young people in facility-based care in WA fell from 17 per cent in 1997<sup>191</sup> to nine per cent in 2005, although WA continues to utilise this form of care more than many other states.<sup>192</sup> As elsewhere, male rather than female children and young people largely populate this form of care.<sup>193</sup> The age of children in facility-based care in WA was, and for some time has been, significantly

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<sup>180</sup> On 30 June 2004, 56 per cent of the young people in care were nine years old or younger (DCD, *Annual Report 2003-04*, p. 49). AIHW data show that while these figures are close to the national average, currently children being taken into care in WA are more likely to be very young - with 45 per cent being under four years old, compared to 38 per cent nationally (AIHW, *Child protection Australia 2004-05*, p. 43).

<sup>181</sup> Such as the increasingly complex family situations of children associated with parental substance abuse, mental health and family violence.

<sup>182</sup> AIHW, *Child Protection Australia 1996-97*, AIHW, Canberra, 1997, p. 42.

<sup>183</sup> AIHW, *Child protection Australia 2004-05*, p. 49.

<sup>184</sup> Murray Report, p. 13.

<sup>185</sup> AIHW, *Child protection Australia 2004-05*, p. 51.

<sup>186</sup> AIHW, *Child protection Australia 2004-05*, p. 51.

<sup>187</sup> Fifty-three per cent of Indigenous children and young people compared to 25 per cent of non-Indigenous young people in care (DCD, *Annual Report 2004-05*, p. 56). Non-Aboriginal children are far more likely to be placed in 'Department non-relative foster care' (44.9% compared to 17.6% Indigenous young people). Murray found that non-relative foster care had a 'lower inherent likelihood of abuse' (Murray Report, p. 39).

<sup>188</sup> AIHW, *Child protection Australia 1999-00*, AIHW, Canberra, 2001, p. 51.

<sup>189</sup> Cant Report, pp. 23-27; Murray Report, pp. 34-36. Cant (at p. 24) reports that in fact not all 'relative carers' are relatives or even well known to the child.

<sup>190</sup> Facility based care includes residential care, where placements are at a residential building and there are paid staff (which may be operated by government and non-government agencies); as well as family group homes where children are cared for round the clock by resident substitute parents (and not paid staff) (AIHW, *Child protection Australia 2004-05*, pp. 46, 78).

<sup>191</sup> AIHW, *Child protection Australia 1996-97*, p. 39.

<sup>192</sup> AIHW, *Child protection Australia 2004-05*, p. 47. The national average is five per cent.

<sup>193</sup> Most recent data from 1997 indicates that 71% of those in facility-based care nationally were male, 62% in WA (AIHW, *Child protection Australia 1996-97*, p. 67).

younger than other states, with 41 per cent being nine and under compared to a 15 per cent national average.<sup>194</sup>

ACSS residential care constitutes only one aspect of facility-based care in WA, which also includes country hostels run by the Department and not-for-profit residential and family group home facilities. As indicated below, however, young people in ACSS residential care do not appear altogether typical of those in care generally or of those in other forms of facility-based care in the State. Most significantly, the young people who access ACSS are generally said to be those who have no other placement options, often due to their extreme behaviours. This is discussed further in Chapter 7, after I consider the development of ACSS.

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<sup>194</sup> AIHW, *Child protection Australia 2004-05*, p. 61; and see AIHW, *Child protection Australia 1996-97*, p. 66. Note however, this was a smaller proportion of the nine and under age-group than for all forms of care in WA (57%) (AIHW, *Child protection Australia 2004-05*, p. 60).

## Part III The Adolescent and Children Support Services (ACSS)

### Chapter 6 Development of the Service

The allegation which prompted this investigation specifically concerned the treatment of children and young people in ACSS hostels. As can be seen from Chapter 4, those hostels were developed after the implementation of major changes in the Department's role in relation to the direct care of children and young people, most particularly the loss of custodial functions. ACSS was also being developed at a time during which the long-term trends towards non-institutional care, and indeed away from taking children into care at all, were possibly at their peak, as outlined in Chapter 5.

ACSS was a response both to the loss of the Department's custodial functions and to what the Department identified as a small group of young people in care and for whom alternative placements were scarce or non-existent. The development of the service is detailed in this chapter, with particular reference to the issues which the Department had sought to address by the development of this new service, and to how the service was intended to operate.

#### 6.1 Introduction

'I guess probably in the mid 90s we were really concerned about the culture in the [Department's] hostels. We had a number of incidents between staff and kids and we had a lot of worker's comp claims and our worker's compensation premiums were going through the roof and a lot of the incidents were because of ... incidents or physical clashes between the workers and the young people.'

Senior Manager

By 1992, the Department identified concerns that the '*McCall hostels*' did not conform to the '*philosophy of the normalisation of services to young people*' because of the hostels' condition and layout.<sup>195</sup> Senior Departmental officers had become aware of a large number of incidents between staff and young people occurring at its hostels, and increasing worker's compensation claims by hostel staff.<sup>196</sup> This was seen as in part attributable to the physical set up of the hostels, but also as indicative of the development of a concerning culture in the hostels. Neighbour complaints had also become a problem for what were known as the '*McCall hostels*' at that time, particularly about the Bedford hostel which provided a crisis and assessment service.<sup>197</sup> By 1996 the Auditor General had commenced a study of young people in care which, according to the Department, prompted its development of a new residential care service.<sup>198</sup>

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<sup>195</sup> DCD, *Hostels Report*, p. 34.

<sup>196</sup> The DCD *Annual Report 1993-94* (at p. 70) refers to a budget variation to the value of almost \$200,000 excess for increased worker's compensation premiums.

<sup>197</sup> DCD, *Hostels Report*, p. 34.

<sup>198</sup> DCD, *Annual Report 1998-99*, p. 23.

From 1992 until 1997 the Department's preferred option was to relocate all of its metropolitan hostels. The Department's re-examination of the services for children and young people who were particularly troubled and difficult to serve at that time also resulted in a proposed Adolescent and Child Support Service which would replace the *'McCall hostels'* through a phased implementation process from 1998. The relocation and new system was intended to change both the culture as well as the physical conditions of the hostels. In his report in 1998, the Auditor General highlighted, amongst other things, the risk of damaging peer pressure arising from the lack of placement options for children and young people in the Department's care, in particular those placed in the Department's hostels which catered for young people with a multiplicity of needs and who were considered difficult to serve. The Auditor General cited ACSS, which was to become operational in 1999, as a step taken by the Department to reduce these risks.<sup>199</sup> In 1997/8, over \$2 million was allocated towards the development of the new service.<sup>200</sup>

## 6.2 Facilities

ACSS was intended to operate as a three tiered system with emergency accommodation, assessment and planning facilities, and intervention and monitoring. There were to be five hostels offering 35 beds in the metropolitan region and a One-on-One service of intensive foster care which could place 12 young people. The hostels were to include a new purpose built Assessment and Crisis Care Centre, replacing the Bedford hostel, and it was to be one of the most fundamental differences between ACSS and earlier versions of the Department's residential services.<sup>201</sup> The Crisis and Assessment Centre was originally intended to provide for up to 60 of the *'more difficult'* children and young people over each year, who would be subject to *'an intensive form of assessment and a behaviour modification program'*.<sup>202</sup>

However, extensive difficulties confronted the Department in trying to relocate its hostels. A primary objective had been to build a purpose built crisis accommodation and assessment facility in the metropolitan area<sup>203</sup> but eventually:

'The Department was finally left with no alternative but to locate the assessment centre on land it already owned at Stoneville [the old Hillston institution]'.<sup>204</sup>

Because of the distance from emergency services the crisis accommodation function of the new facility was abandoned, and the Kath French Centre (KFC) was intended to operate solely as an assessment centre providing a maximum six-week program for its residents. Interestingly the *'purpose-built'* design of KFC continues to bear witness to an original intention for that facility to provide short-term *'secure'* detention for at least some of the young people resident there.

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<sup>199</sup> Auditor General, *Accommodation and Support Services*, p. 25.

<sup>200</sup> DCD, *Annual Report 1997-98*, p. 37.

<sup>201</sup> DCD, *Hostels Report*, p. 39.

<sup>202</sup> DCD, *Hostels Report*, p. 35.

<sup>203</sup> A DCD staff member involved in trying to secure another site advised that hundreds of different venues were considered inappropriate due to complaints from local residents, environmental issues and a range of other problems.

<sup>204</sup> DCD, *Hostels Report*, p. 37.

'... Kath French was designed with this debate in mind, and it is one of the ones that we really need to front up to in Western Australia ... the concept of secure detention for kids. So in the suite of responses ... we have general foster care ... and at the moment our last resort is basically this hostel system; but there is an option beyond that where in Western Australia there's been a really strong philosophical perspective against not having secure detention for some kids ... whose behaviour, if we don't get on top of it and manage it, there's a good risk they will do something really bad to themselves or someone else. Kath French was originally designed at a time when there was a lot of debate around that...'

Senior Manager

Arguably to this day, as indicated by this report, the gap remains in the services available for children and young people in care arising from the loss of what was to have been a cornerstone of the new residential care service, a purpose built crisis accommodation facility with a '*secure welfare*' option.

Given the difficulties confronting the Department when it tried to locate a new venue for its proposed Crisis and Assessment Centre, it also abandoned its plans to relocate the other hostels and instead settled on refurbishing existing facilities: the Mt Lawley Hostel (Tudor Lodge) was to operate as Preparation for Placement, Bedford Lodge was to continue to operate as Emergency Accommodation, and the old Kyewong Hostel at Como was to operate as Equip. The other ACSS facility was to be Darlington House.

By the time these facilities became operational, a specific function was identified for each hostel which was to meet the needs of identified cohorts of children and young people in care, as follows:

- Kath French Centre, no longer intended to deal with crisis accommodation, was an assessment and planning centre catering for up to eight young people from 10 to 17. Placements were to be for the purposes of assessment only and be for a maximum of six weeks.
- The Emergency Accommodation Service (EAS) was to be a crisis response service, for up to eight males and females between 12 and 17, limited to a maximum of five-day stays. It was expressly noted that there would be no overflow capacity to other hostels. There was no programmatic focus for this hostel as it was intended to operate only as a short-term placement.
- Preparation for Placement (PfP), as the name implies, was supposed to be a short-term placement for up to six young people between 10 and 17 who were awaiting long-term accommodation.
- Youth Equip (Equip) was to operate with a newly developed 17-week residential program including anger management, social skills and social decision-making components, for up to eight young people between 13 and 17. Equip was intended to only be utilised by young people who had consented to take part in the Equip program and had been assessed as suitable.
- Darlington House was to be a cottage model home for young people (10 to 15) requiring long-term accommodation and who could not be accommodated elsewhere due to the severity of their behaviour. It was to operate on the basis of a '*behaviour modification program*' as had been developed at McCall.<sup>205</sup>

Even after deciding not to relocate the hostels, difficulties continued to hinder the Department's efforts to implement change. There were protracted legal proceedings over its refurbishment of

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<sup>205</sup> Materials provided in a file by the Department, September 2004, marked "E" and titled Darlington Proposals for Service Delivery Approaches.

the Bedford facility.<sup>206</sup> The relocation of the EAS for refurbishment of the Bedford Hostel to the Mt Lawley site resulted in local residents, with the support of their local authorities, '*lobbying strongly*' to have the two ACSS hostels '*moved out*'. These efforts resulted in the 2001 report on the then Department of Family and Children's Services' Accommodation Hostels, one of the very few reports on children and young people in care to focus solely on government run hostels. Although the report recommended that the existing hostels be retained, noting the difficulties faced by the Department in seeking to relocate hostels in the past,<sup>207</sup> the Mount Lawley hostel was subsequently closed. The old McCall Centre, in spite of its '*institutional*' character and the concerns about the McCall '*culture*' referred to previously, became PFP; however, the Bedford hostel continued to operate as the EAS.<sup>208</sup>

## 6.3 Culture

As part of the proposed restructure and cultural change in the late 1990s, the Department:

- created a number of new Level 3 Direct Care Workers to work with its new programs at two facilities, KFC and Equip;
- introduced new training on de-escalating and managing crisis incidents;
- relocated team leaders and professional support staff to the sites;
- introduced '*comprehensive assessment*' of all young people entering these facilities;<sup>209</sup> and
- in particular, introduced the '*Equip program*', utilising peer influence and focusing on anger management and the development of social skills of participants;<sup>210</sup> this was seen as a major departure from the style of interaction between DCWs and young people in residential care.

The decline in worker's compensation claims (from a total for the Department of 77 in 1998/9 to 49 in 2003/4) was attributed to the success of these initiatives.<sup>211</sup>

'The [residential care] environment lends itself to stress for both staff and kids. It lends itself to workers compensation and all these things can be headed off with a good corporate strategy ... I think we do pretty well actually. When I first started I think there was 22 people [in residential care] on worker's comp. And a couple of years back we didn't have anybody and I think we've got maybe two at the moment.'

Senior Manager

A key initiative in relation to the development of ACSS was the relocation of professional staff, such as Social Workers, a Clinical Psychologist and Team Leaders, to the hostel sites. This was intended to provide young people with some continuity of access to particular staff members, who worked standard hours, compared to the irregular shifts of rostered DCWs. It was also intended to

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<sup>206</sup> *City of Bayswater v Minister for Family and Children's Services* [2000] WASCA 151.

<sup>207</sup> DCD, *Hostels Report*, p. 75.

<sup>208</sup> In its 2001 Report, the Department also recommended the development of another cottage model hostel similar to Darlington House in the metropolitan area (DCD, *Hostels Report*, p. 79). This did not occur, and after a number of substantiated Child Maltreatment incidents associated with that hostel, Darlington House itself was closed for refurbishment at the time this report was being drafted.

<sup>209</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 19).

<sup>210</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 19).

<sup>211</sup> DCD, *Annual Report 2003-04*, p. 23. It was reported that a number of stress related claims were lodged by staff as a result of critical incidents occurring in the hostels, the bulk of which occurred during the period 1997 to 1999 (DCD, *Hostels Report*, p. 52). However, in 2004/5 the total number of claims in the Department increased to 61 (DCD, *Annual Report 2004-05*, p. 22).

encourage a different style of interaction with young people, from the '*correctional model*' referred to in Departmental documents towards the '*caring*', '*non-punitive*' or '*child focussed*' approach of engaging with young people which was seen to be associated with the professional qualifications which were an entry-level requirement for the ACSS Social Worker, Team Leader and Clinical Psychologist positions at that time.

It appears that the efforts of the Department to implement cultural change in its residential care facilities, like its efforts to relocate/refurbish its hostels, did not progress easily. Original plans to have only Level 3 Direct Care Workers operate at KFC and Equip created equity issues with the other Departmental residential care facilities, which were operated by Level 2 DCWs. This resulted in a restructure of the staffing at all of the facilities, with a mixture of Level 3 and Level 2 DCWs at all hostels. However, DCWs stated that the distinct roles of the two levels of workers have never been adequately clarified.

'... we were told that when I came across as Level 3 that we had no powers on a shift. We were responsible for the shift but we couldn't tell any experienced staff member what to do. That makes it stressful for us because we take responsibility for everything that happens yet we have got staff that can turn around and say you can't tell me to do that and they can make it quite stressful for us because we take responsibility for everything that happens. ... Certainly a few other people that hold the same position as myself feel very disempowered with that as well. So we feel like we are there to take the blame and I don't think there is anyone who should have a JDF that says you are to blame.'

Direct Care Worker

The attempt to alter the Department's residential care culture also coincided with the raising of concerns about the '*institutionalised practices*' of staff in the ACSS hostels. These concerns eventually prompted the public interest disclosure to my office, in the second half of 2003, and the allegation that these practices were resulting in the consistent abuse in care of the young people residing in the ACSS hostels.

## Chapter 7 Young People in ACSS

An essential component in assessing the capacity of ACSS to prevent, detect and respond to abuse in care is an understanding of the young people in ACSS residential care. This is not only because, as mentioned in Chapter 5, these young people often appear to be atypical of those in care generally, but also because ACSS was developed to meet the needs of certain identified cohorts of young people in care as outlined in Chapter 6. In this chapter I review Departmental data in an attempt to identify the young people who access ACSS hostels.

### 7.1 Available data

In its 2001 report, the Department published data on the young people admitted to ACSS residential care between April 2000 and March 2001 as follows:

Table 1: Young people in ACSS residential care 1/4/2000 to 31/3/2001<sup>212</sup>

Service	Admissions	Average Age	Male - %	Female - %	Aboriginal - %	Ward
Emergency Accommodation Service	250	14	60	40	13.7	40
Kath French Centre	29	13.1	66	34	4	10
Darlington House	13	11.2	85	15	0	11
Youth Equip	13	14.6	100	0	0	7
Preparation for Placement	13	14	95	5	0	10
<b>TOTAL/AVERAGES</b>	<b>308</b>	<b>13.8</b>	<b>65%</b>	<b>35%</b>	<b>11%</b>	<b>78 (25%)</b>

Data was requested by my office in relation to the young people admitted to the same services between January 2002 and June 2005, with the following results:

Table 2: Young people in ACSS residential care 1/1/2002 to 30/6/2005<sup>213</sup>

Service	Admissions	Average Age	Male - %	Female - %	Aboriginal - %	Ward
Emergency Accommodation Service	858	14.5	53	47	40	311
Kath French Centre	37	12.1	100	0	22	20
Darlington House	12	10.1	100	0	8	8
Youth Equip	50	14.2	64	36	6	26
Preparation for Placement	32	14.9	100	0	0	23
<b>TOTAL/AVERAGES</b>	<b>989</b>	<b>14.3</b>	<b>57%</b>	<b>43%</b>	<b>36%</b>	<b>388 (39%)</b>

The most striking aspect in comparing the data in Tables 1 and 2, is that in spite of the widely held belief expressed by people working in the ACSS hostels that the average age of young people in the hostels had declined, quite the opposite was the case, at least since 2001 (from 13.8 to 14.3).

<sup>212</sup> DCD, *Hostels Report*, p. 47.

<sup>213</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 11).



Table 3: Length of stay of young people in ACSS residential care 1/1/2002 to 30/6/2005<sup>214</sup>

Service	Admissions	Recommended stay (days)	Average length of stay (days)	Median	Longest stay
Emergency Accommodation Service	858	5	6.5	2	210
Kath French Centre	37	42	169	130	650
Darlington House	12	365 - 548	630	502	1,552
Youth Equip	50	119	115	114	330
Preparation for Placement	32	365 - 548	257	160	1,051

However, as indicated in Table 3, this may be the result of a large cohort of older young people who spent short periods in EAS. In three of the four other residential care facilities the average age of residents had declined. A 'snapshot' of those in the ACSS residential care on 30 June 2005 indicated that the average age was 12.4 years old (refer to Table 4 below).

The increase in the proportion of Indigenous young people accessing ACSS hostels is also of note (from 11 to 36 per cent). However, again it should be noted that the vast majority of these access only the EAS, and otherwise constitute a small minority, if any, presence in the other hostels. A 'snapshot' of those in the ACSS residential care on 30 June 2005 indicated that 22 per cent of children and young people were Indigenous (refer to Table 4 below). Indigenous children and young people tend to be under-represented in residential care in comparison to their overall representation as one in every three of the children and young people in the Department's care. The differential is striking in the context of another very troubled population of children and young people: the Indigenous juveniles who constitute approximately 75 per cent of those held in the Department of Corrective Services juvenile justice institutions.<sup>215</sup>

Another significant issue raised in discussions with Departmental staff was the extended stays of young people in residential care beyond the program design. Again, although this is apparent from the data at Table 3 in relation to 'Longest stay' column; the 'snapshot' at Table 4 below further validates staff concerns about the length of time young people may be spending in these facilities.

## 7.2 Who is in ACSS residential care?

'I challenge Placement Services to provide any outcome data. They have five programs running. Where are the outcome studies? Where are the statistics? If you ask who is in the programs today you will see this mad flurry of e-mails saying I want to know who the residents are; I need the information for the Director. There isn't even a finger on the pulse half the time so there is no program. I don't know what you understand by program ... but a program needs to be a set of principles. I can be more generous than that; I can say that Preparation for Placement is about preparing young people for a role in the world and I can say that essentially it has a life skills focus, you know, help kids with bus passes, using a Phone Directory, maybe move into a flat. Still not a program.'

Residential Care Manager

When developing its residential care programs and services for ACSS, the Department's starting point was to identify who would access ACSS residential care, on what basis, and for how long. As indicated above, however, the more recent data may be somewhat distorted due to the large number of short-term residents, particularly at EAS, who appear to be disproportionately older, female and Aboriginal young people.

<sup>214</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 11).

<sup>215</sup> Office of the Inspector of Custodial Services, *Report of an Announced Inspection of Rangeview Juvenile Remand Centre* (Report 29), Office of the Inspector of Custodial Services, Perth WA, 2005, p. 8.

Table 4: Young people in ACSS residential care 30/6/2005<sup>216</sup>

Service	Average Age	Male	Female	Aboriginal	Ward	Average length of stay (days)	Recommended stay (days)
Emergency Accommodation Service	11.9	6	1	3	5	47	5
Kath French Centre	11.5	6	-	1	6	319	42
Darlington House	10	4	-	-	4	758	365 - 548
Youth Equip	14.2	2	4	2	3	123	119
Preparation for Placement	14.7	4	-	-	4	243	365 - 548
Average/Percentage	12.4	82%	18%	22%	81%	259	N/A

Once the '*distortion*' of the high number of short stay residents is removed by taking a '*snapshot*' to identify the children and young people in these facilities on a particular day,<sup>217</sup> the data more closely accords with staff accounts of residents, as follows:

- 18 per cent were female;
- 22 per cent were Aboriginal;
- 15 per cent were between the ages of five and nine;
- 67 per cent were between the ages of ten and 14;
- 18 per cent were between the ages of 15 and 17; and
- the average length of stay in three of the five hostels substantially exceeded the recommended stay (EAS, KFC and Darlington).

The data reveal that 15 per cent of those in ACSS are under ten. The data accord with the views of staff generally, and, in particular with senior Departmental managers, who believe that a reduction in age of those in hostels has meant that the '*programs*' can no longer operate as originally intended. Others highlight different concerns:

'Younger kids don't make choices; they are stuck in the hostels: an abusive environment with nowhere to run. The 16 year old has some options. Given the problems happening in hostels, it's a wonder 100 per cent of the young people in there aren't being assaulted in one way or another.'

Direct Care Worker

The most striking data, however, are those indicating the length of stay - every one of the residents in EAS and KFC on 30 June 2005 had exceeded the stipulated maximum stay requirements. This can have serious consequences for these children and young people:

'EAS is supposed to have kids short-term, not train them up, just give them a basic idea. However, now there are kids both long-term and short-term, staying from overnight up to months. The dynamics are bad - there is no stability. The long-term ones see others coming and going all the time. Their behaviour deteriorates and with eight kids it is not possible to supervise them adequately and they run off. There are no consequences because they don't know how long they'll be there anyway. Also you don't want to give them unrealistic ideas as they may not

<sup>216</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 11).

<sup>217</sup> Data based on the characteristics of the 27 young people in ACSS residential care on 30 June 2005.

want to leave otherwise. You want to give them what they need - but you don't want to make it so they don't want to move out when they have to.'

Direct Care Worker

Although not apparent from the above data, during interviews with staff and from the documentation provided, it also seems that Equip had begun operating as an overflow for crisis accommodation:

'... due to the fact that the upper level of the Department started placing kids with us that were not interviewed by us, were not selected by us, they were not appropriate for the program either, cognitively they were too young and couldn't understand the concepts of the program so generally the program began to degrade ... and that has made it very difficult and quite frustrating for myself as a staff member working there and quite upsetting to see the differences in the young people being placed there without any real consideration for their age, their history, their needs.'

Direct Care Worker

'We understand the frustration from out in the offices because they have nowhere to send the children to and you turn around and say well if they don't stay with you where do they stay? There is nowhere. Foster placements don't have anybody, all the residential units are full all around the city or the YSAP [Youth Supported Accommodation Program] Services. So basically you are stuck, you have got to keep them and you have got to try to keep them safe.'

Senior Manager

PfP had long before been revised to offer long-term rather than short-term accommodation and it was felt that '*Preparation for Placement*' was a misnomer as these young people had nowhere else to go:

'No the name is wrong because we can't do that, we can't prepare them, there is nowhere for these kids to go - the ones we are dealing with. And they are all too young to go into independent living but there isn't anywhere in the interim for them to go. Their behaviours are unacceptable and that makes it very, very hard to place a child with these behaviours. So then we do the best we can with them. There have been some successes but it was hard work getting to them but once the kids got there they saw the advantage in it.'

Direct Care Worker

There was broad agreement among staff working in ACSS residential care that the intended functions of the various hostels were defunct, largely as a result of the absence of suitable placements for the young people coming into, and trying to move on from, ACSS.

'We just had to take kids because there was nowhere else for them to go and that caused a lot of angst amongst my workers because they believed I was compromising their programs and I probably was.'

Senior Manager

'There are now very pressing questions about whether it is better for some of the young people to be returned to their families rather than be exposed to the violence and abuse in hostels. One young girl ... had a family which was affected by drugs and alcohol. There was neglect, but no sexual abuse. When she came into the hostels ... she had a "high moral" stand. Since then she has been exposed to the promiscuousness of severely sexually abused young girls. She has become involved with an ex-DCD hostel 17-year-old boy who lives close [by]...'

Residential Care Manager

When asked how happy she was in the hostel, this young girl indicated multiple scars on her forearms and said:

'I get so upset I self-harm'.

The general deficiency in appropriate placements was noted in the Cant Report as '*the single biggest risk for abuse in care*'<sup>218</sup> and, with specific reference to ACSS facilities that report found:

'Placement shortages for difficult to place children and young people appear to have severely compromised parts of this service. For example ... the Kath French Centre was intended to function as a 6 - 8 week assessment centre for children who had experienced three or more placements and were difficult to place. It is now accommodating for lengthy periods very damaged children for whom there are no alternative placements, a function for which it was neither designed nor is it suited. These situations carry a high risk of abuse in care, particularly if circumstances necessitate the placement of young or vulnerable children with children or young people with a history of violence toward, or sexual assault of, other children.'<sup>219</sup>

### 7.3 Conclusions

Murray stated that '*the very nature of children in out of home care is complex and fluid and is therefore difficult to report on*'.<sup>220</sup> This is demonstrated in the data outlined above: children and young people in ACSS appear to form a very specific '*sub-group*' of those in residential care, of those in facility-based care, and of those in care generally.

If these residential care facilities are to meet the needs of the children and young people residing there, it seems to me that the Department needs to monitor who they are and to try to ensure that the facilities have the flexibility and capacity to meet their individual needs. More recent academic research brought to my attention by the Department has highlighted the general lack of data about the children in residential care.<sup>221</sup>

I recommend that:

2. The Department monitor data on the characteristics of the specific cohort of young people who reside in ACSS facilities to assist it design and review its programs to try to ensure, as far as practicable, that there is a match between its programs and those young people's needs.

The Department has agreed with this recommendation and states that an information system is being developed which will enable the better matching of children and young people with the programs available to meet their needs. It further states its current review of the outcomes of its residential services includes a change management process that will implement a new regime of treatment, assessment and intensive care and support. This will include the development of a database capable of tracking the care journey of each young person and the services provided as part of their stay, which will enable the clear delineation of outcomes at individual, unit and system levels. The Department expects the development of the new residential care system will take up to 18 months due to the complexity of the consultation, design, research and evaluation involved in the delivery of best practice systems.

I welcome this response by the Department.

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<sup>218</sup> At p. 10.

<sup>219</sup> At p. 11.

<sup>220</sup> Murray Report, p. 9.

<sup>221</sup> J Cashmore, DJ Higgins, LM Bromfield and DA Scott, "Recent Australian child protection and out-of-home care research: What's been done - and what needs to be done?", *Children Australia*, Vol 31(2), (2006), pp. 4-11.

## Part IV The Role of Young People

### Chapter 8 The Role of Young People in Preventing Maltreatment

#### 8.1 Introduction

Young people can be the victims, witnesses or perpetrators of maltreatment in the Department's residential care facilities. Their role in the prevention of maltreatment is therefore crucial.

The informant and others alleged that systems to assist young people prevent and report maltreatment were not always effective. Included were allegations that:

- the lack of access to Case Managers meant that there could be a failure of external supports for young people in residential care;
- some Case Managers failed to deal with young people directly, instead speaking with residential care staff;
- the Department's Consumer Advocate was almost unknown in those facilities; and
- plans generated by field staff for the management of young people in residential care were not always provided in time, and could be generic or inconsistent.

We examined each of these allegations as they concerned important measures which are intended to assist young people in ACSS (and other forms of care) avoid maltreatment and to minimise the risk some pose as the perpetrators of maltreatment.

#### 8.2 Resisting the development of a 'secret world'

In recent academic work discussing liability for the abuse of children and young people in government institutions, it was proposed that a more thorough approach to prevention of child abuse includes '*openness and actively resisting the development of a secret world*'.<sup>222</sup> In this context the connections between children and young people in the Department's residential care facilities and people outside the intuitions can be crucial. This is discussed below with reference to both the Department's Case Managers and other support people.

##### 8.2.1 Case Worker support

A primary contact for children and young people in care is their Case Manager. It is of note that '*continuity of case worker*' is an indicator of Australian governments' objective to ensure child protection services are delivered in an effective manner:

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<sup>222</sup> M Hall, '*After Waterhouse: Vicarious Liability and the Tort of Institutional Abuse*', *Journal of Social Welfare and Family Law*, vol. 22, 2000, 159, at p. 163 quoted in J Wangmann, '*Liability for Institutional Child Sexual Assault: Where does Lepore leave Australia?*' in (2004/5) *Melbourne University Law Review* at <http://www.austlii.edu.au/au/journals/MULR/2004/5.html>.

'The turnover of workers is a frequent criticism of the quality of child protection services. Effective intervention requires a productive working relationship between the worker and the child and family.'<sup>223</sup>

The Cant Report stated that '*not only is it good practice to ensure that the child's progress is closely monitored and reviewed, it is essential if the risk of abuse in care is to be minimised.*'<sup>224</sup>

Concerns have been raised that there was compliance in only 73.5 per cent of cases with the then requirement for Case Managers to have contact with wards on at least a quarterly basis,<sup>225</sup> and about the high turnover of the Department's Case Managers.<sup>226</sup> State Government efforts to reduce Case Manager caseloads including most recently '*the single biggest allocation of funding in the department's history*',<sup>227</sup> continue to be subject to criticisms that resources remain inadequate.<sup>228</sup> The Department states, however, that 2006/07 Budget initiatives should better support Case Managers through extra funding to reduce caseloads and staff turnover. The Acting Director General stated that:

'Reducing caseloads will enable workers to devote more time to each individual child and young person's needs. They will be supported to develop relationships with children and young people and meet appropriate care standards, through regular visits and more planning for children's needs.'<sup>229</sup>

In interviews and discussions with my officers, field staff expressed a variety of views in relation to prioritising contact with the young people in Departmental residential care:

'I probably would have had a caseload of around about 30 kids at that time so, pretty full on. And I guess, what we've just talked about when a young person is in a hostel I guess there's an expectation with paid professional staff there's going to be a higher level of supervision so therefore maybe the Case Manager, you know, concentrates on other kids in care with whatever specific needs they may have. I mean I couldn't tell you what my caseload consisted of but I'm sure it was a mix of babies up to teenagers you know. A lot of foster care placements, possibly some breakdowns in placements I don't know. I mean I'm not trying to make any excuses for my practice it's just a case of our practice, like a lot of case workers we prioritise our work, and whatever needs attention that day gets it, and every day has a different priority often you know....'

Field Officer

'In theory no [a Case Manager should not generally differentiate in the frequency and type of contact with a young person in a DCD hostel, as opposed to other hostels or foster care]. When it comes down to the practicalities Case Managers are well aware that the kids are being managed by professional staff and often the practicalities and when you get a very busy, when you get an extremely busy case load with things like, things awaiting allocation and so on, there's an

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<sup>223</sup> Productivity Commission, *Report on Government Services 2006*, 15.14

<sup>224</sup> Cant Report, p. 35.

<sup>225</sup> Cant Report, p. 36. There was also no formal assurance in place monitoring the contact with '*non-wards*' in care (Cant Report, p. 36). The C&CS Act no longer uses the term '*ward*' and instead all children in care are referred to as being '*a child in the CEO's care*'. The Act requires that care plans for all children in the CEO's care be reviewed at least annually (s. 90) and that the '*principle of child participation*' applies to the reviewing of these plans (s. 10(3)), but there is no specific legislative requirement as to contact with case workers.

<sup>226</sup> See for example, Cant Report, pp. 35-39.

<sup>227</sup> Minister for Community Development, '*Review to help improve child protection*' (Media Release), 21 December 2005.

<sup>228</sup> D Gibson & J Strutt, '*Tired State aid workers close office in protest*', *The West Australian*, 30 March 2006, p. 17; '*Stories from workers at DCD*' presented at a members meeting to the Hon. Minister Sheila McHale, Director General Jane Brazier and others, 2 November 2005; and D Gibson, '*Budget fails on child abuse, claims union*', *The West Australian*, 13 May 2006, p. 48.

<sup>229</sup> Message from the Acting Director to DCD staff, 11 May 2006.

element of reactive practice. So it depends on what's happening at a particular time but if anything's going to drop off it's going to be where there is an element of safety in place. In other words if you've got a kid in a hostel, then ideally you'd still be visiting that kid you know, at a reasonable frequency once a week or whatever else. But if you've got to prioritise your work, then it's reasonable to assume that if a kid is being well cared for within the hostel system, what then happens is that you know, you start getting the hostel saying you haven't visited your kid within a week. And they require that you do keep up the you know, the reasonable level of contact, because that's what your job is. But if anything's going to drop off, those are the kids that will drop off.'

Field Officer

[In giving priority to ensuring contact with babies and small children] ... I guess for a teenager, like teenagers are able to vote with their feet, you know, they are able to get themselves out of situations that they don't feel safe in so that's the rationale for that I assume.'

Field Officer

Whether viewed as placements with the benefit of trained staff and professional managers, or as sites where those in care are old enough to '*vote with their feet*', Case Managers and others informed my staff that in practice they have less contact with children and young people in Departmental residential care than with those in other forms of out-of-home care.

The limited contact with Case Managers was keenly felt by some young people in residential care:

'My Case Worker left, after two years. She's gone to [another division in the Department]. She didn't even say goodbye. She told them [hostel workers] not me.'

Young Person

'I had contact with my Case Worker three weeks ago; she hasn't been in touch again since... I don't know the time I saw her before that.'

Young Person

'My Case Worker dropped me off at the hostel a month ago and left. Before that I'd only seen her once... I hung up when she rang me - she just said I had to go to the doctor. Didn't say "*hello*" or anything.'

Young Person

As with most aspects of this investigation, however, this was not invariably the case:

'I've had lots of contact with my Case Worker. I've had eight over my life - the longest Case Worker was for five years... I saw my Case Worker just last week; she makes an effort as she has lots of cases. Sometimes I see her here [at the hostel], sometimes at school.'

Young Person

Case Managers, Team Leaders, DCWs and young people in residential care acknowledged that the contact and relationship between Case Managers and young people varied from very good to virtually non-existent. It appears that this preventative measure is not consistently effective in the Department's residential care facilities.

The Department states that regular contact between children and young people in the CEO's care and their Case Managers is essential to building a good quality working relationship and enabling the Department to best assist the child or young person. The Department agrees, however, that for reasons including workload pressures, the amount of face-to-face contact between Case Managers and children in care including those children in residential care has varied. The Department highlights the additional resources that have been provided for children in care in the 2006/07 Budget and advises that, specifically for children in residential care for periods of less than three

months, additional Case Managers are being employed to ensure more regular visits and contact occurs. In addition residential care services will be provided with staff to provide casework and treatment services for children and young people in residential care. When a child or young person is in care for more than three months their Case Manager will become part of the residential care system. The Department believes that this will result in frequent face-to-face contact between children and young people and their Case Manager and will allow for a better and more immediate response when issues arise for the young person.

### 8.2.2 Other supports

There are other external supports available to children and young people in residential care. Potentially significant supports exist if children and young people have retained positive relations with their families or have the capacity to develop good relations with other young people or staff in school or work. It would appear, however, that these options are not likely to be consistently available for all children and young people in residential care.

There are also various Departmental positions including the Crisis Care telephone service operators, mentors, the Consumer Advocate and the recently created Advocate for Children in Care. Again, based on the information from Departmental staff and young people in residential care, these external supports appear to also be of variable availability or assistance. In particular, and according to internal Departmental correspondence relating to a request for a mentor for a young person in an ACSS facility, the provision of mentors for children and young people in residential care does not appear to be a priority, possibly relating to the already relatively high cost of maintaining children and young people in this form of care. Similarly the Consumer Advocate, although intended to have a special role for children and young people in residential care, appears to have been unable to meet the various demands on her time and, on the information provided by young people and residential care staff, was virtually unseen in the Department's residential care units. This information is consistent with the Cant Report findings.<sup>230</sup>

The position of the Advocate for Children in Care was more recently established, in January 2006, as a result of a recommendation in the Cant Report about providing children in care with '*access to an independent third party*'.<sup>231</sup> This was based on the significance for young people in care of having access to an Advocate if they were uncomfortable to approach their Case Manager or felt that their concerns were not being acted upon. The role of the Advocate will be to provide a complaints management service for children and young people in care, including advancing the rights of children and young people to participate in decisions and actions that impact on their lives. The Advocate will also provide strategic advice to the Director General. The Department advises that the Advocate has worked directly with children in residential care and, by June 2006, had received 45 referrals from children and young people in care, with a significant proportion coming from those in residential care. The Advocate has also supported children in residential care who have experienced abuse in care.<sup>232</sup>

While the achievements of the Advocate for Children in Care are acknowledged, the value of an independent third party's access to residential care facilities for young people is demonstrated by the information my officers obtained during this investigation. I discuss this issue further at 16.3.

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<sup>230</sup> Cant Report, p. 39.

<sup>231</sup> Cant Report, pp. vii, 39

<sup>232</sup> '*Advocate for Children in Care*', undated memorandum provided by the Department in response to our preliminary report received in June 2006.



### 8.3 Preventing maltreatment by young people

In addition to the individual care plans<sup>233</sup> developed by Case Managers for each child or young person in care, there are ‘*Looking After Children*’ (LAC) forms,<sup>234</sup> and for particularly high-risk children, safety plans.<sup>235</sup> The intention of each of these documents is to ensure that the individual circumstances and relevant histories of each child and young person are available to those who care for them; that their individual needs and vulnerabilities are assessed; and that plans are in place to address these needs and ensure safety, including through the identification of suitable placements.

The safety plan initiative as it relates to Departmental (and other) residential care is of significance. The (previous) Director General’s Administrative Instruction 458, concerning the placement of children or young people in care seen to be at risk to others, stated that:

‘The placement should not occur if safety factors cannot be put in place. In particular, children with a history of extreme violence or sexual assault should not be placed in households where younger children are present.’

The Cant Report highlighted that the focus of the policy on Departmental foster carers, cottage and group homes was too narrow and that it needed to be extended to include other forms of Departmental accommodation and to the non-government sector as well.<sup>236</sup>

In its new policy, the above standard for the placement of children who pose a risk to others remained in place in relation to foster and relative care but was expanded to also protect children who are developmentally delayed or have a history of abuse. However, in relation to other forms of care including Departmental residential care (and therefore of significance to this investigation), revised Instruction (now number 62)<sup>237</sup> reads:

‘Placement in a Departmental or not-for-profit hostel or group home

It may not always be possible to avoid placing children/young people who pose a risk to others in the same hostel or group home as other children, especially in emergency situations. However, it is expected that these types of placements should be able to put more stringent safety plans in place than is possible in a foster placement.

However, children/young people with a history of extreme violence or sexual assault should not be placed in residences where there are younger children, children/young people who have developmental delays or children who are especially vulnerable for other reasons such as previous abuse.

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<sup>233</sup> These are plans developed by case workers that outline the individual care needs for each child or young person in residential care, and include details about the school or workplace attendances, contact with family and guidance to staff about issues such as the use of physical restraints for those with abuse histories, or other specific management strategies. Care plans are now required to be prepared and implemented under the new legislation (C&CS Act, s. 89(2)).

<sup>234</sup> A form completed by Case Workers to provide information to carers about children and young people to be placed in their care at the time of placement or as soon as possible afterwards, it must include a record of any risks posed by the child or young person. (Now known as Assessment and Planning System forms.)

<sup>235</sup> Initiated as part of the Director General’s Instruction 62 and in response to the Cant Report recommendation about reviewing the policies on the placement of children and young people considered a risk to others in February 2005; safety plans are to identify risks posed by the child or young person and specific strategies to overcome these.

<sup>236</sup> Cant Report, p. 11.

<sup>237</sup> As authorised on 11 January 2005.

In emergency situations, when it is unavoidable for a child/young person who poses a risk to others to be placed in residential care, extreme caution must be used and a comprehensive safety plan must be developed to ensure the safety of others in the facility. The plan must be approved by the Director Placement Services for ACSS services or by the district manager for other services ' (my emphasis)

This policy expressly recognises that children and young people with histories of extreme violence or sexual assault might be placed with ' *younger children, children/young people who have developmental delays or children who are especially vulnerable for other reasons such as previous abuse* ' in Departmental residential care. In this sense the concerns expressed below have some validity:

'Safety Plans came in as part of the new policies in April. I have concerns that these are not being implemented as required - with some only being developed for young people after I spoke up about them. The problem remains however that the Plan is not informing where the young person is placed - instead it is developed after the placement.'

Direct Care Worker

The problems arising from the mixture of young people in these facilities have been known for at least eight years: refer for example, the Auditor General's assessment of residential care in 1998.<sup>238</sup> In this context the following comments of another witness also have some validity:

'... if for example you have a young person in the unit who is a perpetrator of sexual abuse and stuff, then obviously it's an undesirable mix, yeah, and I take that at face value. But it's also true that... that the Department of Community Development and Adolescent and Child Support Services is the only place, in some sense, for those very hard end kids. Right? If they've offended sufficiently they go to jail, but that is the nature of the beast, right? That is their core responsibility. There are other accommodation agencies, you know, the Parkervilles and the rest of the non-government sector, but in general the Department's job is to look after the most vulnerable, and the most vulnerable unfortunately have the most difficulties. You know the suicidal behaviours and that sort of the thing. So in a sense the mix is a little bit of a mystification because you're never going to have an easy mix, right? What is the likelihood if you've got a six bed facility catering for people by definition who cannot live at home because their families don't want them; who have histories of physical, verbal, sexual abuse; what is the likelihood that the mix is going to be good. ... It's difficult for sure, but it's a furphy to say that no-one's helping us with the mix, because the mix ain't ever going to get better. The mix is what it is, you know ... the mix in residential care contains high needs young people and that's going to be pushed at you, I think it's going to be pushed at anybody that asks questions as sort of the blanket thing about how difficult the work is. The work is difficult but the mix is an inevitable thing...'

Residential Care Manager

In the context of what is an acknowledged high-risk environment, residential care staff indicated that the availability and effectiveness of the LAC forms, individual care and safety plans varied. For example,

'The LAC forms should be updated when young people move to different settings. However sometimes these are not available or are not up to date when a young person comes into residential care; it could be because of the Case Worker's caseload. [A young girl] had been at [the hostel] for a week but there was no LAC form. She had been brought in on Friday night by Crisis Care. Field staff don't work weekends... The LAC arrived one week later. Direct Care Workers might ring around other hostels asking what they know about the young person. The DCD files however are kept at the Kath French Centre and these are also locked up during the weekend. Generally the caseload for a Case Worker will be about 20 - sometimes including all the kids in one family... There is an enormous amount of stuff that happens to kids - especially

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<sup>238</sup> Auditor General, *Accommodation and Support Services*.

when they get older. The Case Worker could not follow up on it all and so there is a tendency to minimise things and move on. There is an issue of work loads and what's realistic – this is not reflected in policies.'

Residential Care Manager

'... even now I think sometimes even though the kids have come in, the Social Workers [haven't] put the [safety] plans into place, even when kids have been admitted. And safety plans are quite broad, I don't like them very much, they're very broad... They're useful, I mean but, I could've written one ... I mean these people know their kids. More than, you know for what they say ... I mean I'm not quoting anybody, but I'm just saying some of [the safety plans] can be quite broad to say you know, what [the kids] can do and what they can't do which then falls on us ... what we think it means – can they do that, can they not do that? Yes so a bit more specifics would be good... They do identify some sort of the risks yes. But ... the contacts [that kid's are allowed to have] and stuff can be quite broad still. On one hand they'll say: "*Supervise this child because other kids could be at risk with this child*", but then we put this kid on a bus, he's allowed to get on a bus and go to school on his own, you know... And you scratch your head and you wonder...'

Direct Care Worker

Other reviews of out-of-home care have reiterated the concerns about the delay in the availability of these documents and this too was attributed to the large caseloads of Case Managers. Indeed in describing the limited resources available for these purposes in Queensland, the Murray Report used the analogy of child welfare agencies '*becoming dangerously like one of the children for whom it had a statutory obligation; that is, "like a neglected child"*'.<sup>239</sup>

Nevertheless, as one witness commented:

'Everyone does what they can but in the meantime the kids are suffering'.

Direct Care Worker

## 8.4 Conclusions

The information obtained supports the conclusion that:

- the contact and relationship between Case Managers and young people in the Department's residential care facilities, as with other external supports, varies;
- the Consumer Advocate was virtually unknown in the context of Departmental residential care; and
- the availability and effectiveness of Departmental forms intended to ensure that carers are advised of young person's individual needs and to minimise risk varies.

The establishment of a dedicated Consumer Advocate for Children in Care by the Department is a positive initiative. However, with over 2,000 such children throughout the State, this new role will face the challenge of addressing the existing gaps in the systems available to young people in Departmental residential care to assist them avoid maltreatment and to minimise the risk some may pose to others. It is of note that the Department disagrees with this comment, stating that the Advocate for Children in Care is not the only option to advocate and support young people and that the reference to over 2,000 children in care throughout the State fails to acknowledge that most have positive experiences.

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<sup>239</sup> Murray Report, p. 8.

## Chapter 9 The Role of Young People in Reporting Maltreatment

Young people in residential care can play a crucial role in reporting maltreatment against themselves or others in care.

There appear, however, to be a range of barriers to young people in residential care reporting maltreatment, including a perception that “*they*” *only believe the adults*. The apparent lack of information for young people about how to complain and the reasons why young people believe they are not listened to are examined below.

### 9.1 Access to information on how to complain

‘You can ring the Consumer Advocate or the CCU [the Department’s Crisis Care Unit].’

Young Person

Should children and young people consider either they or other residents have been subjected to maltreatment, they need to be aware of how to deal with their concerns. As indicated by the above comment and by some of the case studies examined for the purposes of this investigation, some young people are aware of avenues to raise their concerns and have made use of these, for example, reporting concerns to residential care Team Leaders, to the ACSS Clinical Psychologist, to their Case Managers and to the Crisis Care Line. In some of the Department’s residential care facilities there are residents’ meetings, providing another avenue for young people to raise their concerns. In one instance, a group of residents insisted that Police be called because of the allegedly disruptive and destructive conduct of one of the residents at the facility. In other instances Police have been called as a result of allegations by young people of sexual assault by residents and of physical assault by residential staff. One young person kept his own ‘log’ of events at the facility (in response to the recording of his activities by residential care staff) which he reported to Departmental officers outside the facility: *‘I write it all down and show my Case Worker.’*

It is evident that at least some children and young people are informed of, or able to develop their own, means of reporting their concerns. However, there appear to be no standard means by which young people are informed of the options available to them to do so. Some hostels had residents’ information brochures or ‘contracts’ which set out the various responsibilities and rights for new residents, and all hostels had an induction for new residents which was conducted by DCWs. However, none of the written materials highlighted the options available for young people to address their concerns or complaints, although one brochure did refer to residents’ meetings which were *‘held to discuss problems, wishes and activities’*.<sup>240</sup>

Some academics have questioned whether institutions contribute to an environment in which abuse can flourish. One example is: *‘Does the ... environment create a situation in which young people are encouraged in their views, able to question things and have a concept of their “rights”?’*<sup>241</sup> Interestingly there was a recommendation to develop a ‘Charter of Rights’ for young people detained in institutions in 1986;<sup>242</sup> but this did not occur.

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<sup>240</sup> KFC Orientation Brochure.

<sup>241</sup> J Wangmann, ‘Liability for Institutional Child Sexual Assault: Where does Lepore leave Australia?’ in (2004/5) *Melbourne University Law Review* at <http://www.austlii.edu.au/au/journals/MULR/2004/5.html>.

<sup>242</sup> DCD, *Juvenile Justice Systems*, p. 116.

In this context, the development of a Charter of Children’s Rights by the Department, as required under the new C&CS Act,<sup>243</sup> is a very positive initiative. I recommend that:

3. In conjunction with the Charter of Children’s Rights, the Department develop posters and other materials for distribution to its residential care facilities outlining the various avenues for children and young people to raise their concerns or complaints; and the Department ensure that this information is included in all induction materials and processes for residential care.

The Department states that information about complaining to the Consumer Advocate, CREATE and Case Managers has been provided to young people in residential care for two years (although my staff were unable to locate this information upon reviewing the induction material for residents). However, the Department has agreed with the above recommendation and states that it has developed posters, a CD and other material for distribution to children in residential care facilities outlining avenues for children and young people to raise their concerns or complaints, which include information about the role of the Advocate for Children in Care. The Department also reports that another innovation, of having a suggestion box in residential care facilities, has been well received by young people and staff. It advises that the Induction Program for staff includes information about the importance of supporting children and young people in raising their concerns and complaints, and the same information is now provided to young people when they are admitted into residential care. These are positive developments.

## 9.2 Reasons not to complain

Being aware of how to raise concerns or complaints, and even encouraged to do so, is only an initial step in assisting young people to report maltreatment in residential care. Children and young people must also have confidence in the systems for responding to maltreatment.

When asked about how they might complain, responses given were as follows:

‘But they only believe the adults.’

Young Person

‘They don’t help.’

Young Person

‘I’d run away and was told to “*get home now*”.’

Young Person

Lack of confidence in the systems for addressing their concerns may contribute to young people’s failure to utilise these systems. A number of factors may be associated with this: a lack of feedback about complaint outcomes, a perceived failure to act quickly, appropriately, or at all, and a failure to separate the child from the alleged perpetrator once a complaint is made. These are discussed below.

### 9.2.1 Lack of feedback

For a range of reasons, there can be considerable limitations on what a young person in care, who has raised concerns about staff, can be advised about the outcome of an investigation into those

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<sup>243</sup> Section 78.

concerns. The lack of feedback to children and young people may contribute to their sense that they were not believed:

'I told [the Team Leader]. She talked to the staff. They don't believe us. [The staff member] said "That's not what I said" and they believed her.'

Young Person

It is also of note that, similar to the young people, some residential care staff interviewed felt that they were not believed and that Managers were not appropriately addressing concerns about the conduct of some residential care staff. However, when my officers pursued some of these allegations, it appeared that in fact the concerns had been dealt with appropriately, for example, through performance management. The problem appeared to be that the staff members, similar to the young people raising concerns, had not been given any feedback and felt that their concerns were not addressed.

There are undoubtedly constraints on those dealing with or investigating a complaint because of the confidentiality of performance management processes. Not all complaints will be addressed through performance management, however, and it is also the case that the constraints in the residential care environment go beyond the issue of employee confidentiality, as indicated by the following example.

An officer who conducted a substantial investigation of a young person's allegation of being maltreated by a DCW, and who had substantiated some aspects of the complaint, felt constrained about what the young person could be told of the outcome:

'I know it doesn't sound very fair, but I guess he [the young person complaining] was there [in the hostel] and could have used that [information about the outcome of his complaint] you know, ... arcing up with [the Direct Care Worker the subject of complaint] and that again, and that they had to manage his behaviour. I know it doesn't sound fair and it isn't fair but...'

Field Officer

It appeared that there is concern that negative feedback about a worker may somehow compromise that worker's capacity to deal with the undoubtedly difficult children and young people in their care.

It is of note, however, that this does not appear to be a universal concern. In one instance brought to my officers' attention, a Residential Care Manager apologised to a young person for an incident which had been mishandled. Another staff member stated:

'I've chastised myself thinking I could have handled that better, and no I should not have used that wording because I didn't think they understood, but it is too late. You can always go back later, like with [the young person] this morning he needed to apologise to a staff member, the words he used on her yesterday were absolutely, I could have grabbed him by the neck and probably would have run him outside again, were foul. So I said to him you need to apologise to [the Direct Care Worker] and you have got until 9 o'clock tomorrow morning, which was the time to go to school, to do it. This morning he was only speaking to me, he wasn't speaking to [the Direct Care Worker]. I said this is not on, you need to apologise to her and I said look I apologise to you, I am not ashamed to apologise to you, you shouldn't be ashamed to apologise to anyone. It just means you are a better human being. He made it on the third attempt. He did apologise.'

Direct Care Worker

I recommend that:

4. The Department, in consultation with Direct Care Workers and other residential care staff, should develop mechanisms to give young people and others confidence in the complaint handling system in ACSS, for example, by developing guidelines which adhere to the principle of procedural fairness and relevant legislative protections for

staff but which allow for feedback to young people and others raising concerns or complaints about a staff member.

The Department agrees with this recommendation. It advises that the complaints mechanism for its residential care services is being reviewed and that it will include a universal and transparent set of guidelines that will be used by both staff and young people. The project is expected to be completed by February 2007. I welcome this response.

### 9.2.2 Consequences of complaining

Other factors which may contribute to young people not reporting their concerns, particularly about maltreatment, relate to the consequences of complaining.

The Department's policies require that to ensure a young person's safety, he or she should be isolated from the alleged perpetrator as soon as possible after an allegation of maltreatment is made, or at least protected in that environment.<sup>244</sup> In a number of the incidents brought to the attention of my office for the purposes of this investigation, which potentially involved abuse by children and young people against other residents, nothing occurred:

'Two kids are [at the hostel] at present; there was a Police investigation and then the second child made a counter allegation. In the end neither allegation was verified by Police. However, [Director General's Instruction] 59 was breached because a child made an allegation about another child concerning sexual abuse. Police spoke to them – but they are still living together in the same hostel. The Department doesn't know where to place them! There have been two other substantiated complaints about young people's abuse of each other in the hostels – one resulted in the young person being put in custody.'

Direct Care Worker

Again the lack of placement options appears to result in children and young people in residential care potentially being at significant risk. Of relevance here, this inability to remove young people from each other's company can operate as a deterrent to raising concerns. If a child or young person is required to continue to reside with the alleged perpetrator, they will be vulnerable to retribution and potentially further abuse.

On occasions, no action has been taken to isolate young people from alleged perpetrators, when the allegations relate to maltreatment by staff. In one instance, when a young person contacted the Crisis Care Unit alleging physical assault by a Direct Care Worker, and stating that he had received medical treatment for a physical injury, the Unit contacted the residential care facility. Departmental documents record that the young person was returned to that hostel because the workers the subject of the allegation stated that '*there would be no repercussions tonight and the incident could be dealt with tomorrow with case workers and police*'. The young person and alleged perpetrator remained at the same facility for some days. (On another occasion involving similar circumstances Departmental documentation indicates that the Unit adopted a much more rigorous approach to the return of the young person to the facility and record that '*it is not*

<sup>244</sup> The Department's *Best Practice Manual* 1.4.10.3 states:

'When there appears to be substantiated evidence to support the allegation, prior to a full assessment occurring, the officer is to be removed from contact with the child who has made the allegation, and from other children who may be at risk of abuse.'

It also requires that '*If the allegation has been made by a child, the child must not be left alone in any situation where pressure may be applied for the child to change or withdraw the allegation.*'

Field Worker Guideline 7.5.1 states that in cases assessed as a CMA an immediate risk assessment must be done to determine '*if the child/ren can remain in the placement safely*'. However, if the matter is assessed as a notifiable Critical Incident under Director General's Instruction 59, but not a CMA, the relevant Field Worker Guideline 7.6 does not state that a risk assessment is required. See also *Case Practice Manual* 4.10.

*acceptable for [the young person] to [be] returned to the care of the hostel without an assessment being completed [and] that it is not fair for staff to be placed in a similar position, as the rights of staff need to be considered as well.'*)

In a number of other instances brought to the attention of this office, there appeared to be a considerable delay in removing either the young person or the staff member the subject of the allegation from the residential care facility. It was almost two weeks before one staff member, who had been the subject of allegations of child maltreatment, was removed from that work location. In that instance, the investigation eventually substantiated a number of Child Maltreatment Allegations (CMAs) for emotional and verbal abuse against a number of children and young people who had remained at that facility. In other more recent instances brought to the attention of my officers, efforts were made to quickly remove the worker from the environment once an allegation was made, although it was alleged that, after being reassigned to another location when an investigation was being undertaken, one staff member subject to an allegation continued to visit the hostel where the young person resided.

The practice of leaving young people in contact with alleged perpetrators who are staff members can result in young people feeling pressured to retract their complaint; or possibly not complaining at all. For example in one instance the Team Leader investigating an incident involving a DCW reported:

'I am concerned that [the young person] is actually at risk - will be targeted by [the Direct Care Worker who was the subject of the allegation] and other staff. [The young person] is saying that he wants to withdraw his complaint, he doesn't want [the Direct Care Worker] sacked he has a [family] to support - I believe he is being pressured by other staff and that this will continue. [The young person] will be the one who ends up in Rangeview or somewhere like that [and] staff will not protect him. [The young person] has not made an official complaint [and] I am investigating an incident of harm to a child in care.'

The Case Manager for this young person was asked to comment:

'So it's pretty clear [that the young person] didn't want to talk about it. This is a common, fairly common. I mean it's similar to [another incident of alleged abuse in care where the young person] ... if he wanted to continue to reside at [the hostel], that he didn't want any further action to take place with the investigation down there, the CMA. You know, these young people are in a compromising situation if they continue to reside at these hostels, they continue to be supervised and managed by Direct Care Workers. Obviously the young people don't want to be placed in a compromising situation. So I guess what this is saying is [that the young person] didn't want to get [the Direct Care Worker] into trouble, and I guess what I'm doing there is kind of respecting that. It places the Case Worker in a difficult situation as well, you want to retain the trust of the young person, but you also want to make sure that the young person is safe and well cared for. And of course there's the professional, you don't want to create a professional conflict between yourself and the staff because that might impact negatively on the young person as well. So it's not easy but I guess, [the ACSS Team Leader] is saying she's investigating [as a work place issue]...'

Field Officer

The issue of moving the young person is a difficult one, however, as can be seen from the following comments:

'Another negative aspect of the maltreatment investigation process was that [a young person] making the allegation had been removed from the hostel immediately on the say so of the Case Worker. Neither the young person nor the Direct Care Workers had had the opportunity to discuss the incident and this was very difficult - there was no closure for anyone. Recently the young person rang the hostel and at least we had some opportunity to discuss what had occurred. I guess that's the only closure either of us will get.'

Direct Care Worker



In the above instance the young person had been resident at the hostel for many months and it was another significant upheaval in what had already been a turbulent life for this young person to be removed from what had become his home.

It would seem preferable, in at least some instances, to remove the worker. However, the difficulty in managing these issues in some respects has increased recently. It appears that the previous practice of allowing staff to take paid leave while the subject of a CMA investigation<sup>245</sup> was not in accordance with employment conditions. As a result:

'... initially we used to put them off on full pay and that changed 18 months ago and I'm not allowed to do that anymore... the advice I was acting on from previously anyway was ... where you could put people off on full pay; now you had to ask people to take leave if they had accrued leave... And so I've had people come to me and say well look I haven't got leave or anything like that so I've put people in Head Office...'

Senior Manager

I am informed that there has now been an improvement, however, with the undertaking that District Offices have to take residential care staff when they are being investigated; as a Senior Manager commented, '*so I've now got somewhere to put them.*' Although this is an improvement, it does not resolve all of the issues. There are also delays in addressing these allegations which can be outside the control of ACSS, such as delays in the investigation by field officers, and problems arranging for replacement staff.

It is clear that apparent inaction or actions perceived as inappropriate in relation to allegations of abuse by young people have the potential to seriously impede the likelihood of young people reporting maltreatment in residential care. Although there would seem to be a place for flexibility in practice in relation to management response to these allegations, I recommend that:

5. The Department develop guidelines to assist in determining the appropriate placement of staff while the subject of child maltreatment and/or standard of care allegations and give consideration to the frequency of these incidents and impact on staffing requirements when calculating the workforce requirements for ACSS.

The Department agrees with this recommendation and cites its interim guidelines, referred to above, which were implemented in November 2005 and which provide for an employee to transfer temporarily to their nearest District Office or to take accrued leave. The Department also advises that discussions are proceeding to determine the feasibility of an employee the subject of an allegation remaining with Placement Services (the new division incorporating ACSS) but not having contact with children.

### 9.3 Critical incidents

There is presently a process for reporting critical incidents involving young people in ACSS hostels, including the use of physical restraints. The reporting of critical incidents is one means of alerting Team Leaders, Case Managers and others, of significant incidents involving young people in the hostel and also alerting them to any incidents potentially involving child maltreatment by residential care staff.

Some of the potential areas for improvement in this process are described later in this report, at 13.4. Perhaps the most significant impediment to the effectiveness of the process, however, is that it does not currently incorporate any independent record of the young person's account of the incident. At present, even when the content of the report causes concern, young people stated,

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<sup>245</sup> As confirmed for example, in the Cant Report, p. 49.

and it was confirmed by field staff, that Case Managers might contact the residential care staff and not speak directly to the young person involved. As indicated in the following example, the availability of the young person's perspective may indicate a very different kind of incident to the one described by staff.

A Critical Incident Report<sup>246</sup> stated that a young person was acting in a threatening and aggressive manner towards a staff member and another resident in the back seat of a moving car. The staff member stated that he pushed the young person away to gain space and then used a '*wing restraint*' for 15 minutes in the vehicle. When the young person subsequently discussed the incident with an independent party he stated that he had been '*slapped with an open hand in the face*' by the worker. He also alleged that the restraint which followed was excessively forceful:

'He refers to his wrists being held very tightly, he refers to his little finger being squeezed in a doubled over position, and he refers to being held very tightly by an elbow to the throat.'

The young person's version of the incident contrasts starkly with the worker's version as recorded in the Critical Incident Report. The recording of the young person's version would go some way to addressing the concerns of young people that there is only a partial record of events in the hostels. For example when there are altercations with staff, one young person complained '*They write down everything you say in a book - but not what they say* [to provoke the young person's behaviour]'. Recording the young person's version of events would appear crucial.

I recommend that:

6. The Department undertake a review of its ACSS Critical Incident Form so that it includes a section for the child or young person to complete about their version of events; or requiring a person not involved in the incident, such as a Team Leader, Case Manager or someone of the young person's choice, to speak with the child or young person about the incident and record their version of events.

The Department agrees with this recommendation. It advises that since March 2006 the revision of the ACSS Critical Incident Form has been prioritised, and the form will include a section for the child or young person to complete their version of events or, if required, for a person trusted by the child or young person to meet with them. The Department also advises that since January 2006 the Advocate for Children in Care has been meeting with young people in residential care and has followed up with those who wished to discuss critical incidents. It states that the involvement of the Advocate provides an independent review mechanism for critical incidents and ensures that prompt advocacy on behalf of the child occurs as a priority.

Subsequent advice from the Department was that its revised Critical Incident Report form ensured that the young person involved in a critical incident would always be spoken to directly about the incident. On reviewing the draft Critical Incident form provided to my office, however, it did not appear that it was sufficiently differentiated from the old form to make it clear that young people were to be given the opportunity to record their own version of events or that an independent party do so on their behalf. Accordingly, my recommendation stands.

## 9.4 Identifying maltreatment

One of the key impediments to children and young people in residential care reporting maltreatment appears to be the very histories of abuse which resulted in their placement in these facilities to start with:

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<sup>246</sup> An ACSS form for use in its hostels. The ACSS Procedures Manual (p. 6) states that these are to be completed for '*an event which involves an injury or potential for injury, and/or a strong stress reaction in a young person or staff*'. These currently record a staff member's version of a critical incident involving a young person resident at the hostel.

'[The young person] came from a background of significant physical abuse and often kids that come from that background believe that is what happens. [The young person] would kind of see it a little bit as "I was around the office, I wasn't doing what they wanted me to, I wasn't doing the right thing so therefore they were entitled in some sense [to maltreat me]"; that is kind of partly where [the young person] was coming from but there is also the stuff about the pressure coming from staff.'

Residential Care Manager

'A real problem is having young people in care with each other when they should not be together. These young people bond in residential care. There is also a need for more accountability from the field. But even that makes no real difference - as you can't stop the young people copying each other's behaviour. ACSS is the end of the line - young people don't want to be there, but they can't function in their families and they can't protect themselves.'

The problem is what the kids think is normal; they have been abused in their own families and then come into residential care and think what their peers do in there is normal too. They therefore tend to minimise things, for example, incidents.'

Residential Care Manager

Apart from concerns about what children and young people with sometimes extreme histories of abuse will detect as '*maltreatment*' there is also an issue about the attachment that young people might have for their carers.<sup>247</sup>

One instance which highlights the potential significance of such issues involved the maltreatment of a child by a residential care worker. The incident resulted in the criminal conviction of the worker for assault.

Departmental officers who investigated that the incident noted:

'It is understood that both [the child] and [the officer] have a mutual liking for each other... [The child] has not presented overtly suffering any significant harm from this incident which may mean (a) that he has been unaffected by it or (b) he has been desensitised to incidents of this nature because of family of origin issues and long-term institutional care.'

Some four months after this incident my officers met this child at one of the Department's facilities. They were taken to his room which was badly marked and damaged; bare other than a mattress on the floor. The child spoke of all his property needing to be kept securely in another room so he wouldn't destroy it. Staff spoke of having to restrain the child frequently and also of his extreme behaviours, including smearing faeces on the walls.

When my officers had the opportunity to have informal discussions with the young people, without the presence of residential care staff, they asked how the residents were treated. The young people complained about the use of restraints, and one young person referred to an incident of maltreatment which allegedly occurred at the facility more than two years earlier. However, the child the subject of the above incident did not refer to it, although just less than three months before he had been interviewed by Departmental staff and Police. It was reported that when interviewed by Police, the child acknowledged that he was subjected to the alleged assault but stated that this was because of his conduct.

The above investigation highlights what is an extreme example of the difficulty in relying upon the children and young people in residential care to report maltreatment.

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<sup>247</sup> As an example, see '*Messagestick*' transcript for the program '*Rosie*', a docudrama shown on 10 February 2006, exploring the life of author Rosalie Fraser, who as a child suffered physical and emotional abuse by her foster mother. (Available online at [www.abc.net.au/message/tv](http://www.abc.net.au/message/tv).)

Although not '*closed*' institutions like detention centres, the vulnerability of children and young people, and particularly those resident in these facilities, can limit their ability or willingness to recognise and report maltreatment. It also highlights another issue of concern. The incident referred to above which resulted in the criminal conviction of a Departmental worker for assault against a child was witnessed by a number of youth workers for a not for profit agency, which received funds from the Department. One of the workers reported the incident to the Department some two months after it occurred, stating that he had been told by his employer '*to go no further with it and keep it quiet*'. The Department advises that it pursued this matter with the agency and explained its obligations to inform the Department of such incidents.

It follows that the role of residential care staff in the reporting of maltreatment is also crucial, and this is discussed in Chapter 13 below.

## 9.5 Conclusions

My investigation highlighted both the significance of systems to assist young people report maltreatment in a residential care environment and some of the obstacles to the effectiveness of those systems. Recommendations to improve access for young people to information about how to complain and to address some of those factors which appear to have resulted in young person's lack of confidence in the systems for addressing their complaints should go some way to enhancing the contribution which can be made by young persons to the safety of the facilities in which they reside. An emphasis on routinely including the young persons' version of critical incidents in reports is likely to provide a further mechanism for the reporting of maltreatment in the Department's hostels.

There is reason to be cautious, however, of relying too heavily upon children and young people with histories of abuse to identify and report maltreatment. Other systems for the prevention and reporting of maltreatment are of critical importance.

## Chapter 10 Other Issues for Young People

Before turning to the role of residential care staff, there are two issues of significance to the young people consulted for the purposes of this investigation which, although not directly relating to maltreatment in the Department's residential facilities, warrant some attention.

### 10.1 'We're always locked up.'

Departmental staff at all levels disavowed the use of '*detention*' of children and young people not subject to a justice order in accordance with contemporary approaches to this issue. However, in discussions with young people, repeated reference was made to concerns at being '*locked in*' - fear of other young people; fear over delayed access by facility staff; fear over potential fires: '*We're always locked up.*'

'You have to ask permission for everything ... to go to your room, to use the lounge. It's all locked.'

Young Person

The factual basis for these perceptions was unclear, but it appears various parts of the residential facilities may be locked to keep different young people separated and to disallow, for example, access to television and computer games during school hours, as an incentive for school attendance. In almost all the facilities we visited, young people's rooms are always locked; with young people needing to request that staff allow them access. These rooms are locked to prevent other young people stealing residents' personal items. However, in one instance, where a young person was adept at picking the lock to allow him access to his room, a DCW was reported to have affixed a steel plate over the lock.

Young people's perception of being '*locked in*' in the circumstances described above is understandable, even if, as staff advised my officers, no resident can be locked into their room because of potential fire hazards. It is of note that the perception of being '*captive*' and the fear associated with it for some young people may be aggravated by a history which in some instances includes being subjected to extreme abuse, including being confined to rooms and cupboards in very traumatic circumstances or on an ongoing basis. The sensitivities to these issues are therefore considerable.

My officers were told that some time ago at EAS, young people were allowed to have their own keys if they chose to, but that this caused problems when young people lost the keys or had keys cut and then later used these to access others' rooms. These problems might be able to be addressed by the use of patent protected keys and providing a '*deposit*' on the issue of keys commensurate with young persons' income; although the residential care staff and residents would be best placed to develop innovative means of trying to address these concerns.

Although the factual basis for perceptions of being locked up is unclear, this was a very real fear expressed by the young people consulted. It is also clear that young people in Departmental residential care facilities cannot access their own rooms and need to request that a staff member to unlock the door for them. Access to keys for their own rooms may go some way in assisting the children and young people in residential care by giving them a greater sense of control over their environment and also by reducing the resemblance to a custodial setting.

In my preliminary view, I suggested that the Department consider consulting residential care staff and young people about whether measures could be put in place to enable young people who elect to do so to be issued with keys to their own bedrooms. I am pleased to note the Department's advice that it is addressing this issue.

## 10.2 Legal advice for young people

A separate issue arose while my officers were examining the processes associated with critical incidents in residential care. It appears that in some critical incidents involving physical confrontation between residential care workers and young people in care, one or both parties involved have reported the incident to the Police and wanted charges laid.

In one instance, a young person alleged he was a victim of a physical assault by a residential care worker and the residential care worker wanted the young person charged for assault. The young person attended the police station to be interviewed, according to internal Departmental records, '*regarding the charge of assault against staff*' and he was accompanied by a Departmental Field Officer. It appeared that at some stage during the interview the young person was issued a standard caution by Police advising him that anything he said could be used against him in court. In what appears to be consistent Departmental practice, the Field Officer did not suggest that the young person may wish to seek legal advice before answering any further questions.

Departmental staff stated they were not given any specific training to act as advocates for young people in these circumstances, and explained their role as being to ensure there was no undue pressure placed on young people in the Department's care. Some said it was to encourage young people to be truthful:

'If my team leader's saying I want you to take [the young person to the Police for an interview], I want you to be there, that's fine, I'd do that. Then you sit there, you might say very little, you wouldn't say anything really - support them before they go in, do you want a drink, how're you feeling, always be honest... that's up to them what they want to say, purely. You just encourage them to be honest, I would personally.'

Field Officer

In another incident, a Departmental report states that a young person was removed from a hostel by Police after a physical altercation with staff. No Departmental officer accompanied the young person when he was interviewed by Police, although he was in the Department's care, and the young person was charged with assaulting a Departmental officer. Up until the hearing of the charges the young person maintained he had been provoked, however, apparently on legal advice he changed his plea on the basis of admissions he had made during the interview. When the young person was asked if he wished to pursue charges against the residential care worker, he is reported as having said that no-one would believe him and declined to do so.

Subsequently a Departmental CMA investigation found that the incident had involved child maltreatment by the Departmental worker. Police subsequently charged the worker.

As is discussed further below, the Director of Community Based Services in the then Department of Justice WA highlighted the findings of the NSW Community Services Commission Report, *The Drift of Children in Care into Juvenile Justice System - Turning Victims into Criminals*, as being relevant to WA. That report found a high likelihood of young people in residential care being involved with police and criminal justice processes,<sup>248</sup> although I also note that the Department's view is that significant differences exist between Western Australia and New South Wales.

It might be considered best practice to have legal advice available for all young people in the Department's care when they are being interviewed by Police about a complaint laid against them. In situations where a young person in the Department's care is being investigated by Police because of allegations by a Departmental officer, there are particular difficulties for another Departmental officer to also be involved as the support for the young person; more so when it appears such

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<sup>248</sup> Wells, '*Juvenile Justice in Western Australia*'.

Departmental officers do not, and are not trained to, view their role as an advocate for the young person in these circumstances.

In my preliminary view, I suggested that the Department consider whether its field staff requires training or guidelines on their role as the adult support for a young person in care who is attending a Police interview where there is a likelihood of charges being laid against the young person. At the very least, I suggest that the Department give consideration to ensuring that legal advice is available for such young people once a Police caution is issued and the potential charges relate to a Departmental officer. I am pleased that the Department agrees with my suggestions and advises that:

- staff receive training and supervision about attending Police interviews with young people in care;
- the Department's legal section is regularly consulted on these matters; and
- staff obtain details of the charges and endeavour to support the young person through the court process.





## Part V The Role of ACSS Residential Care Staff

### Chapter 11 What is the Role of the Department’s Direct Care Workers?

#### 11.1 Introduction

The Department’s residential care facilities are one component of a system of out-of-home care that is intended to protect children and young people from abuse and neglect. A description of the service by the Department states:

‘The Adolescent and Child Support Service is designed to be integrated into Metropolitan Service Delivery and is:

- Child focussed and family centred;

...

- Providing services which are non-punitive, safe, comfortable and oriented toward positive change for young people and their families;
- The focus of all units is to positively engage with young people. However there is no legislative provision to physically contain a young person against their will...<sup>249</sup>

The initial disclosure to my office in 2003 identified Departmental residential care facilities as sites of the maltreatment of children and young people: maltreatment allegedly perpetrated not only by other residents, but also by Departmental staff.

The initial disclosure and subsequent information provided to my office alleged that instead of contributing to the prevention and detection of maltreatment, some DCWs:

- interacted poorly with young people, on occasions goading them into misbehaving;
- failed to create the good relationships with young people which would avoid escalation of inappropriate behaviour;
- contributed to the maltreatment of young people by other young people in these facilities by not being vigilant of young people who were at risk of perpetrating, or being victims of, sexual offences, even when this was highlighted in the young person’s LAC form and individual care or safety plans; and
- were punitive, imposing penalties which breached young people’s human rights (for example withholding food), or which constituted child abuse given the particular vulnerabilities of the young people in their care.

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<sup>249</sup> ‘Overview of ACSS’ in materials provided by the Department, September 2004, in “A”.

It was also alleged by the informant and other Departmental staff that attempts to alter the relationships between DCWs and young people to ensure that these were '*child focussed*' were undermined by a culture of resistance to change by DCWs, and by their insularity. Senior Management, it was said, was equally resistant to change and in any event was hamstrung by concern about the industrial strength of its workforce.

In Chapters 12 and 13, I consider those systems which are in place to assist residential care staff prevent and report maltreatment. A preliminary question which needs to be addressed, however, is a more general one: what is the current role of DCWs? Chapter 4 provided some detail about the history of Departmental residential care, and the perceptions associated with that history. In the section which follows, consideration is given to the tensions around the contemporary role of DCWs which arise from those perceptions.

## 11.2 Behaviour management and treatment

The following comments illustrate a division in opinion over the model of care to be adopted by residential care staff in interacting with the children and young people in their care.

'I don't think they [DCWs] got their heads around the fact that there is a difference between behaviour management and treatment, so we were constantly at loggerheads about behaviour management coming into the program. Because the program was a positive program, it was meant to be working on positives, behaviour management in that area was working on the negatives. So it was trying to balance the two.'

Residential Care Manager

'They [kids] all run amok and there are no consequences. The problem is that there is nothing to take away from them. Kids will actually articulate: "*We have nothing to lose*". They can lose their TV, \$3 pocket money a day - but they will say the internal excitement of misbehaving is better - "*It's worth it*". This makes staff despondent. They are totally frustrated. They try to put positive incentives in place but it is not enough.'

Residential Care Manager

'It depends on the sort of kids you have, if you get kids in there that are just wild and really don't care, and can earn more money in the community. I mean you're really battling the community, what the community offers but we can't compete. You know, I mean if they go, in the old days ... kids would go to Hyde Park because they can get more money at Hyde Park than what our program can offer. And Hyde Park had a reputation for prostitution and all that sort of stuff, so you know. ... so they didn't care, whatever you could offer them, you know one to one, individual program, it didn't work. It's just the community can outdo it easily. Which is a bit sad, but that's when you've got those sort of kids that are a bit more vulnerable or, you know, I suppose when they get abused and then afterwards they just don't care.'

Direct Care Worker

This difference of opinion about appropriate approaches to '*managing*' or '*treating*' children and young people raises other issues. In particular based on my investigation there appears to be a lack of clarity about what the role of DCWs is supposed to be. For example, the Department's report of 2001 referred to previously, approvingly cites a case study where a young person was '*given firm guidelines and boundaries that showed him his behaviour had consequences*'.<sup>250</sup>

DCWs, however, were criticised in the course of this investigation for being preoccupied with imposing '*consequences*' for young people's misbehaviour:

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<sup>250</sup> DCD, *Hostels Report*, p. 17,

'Consequences, so everything was on consequence. So there was no incentive [in how DCWs dealt with young people]; there was consequence.'

Residential Care Manager

When asked what '*practical guidelines there were on sanctions and penalties*' to assist DCWs in this respect, the Department referred to 20 various pages in the ACSS Manual.<sup>251</sup> On reviewing these, while there was some indication of what sanctions could not be used, for example, food (in accordance with the United Nation's Charter on the Rights of the Child), there were no examples of a measure which could fairly be utilised to sanction misconduct by young people in residential care.

There appears to be little guidance available to DCWs about what measures can be implemented to manage the behaviour of those in their care. Young people have alleged, and DCWs have admitted to, removing young people to the outside of hostels and locking them out, to cutting off the electricity supply to parts of the hostel facility, including lounge rooms and bedrooms, as management tools. DCWs have also been criticised by other Departmental officers for doing so:

'... but I mean, "[The young person was] escorted outside to cool down." What does that mean? You know, how was he escorted outside to cool down. ... You know I've got a real problem with the outside thing for a start. And I guess I questioned that ... about why we insist young people have to go outside. It wouldn't happen in a normal house. You don't ask your teenager to go outside to cool down - you try to talk it through, or you listen to what they're saying.'

Field Officer

In some instances it appears that these actions by DCWs have prompted responses of the same kind by young people, such as blocking entry and exits to staff offices, and disconnecting power supplies to the hostels.

The Department indicates that it will be addressing this issue through the engagement of an external consultant with extensive expertise in these issues, reviewing the ACSS Manual and providing additional training on de-escalation techniques to DCWs.

### 11.2.1 Police as a 'consequence'

Studies have shown that there is an increasing tendency for young people in residential care to have an involvement with the juvenile justice system. In 1999, the Director of Community Based Services in the then Department of Justice WA highlighted the findings of the NSW Community Services Commission Report, *The Drift of Children in Care into Juvenile Justice System - Turning Victims into Criminals*, as being relevant to WA. Particular reference was made to:

'the increasing use of Police and the justice system to manage aggressive and violent behaviour of children in hostel care. In many instances behaviour in group homes [which] lead to charges are those which would be disciplinary matters in a family home, such as malicious damage and assault. Young people in hostel or residential care are likely to be those for whom all other models of care have failed due to their non-compliant and difficult to manage behaviour.'<sup>252</sup>

The Department in its response to my preliminary view advised it does not accept the validity of the comparison between the Western Australian and New South Wales jurisdictions in this context. The Department states that the New South Wales experience of '*drift*' from residential care into the justice system may not parallel the experience of Western Australia, referring to the far larger cohort of young people in care in NSW, and that consequently many of these may have dealings with the justice system. In WA, the number of young people in care is far smaller, and while the

<sup>251</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 9).

<sup>252</sup> Wells, '*Juvenile Justice in Western Australia*', p. 6.

Department does not deny that some children in residential care do enter the justice system in the Department's view there is little research to validate the NSW experience. In the Department's view it is '*dangerous*' to take the experience of one jurisdiction and compare it with another, given the differences, complexities and legislative framework between the two populations and service delivery methodologies.

The Department states that without evidenced-based national research it is difficult to say definitively if the positions as delineated in the NSW report are comparable nationally.

However, I note that the high rates of involvement of hostel residents with the justice system is broadly consistent with the findings of the WA Auditor General in his examination of young people unable to live at home and who were in receipt of accommodation and support services<sup>253</sup> and of the research conducted into women in prison in WA.<sup>254</sup>

The Police Protocol entered into between ACSS and WA Police states that:

'Circumstances where police assistance should be requested

Police attendance should be requested in specific incidences such as to assist in the management of a young person who is threatening the safety of other residents of the service, a staff member or a member of the community.

Police attendance will always be requested in cases where a young person attacks or assaults a person with intention of causing harm to that person. It is likely that Police should also be called:

- if a person is threatened by physical aggression from a young person, depending on the seriousness of the threat;
- if a young person commits an act of verbal violence or aggression, intended to intimidate or cause distress, depending on the forcefulness of the intimidation;
- if a young person has a dangerous weapon.'<sup>255</sup>

DCWs and Team Leaders stated in interviews with my officers that staff will often refrain from calling Police even if they are subject to assault, particularly if the child or young person is '*acting out*' rather than targeting staff members personally. DCWs have also indicated that they are reluctant to call Police as they are unsure how the Police will respond. In one instance, a DCW stated some Police officers stated '*well, you know can't you manage it yourselves... To us in some way, consequence is police involvement, and to them it seems to be it's wasting their time*'. Another stated:

'A young girl who spat at me was laughing about it. I'd called the Police and they wouldn't follow up. There is now a plan to send incidents to Juvenile Justice Teams but as I am a public officer this is not allowed [because of the seriousness of the offence]. The girl was told she was not going to be charged; it's bad enough to be assaulted; you don't need to be laughed at as well.'

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<sup>253</sup> Auditor General Western Australia, *Accommodation and Support Services provided to Young People unable to live at home* (Report No 11), Office of the Auditor General Western Australia, 1998, p. 3. As indicated at note 166, 18 per cent of the AG's sample group were arrested and charged by police within two years of leaving care compared to 8.6 per cent of the general population of that age group.

<sup>254</sup> J Salome, *Towards Best Practice in Women's Corrections: The Western Australian Low Security Prison for Women*, [circa 2004], p. 4. As indicated at note 167, a survey of women prisoners in WA in 2002 found that one in five had been wards at some time in their childhood.

<sup>255</sup> Protocol between the Western Australia Police Service and the Department for Community Development's Adolescent and Child Support Service, p. 7.

Descriptions of working in a residential care environment such as the one below indicate that residential care staff do not seek the assistance of Police as often they might within the terms of the above protocol:

'...you see [what] kids are exposing each other to in regards to their self-harming and at risk behaviours. The bullying and threatening between one another of the residents so that causes its own set of stresses ... And then you have issues of, personally and other staff, being targeted; you are constantly verbally abused and put down, threatened, minor assaults going on, pushed and shoved and spat on and all those kinds of things. It is highly stressful. ... But then you have the external stress of the fact that you are trying your best to care for these kids that are already damaged and have got their own set of needs and you are writing these reports saying such and such is being abused; such and such is 12 years old and he shouldn't be here with a 16 year old drug user or a 16 year old that is absconding and has sexualised behaviours and you are documenting it and you are seeing these poor kids, the terror in their eyes because they are being mixed and matched completely inappropriately ... and there is nothing in place for them.'

Direct Care Worker

There was also one recent incident, reported to my staff, when it was the young people resident in a hostel who insisted that Police be called to charge another resident over his allegedly destructive and disruptive conduct.

Others, however, criticise DCWs for resorting to Police intervention, and hence criminal prosecution, too frequently:

'Young people come through the courts charged by hostels staff all the time, for example, for "assault", minor property damage, and so on - breaking the wing mirror of a vehicle. This is embarrassing. Kids from the non-government sector aren't charged in this way.'

Direct Care Worker

On occasion, DCWs have also requested Police assistance to take sick young people for medical assistance. On one occasion, the Police were called to take a suicidal young person to hospital.

'But this business of using the Police, I have got some material here where a boy who attempted suicide, [and the hostel's] key response to that was to call the Police and to let them provide advice on the circumstances? I am not saying [the hostel] got bad advice but of the responses and the repertoire to use, calling the Police was one, and in spite of the fact that this boy attempted suicide on that day, about a week later he was again restrained and the Police were called and took over the restraint and then charged the boy and as far as I am aware the boy still has those charges hanging over him and this sort of heavy handed business of, "We work with the coppers", it's good to have inter-agency co-operation and so on and so forth, but I think inferentially it is indicative of the punitive nature of the culture of all the agencies.'

Residential Care Manager

I note the Department has expressed its grave concerns about such a response, stating that calling police to assist with a young person's attempted suicide would only be acceptable in exceptional circumstances, such as if no other Departmental staff were available to assist.

### 11.2.2 'Treat them like your own kids'

When those critical of DCWs' interaction with young people were questioned about the appropriate means of managing these young people, reference was made to workers treating these children and young people as they would treat their own children. The 2001 Departmental report states that *'The Department should attempt to provide the same standard of care expected of all parents in the community, while, on the other hand, not attempting to displace the child's natural*

parents'.<sup>256</sup> The report also states that young people should receive 'from the hostel workers that "certainty, love, security and attention" that is the right of every child'.<sup>257</sup>

The idea that DCWs should provide the same standard of care as parents in the community and 'certainty, love, security and attention' for the children and young people in their care raise issues about what exactly is the nature of the relationship that DCWs are expected to engage in with the young people in residential care.

The view that the guide for good practice by staff in these facilities is '*how they would treat their own kids in the circumstances*', gives emphasis to the style of interaction currently encouraged by the Department, of being empathetic to the needs of the children and young people in care. However, this appears to be at odds with circumstances confronting residential care workers and the fact that the situations with which they have to deal may go well beyond the realms of the behaviours of their own children. At the very least treating the young people in care as if they were the workers' own children appears to be contrary to the standards which may be expected of professionally trained and paid staff. It is also of note that, if staff are then subject to criticism for their approach when applying their own parenting styles, according to a Residential Care Manager, it becomes '*personal*'.

There appears to be no generally accepted and agreed vision of what it is that DCWs are to provide for the children and young people in their care. In the next section, consideration is given to the specific policy information which is currently available from the Department to guide residential care staff about their role.

### 11.3 Policies for residential care

In 3.4 above, I noted the plethora of policy materials provided to my office for the purposes of this investigation. Notwithstanding this, however, DCWs interviewed stated that they remained largely unaware of general Departmental policies, and that such policies, in any event, were not written to guide their work practice:

'We are informed via a folder or file that we have at work that has the procedures and policies of the Department there. They are not really, to me haven't been set down and said these are the ones that are really important or this is the way it happens or the way it doesn't happen and [we] haven't really been trained through the exact policy and procedures of working in the residential care hostel.'

Direct Care Worker

'They [policies and procedures] do change things as they go along but they don't affect us, they more or less affect Social Workers and head office staff. We get affected by some of it but I haven't really noticed anything great that has changed ...'

Direct Care Worker

To the credit of ACSS management, a user-friendly and concise Manual was developed as a reference for DCWs. This Manual also appears to have been designed to address the issue referred to previously, of the lack of clarity about which of the many Departmental policies relate to residential care. The ACSS Manual, in our view, is a useful document.

However, few of the Department's residential care staff we spoke with or interviewed referred to it as a policy document they found useful. Indeed, many commented upon how the Manual was always

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<sup>256</sup> DCD, *Hostels Report*, p. 17

<sup>257</sup> DCD, *Hostels Report*, p. 7.

under review and in draft form, and some felt that written policies were of little assistance in any event:

‘We do have a procedure manual somewhere (laughter). Everybody’s supposed to have one, every hostel’s supposed to have one. It’s always getting worked on I know that. Someone’s doing something or, I don’t even know if there’s one in the unit at the moment.’

Direct Care Worker

‘I am not sure if there are specific ones just for our hostel or if there are the same procedures for all the hostels or not.’

Direct Care Worker

‘I don’t even know where the manual is.’

Direct Care Worker

An example of the divergence between written Departmental policy relating to ACSS hostels and the expectations of DCWs expressed by other staff is considered below.

### 11.3.1 Supervision of young people

The issue of supervision of young people in residential care is a contested one. Referring to the practice in residential care facilities some years ago, one Manager commented:

‘My biggest concerns were that the children were not being supervised. Especially when we [Managers] were not there [at the hostel], or when they went on an outing, ... the Group Workers’ understanding was that these kids don’t need to be supervised when they go out, and that they can be left wherever they are and they can just make their own way home. So that was always a big concern. There was a big concern in terms of supervision of children in the rooms, and how we did that, especially at night-time... Well, there were children who were either, who could self harm, or there were children who could sexually impose themselves on others.’

Residential Care Manager

While there is an emphasis on not detaining children and young people without the authority of juvenile justice processes, there is also an expectation, expressed in the care and safety plans of some children and young people who exhibit violently aggressive or sexually predatory behaviours, that they will be the subject of constant surveillance by residential care staff. Although in a sense a contradictory position to adopt, it is also understandable in a context where, for example, two of the substantiated CMAs in 2004/05, involved the same young person sexually abusing two other young people (all male) in residential care on separate occasions. And it appears that at least some DCWs do attempt to fulfil these expectations while the young people are within the hostel, and in spite of the difficulties:

‘It is good work but the conditions can be really, really atrocious... One aspect may be that we get a young child that we are told we have got to take in. We had three or four [children who were sexually acting out] staying in the hostel, and this child has just been sexually abused and we sit there and we don’t get a choice, we have to take the child in and then we spend the whole shift watching everyone like hawks and do you know to have that level of alertness over eight hours is really, really nerve racking and is incredibly tiring. Generally our view is that that child should not be put there in the first place because possibly the situation they have come out of may not be any safer than the situation they have been put into.’

Direct Care Worker

In responding to my preliminary view, the Department stated that staff receive regular supervision and support from Team Leaders and Managers when monitoring and surveillance is required for high-risk children and young people. The Department also stated that constant surveillance is not the norm in residential care and only used when it has been assessed that the young person poses a risk

to themselves or other children. The Department further advised that the ACSS Manual is being reviewed and updated and that a new section will be included that outlines the policy and procedures for monitoring and surveillance of young people. I welcome this advice.

There is less clarity around what happens off site. A DCW was quoted previously referring to a safety plan requiring the constant supervision of a young person in the hostel, but which also provided for the young person to catch the bus to school. The result can be that a young people may be subject to constant surveillance unless they leave the hostel.

A young person may also leave the hostel without permission. In interviews DCWs stated that they do follow young people they consider to be at risk, but in terms of how far DCWs are expected to follow the absconding young people the policy documents are clear. The Department's draft protocol with WA Police, from 2001, indicates only that DCWs are to follow the residents '*until they leave the vicinity of the hostel*'. It would appear the purpose of following the young person, at least at that time, was to minimise the nuisance to hostel neighbours - an objective which cannot be dismissed in light of successful local community action to shut one of the Department's facilities - Tudor Lodge. According to the ACSS Procedures Manual:

'Staff should make every effort to have the young people remain on site. Where this is not possible, a staff member should follow the young person a short way to attempt to persuade them to return, or failing this to ascertain their intended destination.'<sup>258</sup>

Yet, as indicated below, there is an apparent expectation that DCWs should do more than follow the person '*a short way*'.

'... when [the children abscond and are] walking down the road you [are supposed to] follow them. Then I had a whole lot of issues ... [Direct Care Workers would say] I've got a bad back, I've got bad legs, I can't run, I can't chase, I can't do this, and then there was the, who am I going to send to walk down the road when the child leaves the hostel?'

Residential Care Manager

'If young people left the hostel, you tried to talk them out of it. You chased them down the street. You would know their background and could start heading around to locate them. We did more before than they do now.'

Senior Manager

The management challenges inherent in dealing with the diverse and unusual needs of many of these young people are significant, given their frequently highly traumatic histories.

In responding to my preliminary view, the Department notes that the challenges for staff managing a group of children and young people in residential care are made more difficult when a young person decides to leave without permission. It states that staff are frequently caught in the dilemma of wanting to try and persuade the young person to return while also having the responsibility of providing care for the other children in the residential care unit. The Department states that it provides after-hours assistance which helps staff deal with this type of situation. However it also acknowledges that improved policy and guidelines are needed and that work on developing these policy and procedures will occur during the review of the ACSS Manual.

## 11.4 Conclusions

There appears to be a division of opinion within the Department over what care model should be adopted for young people in the Department's hostels. As a consequence of the lack of an agreed

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<sup>258</sup> ACSS Procedures Manual, p. 13.



care model, there appears to be little guidance for DCWs about the specific measures they can implement to manage the difficult conduct of the young people in their care.

Discussions with residential care staff indicated that the ACSS Procedures Manual was not as useful as it could have been. In my view, ongoing consultation with, and the involvement of, DCWs in the development and review of the Manual may make it a more relevant and useful guide for practice. I recommend that:

7. The Department institute a program to regularly review the ACSS Manual in consultation with Direct Care Workers and other residential care staff with a view to developing a practical and relevant guide for staff working in that environment.

The Department agrees with this recommendation and states that work has commenced on reviewing and streamlining the ACSS Manual in conjunction with Team Leaders, DCWs and other residential care staff. The Department further advises that Placement Services, which incorporates ACSS, has been undergoing a change process since March 2006 and that the Manual will be updated over the next 12 months to ensure that new models of working are incorporated.

The ongoing review of the Manual to ensure that there is consistency with broader Departmental policies and training on what constitutes best practice in the management and care of young people may also contribute to the development of a generally accepted and agreed vision of what it is that DCWs are to provide for those in their care. I recommend that:

8. The Department institute a program to regularly review the ACSS Manual to ensure that there is consistency in the articulation of applicable standards of care in all relevant Departmental documentation.

The Department also agrees with this recommendation and advises that once the review of the ACSS Manual is completed, a 12-month review cycle will be established and Team Leaders, DCWs and other residential care staff will be involved in the regular review process. I welcome the Department's response to both these recommendations.

## Chapter 12 The Role of ACSS Staff in Preventing Maltreatment

### 12.1 Introduction

Departmental staff at all levels who were interviewed for the purposes of this investigation identified the following factors as assisting in the effectiveness of ACSS residential care workers' role in preventing maltreatment in the Department's hostels:

- a skilled and trained residential care staff;
- professional managers;
- specialised skills and techniques for dealing with crises; and
- access to professional support services for staff.

Residential care staff face the challenge of preventing maltreatment in an environment in which the lack of available placement options, particularly for those difficult young people in the Department's care, has significantly eroded the manner in which the Department's residential care facilities were intended to function. In 2001 the Auditor General found that it was the availability of the placement, rather than the young person's needs, which determined the placement.<sup>259</sup> Plans are developed to meet the needs of children in potentially far from ideal placements. The lack of placement options not only has meant that the combination of young people in the Department's residential facilities was often high risk, but young people often remained for much longer periods than the '*programs*' which were available.

Against this background, the following sections consider the success of those factors identified by Departmental staff as preventing maltreatment.

### 12.2 Direct Care Worker recruitment and career structure

#### 12.2.1 Recruitment

Previously known as '*Group Workers*', DCWs provide direct care to the children and young people in Departmental residential care facilities. DCWs are Level 2 or 3 workers who currently are required to have at entry level: a minimum Certificate 3 and 4 in Human Services (or equivalent); Senior First Aid Certificate; Driver's Licence; medical and physical clearances; Police clearance; and checks against Departmental records. Since December 2001, DCWs have also been subject to psychological testing, applied by the Australian Institute of Forensic Psychology, and adapted from testing implemented by the Department of Corrective Services for its custodial staff. However, no permanent DCWs have been employed since 2000.<sup>260</sup>

The selection criteria for DCWs include having knowledge of individual, adolescent and family development, and good communication skills. A selection criterion for a Level 2 DCW, that they have the '*capacity to take physical control of young people in a safe and caring manner, in accordance with specified standards*', is of note, given the contentious nature of physical restraint of young people by DCWs.

The draft *Care Responses into the Future* report notes:

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<sup>259</sup> Auditor General Western Australia, *Second Public Sector Performance Report 2001*, Office of the Auditor General Western Australia, 2001, p. 36.

<sup>260</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 2).

'The lack of highly skilled and trained direct care workers ... (most direct care workers are level two ... ) is an anomaly when considering the needs of children residing in Placement Services, and the function of the placements.'<sup>261</sup>

A further issue arising in relation to recruitment of DCWs concerns the balance of male and female workers on shifts. Information provided by the Department in October 2005 showed that some 44 per cent of DCWs were female, with 34 per cent of these being casual staff.<sup>262</sup> Generally the view expressed by residential care staff was that a mixed shift of male and female DCWs best met the needs of the children and young people in these facilities. This was based on a range of factors, including the better rapport that young people might have with male or females, sometimes associated with the histories of abuse of many young people in care; and that individual young people might be more receptive to the different styles of interaction generally employed by men and women.

One example cited during my investigation was of a young girl brought into a residential care facility very late one night, distraught after being removed from her parents. Apparently there were two male DCWs on shift and something of a standoff developed when the DCWs told the girl to go to bed for the night. This escalated to the point where there was a physical altercation between a DCW and the girl. My officers were told that the matter was eventually resolved when one of the DCWs suggested that the young girl speak with a female staff member on the Crisis Care telephone line. It appears the young girl was concerned about wetting the bed, but had been reluctant to speak with male staff about her situation or to go to bed when she was told to do so. She later alleged child maltreatment and the DCW involved in the altercation with her was subsequently stood down while the allegation was investigated.

Although incidents of this nature may rarely occur, it highlights the potential aggravation of already high-risk situations through the lack of a gender balance on shifts, especially in mixed-gender hostels. I recommend that:

9. The Department increase its efforts to ensure a gender balance amongst Direct Care Workers and generally seek to have a balance in the staff rostered on shift; and a gender mix on shifts be a requirement in those Departmental residential care facilities which accept male and female residents.

The Department agrees with this recommendation and acknowledges the importance of endeavouring to achieve greater gender balance of staff to work in residential care and on shifts. However, it notes that it has difficulty in recruiting female staff to work as either DCWs or in other residential care positions, and states this is an Australia-wide problem. The Department also states that it is exploring innovative recruiting practices, such as on-the-job training and professional development, for targeted staff profiles including women, Aboriginal people and youth. The Department states that it currently tries to ensure gender balance on all shifts, but when this is not possible, priority is given to meeting the specific needs of individual children; for example, if a female resident had been sexually assaulted, the Department would endeavour to have a female worker on shift to support her.

### 12.2.2 Career structure

Because of their employment conditions, DCWs who are rostered and work varying shift times are entitled to additional pay and leave. These can act as an incentive to remain in the sector and, with other factors discussed below, may affect the mobility of the residential care workforce.

<sup>261</sup> Anderson, (Draft and Confidential) *Care Responses for the Future*, p. 43.

<sup>262</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 3); the gender of the worker could not be identified from the information provided for 6 of the total of 99 DCWs listed.

As I understand it, the Department formerly had an '*Institutions*' directorate during the 1980s which included all of the Department's custodial and non-custodial facilities. In order to integrate hostel services with the Department's field operations and to make the various Departmental services '*more aware of each others' problems*', a recommendation was made in the 1984 Carter Report (referred to previously) for the case management of young people leaving the hostels to be removed from institutional staff and allocated to relevant District Officers.<sup>263</sup> Current practice has seen the case management of young people at all times, including while they are resident in hostels, managed by the field. However, some current residential care staff expressed the view that there was inadequate consultation about the young people in their care by field staff.

With the loss of custodial functions, the Institutions directorate was disbanded and the management of the Department's residential care facilities was allocated to the child protection-focused regional Divisions of the Department. However, at the present time these facilities continue to have no ready access to the Department's mainframe and internet resources, including policy manuals:

'the hostel system sits outside the general district or DCD structure so when I first started we didn't have computers that were linked up to the main data ... we sort of had dial up access to it but you just didn't have the same level of access or the same reliable accesses that you did in the District Offices and so it was almost like the ACSS unit was, as a whole, sitting outside the Department and was very much treated like that. You worked in isolation a lot of the time and stuff that happened within the general wider DCD range didn't really flow on as quickly as it should have to the units...

I think it is just one of those things where you have a core business, like DCD [has] a core business, the child protection side of things and the District Offices are all geared up to respond to that and then you have got the secondary business which is providing accommodation to young people and it doesn't technically fall into that child protection framework as such so it becomes isolated because it is not part of the mainstream.'

Residential Care Manager

Managers spoke of the challenges facing staff in a physically and emotionally demanding work place.

'...it is not an easy job. Putting difficult young people together in a group environment and trying to manage those dynamics can be quite difficult and can be quite volatile at times but that's what they are there to do and that is what they are trained to do and a lot of the comments about we can't handle these kids has come about through periods of calm where you haven't had to handle and we have had kids that would restrain themselves at times. They were easier to manage and all of a sudden you get someone volatile and that is when they start arcing up. I think it is a difficult environment but I think also some of the expectations of the Direct Care Workers [are] not realistic in terms of what they are there to do. There is also the problem of where they go...'

Residential Care Manager

As indicated previously, the Department created a range of new Level 3 positions in 2000 to introduce new approaches into the sector, and states that this initiative was successful. Senior Managers have also advised that they have attempted to encourage further education and career opportunities for DCWs through employment conditions which include long-term career break provisions and a variation to the residential care Team Leader job requirements so that tertiary degrees are no longer an essential prerequisite.

Senior Managers of the Department are aware of the risks inherent to the current workforce structure in residential care and appear to have taken efforts to address these. Comments from staff and management in the course of the investigation confirm the importance of this

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<sup>263</sup> Carter Report, pp. 74, 187.

'revitalisation' process for all concerned and the need to ensure it is effective. Nonetheless, the Department's original advice was that it has not undertaken any permanent recruitment of DCWs since 2000 because there have been no vacancies arising for permanent DCWs over the last five years.<sup>264</sup> This appears contrary to staff perceptions that there was a policy to increase the casualisation of the sector, which they said leads to inexperience and heightened risk in the work place, but may be indicative of the reduced mobility of those employed in the sector.

In responding to my preliminary comments on this issue, the Department stated that it has been reconsidering the role of DCWs for the last two to three years as part of its strategic planning related to reforms of Placement Services and had decided not to employ permanent staff. The Department subsequently clarified this issue, referring to the commissioning of the report, *Care Responses into the Future*, in 2004 which was a research project aimed at assisting the Executive develop its reform strategy for children in care, including children in residential care. During the course of this project, the Department advises, it became evident to the Executive that the DCW role needed to be reviewed and considered in terms of the overall reforms planned for residential care. Therefore from mid to late 2004 onwards it was decided not fill permanent positions until the above work had been undertaken. The Department states that this decision was formalised in October 2005 when the positions were quarantined.

## 12.3 Training

Training can assist staff mobility, reducing the problems associated with a static workforce in a demanding workplace. It can also contribute towards the continuous improvement of an agency through increased staff effectiveness, awareness of agency policies, and greater job satisfaction. This section provides an overview of the training available for DCWs, within the context of Departmental staff comments relating to the rapidly changing area of protecting children and assisting them to reach their potential whilst in residential care.

### 12.3.1 Access

'But I do think a lot of [the young person's difficult conduct was] contributed to by his childhood, and if they had workers that had a better knowledge of behaviours and how to manage them, constant training, because these lads are moving along and we've got to be able to move with them.'

Field Officer

'...maybe it's more about training, maybe it's more about helping them [Direct Care Workers] to have empathy with the kids. I think they don't really have an understanding about where [the kids'] difficult behaviours come from. I think sometimes they just think they're acting difficult to piss them off instead of really, you know, that there's really underlying causes for this that these kids have suffered more than we'd ever know.'

Residential Care Manager

It appeared from this investigation that the Department does not comprehensively record and monitor training provided for its DCWs. This was of particular concern in relation to Crisis Care

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<sup>264</sup> Clarification of the number of permanent vacancies was requested when information provided to my office in April 2006 as a result of an internal Departmental review indicated that 'a high percentage of Direct Care Worker positions are substantively vacant' and that as a result 60 per cent of DCWs 'are on contracts of 6 months or less'. The Department provided information by email on 8 May 2006 indicating that ACSS had 90.5 Full Time Equivalent positions (FTE), including 68.5 DCW positions. Of the total of 28.5 vacant positions, 17.5 were DCW positions. However 12 of these were kept vacant to cover the seven-week annual leave entitlements of each DCW, and these 12 positions were never intended to be filled permanently. As a result only 5.5 permanent DCW positions were substantively vacant. It seems that less than ten per cent of DCW positions are substantively vacant.

Management (CCM)<sup>265</sup> training, which includes the approved techniques for physical restraint, and which according to all of the materials provided by the Department requires regular refresher courses. CCM is discussed in more detail below at 12.5.1.

According to the Department in September 2005, the most recent training attended by most DCWs was a two-week program in June 2003 conducted by a trauma expert.<sup>266</sup> That training included crisis intervention including a session on the techniques of physical restraint. On the information provided, one in every ten DCWs had no training in CCM. The Department states this data is inaccurate and also advises that all DCWs have been trained in Therapeutic Crisis Intervention (TCI) which superseded CCM, and is now considered to be '*best practice*' nationally and internationally for residential care.

Of those who had received CCM training (in at least one of the various forms it has taken over the years), the most recent training for some 50 per cent of DCWs was in 2000 or earlier. The most recent training (other than First Aid) recorded for 80 per cent of permanent DCWs was 2003 or earlier.<sup>267</sup> Although Case Managers have raised concerns about their inadequate access to training,<sup>268</sup> it appears from discussions with Departmental workers at all levels that the access to training by DCWs is very limited; one Field Officer describing the residential care sector in this respect as '*the poor cousin*' of the Department.

Reasons for this are varied, but a core problem identified by DCWs was the apparent difficulty in getting '*off roster*' and away from the hostels to undertake training. This appears to be largely due to a lack of available and trained staff to fill vacancies which either results in Managers being unable to release DCWs, or DCWs' concerns at leaving colleagues on roster with inexperienced casual staff. In its response to my preliminary comments on this issue, the Department advised that this problem has been addressed as the result of additional resourcing in 2006/07. It states that all staff must attend core training and that the roster system now enables staff to do this.

It may be that the lack of access to training provides the context for the '*lingering doubts*' expressed by field staff that contemporary methods of managing children and young people have not been operationalised in the residential care sector:

'So I think in many ways the culture [in the Department's residential care facilities] has been stagnant even though there's been some turnover obviously of staff, as they retire or you know. I think there's certainly a lingering concern ... for field staff that cultural changes that have certainly influenced the Department's work over the last probably 15 to 20 years have not been as effective or as applicable in the, in our residential care sector.'

Field Officer

I recommend that:

10. The Department set up a system for recording all training provided to its Direct Care Workers and monitoring their training needs, and take steps to ensure that ACSS has capacity to release Direct Care Workers from roster to access ongoing training on the same basis as other Departmental staff.

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<sup>265</sup> This was the training package for DCWs on how to respond to critical incidents including risks of violence at the time this investigation took place. The course was run by the Department's Learning and Development Unit and DCWs and includes topics on minimising the impact of critical incidents, preventing the escalation of violent behaviour and securing the safety of clients. A component of the training is '*physical intervention*' and DCWs are not permitted to use physical restraint of young people until they have been accredited.

<sup>266</sup> Departmental correspondence, 2 September 2005 (Response to question 3).

<sup>267</sup> For Fixed Term DCWs the most recent training for 70 per cent was 2003 or earlier; most casual DCWs had received training in 2005.

<sup>268</sup> Murray Report, p. 80.

The Department agrees with this recommendation and states that since 2004 it has deployed a computerised information system so that data on staff training needs and attendance at training can be collected. The Department states that it envisages that professional development data will enable staff to work towards prior recognition of learning, on-the-job assessment and further study. The Department further advises that the database was recently reviewed and is currently scheduled for redevelopment in the next two to three months.

Generally in relation to training, the Department advises that a formal induction program has also commenced for all staff working in residential care and that extensive work is underway to improve their skills. The Department states that additional resources provided in 2006/07 for training will be used to establish an integrated approach to training for ACSS staff, built on the national competencies framework supported by learning pathways. Through four competencies: entry-level training; core skills development; advanced skills development; and specialist skills development, the Department believes that a skilled workforce will be developed in Placement Services.

### 12.3.2 Dealing with mental illness and intellectual incapacity

Some staff we interviewed expressed concern about the nature of interactions between DCWs and mentally ill young people in their care. For example:

'[A young person was] exposing himself and ... female staff were finding that incredibly offensive and while I do understand how that behaviour could be offensive, ... I am saying that the inherent requirements of the job is that they work with difficult young people. So if those young people do expose themselves that is not because they are coming on to you or because they want to jump on you. It is because they are struggling with some sort of psychic conflict and sort of trying to communicate with you. [Hostel staff] called the police the last time [the young person] exposed himself. Again, [the hostel] addressing difficulties in what I would see as a heavy handed and punitive fashion. I did not think that calling the police is an appropriate intervention for a young man with [this person's] sort of disturbed history. The most significant thing about [him] is that whatever his diagnosis he is not dangerous. ... I am not saying he has never been aggressive or that he isn't capable of being very angry, but [he] is a boy that other boys bullied in the program. [He] is not hanging out to cause other people harm.'

Residential Care Manager

Residential care staff identified numerous shortcomings in their capacity to deal with an increasingly large proportion of children and young people suffering from various forms of mental illness and intellectual incapacity. Concerns were also expressed about the issue of high-risk medications.

Much work has been done in recent years to highlight the lack of appropriate care for adult prisoners and juvenile detainees suffering from mental illness and intellectual incapacity.<sup>269</sup> While the increasingly difficult mental health needs of children and young people in care is acknowledged in current research,<sup>270</sup> there has been little research done in WA into the appropriate facilities to meet these needs.

I recommend that:

11. The Department ensure that training on the management of children and young people suffering from mental health issues or intellectual disabilities, and good practice in the management and distribution of high-risk medications, be available for Direct Care Workers.

<sup>269</sup> See for example, the Attorney-General's *Report on the investigation into mental health and DSPD services for prisoners in England*, Government of Western Australia, 2005; and D. Mahoney's *Inquiry into the Management of Offenders in Custody and in the Community*, 2005, pp. 344-347, 355-368.

<sup>270</sup> Anderson, (Draft and Confidential) *Care Responses for the Future*, Appendix 1, pp. 3-4.

The Department agrees with this recommendation stating that as part of the ongoing training and professional development calendar, a range of competencies need to be achieved for DCWs and other residential care staff. These include mental health, advanced behavioural management, pharmacological awareness, developmental delay and challenging behaviour to name but a few. The Department states that it is likely given the need for this training to be ongoing that the calendar will be on an 18-month cycle and involve workplace assessment to ensure a high degree of competency.

## 12.4 Residential care management

### 12.4.1 Relocation of professional staff to the hostels

A major initiative in the creation of ACSS was the relocation of '*professional staff*' (this term was a reference to the requirement, at the time, that all employees in these positions have tertiary qualifications) to the residential care facilities. This was intended to provide support for DCWs but also was an attempt to alter what was said to be the culture which had developed in the Department's residential care facilities by the mid 1990s by ensuring a better style of interaction between DCWs and young people. A diagram of the ACSS structure is included at Attachment 1.

As with most of the initiatives examined as part of this investigation, staff we interviewed held mixed views on the effectiveness of this development. Some Managers felt it was not possible to alter an ingrained and resistant culture which had developed amongst DCWs:

'The resistance is resistance to change. Of course, they are very fixed in the way that, you know, we used to do this in Nyandi, we used to do this in Rangeview and why do we have to do this now? They don't like the welfare model, they prefer the more autocratic behaviour management negative stuff than they do for, you know, how do we do a treatment program.'

Residential Care Manager

'... they'll always bring up the worst-case scenario. This is the reason why we don't do it [allow young people access to the kitchen] because 11 years ago one of the kids weed in the bottle of milk or something like that, you know what I mean. You know, it's not dealing with the here and now, and maybe the kids would - I mean they're very innovative I can tell you. They have to get their needs met somehow and they've learnt how to get their needs met in some very strange ways, and I wouldn't put it past them ... however they might not do it so why can't we give it a go.'

Residential Care Manager

An example cited as evidence of the insularity of DCW culture was one occasion where a professional staff member had been requested to provide advice to DCWs on the management of a mentally ill young person. DCWs, in questioning the value of the advice, asked '*How long have you been a Direct Care Worker for?*'

In interviews and discussions, DCWs expressed scepticism about people who had not been on shifts with them and their understanding of what DCWs may confront on a daily basis. This continues to be an issue because the '*professional staff*' relocated to the residential care facilities generally work standard hours when most young people are at school or work.

'Staff feel like they are powerless - they are in a "*war zone*", and want management to see it. Given that management only work standard hours it really meant they didn't get to see how things were with young people on site.'

Residential Care Manager

Team Leaders were not paid on-call allowance but, staff advised, generally made themselves available for out-of-hours emergencies occurring at the facilities. However, DCWs expressed mixed views on this, some saying they did not like having the Team Leaders present and that they should be allowed to do their job.



Nonetheless, it was also evident that in some instances there were positive relations between on-site managers and DCWs. This seemed to be in situations where different views about approaches to the management of children and young people in residential care were the subject of discussion. As the incident described by a Manager below indicates, it also appears that Managers' personal experience of crisis situations in residential care may significantly influence their appreciation of how difficult the role of DCWs can be:

'I came into work at the hostel on Monday. Usually hardly any kids are there, but on that day all of them were lying on the floor and screaming. They refused to get up, go to school or stop. One boy spat on me. I instinctively put my hand on his arm and told him to stop. He said "*You can't do that*". All of the Direct Care Workers were shocked as well. They believe that they can't touch a young person [in circumstances like that] - either because it is unlawful or in any event because the investigation into their conduct makes it not an option.

... I don't think that the approach which Direct Care Workers are being subjected to - of not being able to respond to kids' bad conduct - really helps the young people. Surely the idea is to assist the kids to re-enter the "*real world*" - but in the real world you can't just spit at people or assault them; there are consequences for their actions.'

Residential Care Manager

#### 12.4.2 Performance management and supervision

Staff performance management and supervision are crucial functions of Residential Care Managers in preventing maltreatment. The Department has provided documentation outlining a well-developed performance management process for its ACSS DCWs.<sup>271</sup> The process requires that there is '*formal supervision monthly*', that sessions be recorded and retained for audit purposes, and that crisis incidents are '*routinely examined and managed to*:

- ' ...Provide adequate support for staff and children involved.
- Increase staff knowledge/understanding of the event/s and explore ways of reducing the likelihood of similar events.
- Develop a team work approach to explore possible solutions to difficult situations.
- Ensure crisis processes reflect CCM principles and guidelines.'

In practice, however, the implementation of performance management appeared uneven. A number of reasons were given for this, such as time constraints, particularly given the limits arising from rostered hours of attendance; DCWs who were resistant to and sceptical of management; and poor relations between Team Leaders and DCWs.

'I attempted to meet with each staff member. It wasn't terribly successful, on a regular basis just to do supervision; "*How are you going?*"; "*What is happening?*" When you do that in the field, staff members come in and have conversations with you and we all talk together. When you do it at ACSS you say how have things been? They are fine. Is there anything I can help you with, I noticed that such and such; it's okay. So you get nowhere; so it is really hard to do any of that sort of stuff and no matter what you try and do you are always the enemy, so there is no conversation that comes from them.'

Residential Care Manager

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<sup>271</sup> '*Attachment to Team Leader Behaviours and Performance Management Agreement*', in a folder of materials provided by the Department in September 2004, marked 'M'.

'I have been getting incredibly bad support [from management] for the last three years. Now I get mediocre support and so it has been a huge improvement for me and I can say that the Team Leader I have at the moment has actually been putting the effort in and I think that needs to be noted... No direct supervision. Just a kick in the pants when they don't agree with what you have done and you have made a decision, you should have done it this way or you should have done it that way ... I have never been performance managed. I have asked for it many times and I have never had it.'

Direct Care Worker

Some Team Leaders advised they tried to provide supervision and education at staff meetings:

'... we had staff meeting once a week and they, they being the direct care staff, would avoid them if they could and not everyone could be there because it was a rotating staff. We set it up so that the roster was that we had as many people as we could get on that day so that they could be at the meeting. And part of that was to do some stuff about education about talking about where these young people come from. So giving some understanding of background and all of the things that have happened to these young people so that you can have some compassion for them; so that you can have some understanding. ... [The staff were] very resistant to all of that. It was kind of like yeah we will sit and listen to her and then we go and do what it is that we do because this is what we do and at the end of the day we know how to do it and as long nobody says anything to management we will keep doing it the way we have always done it. And I made no difference at all. Pretty horrifying but it is true. That is my feeling, at the end of the day that is what I felt...'

Residential Care Manager

Some DCWs indicated that they had found the performance management and supervision processes helpful:

'... it depends on the Team Leader really. We have had some really effective Team Leaders and a really positive on site and really good environment and that, and then you have had some that you wish they were not there, you know, they are not skilled or fit to be in that position or whatever I don't know. I guess some people are better than others in that sort of a role so when you have got a Team Leader that is in the role that isn't as good as the previous one or doesn't, you know, can't seem to operate the way or the most effective way, it does actually make it more difficult, I guess... [What made team leaders effective was] just good leadership skills. Very focused, very positive, very supportive, very professional. They are the attributes that really set Team Leaders apart. You get Team Leaders in there that don't really have the leadership skills or the staff supervisory skills and the focus and the drive to lead the ship or the program in the way it should be going, then the rest of the staff are sort of running it along as best they can and if you haven't got someone that is great in that role or a very good leader ... it doesn't seem to work.'

Direct Care Worker

Because in my view it is of particular importance that the Department has an effective performance management process to assist staff and managers in the highly stressful environments the subject of this investigation, I recommend that:

12. ACSS review its performance management program to ensure it is achieving desired outcomes and monitor its ongoing implementation.

The Department agrees with the recommendation and states that it is currently undertaking a review of the outcomes achieved by Placement Services staff. The Department also states that underpinning the overall performance of Placement Services will be the review and strengthening of the Department's staff performance development and supervision processes. The Department states that this review will ensure that the performance and development process established within ACSS meets desired outcomes and that processes will be established to monitor the new system. The Department further states that performance development will also become a key module in the leadership and management programs which are developed for ACSS staff. I welcome this advice from the Department.

### 12.4.3 Performance management records

One issue that arose from the cases examined for this investigation was the retention of performance management notes for residential care staff. These notes can provide one important means of tracking the standard of care provided by individual residential care workers. For example, they may record a manager's concerns about the interactions between the worker and the children or young people in their care, such as allegations of goading by the worker or the unnecessary or inappropriate use of restraints. These notes may also be significant as a means of risk managing potential abuse in care. This is of particular importance as one category of maltreatment is defined not as relating to a single incident but to persisting actions or inactions which cumulatively may amount to significant emotional or psychological harm to the child.<sup>272</sup>

There appears to be a lack of consistency in the retention of these notes, thereby reducing their usefulness to assist in early identification of any patterns of substandard conduct. The inconsistency is evidenced by the following comments:

'... performance management material should be [kept] centrally ... So when I do performance management I give a copy to the person and then I send it up to ... KFC yeah. And they forward it to Head Office and with the people I see ... it doesn't go on the personal file up there [at KFC] because ... there's too many people have got access to that room but in the terms of people I supervise I've got a working file on them. So I keep a copy so that when I go back for supervision again I don't have to call for the Head Office file: "*Oh it's missing*". Every Manager's position I've inherited and gone in, you've got working files from about three different Managers in different cabinets. It's only the annual performance management that goes to Head Office... General supervision notes - the Team Leaders have their own files and some of that stuff may go onto the files up there [KFC] but I doubt it. I think that it'll just be kept in their room in a locked cabinet. [If a staff member changed hostels] ... I presume it would go with them.'

Senior Manager

In one matter examined by my officers, it was clear that these materials did not transfer with the staff member.

When asked for clarification on its policy on retaining relevant documentation on an individual employee's files, the Department referred to the *Best Practice Manual*.<sup>273</sup> The guideline outlining what is to be retained on Head Office employees' personal files states that '*relevant performance management documentation*' is to be retained on those files.<sup>274</sup> There does not appear to be any definition or guidance about what might be considered relevant. In responding to my preliminary view, the Department offered the further clarification:

'The Department's current Best Practice Policy on Performance Management states that there can be a variety of approaches to performance that may be adopted, there is no required form that must be used. The policy states that written documentation is important where there is more than simply continuous improvement discussions/actions occurring (eg significant employee development, or an impact on the employee's contract of service such as, permanency, pay increments, discipline).

Documents communicating decisions directly related to the employee's contract of service (eg permanency, pay increments, discipline) shall be stored on the employee's personal file. Such documents should describe clearly and concisely the grounds upon which decisions were made. The policy states that the management of any other documentation that may be created from the use of this process is subject to the particular performance management approach adopted.

<sup>272</sup> DCD, *New Directions in child protection and family support*, p. 19.

<sup>273</sup> Attachment to DCD email to this office, 24 February 2006.

<sup>274</sup> Staff Management 1.4.1 '*Establishment/Maintenance of Employee Records*'.

The Department has made the issue of Performance Management and Supervision a priority and resources have been provided in the recent budget to assist with improving these processes. To date considerable research and consultation has been undertaken with key stakeholders to identify existing and related supervisory and performance management and/or development practices. A pilot program will now be implemented in two offices (one metro and one country) to examine existing practices and design a process that is flexible and credible. Appropriate tools will be put in place to support management and staff to participate positively in an ongoing performance management and development system. This process will commence in August 2006 and completed by December 2007.'

I recommend that:

13. In the interests of improving its records management processes, the Department review its policy on the retention of performance management records for its residential care staff to ensure that these are accessible to supervisors and that there is clear guidance to supervisors to ensure that these notes are retained in a consistent manner.

The Department agrees with this recommendation and states that, pending its review of the performance system referred to above, amendments will be made to existing policies and guidelines to provide clear guidance on the retention of performance records. The Department also refers to the redevelopment of its client information systems over the next two to three years, through the project called '*Assist-D*' (see 3.4), as modernising the collection of information which will enable more comprehensive performance management.

#### 12.4.4 On whose side?

One of the reasons for having '*professional staff*' on site working standard hours was reportedly because this allowed young people to have continuity of contact with staff members; shift working DCWs often being rostered off for considerable periods of time. Information provided in the course of this investigation indicated that on occasion young people have developed good relations with Team Leaders and other management level staff located at the hostels, and these relationships indeed had been avenues by which the risk of maltreatment by staff members had been identified and attempts made to address this risk.

In one instance, however, the apparently positive relationship between a young person and the Team Leader, which saw the Team Leader take up the young person's concerns with staff, was the subject of criticism. Some DCWs stated that the Team Leader was there to represent staff interests, while it was the role of the on-site Social Worker to advocate for the young people in residential care. The Department states, however, that while Social Workers have a support and advocacy role with children and young people in care, this is not an exclusive role and other staff share this responsibility. It believes that the example provided where the Team Leader raised concerns that a young person had raised is a good indication that the officers was responding appropriately to a complaint and fulfilling their duties.

Efforts have also been made by the Department to assist the relationship between Team Leaders and DCWs. For example, while Team Leaders are tasked with staff supervision and performance management, disciplinary and industrial relations issues are referred to the Manager and the Director of Child Placement Services.

However, unlike the Social Worker role which has no supervisory duties and can more easily focus on the needs of young people in the residential care facility, the Team Leader role, like the Department itself, must straddle, at least, the dual obligations of seeking to act in the interests of young people in ACSS and of ACSS staff. As indicated earlier in this report, the multiple duties of care arising in the context of residential care facilities emerged as a key issue in the investigation.

In my preliminary view I proposed that to ensure that its residential care staff were aware of these multiple duties of care, the Department clearly elaborate for its residential care staff at all levels the various obligations which attach to the Department and in particular its ACSS Team Leaders, who are neither advocates for young people in care nor representatives of hostel staff, but must take into account the interests of both sides. The Department commented that its Team Leaders

are part of the Placement Services Management Team and while the role does involve supporting staff its primary function is ensuring that children in residential care receive appropriate standards of care. The Department also stated that *'the role of the Team Leader is clearly understood by staff in Placement Services and this has been the case for some time'*, and that any lack of clarity was addressed through the Placement Services Induction Program recently undertaken by new and experienced staff which reinforces the roles and responsibilities of all staff groups.

I welcome the Department's initiative to address any lack of clarity about staff roles in its Induction Program.

I recommend that:

14. The Department clearly elaborate for its residential care staff at all levels the various obligations which attach to the Department and in particular its ACSS Team Leaders, who are neither advocates for young people in care nor representatives of hostel staff, but must take into account the interests of both sides.

I am pleased that the Department has accepted this recommendation.

## 12.5 Crisis management

'... that night was particularly difficult; [there was] self-harm... blood was dripping ... so [the kids] were highly stressed; a lot of sexualised behaviour going on, being displayed by the boys and the girls and all that kind of stuff; and that was when I got assaulted. All that happening within the space of four or five hours and staff were exposed to that on such a regular basis, those sort of behaviours, those sort of self-harming and outrageous behaviours by these kids and they are stressed because they shouldn't be there and they shouldn't be placed there and being exposed to it and trying to deal with it. You are trying to document it, there is so much involved and it is such a highly stressful, responsible situation to be in, you have got to process it as best you can but there is nothing in place.'

Direct Care Worker

Life in residential care has a high potential for *'crisis'*. The difficulties confronting children and young people in these environments, many of whom are resentful at not being with their families or other carers, are compounded by the range of age groups, by a mix of both males and females in some instances, by children and young people with mental illness or intellectual disability, and by those who may engage in sexualised behaviours as either a perpetrator, victim or both. This can make for a highly volatile environment. Reference has been made earlier to a report highlighting the manner in which children and young people in care may act out of anger and frustration.<sup>275</sup> My officers have also been told of young people who will deliberately provoke carers to pre-empt the eventual rejection which they feel has characterised all of their relationships in the past. Certainly one of the major concerns identified in consultations with young people in Departmental residential care was concern over other young people's conduct; few said they felt safe and the major concern was fear of other young people, *'some kids here are psycho'*.

DCWs are expected to be trained to deal with crises - but more importantly to recognise the risk factors, and take steps to dissipate the occurrence as far as possible. This was the main focus in CCM training. An example of the innovative techniques used by DCWs to *'de-escalate'* situations is provided below, although the Department notes that it could not be used in all instances, for example if a young person was likely to self-harm.

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<sup>275</sup> DCD, *Hostels Report*, p. 11.

'So, to diffuse things, it might mean that you distract them, take them out on another, try and change the activity. Sometimes it's just because they're getting frustrated ... it depends on the circumstance. You might try and take one for a drive and say look you're getting really het up here, let's go for a drive somewhere. If that works with the staff on shift, and driving with a kid's really, that's the best time to talk to them because they don't have to give you the eye contact. I always find that's often quite methodical - and you might just drive all the way up to Hillarys or up to the end of Joondalup just drive on the freeway and back and talk to the kid. Sometimes that helps, you know to diffuse, if you remove them and take them for a drive. And some staff might see that as a reward but some might see it as diffusing and that's where it's important to know why you're doing it and be able to justify why you did it.'

Direct Care Worker

### 12.5.1 Restraints

'... the single person restraint basically initiates the staff member wrapping yourself around from behind the young person, their arms around their sides ... and you have one hand from behind and you bring them down to the floor and they are sitting in between your legs like that ...'

Direct Care Worker

The expectation that DCWs physically restrain the children and young people in their care is in the Job Description of the Level 2 workers, in the Departmental training for DCWs, and in the ACSS Critical Incident Report form (Attachment 5).

The use of physical restraints is subject to some clear directions in the various training materials and policies, including that these are not to be used as a punishment or involve any pain-inflicting or locking holds. Other guidelines are more ambiguous, and there have been variations in approach in the training materials on restraints over the years.<sup>276</sup> There are also inconsistencies within the same manual, of particular significance, in relation to whether it was ever appropriate to use restraints against children and young people with a history of sexual abuse.<sup>277</sup> It is also of concern that few of the DCWs my officers spoke with were aware of the different restraint techniques to be applied to young people with a history of abuse - in particular that they should not be '*straddled*'. Another gap in current training materials is the absence of any guidelines on '*removal*' and '*separation*'. Although both of these items appear with '*restraint*' in the Critical Incident Report forms, and therefore apparently are intended to refer to particular forms of physical intervention by workers, how these terms are defined and what techniques should and should not be utilised are not included in any current training materials.<sup>278</sup>

Another problem identified with authorised restraints is that, at its optimum, a physical restraint requires two staff members to be on the ground with the young person ('*the two-person restraint*').

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<sup>276</sup> For example, the *Therapeutic Crisis Intervention Student Workbook* (provided by the Department, 2 September 2005 (Response to question 7)), said to '*underpin*' all models of crisis intervention, appears to have been used to train some DCWs in 1998. Those materials and the *Caring Crisis Management Course Materials* (also provided by the Department, 2 September 2005 (Response to question 6)) which was referred to as a guide for practice in 1998, include techniques referred to as the '*wing hold*' restraint (also called a '*team restraint*'), the '*basket-hold*' restraint and '*removals*'. The *Aragon Course in Crisis Management Participant Notes* (in materials provided by the Department in September 2004) and used in 1997 and 1998, and the current *Crisis Care Management Participant Workbook* (provided by the Department, 2 September 2005 (Response to question 6)) do not include '*wing hold*' and '*basket-hold*' restraints or '*removals*'.

<sup>277</sup> The current CCM training materials state (at p. 43) that '*restraint should not be used... when the young person has been sexually abused*'; and it states (at p. 61):

'if the youth has been sexually abused, do not straddle them. An alternative is to move alongside the youth, at the same time bringing their arms down by their sides, securing both arms and leaning across the youth'.

<sup>278</sup> As indicated in note 292, some of the older versions of training materials do include a technique for removal. However, one DCW commented that the technique was not in any event useful as it required a young person's arms to be extended with a DCW on either side, making it extremely difficult to manoeuvre the young person through doorways.

With most shifts involving just two DCWs, that left no-one to monitor the other children and young people, or potentially provided an opportunity, according to DCWs, for them to be '*kicked in the head*' by the other residents. The apprehension that other young people could take advantage of these situations does not appear to be unfounded:

'... I have been through a lot of incidents and a lot of sort of critical incidents and stuff and restraints where I have been hit and sort of bitten and all those sorts of things. ... I was involved in one where I just let a young person into [their] room and then I was walking back up the corridor and another worker called out to me and another teenage[r] had run up behind me and then ... pushed me into the doorframe from behind. I turned around to face [the young person] and put my hands up and [they] pushed me again into the door and I thought [the young person] was going to start hitting me so I had to restrain [the young person] and there were only two ... workers on at that time with me and I was lucky because one was going to be leaving shift but ... was staying back because it was becoming increasingly volatile that night. So as I was restraining this [young person]; they weren't physically able to prevent the other young people setting upon me at the same time, so I had another [young person] come out of [their] room and .... grabbed hold of my leg and started pulling me down the hallway and another [young person] came out and starting grabbing me by the shirt and they were basically encouraging the kid to assault me. So that was highly stressful for me so I actually, yeah I felt really in that environment unsafe and unsettled and really quite stressed about it.'

Direct Care Worker

From the perspective of young people, some complained about being '*dropped*' (restrained) for talking back or being '*cheeky*'. This is contrary to the requirements set out in training materials, which limit the use of restraints to circumstances of physical danger for young people or staff, and serious property damage. Young people also refer to being restrained in manners which are contrary to current techniques and requirements in training materials: for example, finger and elbow locks, and of being crushed into the ground by workers so that they found it difficult to breathe.

Irrespective of their training, some DCWs believe that '*instinct*', based on their experience, needs to take over in a crisis. Many of the residential care staff my officers spoke with also indicated that the training is designed in practice for use only on smaller young people – those not above shoulder height.<sup>279</sup> According to one DCW, the authorised physical intervention techniques were '*not something I can use*' and instead he relied on what '*you would normally do*':

'The Department looks at it from the kids' perspective and that's fair enough. So the technique is to make sure that young kids are in no pain under any circumstances e.g. like twisting an arm up. But this is not practical for kids like ours.'

Direct Care Worker

The DCW stated that he'd been injured '*plenty of times*' using restraints: '*You need to intervene physically, but you can't use CCM because of the risks*'. However, it is also the case that the CCM training materials state that:

'Guidelines and policies [on physical restraints] rarely address the issue of what to do with sufficient precision... This lack of precision may well reflect the sensitive nature of the subject. No attempt has been made to exhaust the possible situations that could develop in a direct care situation'.<sup>280</sup>

Staff raised general concerns about the effectiveness of training and policies in these areas:

<sup>279</sup> Although many say a '*basket-hold*' is more appropriate for younger children. Interestingly this hold – involving sitting with a young person encircled in a workers' arms – is not included in the CCM training materials (see comments note 292).

<sup>280</sup> Crisis Care Management (Youth Work) Participant Workbook, 2004, pp. 60, 65.

'A lot of [policy and procedure] probably is not relevant. I mean obviously some of it's going to be, but ... the procedure manual's quite thick so a lot of it's not really relevant, otherwise we'd be looking at it all the time ... Past experience [would assist] I suppose... the one thing we tend to do a lot is just check with whoever's on shift with you as well. You know we've got two or three other people on shift it depends yes, and if it's something you're not sure of, well someone's going to know something and vice versa...'

Direct Care Worker

Senior Management advised that they expect DCWs to review relevant training and policy materials during '*quiet times*' on shift, particularly overnight, but no DCW my staff spoke with referred to utilising these times for those purposes, although some referred to utilising '*down-time*' for study purposes.

As suggested above, a more structured approach to monitoring training may go some way to addressing these issues. However, given the difficulties in the residential care environment, something more innovative may also be of use:

'...I put up a model of a response team that gave [Placement Services] a capacity internally. And in that response team I saw [the Placement Services Manager] being part of it, probably [the Placement Services Director], a Clin Psych, a Senior Social Worker and a Team Leader and ... three or four Social Workers. That way we have the capacity to get out on site ... because I believe you can only get so much out of a book. [You] can give staff books to read in terms of training, but I think we actually need to walk alongside them with our training. Because it's sometimes survival takes over from the care. You know and they don't realise it's happening in terms of institutional practice. So what I wanted to get to was a system whereby given we're 24/7 and if a critical happened on Saturday, I had confidence in knowing someone's going to go in and deal with them there and then.'

Senior Manager

I understand that one of the initiatives being considered to assist in the care of very difficult young people in one-on-one foster care is the expansion of the on call '*response team*' of professional staff to attend and assist in crisis situations on site. As indicated above, it was suggested that this team could also assist residential care facility staff through providing '*on-the-job*' training; literally walking through crisis situations with DCWs, providing assistance and assessing on the job competencies. This idea seems to merit further consideration - not least because it may assist trainers and assessors to recognise how difficult the DCW role can be in practice, but also as a way to address DCW scepticism about other staff members understanding the difficulties inherent in their work environment. I recommend that:

15. The Department extend its 24-hour on-call professional response team, on a trial basis, to assist its residential care facilities, incorporating not only professional assistance and support but also including a role in on-the-job training of residential care staff.

The Department agrees with this recommendation, stating that one of the initiatives undertaken since the creation of the Executive Director Special Projects (in March 2006) was the creation of an after hours response team which provides 24-hour professional assistance for Placement Services. The Department advises that the team is currently operational and includes Team Leaders, with psychologists and senior practice practitioners being incorporated as they are recruited as a result of the Department's 2006/07 Budget. This is a welcome development.



### 12.5.2 What is a lawful restraint?

Until the C&CS Act went into effect on 1 March 2006, DCWs had no legislative basis for applying restraints.<sup>281</sup> Departmental officers advised that a number of legal opinions had been sought at various times on the use of restraints. One legal opinion, which was distributed to staff, is of interest. Advice was given that Departmental staff could be liable to criminal prosecution for assault if there was actual or threatened physical contact with young people in the Department's care unless that contact could be justified or excused at law. The opinion referred to hostel workers using reasonable force to defend other residents, themselves or another worker from physical harm, or if there was '*violence*' to hostel property. With reference to potential civil liability, the opinion stated that the worker might be liable unless such action was justified by '*necessity*'; but that was said to apply only to the urgent protection of others and property and '*It is not sufficient that the restraint is for the child's benefit*'. The legal opinion went on to discuss the Department's duty of care to *other* workers and *other* young people, which required workers to intervene to restrain a young person, or render the Department potentially liable in negligence.

Given that this legal opinion was circulated to Departmental staff, it is of interest that it appears to have interpreted the doctrine of necessity such that it would not apply to the restraint of a young person in that young person's own interests and there was no discussion of any duty of care the Department might have to protect a young person from themselves when the Department has assumed care for that young person. When questioned, senior Departmental staff indicated that this legal opinion arose at a time when the Department had significant concerns about the culture that was developing between hostel workers and young people in its residential care facilities.<sup>282</sup>

Senior Managers were also very conscious of the danger of what they referred to as '*slippage*'; once extraordinary measures are endorsed, for example, the securing of young people into their room, this may become a '*norm*' or '*first option*':

'I guess what you're always worried about is "*Where's the line?*" And I guess what I worry about is lines drift and ... how do you control something that is there for an exception becoming much more prevalent and the threat, the bar raising and especially in a system where you can't monitor and you can't know what's going on.'

Senior Manager

Consistent with the documentation on the development of ACSS, one long-term DCW confirmed that there had been no training in CCM before ACSS was set up, although he stated that de-escalation techniques had been used in the Department's hostels prior to that time. The DCW advised that the rationale for the absence of training in physical intervention techniques before that time was because it was believed that training could make staff rely on physical intervention too readily. With the advent of the ACSS structure it was acknowledged that physical intervention was required; and with the new C&CS Act this has now been enshrined in legislation.

If concerns about '*slippage*' are valid, the recent change in legislation should sound a note for caution for the Department, highlighting the need for regular training of all of the DCWs in de-escalation and physical restraint techniques. This is a particular issue when, as evidenced by the training materials provided by the Department to my officers, notions of best practice in these matters have changed over time. It is of note too that although officers are authorised under the new Act to restrain children, the term '*restrain*' is not defined.

I recommend that:

<sup>281</sup> The DCD *Hostels Report* of 2001, recommended that '*the Department seek the Government's approval for legislative amendments to enable restraining of children and young people in hostels to be accorded a high priority in the legislative timetable*' (at p. 77).

<sup>282</sup> The C&CS Act specifically authorises an officer to restrain a child if that child's health or safety is endangered (s. 114(a)).

16. Given the recent authorisation of DCWs under the C&CS Act to apply restraints to children and young people, the Department undertake regular physical restraint training of all its DCWs to ensure that they are familiar with authorised techniques, restrictions relating to the use of physical restraints against abused young people, and contemporary notions of best practice in these matters.

The Department agrees with this recommendation, acknowledging that there have been different interpretations of what constitutes a lawful restraint within ACSS at different times. However, the Department advises that contemporary policy development is underway to align de-escalation techniques and restraint with the new C&CS Act, ensuring consistency in ACSS with both legal and best practice requirements. The Department states that it recognises the critical importance of training its staff in Therapeutic Crisis Intervention (TCI), which has replaced CCM, and in June 2006 20 staff were trained in the TCI program, with another 20 scheduled to be trained in September 2006. The Department further advises that Dr Howard Bath from the Thomas Right Institute in Canberra, who is regarded as a leading authority nationally and internationally on de-escalation techniques including restraint, is conducting this training. An additional four staff are to be trained by Dr Bath as trainers to deliver the program on an ongoing basis to other residential care staff.

More consistent and regular training will go some way to addressing the problems associated with the use of restraints, although the need to monitor their use is also critical. Under the regulations to the new Act there is a legal obligation to record the use of restraints for review by the Department's CEO. The recording and review of restraints is dealt with in the discussion at 13.4 about Critical Incident Reports.

## 12.6 Alternative measures - the use of locked rooms?

Even when physical restraints do occur within the parameters of approved processes, there are significant concerns about their use on children and young people:

'I don't know what other methods of restraint [other than physical restraints, in particular '*single person restraints*'<sup>283</sup>] could be used, but it is too sexualised, too close, too hot and too sweaty. Confrontation and restraints up the ante - if the young person knows they will go down anyway then they may as well act up more.'

Direct Care Worker

'At times it can feel like a very ... unsafe environment because things, we don't have any consequences in place or any things that we can use for these young people and I feel it is also inappropriate that we are the ones caring for young people and you know setting down the guidelines and rules and then, when forced to, we have to restrain the young people and it is damaging to relationships.'

Direct Care Worker

Although not a common occurrence, staff have confirmed instances where they have restrained screaming and distraught young people on the floor for up to an hour. The concerns about the use of physical restraints are particularly relevant given the history of abuse suffered by many of the hostel residents.

Interviews with residential care staff indicated that they are told not to utilise physical restraints to prevent a resident from leaving the hostel, even if this appeared to them to be leaving children at risk. On occasion, residential care workers said they fear that a young person may be participating in the '*grooming*' process for their paedophile family members or associates, when they take other residents with them from the hostel; in other instances children and young people '*abscond*' from

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<sup>283</sup> Described at 12.5.1; and involving straddling the young person while he or she is on the ground.

the hostels placing themselves at risk. In either instance, the residential care workers believe there is very little they can do:

'There is no, nothing you can do, because nothing you can offer is good enough. There is nothing really. I mean she'll come back when she comes back, then she'll get up in the morning and she might do a few things and then say well I'm just going and she goes. You know, she might have her friends ready down the road to pick her up and stuff, so there's really nothing that we can do. I mean I've followed kids and you try to talk to them when they try to get to the bus, have a chat, but there's nothing you can do. Once they've decided that's it. And locking up, is, I don't know, well you can't because they're not criminals... It's sad yes, it's very. It's, you know, people out there take advantage of these situations yes.'

Direct Care Worker

A number of residential care staff stated at interview that they would in fact, in some circumstances, restrain a child or young person to prevent them '*absconding*' - irrespective of the consequences for themselves. Instances cited were in the case of young or developmentally delayed children putting themselves at risk by wanting to leave the facility during the night.

The resort to physical restraints which appear to fall outside Departmental guidelines occurs because there seem to the staff to be few effective alternatives. For example, the ACSS Manual states that, after following '*absconders*' for a short time, young people should be reported to Police generally after 30 minutes, but possibly earlier or later depending on risk. Residential care staff advised that Police do not routinely take follow-up action, as there has been no breach of the law:

'... with absconding yes, we notify [Police] immediately if they're kids at risk. If they're a bit of an older child or whatever then we do it a couple of hours later, the child's not really at risk. But yes, kids that are at risk it's pretty well immediate. And that goes without saying, there's no question with that yes. They [Police] don't come out we just do it on the phone... the process with them is, in my understanding is, I mean it's a formality for us to do it but they [Police] actually don't go hunting for the kids... They just do the paperwork and it goes on the computer to acknowledge that we've done is basically, and I think they have a period anyway that they wait, and it could be just with normal kids anyway, it might be 24 hours or 48 hours before it then becomes a major or an actual missing person concern. But with us ... and [local] Police it's the immediate response and that's just been what always happens yes... They don't [actually go out searching], no, no, they'll say... well hang on I've got the paperwork here I'll ring you back at about 10:00 if she's not back then I'll put it on the computer...'

Direct Care Worker

As stated earlier, significant concerns were expressed by young people and some staff about the freedom of movement in the residential care facilities by young people. At the same time however, where the alternative is to physically restrain young people on the floor for extended times, some staff have expressed support for considering the option of locking young people into a safe area for a brief period as '*time-out*',<sup>284</sup> where they can be observed but which can also provide them some solitude and privacy.

'Surely it would be better to lock a young person in a room than to "*sit on*" them for half an hour'.

Direct Care Worker

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<sup>284</sup> '*Time-out*' is based on '*Triple P*' (Positive Parenting Program), a program for the prevention and treatment of behavioural and emotional problems in preadolescent children.<sup>284</sup>

The Department's 2001 report on residential care suggests that it had legal advice at that time that securing a young person into a room was contemplated as falling within the capacity to 'restrain' children and young people to protect them and others.<sup>285</sup> This is also reflected in the ACSS protocol with WA Police, which refers to residential care workers restraining young people in their care both physically or by use of locked doors.<sup>286</sup> It is important to note that the legal authority for residential care staff to make use of a 'time-out' form of restraint would be the same as applies to the physical restraint of children and young people, and therefore would also be unlawful if used for improper purposes such as punishment. The Department comments that this could only occur within the ambit of section 114 of the C&CS Act, that is, only to the extent necessary, in the opinion of the officer, to prevent the child endangering his or her safety or that of another person or to prevent the child causing serious damage to property.

The restraint of children and young people in locked rooms who are not involved in juvenile justice processes is a very contentious and serious matter. As alluded to earlier, this is not only from the perspective of those concerned for children and young people in care but also for such children and young people themselves. There is also a well-recognised need to take care in devising measures to protect children and young people. It may be that the measures are themselves experienced as oppressive by those who are supposed to be protected. For example, the following comments which were made in discussions with my officers are relevant:

'They write down everything - I told them about a rape and they wrote it down.'

Young Person

'How would you like it? "He walked outside. He went to the toilet. He had a shower" ...'

Young Person

These comments were made in the context of young people's concerns about the obligation on DCWs to keep a log of events occurring at the residential care facility. In this context the recognition in the C&CS Act of the importance of participation of children and young persons in matters affecting them is a very positive one.<sup>287</sup>

I recommend that:

17. The Department undertake research, incorporating the views of children and young people and residential care staff, on the use of brief periods of confinement in a 'time out' room as an alternative to physical restraint and to determine whether it has been successful in other jurisdictions.

The Department agrees with this recommendation, and states that it will continue to commission and undertake research that incorporates the views of young people and residential care staff.

It is essential that any initiative resulting in such restraint of young people without the protection of a court order would need to be independently monitored so that the broader community could have confidence that it was being utilised appropriately. This is addressed further at 16.3 below.

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<sup>285</sup> DCD, *Hostels Report*, p. 61.

<sup>286</sup> Protocol between the Western Australia Police Service and the Department for Community Development's Adolescent and Child Support Service, p. 5.

<sup>287</sup> Principle of Child Participation, s. 10.

## 12.7 Support systems for staff

Any discussion of the systems available to assist residential care staff prevent maltreatment needs to acknowledge the difficult environment of residential care and that support for staff involved is a critical issue – illustrated by the following comments:

‘Oh look I’d be confident that most of the Direct Care Workers fundamentally understand what their role is. And it would be fair to say that there’s a percentage that are more self-focused than child-focused. And that’s something that can happen when you’re in a war zone for a while.’

Senior Manager

‘And that is the biggest thing that breaks our hearts, the staff. It is a pretty thankless job. These kids on a daily basis, you are abused, you are spat at, you are pushed into walls. You name it, it has happened to us and so we are there to try and, these poor kids have been through a lot and to see them get damaged more by being exposed to other behaviours and other issues or they are being targeted and bullied and basically you have got to keep them completely separated from the other kids for their own safety. It breaks your heart to see that happen.’

Direct Care Worker

### 12.7.1 Debriefing

The current Critical Incident Report form makes provision for staff who are involved in an incident to elect to have a debrief with the Team Leader. Almost all DCWs interviewed indicated that they invariably elect not to have the debrief. My officers have been informed that this is no longer an option and a debrief by Team Leaders after a critical incident is now mandatory.

One of the factors which is likely to impact on the viability of this process is that critical incidents may happen outside the standard hours when Team Leaders are generally on site. Subsequent to the incident, DCWs may not be on a shift during standard hours, coinciding with the Team Leader’s work hours, for a considerable time. DCWs indicated that particularly after the more difficult incidents, they prefer to debrief with the staff who were there at the time, generally other DCWs, or alternatively just go home.

‘I know that now we have no choice, we got that information two weeks ago that there will be no choice, you will go to a debrief [with the Team Leader] after every incident...’

My opinion, the only thing I said was that I am self-contained I don’t really need you. I’ll come and sit in the office for half an hour if you want me to but I don’t have to say anything. So no I didn’t think that that was a - I don’t want to be forced into something I don’t want to do. And probably the best debriefing you can have is the one right after when you are talking with your colleagues who were there and knew what the situation was.’

Direct Care Worker

### 12.7.2 Counselling service

DCWs also have access to a confidential counselling service paid for by the Department. It is important that in this difficult environment access to support services is immediately available and I understand that the contract that the Department has with its counselling service provider requires that counselling be provided to staff within agreed response times, and that if a request is identified as ‘urgent’ the service is required to respond immediately. Although the Department has received no formal complaints regarding the timeliness of the counselling service offered to staff, on the basis of an incident referred to in my preliminary comments on this issue, the Department has undertaken to reinforce the importance of the Employee Assistance Program with its management team who will discuss the arrangements with their staff.

### 12.7.3 Direct Care Workers

Many DCWs indicated that their most significant source of support was other DCWs, whether on an informal basis or as a result of the peer support teams available at each facility. It appears that the Department endorsed this significant network to the extent that it authorised the peer support teams and that Departmental training for DCWs has included topics of peer support and peer debrief.

It appeared from many of the discussions and interviews with DCWs that these networks play a crucial role in supporting DCWs. Interestingly, it appeared that these networks may also on occasion play a significant role in the monitoring of DCW conduct and the prevention of maltreatment:

'There was one kid, I mean he used to push everyone's buttons, so the staff I mentioned just lost it with him and basically put him up against the wall with a hand under his, on his neck sort of thing, or here, holding him against the wall, and said "*Don't you ever do that again or I'll make sure I'll flatten you next time*" blah blah blah, so quite threatening. And I talked to the staff afterwards saying not appropriate, not on, why don't you take a couple of days off. We talked about it, and he apologised and we went back and apologised to the kid...'

Direct Care Worker

'[If I witnessed another staff member speaking inappropriately to or using what you thought was excessive force with a young person] there would be a lot of talking afterwards. I wouldn't step in to a situation if I was going to humiliate either party .... I wouldn't step in, I would observe and let it play out and see what happens and talk about it afterwards. Because there is something to be learned in amongst all that.'

Direct Care Worker

A number of DCWs also indicated that they had raised concerns about other DCWs' interactions with children and young people in care. However, in most instances they felt that their concerns were not acted upon.

'...if I saw something that I think was getting out of hand I would take the person aside and have a talk to them. [If they didn't respond] I would go to the manager [and] I have done, yeah. [There was no appropriate action taken and no response] not at all ... To be on the other side of it where what you had to say carried no weight you know is a pretty disempowering sort of thing... The situation I refer to ... The person's behaviour, I believe they are under incredible stress and I thought they were under such a stressful situation they should not be working. The Manager put it down as being a personality conflict which I thought was really quite funny because up to that point in time I was very close friends with this person.'

Direct Care Worker

It may be that the Recommendation 4, ensuring that there are better feedback processes in place, will go some way to address concerns of this nature. In responding to my comments, the Department pointed out that supervision, staff performance and disciplinary processes are confidential, and stated that it would be inappropriate to provide specific feedback on the outcome of discussions about a worker's performance to his or her colleagues. The Department was also aware, however, that this might give the impression that nothing has occurred in response, even when these concerns have been dealt with seriously and have been addressed. The Department agreed to explore the need to provide some feedback which would not compromise employees' confidentiality.

## 12.8 Conclusions

The disclosure which promoted this investigation concerned the role of residential care staff, alleging that instead of preventing maltreatment, institutionalised practices by staff in Departmental hostels were resulting in the abuse in care of the young residents in those facilities.

This chapter has examined the systems and practices in place which are intended, according to Departmental staff, to ensure that residential care staff contribute to the prevention of maltreatment in the hostels.

In developing ACSS, the Department made significant efforts to improve the standard of care available for young people in its facilities. However, this investigation has identified a number of areas in which the systems for preventing maltreatment may be improved. These include a greater focus on ensuring a gender balance of rostered staff, particularly in hostels which house both males and females; improved monitoring of, and access to, training for DCWs particularly in relation to de-escalation techniques and physical restraints; a review of the ACSS performance management program and more consistent records management; and more timely access to support services for staff.

This report also highlights what appear to be some fundamental unresolved issues that are the legacy of the Department's historical role in providing direct care to children and young people. These concern what measures, if any, may legitimately be exercised in relation to young people in the Department's care which would not apply to adults. I have concluded that consideration can usefully be given by the Department to what alternatives could be available to the physical restraint of young people who are engaging in high-risk behaviours.

## Chapter 13 The Role of ACSS Staff in Reporting Maltreatment

### 13.1 Introduction

The informal role adopted by DCWs in reporting maltreatment has been referred to in 12.7.3. In this chapter, I examine some of the shortcomings of the formal reporting systems for DCWs that also limit the effectiveness of Managers monitoring DCW reports.

### 13.2 A culture of keeping quiet?

'There is a reluctance to report abuse - a culture of keeping quiet. In part it's because some Team Leaders say, "*What's the solution?*" If you don't know then you shouldn't raise the problem... Staff don't speak up, there's a full on culture of not speaking up. In meetings staff won't speak up - it's a full on culture - you're called a "*stirrer*", "*Bolshie*". It's harder when you're a casual, part-time or level 2. But there's a lot of whingeing behind the scenes. There isn't harassment for speaking out. The Team Leader and Manager do the best they can with what they have. It's subtle - you can't put your finger on it.'

Direct Care Worker

Departmental officers, including DCWs, raised concerns about potential maltreatment by staff members during the course of this investigation, and also said that they had raised similar concerns on occasion with Departmental management. As indicated earlier, however, some staff expressed concern that management did not respond to this information appropriately. This may partially be addressed by Recommendation 4, for better feedback mechanisms to be developed. The underlying lack of confidence in management for many of these workers, as discussed at 12.4.2 and 12.7.1, however, could potentially inhibit them from divulging the information to another Departmental officer. This matter is discussed further at 16.3 below.

On the information available to me it appears that to the apparent DCW reticence to complain could be due to a number of factors. The following comments are relevant in this context:

'... there is a culture in ACSS systems that staff stick together and they don't tell management anything and if anybody does they are punished. And if anybody comes in as a new person and joins with the kids or talks to management or in any way doesn't fit within the culture, they punish them and cause them to leave or cause them to change to meet their culture.'

'... I have heard new people be told don't go out and do that with those kids, you will show us all up. I mean that stuff is not said in front of the Team Leaders, it is not said in front of management, but it is said to staff and if you do anything about it you can be in danger. I mean those kids can be dangerous. And you can be left in a dangerous situation.'

Residential Care Manager

'The subculture has a stronghold on people in the Department's hostels. New people begin by questioning it and then get absorbed. This subculture is "*staff first*". Kids are "*ungrateful*", "*bastards*". You really have to be strong to fight the culture. It is called "*going over to the dark side*" when staff give up fighting it ... The mentality is that the kids "*are out to get us*". It is true kids set them up - each time I hear about a false claim I despair. I know that this will make it even harder the next time a true allegation is made.'



The culture also inhibits people telling the truth about incidents. I witnessed a staff member [involved in an incident with a young person]. No incident report was written at the time and the staff spent two hours trying to talk the young person into a different point of view. The Team Leader was not told about the matter at the time. A [Child Maltreatment] investigation was subsequently held. [Any staff member who] told the truth about what occurred [was] vilified by staff.'

Direct Care Worker

'I had a couple of workers come to me at various times and say I can't speak out about what I see someone else doing because I have to work with them for night shift next week and they will set me up with a kid. They will hang me out to dry. We had volatile kids within the units; [if] conflict happens they will leave you to it. Or they will isolate you or they will set you up for some form of allegation or whatever. A lot of the contract workers were scared to talk out about anything anyway. They were scared to voice an opinion whether it was good, bad or ugly just because they didn't have guaranteed employment.'

Residential Care Manager

Some of the incidents described above, of workers being pressured and threatened, can indicate another issue: bullying in the workplace.

The *Occupational Safety & Health Act* 1984 requires employers to ensure so far as is practicable that employees are not exposed to hazards in the workplace, and bullying is now recognised as a workplace hazard. I was considering recommending that the Department develop and implement training for residential care staff on how to address bullying in the workplace. However, I was pleased to be provided with new policies on workplace bullying developed by the Department in April 2006, and to be advised that training was in the process of being implemented throughout the Department at the time of writing.

### 13.3 Concerns about fairness of the investigation process

'It's a volatile area to work in - and staff are degraded by the Child Maltreatment Allegation investigation process. It's bad enough to have that said about you - let alone have a formal allegation followed up.'

Direct Care Worker

'If they were a first time child, a newer child, then obviously the benefit of doubt's always going to be there [if they make an allegation]. But when you've got the history dictates that these kids are always making things up, or alleging things and stuff, it's a little bit harder. [A CMA investigation by field staff] is probably the best way, and they can just decide whether it's happened or hasn't happened.

... But in this particular case, as much as he can be mean and carry on and abuse staff, it was just out of line. I mean she then had the [CMA] team in and had the Police ready to charge him, and the poor kid knew nothing about it and like, we weren't even supposed to tell him about it, and he's coming in the hostel and she's all over him but got this charge happening.'

Direct Care Worker

'All I know is that if a child makes an allegation against you for something and it is followed up basically your job is on the line and you are put off with pay or without pay or whatever until an investigation has occurred. We just know how easy it is for these sorts of things to happen, that is why we always make sure we document and supervise the kids appropriately and watch each other on shift to make sure we know okay where are you going now and what is happening and that everything is documented on how the situations went because if it is not recorded and documented absolutely concisely if the child or someone should make a complaint a day passes and you are scratchy around events of what happened so that is one, but at the same time it is extremely time consuming you have got one or two staff members completely tied up just making sure our i's and t's are dotted and crossed.'

Direct Care Worker

The above quotes are indicative of the range of concerns associated with the making of allegations of maltreatment in a residential care environment. Concerns about the fairness of the processes in place once a matter is identified as potential maltreatment may inhibit residential care staff from reporting matters in this way, particularly if the view that the process is '*degrading*' for staff is indicative of the attitude generally amongst residential care staff.

The issue of residential care staff being subject to CMA investigations warrants exploration. As indicated in 3.1, the Department does not investigate allegations of abuse of children involving people acting in their employment capacity, unless required to do so by separate legislative requirements, for example in child-care centres. Departmental (and non-government) residential care workers are subjected to these investigations because the Department classifies those roles as including the exercise of parental responsibilities for young persons in their care. It is of note that DCWs have stated that Case Managers make the significant decisions in relation to the young people in residential care. It is also the case that other workers would appear to exercise significant powers over young people, including teachers, juvenile justice workers, and boarding school staff. Yet if notified of allegations involving these workers, the Department's practice is to refer complainants to the Police for criminal matters or to the relevant employer to undertake internal disciplinary investigations. The Department's position is that it would only conduct a child maltreatment investigation in these instances if it believed that the allegation raised issues of neglect by the child's parents, for example a failure to take appropriate action to protect the child from further abuse, and as such that investigation would not focus specifically on the worker in any event.

As a result, CMA investigations are rarely conducted in relation to people at work. Because these only occur if the Department classifies the employee's role as one in which they exercise parental responsibilities, it may appear that the investigation is of the employee's capacity as a parent and therefore could be seen as '*personal*'. In this context the attitude that DCWs are being degraded by the process is perhaps understandable. It may be that new terminology, in line with the C&CS Act, will go some way to reducing the stigma associated with these Departmental processes, although that classification apparently will continue to include the broad range of matters encapsulated under the current term, including harm resulting from neglect, or emotional, physical or sexual abuse. The issue of the processes used to investigate maltreatment in residential care is discussed further in Part VI.

On a more general level, however, it may be useful if information for residential care staff highlighted how allegations, and the investigation of those allegations, are an integral part of working in residential care:

'... it goes to the habit of investigations. Gee it is the dead of night, three young people get up or four young people get up to something, there is a fracas with staff and rightly or wrongly we need to have a look at it. ... Incidentally I recall [a worker] saying to me [when he was being investigated] that they don't understand that I have a wife and family, not relevant; ... it is an inherent requirement of the job.

... it is in the nature of the business that young people will make allegations and false allegations too but again it comes to get in the habit of investigating things.'

Residential Care Manager

The information could also outline existing investigatory processes, including the implications for those subject to investigation. It may also be worthwhile for the Department to set up a forum to discuss what measures are in place to address staff concerns about the current system. I recommend that:

18. The Department include information on how allegations, and the investigation of those allegations, are an integral part of working in residential care, what it means if an allegation is made for an employee, and an outline of the assessment and investigation processes in its induction training for residential care staff and on its intranet.

The Department agrees with this recommendation, stating that it has been implemented. The Department advises that in its most recent Induction Program conducted in June 2006, staff were comprehensively trained about their duty of care to children in residential care, and that the areas covered included the obligation of staff to report incidents of abuse in care, the legal and administrative mandate which drives practice in that area, the process for the investigating of allegations including the various roles and responsibilities of staff, and the process should an allegation be made about them during the course of their employment with the Department.

The Department further advises that its Code of Conduct and Code of Ethics are also included in the Induction to ensure that staff are aware of their responsibilities as an employee and public servant. The Department states that the Human Resources Division has also developed guidelines for all Departmental staff that outline the processes undertaken when an allegation is made against them, and that this draft makes specific reference to staff working in ACSS; it will be available to staff once it is finalised. I welcome the Department's response to this recommendation.

## 13.4 Critical Incident Reports

### 13.4.1 Completing report forms

One of the measures in place to assist in the reporting of maltreatment is the obligation on staff involved in the physical restraint of a young person and in other critical incidents to complete a Critical Incident Report. The ACSS Procedures Manual states that these are to be completed for '*an event which involves an injury or potential for injury, and/or a strong stress reaction in a young person or staff*'.<sup>288</sup> Although completing a report when using restraints was not a requirement under the CW Act, it is a requirement under the new regulations related to the C&CS Act.

Prior to this legislative change, however, DCWs interviewed recognised the importance of documenting incidents, although they commented that this was not a universal approach:

'Some staff won't write up incidents - they believe that it doesn't look good. I disagree - it's important to write these up... It's not so much that procedures aren't being followed - it's just that nothing happens [as a result of documenting critical incidents] in the end. The young people are just left there - there are no options.'

Direct Care Worker

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<sup>288</sup> ACSS Procedures Manual, p. 6.

'If you have been around for a long time you realise that eventually it makes an impact to let you know ... if you had done this paperwork and nothing has happened there then you may feel disheartened and you think why bother doing it next time, but if there is enough paperwork there you can do something about it.'

Direct Care Worker

As indicated by these comments, there continue to be barriers to the effectiveness of the procedure; a particular example being the lack of response to certain incidents which DCWs believe should result in a young person being removed from a facility to a different placement. This goes back to the over-riding problem of a lack of placement options identified in Chapter 7.

More critical to the effectiveness of the above process are the shortcomings identified in the ACSS Critical Incident Report form itself. Staff interviewed believed that while the form was clearly linked to the use of physical restraints as taught in CCM, for example by reference to '*triggers*' to the incident and a '*life space interview*' afterwards, this could contribute to the failure to utilise the form to report other serious incidents, such as self-harm, which also needed to be brought to the attention of senior staff and Case Managers.

At present, it appears in practice the form is not completed in every instance of physical intervention. For example, my officers were advised:

'We don't [complete a form for separation] because ... I would use an incident report if I thought it was serious enough. But you may do something like that [separating young people] 15 or 20 times on the weekend shift depending on the population - you might be constantly doing this.'

Direct Care Worker

The tick box option in the Critical Incident Report form of whether the incident involved '*restraint*', '*removal*' or '*separation*' is not supported by a definition of what might constitute '*removal*' and '*separation*' in any of the current training materials. As a result it is not clear that all physical interventions need to be reported.

I recommend:

19. The Department undertake a review of its ACSS Critical Incident Report form so that the forms accommodate a sufficient variety of critical incidents affecting children and young people in care and appropriately reflect the Children & Community Services regulation requirements relating to the recording and reporting of any incident in which an officer '*restrains*' a child.

The Department agrees with this recommendation, stating that as part of the review of the ACSS Critical Incident Report form referred to previously, it will broaden the range of critical incident types to capture the range of critical incidents which occur in residential care.

A significant improvement recently implemented by ACSS to the process of reporting critical incidents and potential maltreatment was the requirement that all staff involved or present during a critical incident complete a report form. Some, however, told us they remained sceptical of the practical effectiveness of this initiative:

'Certainly it's a good idea for all staff to fill in a form, I think that's important. I mean how much of a different story you'd get remains to be seen.'

Residential Care Manager

Improvements to the existing systems and environment of ACSS residential care, including measures to provide greater confidence in the investigation process and anti-bullying training, should help ensure that this ACSS initiative will have practical results in the reporting of potential maltreatment.

### 13.4.2 Monitoring of Critical Incident Reports

Improving the quality of Critical Incident Reports of itself is one step in assisting in the effective reporting of potential maltreatment. However, the essential second step is that these reports are appropriately monitored.

The ACSS system provides for Critical Incident Report forms to be reviewed by the young person's Case Manager, the residential facility Team Leader, the Child Placement Services Manager, and as of March 2006 also by the newly created Special Projects Executive Director, whose responsibility includes the Department's residential care facilities (previously overseen by the Director East Division). This appears to be a sound process to ensure that the use of physical restraints and other critical incidents are adequately reviewed, particularly if these forms are amended to include the suggested reforms referred to at 9.3 and above.

However, one criticism of the existing system conveyed during the course of this investigation was that the monitoring tended to be somewhat ad hoc. A more systematic approach to the review of critical incidents, such as for example, the retaining of statistical data, may assist in identifying trends in the use of restraints in certain facilities or by certain workers. It may also be useful if the use of restraints was monitored by an agency other than the Department, along the lines of the review board which one witness reported was in place in Canada:

'...they had a system in place where any physical restraint that was done was independently reviewed by a board. So they had a few people, community based and professional based, where the information, like a critical incident [report], went to them and they could talk to the staff about [it], so it was looking at quality of work and why we did it and strategies. It was a whole range of things, it wasn't a witch hunt or anything like that, it was to review why we needed to do that, what can we do to avoid this in the future...'

Residential Care Manager

The external review of statistical data and individual instances of the use of restraints in Departmental residential care might conveniently be allocated to the allocation of an Independent Monitor function to an agency external to the Department discussed at 16.3.

I recommend that:

20. The Department maintain statistical data on the use of restraints in its residential care facilities; and consideration be given to the implementation of an independent review function which might, for example, be based on the Canadian model, involving an independent board consisting of community-based and professional members.

The Department agrees with this recommendation, stating that, as described in its response to Recommendation 2, work is underway to capture information in the new information system being developed and this will include data on the use of restraints. The Department also advises that consideration is occurring about a review process being established which will involve the Advocate for Children in Care and CREATE.

## 13.5 Conclusions

This chapter has identified some of the apparent impediments which may limit the effectiveness of the formal systems available to residential care staff for the reporting of maltreatment. In the context of issues identified by Departmental staff, including alleged intimidation and threats for reporting maltreatment, I was pleased to note that the Department had already taken action to make it clear to all staff that bullying was recognised as an occupational safety and health issue and was not acceptable behaviour.

Measures have been suggested which may improve these reporting systems, such as revised Critical Incident Report forms and suggested methods for improved monitoring of these reports. From my perspective, however, perhaps the most significant impediment to residential care staff reporting

maltreatment resided in the concerns expressed about the fairness of the subsequent investigation process. To some extent this may be addressed by the suggestion that information be developed for residential care staff about the assessment and investigation processes which may be brought into play. However, the concerns of residential care and other staff about investigative processes go further than this. The broader issues associated with the investigation of child maltreatment in the Department's residential care facilities are the subject of Part VI of this report.

## Part VI Investigating Child Maltreatment

### Chapter 14 Investigating Allegations of Child Maltreatment

The focus of Part VI of the report is the Department’s investigative processes and procedures for dealing with allegations of maltreatment in ACSS residential care facilities.

The informant’s disclosure not only alleged that there was abuse of young people by residential care staff in the Department’s hostels, it also alleged that the Department had failed to properly address the practices which led to that abuse. In Chapter 2, I considered the Department’s response to the informant’s general concerns and PID Act disclosure. Another aspect to the informant’s allegation to this office, however, specifically concerned the adequacy of the Department’s investigation of child maltreatment in its residential care facilities.

The Department’s response to child maltreatment in its hostels potentially involves two processes – Child Wellbeing Concern (previously CMA) investigations and disciplinary investigations under the PSM Act. Although the Department states that these two processes are independent, my enquiries have highlighted the degree to which each of these processes can impact the effectiveness of the other as a means of responding to child maltreatment allegedly occurring in the Department’s hostels.

In this chapter I examine the strengths and weaknesses of the CMA investigative process. To place this in context, it is helpful to consider the rate of substantiated allegations in these environments.

#### 14.1 Substantiated allegations of maltreatment in ACSS facilities

The sample of substantiated allegations analysed in the Murray Report indicated that the rate of substantiated CMAs per child in Departmental facilities was high. Although a sample of just six substantiated allegations needs to be treated with caution,<sup>289</sup> ten per cent of the substantiated allegations in the review sample related to children in the Department’s residential care, whereas these facilities held only three per cent of the total population of children in care, as set out in Table 5 below. It is important to note at the outset that these instances did not all relate to allegations involving staff, as explained below.

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<sup>289</sup> Murray Report, p. 37.

Table 5: Percentage of children in care residing in placement types for Murray Report<sup>290</sup>

Placement type	Sample population residing in placement type	General DCD population of children in care residing in placement type
Home	28%	10%
Relative care	36%	32%
General foster care	20%	35%
Foster care - non government	2%	7%
Residential care - Departmental	10%	3%
Residential care - non-government	3%	5%

The category used in the Murray Report, '*Residential care - Departmental*', includes the ACSS facilities the subject of this investigation in addition to the other regional hostels which are managed by Departmental District offices. In order to obtain a clearer indicator of the extent of substantiated abuse in ACSS facilities, my office requested information as to the location of each of the six incidents of substantiated allegations occurring in Departmental residential care. The information provided indicated that two of the six incidents related to a non-government residential care facility.<sup>291</sup> After initially being advised that these incidents had been categorised as relating to Departmental residential care because the young people were '*moving around a lot*', my officers were able to confirm that the allegations did not concern Departmental officers, did not occur in a government facility, and should have been classified as non-government residential care.

This correction significantly reduced the rate of substantiated allegations of maltreatment relating to Departmental residential care. However, as the four remaining incidents all concerned ACSS facilities, which held less than half of the young people in the Department's hostels, the rate (at two per cent of allegations with one per cent of the population) appeared disproportionate. Upon further investigation, however, it became apparent that three of the four remaining substantiated allegations did not involve perpetrators of maltreatment who were exercising parental responsibility.

I have referred previously to the Department's general position that it only conducts CMA investigations of alleged perpetrators who exercise parental responsibility for the young person alleged to be the subject of abuse. The Department's position when it first developed the CMA process as part of its *New Directions in child protection and family support* in 1996, was as follows:

'Assault on a child by a "*stranger*" or someone with no care responsibilities, and where there are no protective issues within the family, are generally dealt with by police.'<sup>292</sup>

In relation to the substantiated allegations in Departmental residential care referred to in the Murray Report, two incidents involved sexual abuse by another resident and one involved a Departmental contractor who did not work in the residential facility. Upon reviewing the CMA Output Reports concerning the Department's residential care generally, it became apparent that the policy position outlined in the above quote is not routinely adhered to in practice in these environments. Indeed, the Murray Report refers to Departmental data on substantiated allegations of child maltreatment in care concerning other children in care, family friends, and also a number of matters where '*Information did not meet criteria for recording on departmental computer system*',<sup>293</sup> although the Department states that it does record all data involving duty of care

<sup>290</sup> Murray Report, p. 30.

<sup>291</sup> DCD e-mail to this office, 3 February 2006.

<sup>292</sup> At pp. 17-18.

<sup>293</sup> Murray Report, p. 63.



situations. It may be that, if children or young people are in care, Departmental officers are more likely than otherwise to undertake CMA investigations of those who are not strictly exercising parental responsibility over the child or young person.

In relation to the apparent inconsistency between Departmental policies on the nature of allegations which will be subject to CMA investigations and Departmental practice, officers responsible for monitoring the investigation of abuse in care explained that there is some '*fluidity*' in these matters. It was not seen as appropriate to intervene in CMA investigations if Case Managers and their supervisors felt that such an investigation was warranted in the circumstances, even if it did not involve allegations concerning those exercising parental responsibility. For example, an investigation of allegations about a child in care who had abused another child could result, in addition to the standard records, in an alert being placed on the CCSS database highlighting the need for safety plans to be developed for any future placements for the child.

Lack of consistency in the investigation and recording of CMAs detracts from the reliability of comparative data drawn from the Departmental database. Provided this is acknowledged, however, it would not appear to be of sufficient concern to impede the investigation of allegations to ensure a child's safety if seen as appropriate by the Case Manager. Of more concern is the potential risk to children arising because of a flexible approach to these matters. For example, reference was made to the potential for a CMA investigation of a child who abused other children in care to result in the recording of an alert on the CCSS. I have concerns that a process which is not consistently applied in these matters has the potential to perhaps mislead potentially overstretched Case Managers about the risk posed by a child. However, Departmental officers would be better able to assess the relative risks in these matters, and I raise it for consideration only.

## 14.2 Access to information

Case Managers play a crucial role in the recognition of potential maltreatment of the children and young people they case manage. A critical factor in the effectiveness of Case Managers in fulfilling this role is their access to information. In contrast to foster care, however, Case Managers access to information about the treatment of young people in residential care may be complicated by Departmental management structures and worker confidentiality:

'If [concerns about a hostel worker are directly] relevant to an individual young person yes, very definitely [the Case Manager needs to be told]. The Case Manager is the person who has responsibility for the conduct of the case. All right, under a management supervision structure, but they have the responsibility so yes they need to know any information that can be, that impacts on the care of the young person... [However] I think there's a certain - you know [general] performance issues with staff I think, need to be managed by that person's management structure, manager and so on. And that requires a certain amount of confidentiality and you know, planned work towards resolving the situations and I think that if it's not impacting directly on a child that I have responsibility for as a Case Worker, no I don't think I would be [told].

...if the [hostel] staff member's starting to you know, go off the rails for whatever reason and the behaviour is starting to generalise, then, yes probably [as a Team Leader I'd need to know]. But otherwise no I wouldn't. I think as a Team Leader I'd have to have faith in the hostel systems managing their own performance issues.

...Apart from that, what can I do with it? (laugh). You know, apart from being aware it. I can't manage somebody else's staff and I wouldn't want to. I think that's along the track of what I'm trying to get at.'

Field Officer

In the past, staff who worked within those institutions undertook the case management of young people in Departmental residential institutions. It appears that when the responsibility for case managing those young people was allocated to Field Officers, no guidelines were developed to articulate the appropriate balance with reference to how Field Officers and Residential Care

Managers were to manage concerns about individual Departmental staff member's conduct, while giving due weight to staff entitlements to confidentiality and due process.

In some of the matters examined in this investigation, it also appeared that documentation provided to Case Managers such as weekly '*Progress Reports*' on individual young people in Departmental residential care might be written in such a way that it would be difficult to identify incidents which may otherwise have alerted Case Managers to the potential for child maltreatment. For example, in one incident, referred to previously, where a young person claimed that he was struck, contrary to the staff account of the incident, the Progress Report stated, under '*Emotional and Behavioural Development*', '*Again this weekend an outing was ceased due to poor behaviours...*'

In relation to this same incident another Departmental report recorded the psychological effects of the incident on the young person.

Such a report might be considered important from the perspective of assessing potential child maltreatment with its focus on the degree of harm suffered by a child. However, it was unclear whether the Case Manager in that matter, who would have had primary responsibility to determine if it was potentially a CMA, had the report brought to his attention. The Case Manager indicated he probably could have accessed the psychological file for the young person if he '*needed to*', but would not have known to ask for it. It seems in that particular incident, the residential care Team Leader who was provided with a copy of the report assumed that another Departmental officer had sent it to the Case Manager and that officer assumed that the Team Leader would provide it to relevant parties. Both of those officers believed that it was up to the Case Manager to determine whether the incident warranted being investigated as a CMA. While this incident was also the subject of a Critical Incident Report, that report did not include the young person's version of events.

The suggested alteration to Critical Incident Reports may go some way to ensuring the relevant information is available to Case Managers and others. However, it appears that there also needs to be clarification of the responsibilities of Residential Care Managers and of Case Managers in assessing the conduct of residential care workers. Based on those responsibilities, I believe it would assist if there were a Departmental position on what information is to be passed on to field staff about the conduct of individual hostel workers. I recommend that:

21. The Department, after consultation with direct care staff, field staff, relevant managers and Human Resource experts, develop guidelines about the responsibilities of Residential Care Managers and Case Managers in assessing the conduct of residential care workers. Based on those responsibilities, the Department provide guidelines on what information is to be passed on to field staff by Residential Care Managers about the conduct of individual hostel workers.

The Department agrees with the recommendation, stating that it is working towards developing enhanced guidelines for Residential Care Managers to assist them assess the conduct of residential care workers. The Department further advises that, as a part of the revised guidelines, information will be incorporated in the Field Workers Guidelines to make certain that field staff understand their responsibility and the process involved if they have concerns about the conduct of a DCW. I welcome this response.

### 14.3 Classifying concerns?

To date there has been no published quality assessment by the Department of those incidents which have **not** been identified as abuse in care but perhaps should have been.<sup>294</sup> The Cant and Murray reports examined quality assurance in the assessment processes of incidents which had been

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<sup>294</sup> See the specific reference to this at Murray Report, p. 84.

identified as potential abuse in care: the Cant Report focussed on systems to protect children in care, for responding to allegations of abuse in care, and for monitoring these processes;<sup>295</sup> the Murray Report assessed specific matters which had been substantiated as abuse in care to determine if these were correctly categorised as such, and the adequacy of how those matters were managed.

However, Cant does state that some staff were unclear about what constitutes a CMA, and refers to the reluctance of others, including Field Officers, to call information about harm to a child a CMA.<sup>296</sup> Based on reviews of child protection in other jurisdictions, Murray also reports:

‘a minimising or lack of recognition by child protection workers of high levels of risk both to the immediate safety and to the future well-being of children.’<sup>297</sup>

Murray reported that the reason for this was complex ‘*and has been embedded in the long term “neglect” of children and of child protection systems*’.<sup>298</sup> In considering the effectiveness of current processes relating to the identification and investigation of child maltreatment, Murray also highlighted that:

‘in some cases in foster and relative care; there are conflicts of interest when caseworkers with a long working relationship with carers, undertake the assessment of allegations of abuse recorded against them.’<sup>299</sup>

The Cant and Murray reports identify issues which appear likely to impede the effectiveness of the classification of potential maltreatment in the Department’s residential care facilities. During my investigation witnesses also acknowledged apparent barriers which may hinder the ability or willingness of other staff to identify matters as CMAs, as follows:

‘One reason that a Team Leader might be reluctant to identify something as a CMA is because it occurs frequently in the hostels. Over the last four months there have been critical incidents all the time at [one of the hostels]. Eight kids are the authorised maximum there - but there are more because [a Senior Manager] won’t say no. They sleep on the floor in the lounge and the hallway...’

Direct Care Worker

‘The Case Worker could not follow up on it all and so there is a tendency to minimise things and move on. There is an issue of workloads and what’s realistic - this is not reflected in policies.’

Residential Care Manager

‘That’s a tough one [about whether I would follow up on an incident where the young person alleged being slapped by a Direct Care Worker and suffering flashbacks to his prior abuse] because again, I would have to prioritise and see what else was happening for me at that particular time. Possibly, I mean maybe, maybe not, I don’t know; it’s like you’ve really got to understand the day in the life of a Case Worker in the Department. And if there’s child protection happening for a younger person in care, or there’s something else that needs to be attended to then this would, an incident like this ... A young person in a residential unit with professional people around them would not be, would not get as high a priority.’

Field Officer

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<sup>295</sup> Cant Report, p. i.

<sup>296</sup> Cant Report, p. 45.

<sup>297</sup> Murray Report, p. 7.

<sup>298</sup> Murray Report, p. 7.

<sup>299</sup> Murray Report, p. 62.

Other recommendations in this report, such as improved processes associated with Critical Incident Reports and the proposed Independent Monitor, will go some way to providing assurance that harm to a child is classified as a potential child maltreatment when it should be.

Effective systems will not only address impediments to classifying concerns as potential maltreatment when this should occur; they will also ensure there is no systematic classification of matters as potential maltreatment which need not be. Reflecting some of the concerns of DCWs, supervisors and field staff expressed concerns about classifying matters as CMAs because they believed that the process could be an inappropriate tool in certain contexts:

'I think part of the problem with dealing with allegations from a young person to staff members is that there is no real category for it. A CMA is what we use when kids have been abused intentionally by adults and who have responsibility for their care and all that sort of stuff, but sometimes I think it is an allegation of mistreatment, it is an isolated thing. You know this guy is on shift this day, this happens, he did this or this is what I am saying he did, let's investigate, investigate it from that point of view. I think we call it a CMA when some of this sort of stuff happens because that is the only category we have for it. And I don't know if that is the best way of doing it. It would be very hard, even in that one [where the young person was hit in the face, to conclude] that a staff member abused this kid. You could probably say one way or another whether he actually hit him, but whether you could substantiate an abuse and put him on the system as an abuser of children is probably a little bit harder to substantiate, if you said he did this and it was confirmed that this was done and it was done in this context then you should be able to deal with it as a misconduct or an inappropriate whatever it is.'

Residential Care Manager

'I think there should always be a response [to a concern about maltreatment]. Whether there should be an investigation I don't know. An investigation asks a number of questions - it says did an event happen, who did it and what are you going to do to protect the child. In a nutshell that's what an investigation does and if you do that within a care situation - oh and alongside of that you've got all the recording, you've got records around, you've got a lot of labelling, you've got a lot of recording on our computer systems and things like that - if you're talking about a staff member [in] a hostel situation, that then goes on to their files and all the human resource issues that go with that...

... I think it also needs to be looked at with the understanding of the nature of the problems facing people in that environment. In other words, yes you've got to expect a very high standard from trained staff, but you've also got to look at the nature of some of these kids (laugh). And the fact that alright, they may be trained staff but also human so where's that breaking point. And if there is no, and this is where it starts to come into the general, I suppose general impressions about where the Department is at the moment - the entire Department's threshold is up here somewhere... I wouldn't want to work in that environment ... Because it's relentless, you know there's no break from that, it's just the constant high threshold kids. It doesn't change.'

Field Officer

'...yes you do need to follow that through [concerns about the treatment of a child in care], but it needs to be realistic according to what it is and the difficulty is that the, how that's responded to is often escalated by the fact that you're working within that very procedural and political environment. Because you know that what's going to happen is that, if then don't treat these things as an investigation and then something then comes up, then you're likely to get severely criticised because you didn't.'

Field Officer

In WA, a significant proportion of matters that were investigated as CMAs were unsubstantiated – approximately 50 per cent of completed investigations.<sup>300</sup> It is of particular note in the context of this investigation that, in spite of some of the problems with comparisons based on Departmental data,<sup>301</sup> the Cant Report indicated that in the small sample of allegations concerning Departmental residential care, the rate at which these were found to be unsubstantiated was 80 per cent.<sup>302</sup> These figures may be indicative of a tendency to inappropriately classify concerns as CMA in the context of Departmental residential care.

The Cant Report referred to the Department's proposal to establish a Standard of Care Unit to assess allegations and notifications about children in care,<sup>303</sup> which the Department advises is now known as the Standards and Monitoring Unit. This Unit should assist in addressing any systemic issues which may contribute to the incorrect classification of issues arising in residential care as CMAs.

The Department states that it does not believe that there is any systemic misclassification of abuse in care issues in residential care, and that case audits and the recent establishment of the Advocate for Children in Care contribute to the quality of its classification processes. At the same time, the Department does concede that there has not in the past been any systemic monitoring of either the accuracy of classification of incidents as potential abuse in care, or of incidents which have not been identified as potential abuse in care and which perhaps should have been.

#### 14.4 Child Maltreatment Allegation investigations

The CMA investigation process, with its focus on child protection and safety, has the scope to bring some very positive reforms to residential care settings. Child maltreatment investigations, similar to investigations of '*Child Wellbeing Concerns*', focus upon the potential for harm to the child as assessed by Departmental officers, and the implementation of measures to ensure child protection. Because these investigations are focussed upon potential harm to the child and the implementation of measures to ensure protection, they can have less of the rigidity associated with other kinds of investigations. As the Department advises its staff:

'The evidence to substantiate an allegation need not be conclusive to stand as legal evidence, but needs to provide credible evidence that harm to the child has occurred, and leads you to make a professional judgement that the child has been harmed, or is at risk of further harm.'<sup>304</sup>

Adding to the potential strength of the CMA process is the involvement of Departmental officers who have training and expertise in interviewing children and understanding the behaviours of young people subject to abuse.

However, the benefits of the CMA processes in the Department's residential care facilities appear to have been more limited than might have been hoped. There are a range of specific factors which contribute to this, including those identified in the Cant and Murray Reports, discussed below. In the context of allegations involving Departmental staff, however, there appear to be fundamental problems associated with the application of CMA investigative processes in a workplace, when these were designed primarily to address parental maltreatment. The issues specific to employees are

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<sup>300</sup> Cant Report, p. 6, figures for January 2003 to June 2004. The Department advised that these data were collated manually and no more recent figure is available; stating that it focuses on '*updating information on substantiated allegations, as this is particularly relevant to practice decision-making*' (DCD, correspondence with this office, 2 September 2005 (Response to question 16)).

<sup>301</sup> Discussed at 14.1.

<sup>302</sup> Cant Report, p. 6.

<sup>303</sup> Cant Report, p. 47.

<sup>304</sup> Case Practice Manual 7.25.

discussed from 14.6 below, including the details of the Department's current review to strengthen and enhance these processes.

## 14.5 General issues concerning the investigation of abuse in care

In this section I examine a number of the general issues which have been highlighted by this investigation and other reviews, before considering recent proposals which may address these.

### 14.5.1 Delays and conflict of interest

'I think it's a fair process but it's too lengthy, the time. People don't know where they stand. Especially when it just drags on and just drags on and they're either home, and they can't come back to work. That's probably the biggest gripe that I would have with it, and I would hate to be in that position. I mean everybody's entitled to a fair, I mean even with the kids if they make a complaint. I mean even on their side if things are taking so long, why, what are the kids ... there's no resolution with the kids or no news of what's to happen.'

Direct Care Worker

Even those direct care staff who had confidence in the CMA process had concerns about the length of time taken in some instances for investigations to be finalised, as indicated above. These delays were confirmed in the research conducted by Murray and recommendations were made to improve the processes and timeliness of investigations.<sup>305</sup>

Additional concerns were evident in the comments of other Departmental staff:

'In my view the Department's policies and processes are good. The key problem is that these are not followed. For example, [CMA] investigations should be good, however the investigators are too busy.'

One other problem though is that these investigations are not independent. There should be independent investigations whether investigating allegations in hostels or in other forms of care. People in the field have relationships with people at the hostels and elsewhere. The Team Leaders and Social Workers are all enmeshed; this is a major problem with the Department which generally ... gets overlooked. Investigations need to be undertaken completely outside of DCD.'

Residential Care Manager

The potential for conflict of interest arising from having Case Managers investigate residential care staff with whom they have formed long-term working relationships was frequently referred to in discussions about the CMA investigation process, and has been referred to earlier. Other comments indicated that staff felt that on occasion investigating officers might not have had sufficient experience in the sector to undertake work of this kind and might lack sufficient understanding of the difficult environments of residential care.

### 14.5.2 Standard of proof

Generally it appeared that investigators were conscious of the seriousness of substantiating a maltreatment allegation against a person, in accordance with legal principles such as *Briginshaw & Briginshaw*,<sup>306</sup> and therefore set the standard of proof required at a high level:

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<sup>305</sup> Murray Report, pp. 71-75.

<sup>306</sup> (1938) 60 CLR 336. The *Briginshaw* test (or *Briginshaw* standard as it is often called) possesses a measure of flexibility, so that the more serious the allegation the higher the degree of probability required.

‘you certainly don’t apply the same level of evidence [as a criminal investigation], however it’s fairly, it is still fairly high. It’s a fairly serious matter to substantiate child maltreatment against a person, any person, and it still has to be of reasonable standard, yes.’

Field Officer

However, my officers also found considerable differences in what investigators thought was required in order to substantiate CMAs, in line with the inconsistent approaches by Districts identified in the Cant Report.<sup>307</sup> In particular, there was reference on occasion by investigators needing to establish that there was ‘*deliberate intent*’ or ‘*preconceived intent to harm*’ by the alleged perpetrators. In other instances it was felt there could be no determination of the allegation because there were competing accounts and because ‘*there were no witnesses to the alleged incidents*’. In some instances this appeared to be associated with field staff being particularly conscious of the ramifications of Departmental staff being recorded as a person responsible for causing harm to a child on the Department’s databases.

An internal Departmental review of one CMA investigation overturned the initial outcome because an intent to harm was not a standard which was relevant to substantiating an allegation. It also highlighted that field staff were entitled to balance the probabilities in the evidence to establish whether there was an incident of maltreatment irrespective of there being independent witnesses to an incident.

There are now a number of senior Departmental staff who review all Outcome Reports for child maltreatment investigations and as such there appears to be a sound quality assurance process in place. In the above instance it was this review process which caused the original decision to be reconsidered, with the Departmental report clarifying that:

‘Intent does not define whether the Department should substantiate maltreatment; rather intent is about framing what kind of intervention is required to reduce the likelihood of reoccurrence.’

However, it remains of concern that prior to it reaching that stage, a number of very experienced staff involved in determining the initial investigation outcome and signing off on it had applied standards which seem at odds with the basic requirements for an investigation of a maltreatment allegation.

### 14.5.3 The solution - a specialist investigations unit?

The Murray Report recommended a specialist investigations unit for abuse in care. If implemented, Murray’s recommendation, below, would appear to be able to address many of the issues identified above:

‘10.1 It is recommended that there is an expansion of the Duty of Care Unit to incorporate:

- Additional senior officers based in the Unit to undertake the assessment of allegations of abuse in care with case workers. The officers would attend at District Offices when allegations of abuse in care are received or notified. These officers would team with the case workers and lead the investigations of the allegations, assessment action, outcome findings and recommendations. The officers would be responsible for the documentation of the process and recording of the outcomes within the Duty of Care Unit.

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<sup>307</sup> Cant Report, p. 46.

- The caseworker from the District Office would work alongside the senior officer and support the child or young person. The Placement Officer within the District office would support the carer if this were needed.<sup>308</sup>

It is of note that according to CREATE's comparative data for Australia, WA appeared to be one of the few jurisdictions which did not have an independent investigations unit or involve investigators who did not already have a relationship with the carer or child.<sup>309</sup> In my view the unit recommended by Murray has the potential to address many of the issues identified in the Cant and Murray Reports as well as by this investigation.

In particular, such a Unit could ensure with the development of specialised skills in this area and that the standards applied for investigations of potential abuse in care are consistent. One of the strengths of the proposal as currently articulated is that the '*investigation team*' in most instances would consist of a Team Leader from the Investigations Unit and a Field Officer. This could lead to an improvement in the quality of investigations of maltreatment allegations generally, as the expertise of the specialist unit would be shared with field staff who may, as I am currently advised, continue to undertake investigations of allegations other than those concerning young people in care.

I strongly support the Murray recommendations relating to the creation of a specialised investigations unit for abuse in care and welcome the Department's advice that six additional positions have been allocated to the Duty of Care Unit to centralise the investigations of allegations of abuse in care.<sup>310</sup> However, there are particular impediments to investigations of child maltreatment allegations involving Departmental officers which need also be considered. These issues are discussed below.

## 14.6 The status of investigators' recommendations in a workplace

CREATE, in discussing best practice in relation to dealing with abuse of children, criticises processes which focus on the action or inaction by individuals. CREATE's position is that if there is to be significant reform, there needs to be a systemic approach to addressing issues of abuse.<sup>311</sup>

In a number of the CMA Outcome Reports viewed for the purposes of this investigation, it was apparent that investigators went beyond the issue of whether an individual the subject of the allegation did or did not do something. In instances where the specific allegations were not substantiated, report recommendations have included, for example, additional staff training, changes to a hostel policy of '*young people going outside to calm down*', and that:

'The investigation of this incident has highlighted primarily contextual issues as having a contributing influence to the incident in question, there would appear to be a need to review existing staff training practices, staff/management relationships and the adequacy of team building activities, if any are currently in place.'

As positive as this capacity to make broader recommendations is, however, it does not appear that there is any specific process in place to allocate responsibility to ensure such recommendations are implemented in the hostels. In contrast, where an investigation involves a parent or foster carer, the investigator is usually the child's Case Manager and that person is also largely responsible for implementing the investigation recommendations.

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<sup>308</sup> Murray Report, pp. xiii, xiv.

<sup>309</sup> CREATE, *Do No Harm*, pp. 22-23.

<sup>310</sup> Message from the Acting Director General to DCD staff, 11 May 2006.

<sup>311</sup> CREATE, *Do No Harm*, p. 12.



In residential care, as in other contexts, the CMA Investigator Outcome Reports have very restricted distribution. However, it is generally only in the context of residential care, as opposed to foster care for example, that Human Resource principles will be relevant. Moreover, the CMA investigation process may be regarded as sensitive, if not viewed with suspicion, by residential care staff. The Department advises that:

‘In relation to natural justice, any party that has an allegation made against them would be provided with feedback and information at the conclusion of the CMA process. However, if it jeopardises the ongoing safety of the child or any other children this would not occur. This has been the Department’s practice for many years. Supervisors of employees who are subject to the allegations are currently party to the CMA process and thus are aware of the investigation outcome. However, this process is currently under review.’<sup>312</sup>

Provision is made for staff members to apply for access to extracts from a CMA Outcome Report as it relates to them, but only in the event of disciplinary proceedings being initiated on the basis of that investigation.<sup>313</sup> The access to information and the potential to comment upon adverse findings appears very different to the procedural safeguards for employees’ interests set out in the PSM Act disciplinary processes as outlined in the next chapter.

In discussing the process for implementing recommendations from CMA Outcome Reports in residential care my officers were told:

‘...I would’ve expected the Team Leader to follow up with further discussion with the field [staff who undertook the investigation]. But it gets back to a point ... that it’s quite easy to be critical from a distance in terms of what we do and this is what really puts staff right off. Now they wouldn’t have seen that report I would imagine, the staff...

And this is one of the problems you face about going back to address issues with people and [a Direct Care Worker] particularly who jumps on the bandwagon about saying well excuse me, I want a copy of that. What right have they got?

... But in reading that [Outcome Report] and taking it on face value those comments seem quite valid. But the issue is if people are gonna make those sort of comments it needs to become public to the person that they’re making it about. So that person has the opportunity to say well excuse me.’

Senior Manager

These difficulties highlight the gap in existing policies to address the specific issues which arise in a workplace context.

## 14.7 ‘Holistic assessments’

Another positive aspect of CMAs is the capacity to undertake a ‘*holistic assessment*’ of child safety issues. Murray described this as follows:

‘In reviewing the assessments for individual children, it became clear that a broader examination of issues was required to determine the matters relating to other children in the placement, the assessment of all concerns and ongoing safety and stability. That is, best practice in assessments would be a holistic consideration of the case.

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<sup>312</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 25).

<sup>313</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 25).

The review found that while an assessment of the subject child may have been sufficient; in a number of cases, for example, there were other children in placements that were not considered in the investigation.<sup>314</sup>

In other words, an investigation which substantiates a CMA should result in positive steps being taken to ensure the safety of other young people in the placement; a vital consideration in residential care situations which by definition have multiple placements.

In Murray's review, however, although the standard of assessment of allegations in Departmental residential care was '*sufficient*' in the majority of investigations, no allegations involved a '*comprehensive*' assessment of the broader issues which needed to be determined.<sup>315</sup> Again, this might be related to the difficulties associated with applying the CMA processes to a workplace, and it might be assumed by field staff that residential care managers should manage the broader issues raised by the maltreatment, as discussed previously in 14.2.

## 14.8 Persistent actions

Another of the benefits of the CMA investigative process is its capacity to recognise that persistent actions or inactions which are not of a severe nature in isolation may cumulatively be of significant harm to a child. This allows for greater flexibility in identifying abuse than if the focus is on isolated incidents.

In order to identify persistent actions which may constitute significant harm to a child it is important that there is a means of tracking such incidents, even though each instance of itself may not constitute abuse. However, as indicated previously, the capacity of performance management of direct care staff to provide such '*tracking*' is currently limited by apparently inconsistent practices in filing performance management records although I note that the Department has now undertaken to rectify this (see 12.4.3).

The Cant Report highlighted the significance of being able to track unsubstantiated as well as substantiated allegations of child maltreatment, because of the potential for such incidents to form part of a pattern of behaviour constituting abuse, and also because substantiation is not '*an exact science*'.<sup>316</sup> This is clearly a contentious issue, although it is suggested in a context in which long-standing attitudes have been subject to revision when seeking to identify potential child abuse. For example, the new *Working with Children (Criminal Record Checking) Act 2004*, implemented from 1 January 2006, includes capacity for certain '*non-conviction*' charges to be taken into account when determining the suitability of a person to work with children.<sup>317</sup>

The Department's capacity to track information to identify a pattern of behaviour is examined below.

### 14.8.1 Client Community Services System and the Duty of Care Register

It appears that previously there were difficulties in utilising the Departmental database as a means of tracking prior CMAs against an individual. At the outset, the database was designed as a means of '*tracking*' Departmental clients, initially children, but subsequently extended to also include families who receive Departmental assistance and support. My officers were advised that the

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<sup>314</sup> Murray Report, p. 59.

<sup>315</sup> Murray Report, p. 61. As indicated previously, the comment in fact applies to the assessment of two incidents which occurred in non-government residential care.

<sup>316</sup> Cant Report, p. 60.

<sup>317</sup> Section 12(4) provides that the CEO should issue an assessment notice to an applicant with a '*non-conviction*' charge unless, '*because of the particular circumstances of the case, a negative notice should be issued to the applicant*'.

database was not created with a view to tracking individuals accused of abuse. Nonetheless, for children in care, there are a number of potential opportunities to record an alleged perpetrator's name on the CCSS:

- There is a general Duty of Care Register screen on CCSS that is accessible by all field staff. This Duty of Care Register front screen comes up under the young person's name and the screen can be located by doing an electronic search by the young person's name. It is a '*Notification*' screen which identifies the child, provides details such as whether the child is a ward or otherwise in care, date of birth, Aboriginal/Non-Aboriginal and so on. It then records whether it is an allegation of abuse in care or a critical incident, but does not include a field to record details of the person alleged to have committed the abuse. Persons accused of abuse can be named in a free text box on this screen, but an electronic name search cannot be done on this data field and there is no requirement that the name is provided. A search can be done manually but with approximately 2100 allegations on the system, about half relating to children in care, and 35 to 50 allegations entered per month, a manual search is not practical. However the Duty of Care Unit advises that it checks the free text data as part of its quality assurance role and seeks to ensure that the name is included so that field staff can identify alleged perpetrators of abuse against a child whose records they are checking.
- If a matter meets the definition of a CMA and it is recorded on the CCSS under the child's name, the names of everyone associated with investigation during the '*contact period*' are linked as '*CMA Associates*'. The '*contact period*' is from the time a case is opened until it is closed, while a Case Worker is allocated to the matter. The '*CMA Associate*' is anyone who is important with reference to the allegation during that period, including the alleged perpetrator, a witness or the person notifying the Department of the allegation. It is possible to do a name search for CMA Associates, but this will not provide information about why the individual is associated with a CMA or the outcome of the investigation.
- The person the subject of an allegation should also be recorded on the CCSS database as a '*person alleged responsible*' on a more detailed CMA screen. Data entered into this data field cannot be searched electronically by the alleged perpetrator's name. There is also a related investigation screen which contains the information about the investigation. If the CMA is not substantiated, the name of the '*person alleged responsible*' is automatically expunged. If the allegation is substantiated the person is recorded as an ASH (Assessed as causing Significant Harm) or PR (Person Responsible - basically a person convicted by a court) and these records can be searched electronically by the perpetrator's name. There is also provision for a maltreatment allegation to be substantiated without anyone identified as responsible, for example, preverbal children where the perpetrator cannot be identified.
- When foster carers are recorded on the database as CMA Associates, persons alleged responsible, and PR or ASH, an alert that the person is subject to investigation is entered on the system to let other placement officers know not to place other children there, and other Case Workers with the young person's siblings know what is happening. An alert is not entered for staff in hostels, however, as it was believed that there are other processes in place to handle safety issues - for example, via safety plans and hostel management. If allegations are substantiated against foster carers, they are generally removed from the database, and without an identification number from CCSS they can no longer receive payment. In some circumstances after an allegation is substantiated, a foster or relative carer may stay on the system and continue to provide care if it was not a serious abuse and specified '*points*' are met (based on factors such as remorse, training, supervision, support). According to Departmental staff, these were the foster carers with substantiated allegations identified in the Murray Report,<sup>318</sup> but such instances occur rarely. In considering my comments on this issue, the Department stated that although it responds differently to

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<sup>318</sup> Murray Report, p. 31.

allegations concerning foster carers and Departmental staff, in all instances it is the safety and wellbeing of the child which is paramount.

There appear to have been ongoing changes to the recording of child maltreatment on the Department's database and improvements to the system were recommended in both the Cant and Murray Reports.<sup>319</sup>

Of significance to the identification of patterns of abuse, a change implemented from March 2006 will see the name of a person alleged to be responsible for child maltreatment retained on CCSS whether the allegation is substantiated or not. This change was prompted by concerns about young people in care raised in the Cant Report,<sup>320</sup> but has not been limited to only those instances of abuse alleged to have occurred in care. My officers were told that this was because it would be impractical to restrict it in this way. For example, young people in care move frequently; only recording allegations about a relative or foster carer in their capacity as carers on behalf of the Department, and not concerning their relationship with their own children, may not be adequate. The system is also being changed so that an electronic search can be conducted of the records of 'person alleged responsible'.

#### 14.8.2 Application to Departmental staff

A preliminary issue about the effectiveness of the above system for identifying potential maltreatment in the Department's residential care, however, was the confusion about whether these databases were used to record allegations about Departmental staff. In responding to a number of questions, the Department stated both that *'Allegations of child maltreatment against Departmental employees are currently not recorded on CCSS or the Duty of Care Register'*<sup>321</sup> and that:

'In the CMA process, as prescribed in Case Practice Guidelines, a notification of an allegation of child maltreatment will contain information about the alleged perpetrator and will be retained on the individual child's file. If the allegation is unsubstantiated, the name of the person against whom the allegations was made is retained on CCSS as a CMA associate. The process is standard, whether the person is a member of the general public, a family member, an employee or a foster carer.'<sup>322</sup>

In discussions with Departmental staff about this issue, my officers were advised that the first response cited above was incorrect and that it *'had a Human Resources focus which was not the same as Child Protection procedures'*. It is of note, however, that in one instance investigated, it appeared that a Departmental officer the subject of an (eventually unsubstantiated) allegation was not recorded as a CMA Associate.<sup>323</sup>

If persons alleged to be maltreating children are not recorded on CCSS at all, as appears to have been the case at least with reference to the Departmental worker referred to above, recent efforts to improve Departmental systems risk not achieving desired outcomes. However, it may be that the

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<sup>319</sup> Cant Report, p. viii (Recommendation 33); Murray Report, p. xiv (Recommendation 12.1).

<sup>320</sup> Cant Report, pp. 60-61.

<sup>321</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 23).

<sup>322</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 21).

<sup>323</sup> In that instance the allegation was not recorded on the system until after the investigation, which did not substantiate the allegation, was completed, reportedly due to workload pressures. When the investigation was complete the CMA Outcome Report coversheet stated that *'The staff member involved is concerned that details of the allegation have been recorded on the Department's database, however, as the matter is unsubstantiated this information is deleted.'* It is of note that the relevant Child Protection Guide to Practice (Appendix 16 *'Procedures to deal with allegations of child maltreatment made against Departmental employees and registered foster carers'*, at 1.7) states *'Information regarding the allegation, investigation and person believed to be responsible needs to be recorded on the Client Community Services System'*.

delay in entering the details onto the CCSS which occurred in that instance could not occur now with the improved quality assurance systems in place.

In any event, according to staff who oversee the system, the primary tool available in the CCSS and Duty of Care Register is the identification of the young person's Case Manager - this is the prompt to call for the file if there are any concerns. The issue of what documentation is contained in the child's case and other Departmental files and whether investigators access these is examined further in the next section.

### 14.8.3 Departmental records

The Department advised that, in addition to filing all Child Maltreatment Allegation Investigation Outcome Reports on the case file of the young person involved:

'Information in relation to all child maltreatment allegations against foster carers, whether substantiated or not, is retained on the foster carer's file. If an allegation is unsubstantiated, the carer's name will be recorded on CCSS as a CMA Associate. The notification information will be retained on the child's file. Under the [Corruption and Crime Commission] Act foster carers are deemed to be a public officer and thus any allegations of child maltreatment against foster carers are reported to the CCC.'<sup>324</sup>

The Department has since advised that its own legal advice confirms that foster carers are not public officers under the Corruption and Crime Commission Act.

Departmental investigators indicated that it would be routine to review the child's case file and the foster carer's file in undertaking CMA investigations. As discussed below, concerns about Human Resources-related matters appear to make CMA investigations of allegations involving Departmental employees very different from those conducted if a relative or foster carer were the subject of allegations.

In one of the CMA cases reviewed during this investigation, Departmental investigators did not access the young person's case files. Such files may have been, at least at that time, the only place in which previously unsubstantiated allegations involving the young person and the worker would have been retained. The instance was unusual in that the young person's Case Manager, who obviously would be familiar with the contents of the case file, did not undertake the investigation of the allegation as would be the general process, due to unusual circumstances. Because the investigation occurred some years ago my officers were unable to clearly identify the reasons why the case files were not provided and/or requested. Also, because the investigation materials are not filed separately, but are merged with the case files, my officers were unable to determine what materials were available to Departmental investigators in conducting the CMA investigation.

It is of note, however, that the reluctance to investigate more broadly than the specific incident the subject of an allegation of child maltreatment against a Departmental employee was also consistent with a more recent investigation:

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<sup>324</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 24).

'Well my understanding was ... I couldn't raise [the worker's] past, this was like a separate... [to be treated] as a one-off incident, yep. And that's what I did.

... And I don't know if that's got industrial ramifications, you know. It's like if you start raising somebody's professional performance, past performance, whether that [is an inappropriate thing to do] ... especially in the Public Service. ...And if the person involved is not being performance managed or there's no, there are no concerns about his performance then it becomes very, it gets very political, I don't know what you want to call it but... Well when he turns around with his union representative and says, look I've had no concerns raised against me before why are you bringing all my past history up when no one has mentioned it in the past. As far as I'm aware I'm performing at an adequate level.'

Field Officer

In both instances referred to above there was some discussion with line managers of the persons the subject of the allegations by investigators, but it appears in neither case did investigators attempt to access workers' personal files. As discussed at 14.2 above, it appears that in contrast to foster care, investigators' access to information about the treatment of young people by Departmental staff may be complicated by Departmental management structures and worker confidentiality.

In any event, it is not clear what these files would contain. As indicated previously, there appears to be some inconsistency in the filing of performance management records in Departmental Head Office files which may make these files incomplete. Similarly there is an issue about whether the outcomes of past CMA Investigations involving Departmental officers are retained on officers' personal file.

The Department's 1996 Administrative Instruction 522 on '*Procedures to Deal with Allegations of Child Maltreatment Against Departmental Employees...*' states:

'Regardless of whether an allegation is substantiated or unsubstantiated and/or the officer is convicted/not convicted, the outcome of the investigation including the documentation is to be placed on the officer's personal file.'<sup>325</sup>

An explanatory note to the Instruction states:

'Note that the practice of placing unsubstantiated allegations on an employees file is new. Previously only substantiated allegations, or allegations where the individual is convicted, were placed on the personal file. This change in procedure is in line with Human Resource policy, reflecting the need to have documentation of all suspected breaches of discipline.'<sup>326</sup>

The Instruction was under review in 2004,<sup>327</sup> but had not been replaced at the time of writing this report. It is consistent with the direction in the Case Practice Manual 4.10 '*Management of Maltreatment Allegations made against Departmental Employees*'. However, according to the Best Practice Manual '*Allegations of Child Abuse against Departmental Employees...*', 1.4.10.5, last amended in 1998, and which is subordinate to the Instructions:

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<sup>325</sup> At p. 2.

<sup>326</sup> At p. 3.

<sup>327</sup> Cant Report, p. 49.

'In situations where a clear decision has been made concerning the allegation as in substantiated and convicted, or not substantiated - it is clear that information will be kept on personal files in the former situation, and not in the latter situation.' (my emphasis)

In seeking clarification, my officers were initially advised that the *Best Practice Manual* procedure was adhered to, and that only the outcomes of substantiated reports are filed on personal files.<sup>328</sup> Subsequent written advice from the Department implies that neither unsubstantiated nor substantiated allegations of child maltreatment are retained on employees' personal files.<sup>329</sup> Following discussions with several Departmental officers, it appears that there is no clear identification of which officer is responsible to ensure that the Best Practice Manual policy is complied with, and as a result, if the outcomes of substantiated CMAs are being recorded on an officer's personal files, this would occur on an ad hoc basis if at all.

## 14.9 Conclusions

It seems that there is lack of clarity over Departmental practice in relation to the retention of the outcomes of substantiated and unsubstantiated child protection investigations of Departmental employees. The Department's written responses were inconsistent on the issue of whether the Department's database records CMAs against Departmental employees, and it appears that different areas in the Department have a different understanding of what occurs.

The issue of how to balance conflicting imperatives to protect legitimate employee confidentiality and due process while keeping child protection as the paramount objective is undeniably difficult. However, the current situation where there are multiple relevant policies which appear at times inconsistent and in any event not to reflect actual Departmental practice has the potential to leave Departmental staff without adequate guidance and susceptible to allegations that they acted without authority. It is also important that in the highly sensitive context of child protection, the Department is in a position to readily and accurately advise external review and accountability agencies of its practice, and in particular, to have confidence that its policies indeed reflect its actual practice. I recommend that:

22. The Department take steps as a priority to streamline and rationalise policies and procedures on the handling of child maltreatment allegations against Departmental staff and to ensure that its practice is consistent and is reflected in these documents.

The Department agrees with this recommendation, stating that it is currently reviewing and redeveloping its Concern for Child Wellbeing Report (which has replaced Child Maltreatment Allegations). The Department advises that the re-development will be consistent with the new C&CS Act and the PSM Act and provide clear guidelines and responses to staff and management; it is expected to be developed, finalised and implemented by December 2006.

It would seem that the Department's child protection investigative processes have the potential to enhance its capacity to identify and respond to the maltreatment of young people in the Department's residential care. This potential is likely to be improved with the implementation of recommendations made in the Cant and Murray reports, particularly those associated with establishing a specialist investigations capacity for dealing with allegations of abuse in care.

As highlighted, however, there are a number of impediments to the effectiveness of child protection investigative processes in the Department's residential care facilities. These appear to relate to the origins of the Department's child protection investigative processes as a means of addressing maltreatment in a familial and not a workplace context. These may not be addressed by the creation of a specialist investigations unit. Of significance are the concerns of Departmental

<sup>328</sup> DCD verbal advice to this office, 21 February 2005.

<sup>329</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 23).

investigators and residential care staff about the appropriateness of child protection investigative processes in the workplace environment.

There seems to currently be some debate within the Department about whether the current dual child protection and Public Sector Management processes for dealing with allegations of maltreatment in its residential care facilities should continue. This is a question for the Department to determine. Should the Department decide to continue applying child protection investigative processes in its residential care facilities, existing policies and procedures should be reviewed in light of the specific issues arising in these contexts. In particular, guidelines should be formulated which include the appropriate limits on access to information by investigators, on the recording of investigation outcomes, on the feedback which can be provided to both staff and young people involved in these processes, and on the allocation of responsibility for the undertaking of tasks. I recommend that:

23. If the Department is to continue to apply child protection investigative processes within its residential care facilities, it should review its policies and processes so that there are practical guidelines for investigators articulating how child protection investigations and outcomes are to be managed in a workplace, and the clear allocation of responsibilities to specified officers.

The Department agrees with this recommendation, referring to its response to recommendation 22. It also states that, in relation to the preceding discussion, the Department was in the process of aligning its practices to the new C&CS legislation during my office's investigation and it regards the debates within the Department at that time as being of a healthy and productive nature. The Department further advises that now that this legislation has been implemented, the Department is progressing the resolution of the issues outlined in this section of the report.



## Chapter 15 *Public Sector Management Act 1994* Disciplinary Process

### 15.1 The existing process

The Department of the Premier and Cabinet's guidelines on how to implement the PSM Act disciplinary process is outlined briefly below:

- *Establish whether there is a suspected breach of discipline.*  
There is no legislative instruction on how this suspicion is to be formed. Significantly, however, case law (and policy) require that if more knowledge is sought out than is required to form a suspicion, the investigative process is pre-empted and risks corrupting the eventual findings and actions.
- *Employee to be notified of suspected breach.*  
The employee is to be given an opportunity to respond to the suspicion.
- *If not satisfied by the explanation, an investigation may commence.*  
The investigation cannot commence until the employee has received written notification of the investigation.
- *The investigation is conducted, a report completed.*  
The primary purpose of the report is to report the facts.
- *Findings and actions determined by the employing authority.*  
Minor breach  
If a minor breach, the respondent is notified, proposed action advised and an opportunity given to the employee to object to the finding and comment on the proposed action. The proposed action may be reconsidered but if there is an objection to the finding the matter goes to inquiry (see below). If action is taken, the employee must be notified of their opportunity to object to the action. If the employee objects the issues are re-examined in a disciplinary inquiry.  
Serious Breach  
If the employing agency determines there is a serious breach the employee is to be charged with a serious breach of discipline.
- *The employee is charged with an alleged breach of discipline and admits the charge.*  
The employing authority writes to the employee stating a breach has been found and of the action to be taken. It is recommended that the authority gives the employee opportunity to comment on the action.
- *The employee is charged and a disciplinary inquiry is held.*  
The employee must first be notified in writing. The inquiry process 'is to be conducted, and to be seen to be conducted, as an entirely new and separate process from the preceding investigation'. At this time an employee may be suspended without pay.
- *A breach of discipline is found.*  
The employee is advised in writing of the finding and actions. It is recommended that the employee be given an opportunity to comment. The outcomes are limited to dismissing, reprimanding, transferring, fining, reducing the monetary remuneration, and/or the classification of the employee.

A significant issue, for the purposes of this investigation, is that a public sector employer not undertake any preliminary investigation of a potential breach of discipline beyond that required to

establish whether there is a reasonable suspicion of such a breach.<sup>330</sup> As indicated, relevant Department of the Premier and Cabinet guidelines caution that there is no legislative instruction on how this suspicion is to be formed. Significantly, however, case law (and policy) require that if more knowledge is sought out than is required to form a suspicion, the investigative process is pre-empted and risks compromising the eventual findings and actions.

There are particular risks inherent to the Department investigating its residential care workers in relation to a CMA when there is a possibility that the same alleged conduct may warrant disciplinary action. Although the Department pursues CMA investigations on a separate legislative basis (previously the CW Act and now the C&CS Act) it is also the case that the Department is the employer of its residential care workers and that such investigations appear to be rarely conducted in work contexts other than of its own employees (although not-for-profit residential care appears to be an exception to this). There is a particular risk in this context that the CMA investigation and outcome, whether run preliminary to or concurrently with the PSM Act disciplinary process, may be seen as pre-empting or '*corrupting*' the latter.

The Department advises that, in dealing with an allegation of child maltreatment concerning residential care staff, it initiates a CMA ('*Child Wellbeing Concern*') investigation. This commences with an assessment of the safety of the child but also whether there is '*reasonable suspicion*' against the employee regarding the allegation. If there is reasonable suspicion that there has been a breach of discipline, the disciplinary process under the PSM Act is initiated and the matter will also be referred to the Corruption and Crime Commission if it relates to misconduct.<sup>331</sup> Provided the referral to the disciplinary process is made as soon as there is a '*reasonable suspicion*', this would appear to meet the requirements as outlined in the Premier and Cabinet guidelines. The issue remains, however, of the implications of pursuing issues as part of a CMA investigation process once the matter has been identified as falling within the parameters of the disciplinary process.

## 15.2 Outcome reports

Under the Human Resources disciplinary process, employees have been able to make '*an informal*' request for personal information about themselves in the CMA Investigation Outcome Report. To access the full report they can make application under the *Freedom of Information Act*.<sup>332</sup> Supervisors do have access to the CMA Outcome Report but do not have access to the public sector disciplinary outcome report,<sup>333</sup> and it is also unclear how much information would be provided to those making a complaint in these circumstances.

If after a disciplinary process the allegation is unsubstantiated, the Department advises that the records are only filed on a confidential Disciplinary Register/File that is held in Human Resources.<sup>334</sup> No information about the discipline process is placed on the employee's personal file.<sup>335</sup> The Department advises, however, that:

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<sup>330</sup> See *Cull v Commissioner State Revenue Department* (PSAB 3 of 2001) WA Industrial Relations Commission, 4 February 2004.

<sup>331</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 25).

<sup>332</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 25).

<sup>333</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 25).

<sup>334</sup> DCD, correspondence with this office, 2 September 2005 (Response to questions 21, 24, 26).

<sup>335</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 21).

‘in a situation where although an allegation is not substantiated but there is a pattern of behaviour that may result in issues in relation to the Department’s duty of care responsibilities, other processes would be initiated by the Department to ensure that this was addressed.’<sup>336</sup>

The Department advises that it will, in future, also be checking the Disciplinary Register/File for all staff being employed or reemployed by the Department.<sup>337</sup>

### 15.3 The *Public Sector Management Act 1994* and child abuse allegations

In response to a question from my officers, the Department advised:

‘The Child Maltreatment Allegation (CMA) process and the Human Resources disciplinary process are independent processes.’<sup>338</sup>

However, as discussed in Chapter 14, in practice, Human Resources disciplinary processes significantly impact on how the child protection investigative process is implemented in the Department’s residential care facilities. Investigators appear conscious of the potential for child protection processes to compromise the employment-based processes contained within the PSM Act and relevant case law, and the Department acknowledges the risks, stating that the child protection investigation could result in its inability to take disciplinary action against an employee or result in a successful appeal against it if the disciplinary investigation had been compromised.

The Department advises that its policies in this area are currently subject to review. From discussions with Departmental staff, it appears that one option is for child protection investigative processes not to be utilised in its residential care facilities, and instead reliance to be placed purely on PSM Act disciplinary processes. Some of the considerations prompting this proposal were apparent from a disciplinary inquiry regarding breach of discipline charges against a residential care worker, and these are outlined below.

That inquiry concerned allegations that the worker had, on a number of occasions and against a number of young people in care, sworn at them, engaged in name calling, criticised young people’s family members, inappropriately restrained a young person and hit him with a piece of wood. Based on finding the allegations of the use of general expletives towards and in the vicinity of young people to be founded, recommendations arising from the inquiry included that the employee be reprimanded, transferred from the hostel and undertake training. The recommendation that the employee undertake training was noted as not falling within any of the specific provisions under the PSM Act for a disciplinary breach.

In that inquiry one of the young people who originally made allegations refused to participate on the basis that *‘sufficient information has already been given to others’*. The other young people were interviewed for the disciplinary process more than eight months after the allegations were made and generally for the third time: once for the CMA investigation, once for the PSM Act investigation and once for the PSM Act inquiry. The inquirers believed that the initial CMA process had unduly delayed the PSM Act disciplinary processes and could inhibit young people’s participation in the latter as well as hinder their recall of specific incidents and increase the opportunity for collusion.

The inquirers also stated that:

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<sup>336</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 26).

<sup>337</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 26).

<sup>338</sup> DCD, correspondence with this office, 2 September 2005 (Response to question 21).

'In addition to reducing the number of interviews, a further advantage [of not dealing with complaints about the management of children by hostel staff as CMAs] is that a more appropriate context for investigation is provided than a child abuse one. The use of inappropriate or ineffective management techniques need not constitute child abuse but will require an intervention. The child abuse investigative process is focussed on the presence or not of abuse requiring specific recording of this and responsibilities within the District Office undertaking the investigation and not the management of the staff concerned.'

These concerns appear valid. However, the above inquiry itself highlights some of the limits of reliance upon the PSM Act disciplinary processes in the context of child protection issues:

- A number of the allegations were assessed as '*Not proven*' because young people's recollection of the specific words they alleged were used against them varied over time. This resulted in the evidence being regarded as '*inconclusive*'.
- Other alleged comments the subject of investigation, such as those relating to relatives not wanting the young people, were held to be '*Not Proven*' because they were assessed as not intended maliciously and the inquirers accepted that the '*comments would have referenced their mother's non-acceptance in an attempted rationale for the inappropriateness of their behaviour at the time*'. The inquirers also commented, however, that children may misinterpret such remarks.
- It also appears that if a direction to undertake training had been made to the employee as recommended by the inquirers, even if this had been the most appropriate means of managing the conduct, this could be subject to legal challenge.

The NSW Ombudsman highlights the significant limitations on dealing with allegations involving child abuse through standard public sector disciplinary processes, and the Department agrees that there appear to be similar restrictions on the options available in relation to PSM Act disciplinary proceedings in WA. Limitations include:

- that an employee can be transferred from the facility pending the outcome of an investigation and ensuing disciplinary proceedings, but a disciplinary charge must be proven against the employee before any other action can be taken;
- a high standard of proof is required to establish a disciplinary charge;
- the standard of proof is not diminished by reference to relevant agencies' general duty of care towards children or concepts of risk assessment and risk management; and
- even if a disciplinary charge is found proven, agencies may be limited to imposing one or more of the penalties stipulated by the disciplinary system.<sup>339</sup>

A NSW matter, *Ward v Director General of School Education*,<sup>340</sup> the subject of comment by the NSW Ombudsman,<sup>341</sup> involved a disciplinary charge against a teacher concerning alleged inappropriate sexual conduct towards students. This case highlights some of the problems in dealing with child abuse allegations within existing disciplinary processes. In that case, the charge was not upheld, but nonetheless a warning letter was sent together with advice that additional monitoring of the teacher's conduct would take place. The NSW Supreme Court concluded that the applicable legislation '*set out how breaches of discipline are to be dealt with. This they do exhaustively ... leaving no room for such a breach to be dealt with in any other way.*'<sup>342</sup> The Court also observed that:

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<sup>339</sup> NSW Ombudsman, *Handling Child Abuse Allegations Against Employees*, NSW Government Publication, Sydney NSW, 2000, p. 47.

<sup>340</sup> (1998) 80 IR 175.

<sup>341</sup> NSW Ombudsman, *Handling Child Abuse Allegations Against Employees*, pp. 45-47.

<sup>342</sup> NSW Ombudsman, *Handling Child Abuse Allegations Against Employees*, p. 46.

‘Whilst it is appreciated that the department has a most serious duty to protect the children entrusted to its care ... it does not ... have the authority to set up a disciplinary procedure different to the procedure mandated under the Act’.<sup>343</sup>

The Court found that the departmental letter was ‘*invalid*’ on two grounds. It was indistinguishable from the penalties in the legislation for a reprimand, and so could not be applied because the charge was not sustained. The other ground was that because the direction was not given to teachers generally, but only to one teacher, this meant he was ‘*targeted for special directions applicable only to him on account of unsubstantiated allegations*’. In the Court’s view this was not reasonable and therefore not lawful.<sup>344</sup>

Existing disciplinary processes, according to the NSW Ombudsman, can lead to reduced capacity to manage risk, a restricted capacity to respond to individual employees’ management needs appropriately, and a protracted process which impacts adversely upon both employees and those making the allegations. The NSW Ombudsman recommended that key stakeholders and relevant experts be consulted to develop an appropriate legislative, policy and administrative framework to allow for timely and effective management responses to allegations against staff in the area of child protection. A whole of government response by departments with child protection responsibilities to develop a comprehensive and consistent public sector response to allegations of child abuse against staff was also recommended.

The PSM Act disciplinary processes, which essentially deal with issues between an employer and an employee, is in my view not best suited to accommodate the interests of third parties adversely affected by the conduct involving breach of discipline, particularly in light of the confidential nature of these investigations and outcomes. Moreover, at present there is no scrutiny of these processes in terms of staff expertise and methods to accommodate the particular needs of child witnesses nor is it clear that there is capacity under such processes for consideration to be given to broader systemic issues which may be essential to address child maltreatment as discussed previously. I note that the Department agrees that the PSM Act does not take into account the nature of its business in terms of safety issues for children. These issues are addressed further at 16.2 and 16.4 below.

## 15.4 Conclusions

As indicated, the Department is currently considering whether to retain the dual investigative processes currently applicable to its residential care settings. The capacity for the Department to make its disciplinary processes suitable for addressing child maltreatment concerns may depend upon the implementation of recommendations referred to below at 16.2 and 16.4. These would provide for the independent scrutiny of systems for handling child abuse allegations involving employees of designated government and non-government agencies and, specifically in relation to the issues raised above, the review of the PSM Act to allow for timely and effective management responses to allegations against staff in the area of child protection.

If the Department should decide to retain both the disciplinary and child protection investigative processes, it should ensure that guidelines are available to investigators of allegations of child maltreatment against Departmental staff so that their conduct of the investigation does not compromise the opportunity for the Department to pursue disciplinary action if required.

I recommend that:

24. If the Department is to continue to apply child protection investigative processes within its residential care facilities, it should provide guidelines to investigators of

<sup>343</sup> NSW Ombudsman, *Handling Child Abuse Allegations Against Employees*, p. 46.

<sup>344</sup> NSW Ombudsman, *Handling Child Abuse Allegations Against Employees*, pp. 46-47.

allegations against Departmental staff so that their conduct of the investigation does not compromise the opportunity for the Department to pursue *Public Sector Management Act 1994* disciplinary action if required.

The Department agrees with this recommendation and refers to its response to recommendation 23.

## Volume 2 - Whole of Government Issues

### Chapter 16 Other Issues Arising

This chapter covers a number of disparate issues which arose in the course of this investigation. Unlike the issues raised in Volume 1 of the report, the matters discussed here go beyond the jurisdiction of the Department for Community Development. These matters are put forward here because they raise whole-of-government issues.

#### 16.1 The future of Departmental residential care

Since the conclusion of the investigative phase of this inquiry in early 2006, the Department has initiated major changes to the operations of its residential care. However, during the course of my inquiry, Departmental staff expressed grave concerns about what had been occurring:

‘The general public have no idea what is happening at [the Department’s] hostels. The use of restraints at [one facility] is extremely high; the level of smashed property is also; there are young people giving head jobs on the streets for smokes. One young girl... who was put into prostitution ... would tease staff about getting more an hour than they earned... The only chance you have is to make the hostel inviting - there is nothing else you could do to keep the young people there.’

Residential Care Manager

When the Department undertook its study of residential care in 2001, it noted that there were an increasing number of children entering care because of maltreatment or parental neglect who had suffered significant harm by the time they came into care. It stated that across Australia, the needs of young people in care were more complex than a decade ago and that while most could be assisted by foster care, there was a small group whose behaviours were extremely disruptive and harmful due to these complex needs. The Department estimated at that time that this appeared to relate to between 15 and 20 of the young people in care at any one time,<sup>345</sup> and stated:

‘A small number of Department-run hostels will always be needed to provide support for this small group of children and young people who do not respond to offers of help or whose behaviour is so extreme that they are unable to be accommodated by other services.’<sup>346</sup>

A Senior Manager of the Department stated at interview:

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<sup>345</sup> DCD, *Hostels Report*, p. 10.

<sup>346</sup> DCD, *Hostels Report*, p. 12.

'... the dilemma for us is that there will always be a group of kids [like that] and we have defended those 35 placements vigorously because in other states they've contracted them out and whatever, but we've defended the 35 or 36 [places] whatever it is, because at the end of the day for some really difficult kids we have to be able to say to the citizens of Western Australia, and occasionally to the Courts, or the Children's Court that we have a place we can put this child. So we have done that.'

Senior Manager

In spite of more recent research indicating an intensification of the issues identified by the Department as causing young people to be in its residential care, a draft report in 2005, *Care Responses for the Future* (which has not been endorsed by the Department), noted that the Department's residential care service:

'is overcrowded, has a high risk mix of children, and is continually being moved away from its stated functions and program objectives because of the unplanned crisis nature of admissions. The State's most behaviourally and emotionally disturbed children reside in Placement Services. The problems of contagion of behaviour, a high risk mix of residents with histories of juvenile offending, substance abuse, mental health concerns and histories of sexual abuse and/or sexually abusing other children, overwhelmed workers and a lack of program rigour, all combine to create a less than satisfactory response to children who require intensive support.'<sup>347</sup>

Long-term trends in child protection and the conventional position in WA that the '*care of children should be left in the hands of ordinary citizens and religious bodies*' have seen a decline in the number of children in the direct care of the Department since 1982. My office is aware that there had been proposals to further limit the role of the Department in the provision of direct care to children and young people.

The Department's residential care service is a relatively expensive one - the average cost per child in Placement Services in 2004/5 was between \$100,000 to \$200,000 p.a.<sup>348</sup> (This compares to an average of \$225,000 p.a. in the juvenile justice system.<sup>349</sup>) However, many of those who provided information for the purposes of this investigation, both ACSS and other Departmental staff, believed that given the complexity and variety of needs of young people in care, a broad range of placement options should be available.

For example, staff cited attachment disorders, prevalent amongst this group of children, as making one of the proposed substitute arrangements of intensive one-on-one placements problematic. There was also a risk that the more intensive relationship in these placements could tend towards isolation of the carers if not adequately supported; potentially leaving carers vulnerable to '*being stuck out in a home somewhere with no one to refer to, no one to talk to... you know people [burn] out very, very quickly*'.

Some regarded the opposition to institutions such as residential care facilities as based on generalisations about their nature, when in some instances these may actually be the best alternative for some young people:

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<sup>347</sup> Anderson, (Draft and Confidential) *Care Responses into the Future*, p. 43.

<sup>348</sup> Anderson, (Draft and Confidential) *Care Responses into the Future*, p. 14.

<sup>349</sup> Department of Justice (now Department of Corrective Services), *Annual Report 2004/05*, p. 154.



'I've made the case oftentimes for there being nothing wrong with institutionalisation ... as long as the institution has integrity, institutionalisation is not necessarily a dirty word, right? What it means is that a person grows up in a highly structured environment, they're adequately supervised, they have their needs met and as adults they come to internalise that institution, right? It's not a case of you know, that they're going to be drilled like cadets or you know, they sit there like psychiatric patients with drool, so institutionalisation is not a dirty word ...'

Residential Care Manager

Others highlighted the need for institutions, such as the Department's residential care facilities, as a last resort for some young people:

'I actually really defended that type of care [Departmental residential care] because you actually need a range of care options and I ... really didn't want to get rid of them 'cause one of the things we have is the non-government sector will say to us, "*We will take the difficult kids*"; but if you go and check on most of those kids that are in that [ACSS] system they've been rejected by the non-government system, so as the government we have to be able to respond, they can say they choose... "*You're out of here*" but we don't have a choice, we have to find an option for that child.'

Senior Manager

Should the Department continue to provide for the direct care of those children and young people it currently accommodates in the metropolitan area, it appears that there are a number of measures which could contribute to the effectiveness of this service, and these have been the subject of this report.

Recommendation 17 proposed that the Department, in consultation with its staff and young people, consider the option of managing children and young people in a '*time-out*' room as an alternative means of restraint and the Department has agreed to this recommendation. The broad issue identified in Chapter 4, however, of what should be done to manage high-risk behaviour by children and young people remains to be addressed.

A Senior Manager of the Department stated:

'.. it is one of the holy grails we are going to have to tackle and I have moved, and you do move as time goes on, but I honestly think seeing these kids and seeing, you know, some of the behaviours, that we are fast reaching the point where we need a secure detention option for a very small number of kids and you have legislation and strict rules around how kids get in there and how they're managed and the amount of time they spent there.'

I believe it would be timely for consideration to be given to whether it might be appropriate to implement a '*secure welfare*' option for such children and young people, or whether there are other and better alternatives available. I should be clear that by '*secure welfare*' I am referring to a form of detention, which is regulated by legislation, can only be authorised by the courts for strictly limited periods, and is for therapeutic, generally assessment, purposes. It must be clear that this form of detention is not to be used for punitive purposes. I recommend to the Government that:

25. A review be conducted of the adequacy of the existing powers available to Departmental officers for managing children and young people in care who engage in extremely high-risk behaviours affecting themselves and others. Such a review should include giving consideration to whether a '*secure welfare*' option is necessary, or whether there are other and better alternatives available.

The Department considered a preliminary recommendation on this issue and expressed in principle agreement, noting that '*secure welfare*' would broaden the options available to it to manage high-risk children and young people and also protect the safety of other children and young people in residential care units. The Department reiterates that there is no plan for it to cease providing residential care to children and young people stating that this forms part of a continuum of care responses to the needs of children and young people and it envisages that this service will continue for the foreseeable future.

## 16.2 Investigating employment-related allegations of child abuse

The Department's child protection investigations, previously conducted under section 10A of the CW Act, are generally limited to allegations of maltreatment of children if these allegations indicate abuse by parents or persons '*in loco parentis*'. The abuse may be direct, or indirect if there is an allegation that the child was being neglected, for example, because the parents had failed to deal appropriately with abuse of their children by others.

The Department does not act directly to investigate allegations of abuse of children involving people acting in their employment capacity. Rather, if notified, it would refer such complainants to the Police if criminal conduct was indicated or to the relevant employer to undertake internal disciplinary investigations. Such allegations are not recorded on the Department's databases and nor were any subsequent investigations subject to monitoring or other follow up by the Department. As discussed at 3.4, this position appears to be unaffected by the newly enacted C&CS Act.

I have outlined concerns arising from this investigation into the handling of allegations of child maltreatment within the framework of employment disciplinary processes. These concerns are reinforced by the issues which were raised by previous investigations into another public sector agency conducted by my office. Significantly, and in contrast to other jurisdictions such as New South Wales,<sup>350</sup> there is no external systemic monitoring or evaluation of these processes, even in relation to those government and non-government agencies that have substantial dealings with children.

Explaining this jurisdiction, the most recent NSW Ombudsman's Annual Report states:

'Part 3A was introduced into the Ombudsman Act 1974 in 1998, giving our office responsibility for making sure that certain agencies deal properly with allegations that their employees have behaved in ways that could be abusive to children.

Our work involves monitoring the way agencies handle these 'reportable' allegations – they may involve sexual offences, sexual misconduct, assault, ill-treatment, neglect and behaviour that causes psychological harm to children. We have a dedicated team that carries out this work.

There are over 7,000 government and nongovernment agencies that have to comply with this scheme. They vary in size, and range from schools and organisations running child care centres to substitute residential care providers and juvenile justice centres. The people who are covered by the scheme include paid employees, contractors and the thousands of volunteers who support the work of these agencies.

Under the scheme, the heads of the agencies are required to:

- notify us within 30 days of becoming aware of any allegations of this kind of behaviour involving their employees
- investigate those allegations
- take appropriate management action as a result of their investigations and, if necessary, notify the Commission for Children and Young People (CCYP).

We assess the notifications we receive and decide on the level of scrutiny and assistance that we will provide. This depends on the seriousness of the allegations and the experience and ability of the agency to handle the allegations and run the investigation. Some of the larger agencies, such as the Department of Education and Training, have a lot of experience and we tend to closely scrutinise only very serious matters. Other agencies may be handling this kind of matter for the first time. In these cases we may offer to give them detailed assistance to, for example, draw up

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<sup>350</sup> See *Ombudsman Act 1974* (NSW), Part 3A, and NSW Ombudsman, *Annual Report 2004-2005*, pp. 80-85.

an investigation plan and be in regular contact to monitor their progress and provide further guidance.

We review the report prepared by the agency after they have completed their investigation. This year in over 20% of matters we also closely monitored or investigated the matter. If we are not satisfied with the way the agency has handled a matter, we may ask them to take further action or provide more information.

Another important part of our work is making sure that agencies have systems in place to handle these kinds of matters. Clear policies and procedures are essential to ensure consistency and minimise the risk of things going wrong.

Agencies with good systems in place are better able to:

- be fair to employees who have been accused of behaving inappropriately
- manage the risk that such employees may pose
- manage the expectations of the children and other parties affected
- fulfil their other statutory and professional obligations.

We regularly use tools such as audits to look at the quality of the systems agencies have in place and suggest improvements.<sup>351</sup>

The value of a monitor of employee disciplinary processes where allegations of maltreatment are involved would be to ensure that such processes have the capacity to address the needs of children who may be subject to maltreatment and the Human Resource principles applicable to any investigation of employees. I recommend that:

26. Government establish a mechanism to provide for the monitoring and evaluation of relevant government and non-government agencies' employee disciplinary processes where allegations of child maltreatment are involved.

The Department agreed in principle with an earlier version of this recommendation, stating that it would support a dialogue in an across-government approach to enhance child protection. The Department further notes that it already has specifications and standards in place with each of its funded not-for-profit residential care agencies relating to incidents of child maltreatment.

### 16.3 An independent monitor

The Cant Report recommended that children in care have '*access to an independent third party*'.<sup>352</sup> This recommendation was based on the significance for young people in care of having access to an advocate if they were uncomfortable to approach their Case Manager or felt that their concerns were not being acted on. The Department recently established its Advocate for Children in Care as a result of this recommendation.

In my view, however, it is essential that any initiative resulting in restraining young people in locked rooms ('*time out*') or confining young people to detention in the form of '*secure welfare*' would need to be closely and independently monitored so that the broader community could have confidence that it was not being utilised inappropriately.

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<sup>351</sup> NSW Ombudsman, *Annual Report 2004-2005*, pp. 139-140.

<sup>352</sup> Cant Report, pp. vii, 39

'... if you had secure detention you know, and one of the other things we might want to do in that sort of... and I've been thinking a bit about this, if you had secure detention, you'd have to have a system where someone visits and talks to the kids so if we want to make some changes it might be seen to be a bit you know like locking kids in rooms and whatever, I'd really want to see a system whereby someone comes regularly and talks to the kids in that system about what is happening so we get some early warning from the children 'cause that's who we'll get it from as to what the practices are, and what is happening to them in that hostel, so I mean I appreciate the workers' position but there is also a young person in this situation as well.'

Senior Manager

The value of an independent third party's access to residential care facilities is not confined to the possible implementation of '*time out*' and '*secure welfare*' options. The vulnerability of children and young people, and particularly those in the Department's residential care facilities, can limit their ability or willingness to recognise and report maltreatment. My officers found that it was Departmental officers who often were able and willing to raise concerns about maltreatment for examination as part of this investigation. As such Departmental officers can play a crucial role in the prevention and detection of maltreatment in the Department's residential care facilities.

As discussed at 12.4.2 and 12.7.1, the lack of confidence in Departmental management expressed by Departmental staff during interviews with my officers, however, could inhibit them from divulging the same information to another Departmental officer. The value of an independent third party's access to residential care facilities for young people is demonstrated by the information my officers obtained during this investigation.

I believe that consideration should be given to addressing the need to independently monitor residential care facilities. Such monitoring could include attending the facilities, establishing relations with the children and young people in care as well as the Departmental officers who care for them.

The proposed Commissioner for Children and Young People may be considered an appropriate agency to conduct this level of independent scrutiny of residential care.

I recommend that:

27. Government give consideration to externally allocating the function of monitoring both Departmental and non-governmental residential care facilities.

The Department agreed in principle with an earlier version of this recommendation, although it also noted that it has already established a number of review mechanisms to ensure that children and young people in residential care are able to voice their concerns and action is taken to address their issues, including the Advocate for Children in Care, the Consumer Advocacy Service and the Executive Director Special Projects. The Department advises that both the Advocate for Children in Care and Executive Director regularly visit residential care facilities on an unscheduled and informal basis, so that they can meet and build relationships with children and young people. The Department also states that all critical incidents are now reviewed by the Duty of Care Unit, and where concerns are identified regardless of the initial classification, the Executive Director Special Projects, Executive Director and the Director General all review the actions to investigate and ensure the child's safety and well being is paramount. However, at this time the Executive Director's position is a temporary one.

With respect to the appropriate model to deliver an independent monitoring service, the Department considers that substantial work would be required to determine the most appropriate independent monitoring model for children in residential care and states that it is aware that some other Australian jurisdictions, such as Queensland and Victoria, are in the process of, or have recently reviewed, their model of independent monitoring of children in care.

## 16.4 Review of the *Public Sector Management Act 1994*

The NSW Ombudsman conducted an investigation of *Handling Child Abuse Allegations Against Employees* in 2000. According to the NSW Ombudsman, existing employment disciplinary processes can lead to reduced capacity to manage risk, a restricted capacity to respond to individual employees' management needs appropriately, and a protracted process which impacts adversely upon both employees and those making the allegations. The Ombudsman recommended that the department the subject of the investigation, Education and Training (DET), develop an appropriate legislative, policy and administrative framework to allow it to implement a timely and effective management response in this area.<sup>353</sup> He also recommended that departments with child protection responsibilities develop a comprehensive and consistent public sector response to allegations of child abuse against staff.<sup>354</sup>

The response by the NSW DET was to amend its regulations to provide that disciplinary procedures under the relevant Act<sup>355</sup> allowed for measures to be implemented even if the authority decided not to charge the employee with a breach of discipline. Regulation 14 of the *Teaching Service Regulations 2001* (NSW) provides for:

- a record to be kept of the alleged breach of discipline and the preliminary investigation;<sup>356</sup>
- the staff member to be advised that the kind of conduct was unacceptable and must not be engaged in; and
- the conduct of the staff member to be monitored.

Discussions with the NSW Ombudsman's office indicated that DET was the only Public Sector agency to date which had made amendments to its legislative disciplinary procedures. However as DET made the largest number of notifications of alleged abuse to that office (799 of 1,815 notifications in 2004/5)<sup>357</sup> this was regarded as a very significant improvement.

This and other investigations by my office into the handling of allegations of child maltreatment under Public Sector agencies' current disciplinary processes have raised concerns similar to those identified in NSW about the capacity of those processes to accommodate the needs of children who may be harmed as a result of an employee's breach of discipline or to take effective action to address the risks posed by an employee's conduct. However, the situation in WA may be more complicated than the industrial context of NSW because of the case law referred to previously. This has been incorporated into the Premier and Cabinet guidelines so that no further investigation is to be carried out once there was a reasonable suspicion that there had been a breach of discipline, at which time the disciplinary process must be adhered to.

Staff at the NSW Ombudsman's office indicated that they were unaware of any such restriction applying in that jurisdiction. It is of note that in its assessment of the investigations conducted by the equivalent department in NSW, the NSW Ombudsman stated that if that department was to continue to conduct separate child protection and disciplinary investigations, *'it is essential... that there is no unnecessary duplication of investigative steps and that each investigation would make*

<sup>353</sup> The disciplinary process for public school teachers in NSW is regulated under the *Teaching Service Act 1980* (NSW). The disciplinary process is similar to the *Public Sector Employment and Management Act 2002*(NSW) and the Western Australian PSM Act.

<sup>354</sup> NSW Ombudsman, *Handling Child Abuse Allegations Against Employees*, p. 13.

<sup>355</sup> *Teaching Service Act 1980* (NSW).

<sup>356</sup> That record is not to be kept on the personal record of the member of staff (reg. 14(3)).

<sup>357</sup> NSW Ombudsman, *Annual Report 2004-2005*, p. 143. The Department of Community Services were next with 352 notifications, but the majority of these concerned foster carers. Catholic systemic and independent schools made 126 notifications. Other than 97 police notifications, which are dealt with separately, all other Public Sector agencies made a total of 161 notifications (NSW Ombudsman, *Annual Report 2004-2005*, p. 143).

*relevant information available to the other.*<sup>358</sup> While there appears to be no definitive WA case law on the issue of the capacity of the Department's child protection investigations to compromise its employee disciplinary processes, it is the Department's present and not unreasonable view that these must be conducted separately.

As highlighted in the earlier discussion of the CMA and disciplinary processes, from a child protection perspective there are a number of benefits from the former process—not least the expertise of the staff involved in dealing with children and awareness of the impacts of abuse upon young people's behaviours. Moreover, it is not clear that there is capacity under such disciplinary processes for consideration to be given to broader systemic issues which may be essential to address child maltreatment as identified previously.

The PSM Act disciplinary processes, which essentially deal with issues between an employer and an employee, do not easily accommodate the interests of '*third parties*' adversely affected by the conduct involving breach of discipline, particularly in light of the confidential nature of these investigations and outcomes. I recommend that:

28. Government consider consulting with key stakeholders and relevant experts to develop an appropriate legislative, policy and administrative framework to allow for timely and effective management responses to allegations against staff in the area of child protection; and that departments with child protection responsibilities develop a comprehensive and consistent Public Sector response to allegations of child abuse against staff.

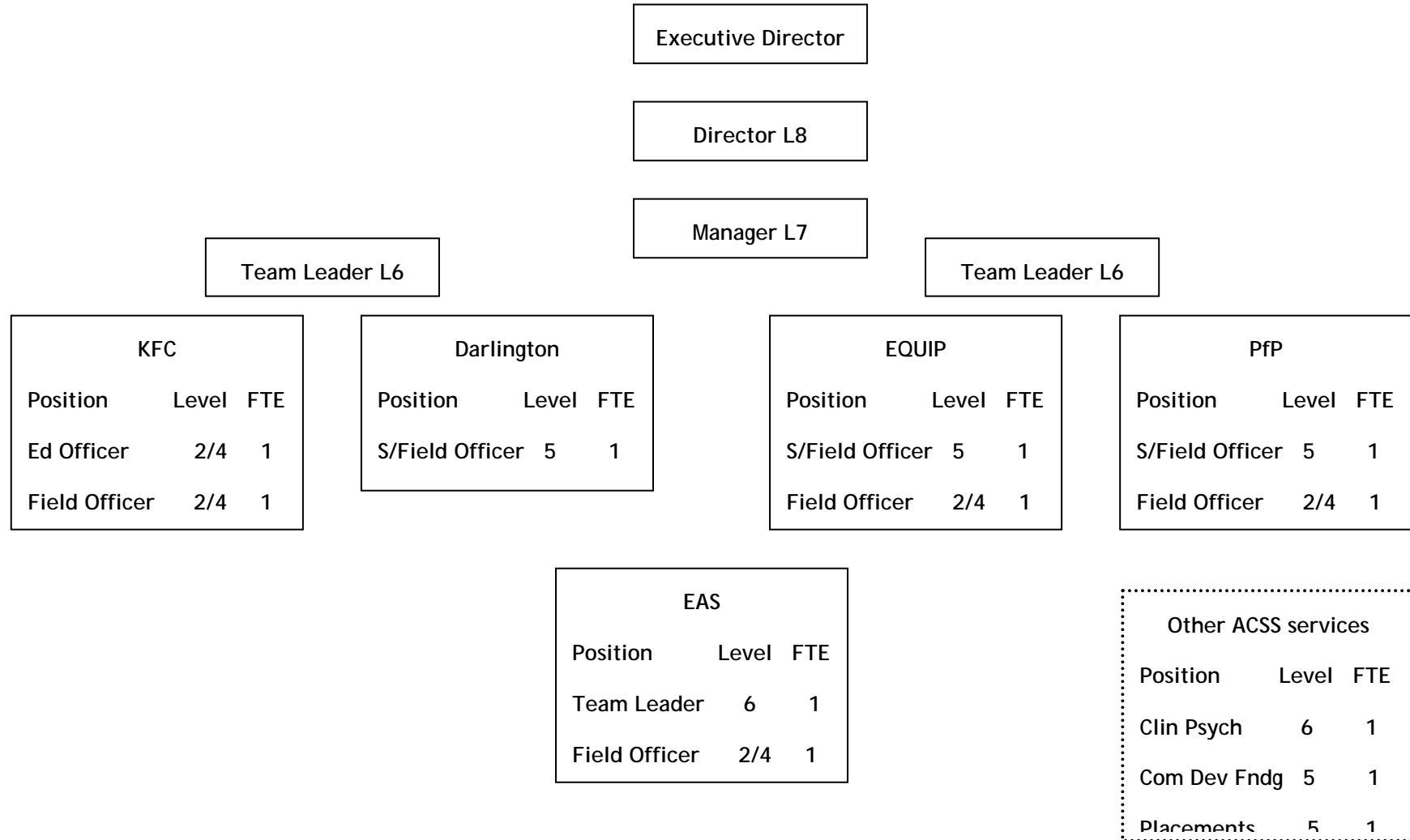
The Department agrees with this recommendation, stating that there are some issues with PSM Act requirements in relation to discipline processes and its ability to accommodate the interests of third parties in investigations. The Department further states that its ability to take into account the nature of its own work in imposing penalties on staff has also raised some concerns from recent investigations and states that it would be eager to participate in any forum that assists in resolving the limitations placed upon it by the current processes contained in the PSM Act.

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<sup>358</sup> NSW Ombudsman, *DOCS: Critical Issues - concerns arising from investigations into the Department of Community Services*, 2002, pp. 12-13.

## Attachments

Attachment 1. ACSS residential care facilities workforce structure





## Attachment 2. Investigation Methodology

Further to 1.4, specific details of the methodology employed for the purposes of this investigation are set out below.

I. Site visits of ACSS residential care facilities occurred during August and September 2005, with notices prepared by my office being circulated by the Department to all staff and residents, and to the relevant union. The ACSS facilities consisted of:

- Emergency Accommodation Service;
- Equip;
- Kath French Centre;
- Preparation for Placement; and
- Darlington House.

II. Staff interviews:

One interview in each of September 2004, October 2004 and May 2005 and the remaining 17 interviews took place between October 2005 and February 2006.

Two interviews were conducted with the informant. The remainder of the interviews were arranged on the basis of written invitation, with most individuals invited to attend the interviews being selected on the basis of their knowledge of specific incidents occurring in Departmental residential care, or the investigation of those incidents. Eight Direct Care Worker participants were invited to attend on the basis of a range of factors including length of service in hostels and employment level, and five accepted. Interviews ranged from two and a half to seven hours, and two interviews were with the one participant.

III. Informal meetings:

There were seven informal meetings, either as a result of interested parties approaching my office, or because of the technical expertise of staff (two meetings were with the one participant).

IV. Young people

A focus group of young people in residential care took place in November 2005. The Department arranged for the appropriate notifications and approvals for participants and it took place at one of the residential care facilities. The group was convened with the assistance of CREATE Foundation. A taped interview with an ex-resident of a Departmental hostel was also arranged with the assistance of CREATE.

V. Documentation

There was extensive documentation reviewed for the purposes of this investigation, including the policy materials referred to in 3.4 and a number of the reports referred to at 1.5. Case and related files for two young people, log books and a workplace relations file were also reviewed, in addition to a substantial number of internal Departmental investigation reports, e-mails, and correspondence.

VI. Preliminary view and comments

A report of my preliminary view was provided to the Department for its consideration on 22 May 2006 and the Department was asked to respond by 30 June 2006. On 26 June 2006, the Department provided a preliminary response to the recommendations and subsequently my officers attended a series of meetings with Departmental staff to formalise the Department's final response. This was provided on 7 August 2006. Relevant individuals were also provided with extracts from the report in May 2006 and made their comments available in writing and/or at meetings with my staff.

## Attachment 3. Darlington House Program: Chores

### 1. BEDROOMS:

Beds are to be made properly with sheets tucked in, quilts put onto the bed so no sheets are showing, pyjamas are to be folded neatly and placed under pillow.

Tables and dressers are to be free of clutter and bits and pieces (photos of family and special cards etc are accepted) draws are to be neat and tidy, no rubbish just tossed inside of them.

Clothes are to be properly put away in correct draws, school uniforms are to be on the single shelf in wardrobe with shoes placed in the bottom, only hanging clothes should be in wardrobe, some residents have been given permission to keep some clothes in their wardrobes.

Floors are to be clean and free from shoes and bits of paper etc, waste bins are to be emptied each morning, sliding doors are to be open except when raining, and light to be turned off.

Towels are to be hung neatly on towel rack behind bedroom door only, not on backs of chairs etc.

### 2. DAILY CHORES / ROUTINES:

Daily chores are listed on whiteboard in kitchen; these are changed each week on a Sunday night. The chores listed in Gold are the night time chores; the ones listed in black pen are the morning chores.

#### MORNING:

- Bathrooms: the bathrooms are allocated to 2 residents 1 per bathroom, these people are responsible to sweep and mop floors, clean basin, ensure there is toilet paper and soap and that toilet is clean, any excess soap etc to be removed from floors in showers, all walls are to be clean.
- Tables & Benches: this person is to wash and dry down all kitchen benches, dining room table, position chairs back in correct positions.
- Sweep Floors: this person is to sweep all tiled floor areas, ensuring under tables etc are free from dirt, also to make sure dirt is then picked up and thrown into bin.
- Breakfast clean-up: this person is responsible for putting away all condiments, bread, milk, cereal etc in their respective places after all residents have completed making their breakfast, they are to wipe down the bench only where the breakfast items were situated. Also to do a final check of kitchen and clean away any dishes etc left behind.

#### NIGHT:

- Washing up: this person is to wash up all meal dishes/pots and pans, then once drying up is finished they are to come back and wipe down sinks, taps and draining board.
- Drying up: this person is to get out everything required for making school lunches whilst waiting for the dishes to be washed, they are to make their lunch first then proceed onto drying up chores, which includes drying all dishes/pots and putting them away in their respective places, they are to ensure everything is clean and free from dirt.
- Tables & Benches: this person is to wash and dry down all kitchen benches, dining room table, position chairs back in correct positions, this person is also responsible for ensuring bins go out on Tuesday nights. This person is responsible for putting away all the items used for making lunches, and cleaning up area.

- Sweep Floors: this person is to sweep all tiled floor areas, ensuring under tables etc are free from dirt, also to make sure dirt is then picked up and thrown into bin, they are to also ensure rubbish/recycle bins are emptied into main bins and bin liner is replaced.
- Mop floors: this person is to mop all tiled floor areas, they are to ensure the floors are clean and free from dirt/stains.

#### **LAUNDRY:**

It is the responsibility of all residents to check the laundry daily for clean clothing and to remove them and put away neatly in their rooms. It is also their responsibility to ensure when putting dirty clothing in the basket to make sure all items are right side out, and that clothes aren't all bunched up and intermingled with other clothing, they are also to check pockets for used tissues and bits of rubbish etc.

Dirty clothes are to be put in laundry daily and not stored in bedrooms; pyjamas go into the laundry every Thursday and Sunday morning.

#### **SHOWERS:**

All residents are expected to shower twice daily ie: in morning and at night as directed by staff, residents are expected to wash their hair at least once per week and are to ask staff to supply shampoo and conditioner, they are not to walk to and from showers in bare feet or wearing just a towel.

#### **CHECKING UNIFORMS:**

All residents are to check their uniforms when they first come out of the bedroom area, things to look for are:

- collars are sitting flat
- clothes are clean and not wrinkled
- shoe laces are tied
- Proper school uniform is being worn ie: not mixing non-school items with school items.

#### **BRUSHING HAIR:**

All residents are expected to brush their hair daily after showering.

#### **BREAKFAST:**

Residents are to make their own breakfast in the mornings, all items will be on bench, if something is not there they are not to ask staff for it.

#### **DISHES:**

Residents are to clean up their own breakfast dishes ie: wash and dry them up and put them away.

#### **TABLE MATS:**

Following meals residents are to wipe down and put away their own place mat and coasters.

#### **BRUSHING TEETH:**

All residents are to brush their teeth following each meal; toothpaste is kept on shelf in bookcase. Tooth brushes are to be kept in top draw of their own desk in room.

### **SCHOOL ITEMS:**

Following chores and morning routines all residents are to put lunch box and communication book and homework into their respective bags.

### **AFTER SCHOOL ROUTINE:**

As soon as returning from school, residents are to put their school bag on the hook in the office hallway, take their lunchbox and communication book out. The communication book is given to staff and the lunchbox is taken to the kitchen and washed and dried and put on top of the fridge. Then residents are to change out of their school uniform and put in laundry basket, they will then proceed to have afternoon tea, following that they will clean up their own place mat and wash and dry their own dishes and put them away.

### **CLEAN UP TIME:**

When instructed by staff that it is time to come inside, residents will pick up all toys, put away all sporting gear, rake and cover the sandpit and ensure yard is clear before they proceed inside for showers and homework.

### **HOMEWORK PERIOD:**

During homework period residents are not to chat and waste time, it is expected that they will do any outstanding work from school then proceed onto Kumon, as homework period is limited residents are expected to get on with the task with minimal supervision.

### **MEAL TIME BEHAVIOURS:**

During meal times residents are expected to use good manners and keep idle, non constructive chatter to a minimum, general, sensible conversation is encouraged, residents are expected to excuse themselves from the table when they are finished and to go on to the next phase of their program ie: brush teeth, chores etc.

### **LUNCHES:**

Each resident is expected to prepare their own lunch after tea/chore each night, it is then to be placed in the fridge ready for the morning, residents decide how many sandwiches and what they would like on their sandwich, they also may have some morning tea and fruit. The last person to make their lunch is responsible for the putting away of all condiments/fillings etc and wiping down the bench where sandwiches were made.

### **BEDTIMES:**

All residents are expected to go to bed at 1930 hrs (7.30pm) each night, they are then able to have their lights on till 2030 hrs (8.30pm), this is provided they have not been given early bed.

### **QUIET IN BEDROOMS:**

All residents are asked to keep noise in their bedrooms to a minimum, this is to ensure that other residents are not disturbed and may go to sleep if they wish, also bedrooms are seen as a place for rest or the place where residents may go to relax if they wish to do so.

### **POSITIVE ATTITUDE:**

Modelling: This is where staff need to be aware of their own actions/language when working in proximity to young people, young persons will model their own behaviours on those of the adults around them, if the adults are swearing, arguing etc then young people see this behaviour and think it is acceptable to do this.

## Attachment 4. Equip Program Schedule

YOUNG PERSON \_\_\_\_\_ WEEK BEGINNING \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

WEEK...	Thurs - Fri			Fri - Sat			Sat - Sun			Target Behaviour Totals		
	N/S	AM	PM	N/S	AM	PM	N/S	AM	PM			
	2230 - 0700	0700 - 1530	1530 - 2230	2230 - 0700	0700 - 1530	1530 - 2230	2230 - 0700	0700 - 1900	1900 - 2230			
Wake up on time (25c)												
Attend day program (50c)												
Shower 1 x 10c day												
Follow Centre Rules												
THINKING ERRORS												
Self-centred												
Minimising / Mislabeling												
Assuming the worst												
Blaming others												
General problems												
Low self-Image												
Inconsid to Self												
Inconsid to Others												
Specific Problems												
Authority Problem												
Easily Angered												
Aggravates Others												
Mislead Others												
Easily Mislead												
Alcohol or drug Problem												
Stealing												
Lying												
Fronting												
O Time Sheet												
Anger Manage Skills ✓ or ✗												
Use of Social Skills ✓ or ✗												
Attend meeting (up to 50c)												
BED ON TIME (25c)												
STAY IN ROOM (30c)												
Sub Total												
Minus Fines												
TOTAL EARNING												

### Attachment 5. ACSS critical incident form

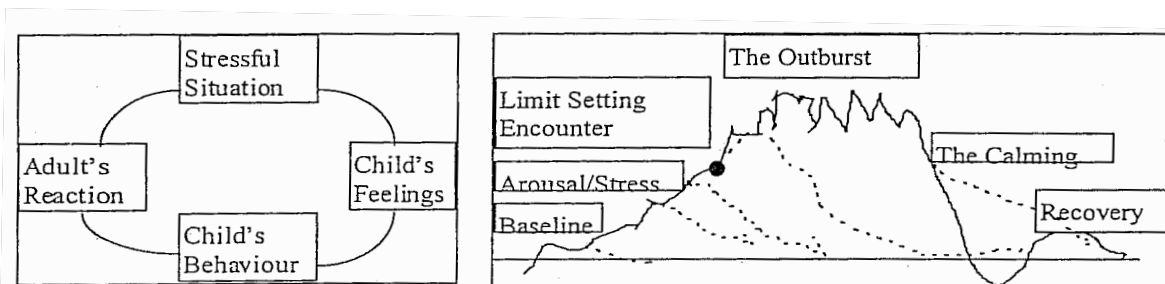
# ADOLESCENT AND CHILD SUPPORT SERVICES CRITICAL INCIDENT REPORT

Name(s) of young person(s) involved: \_\_\_\_\_

Name of staff involved: \_\_\_\_\_

Date/time of incident: \_\_\_\_\_ at: \_\_\_\_\_ am/pm

Place of incident: \_\_\_\_\_



Report completed by: \_\_\_\_\_

#### PLEASE PROVIDE A DESCRIPTION OF THE INCIDENT

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Can you identify any events (triggers) that may have contributed to the young person's arousal and stress prior to the incident? For example, recent events, school or family issues, conflict with another young person?

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What occurred during the outburst phase?

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What did the young person say and do during this phase?

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How did staff respond?

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Was this consistent with the young person's care plan?  Yes  No

If not, please specify:

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Were any physical interventions used? (please circle)

Restraint                      Removal                      Separation                      None

If yes, what technique (s) was used and how many staff were involved?

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Please describe what occurred during the calming phase. How long did it take for the young person to calm down?

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Please describe what occurred during the recovery phase. Was a sense of closure achieved between the young person and staff member e.g., a life space interview conducted?

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Did any injuries occur:

To the young person?  Yes  No

To the staff?  Yes  No

Please describe the injuries:



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If yes, please complete the accident/incident report attached.

Were the police called?  Yes  No

Name of the officer(s):

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Name of police station: \_\_\_\_\_

Police action / outcome:

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Have the staff concerned been able to defuse/talk over the incident with the Unit Team Leader?

Yes  No

Do staff feel this incident requires a formal debriefing?

Yes  No

Do any other concerns exist that require further consideration? If so, please describe:

For the young person(s)?

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For the staff?

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Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Team Leader: \_\_\_\_\_

Date: \_\_\_\_\_

COPY OF REPORT TO BE SENT TO:

- Team Leader
- ACSS Administration
- Young Person's Case Manager
- Young Person's Psychologist (if applicable)



## Attachment 6. Western Australian children in residential care: A Composite Profile

### 1. Introduction

A definitive profile of the young people in the care the Department for Community Development (in the CEO's care) living in Placement Services is a vexed issue. At any one time there are approximately 40 young people residing within Placement Services hostels and group homes. All of these young people have individual, varied and complex needs that are the result of numerous contributory factors. To date no research has been undertaken in Western Australia to examine the needs and issues facing these children. No local research is able to provide a characterological assessment of these children. This paucity of research is a consistent theme in the out of home care literature where there is a paucity of quality data derived from empirical research (Bromfield, Higgins, Osborn, Panozzo & Richardson, 2005; Cashmore & Ainsworth, 2004).

Consequently, most of the data that is available about this cohort is qualitative in nature and best used indicatively. However, for the purpose of this paper a characterological profile will be derived from Department for Community Development file notes, case experience, data bases and interviews with the young people. This information will be discussed thematically, along ecological lines that provide a holistic picture of these children's world view and experience.

Bronfenbrenner (1977) articulated an ecological systems theory that examines the interaction of various components in a person's life. For example, an individual's family of origin, school experience, psychological and physical health, substance abuse, recreational and sporting activities, community connectedness, friends, employment, socio economic status, housing etc impact upon the individual and their world view. It is from this perspective that the following information is provided.

### 2. Family of Origin

Many of the children entering Placement Services do so because there is no one else in their family that can, or is willing, to care for them. Some have severely abusive backgrounds (e.g. physical, psychological, sexual and neglect) that have led to the development of a range of behavioural and psychological problems making it difficult for them to settle in alternative placements (including relative care). The family of origin of many of these children may be characterised by some of the following:

- Drug and substance abuse,
- mental health issues,
- domestic violence,
- inappropriate parenting strategies,
- homelessness,
- violence,
- poor nutrition and health care,
- social isolation,
- lack of consistency,
- financial difficulties,
- unemployment,
- criminal activity
- parental physical health issues

- sudden death of a parent
- family conflict
- poor early development outcomes

The often chaotic nature of many such families leads the children to predict the unpredictable making it sometimes difficult for them to make the transition to alternative care. Consequently many of these young people have multiple placement breakdowns prior to entering a Placement Services facility. This further compounds their sense of low self worth and sense of rejection.

### 3. Psychological

Many of the young people in Placement Services can be diagnosed with reactive attachment disorder. Reactive attachment disorder (RAD), as defined by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, requires factors, such as gross deprivation of care or successive multiple caregivers, for diagnosis (eMedicine - Child Abuse and Neglect: Reactive Attachment Disorder, 2006).

According to eMedicine, in *"inhibited RAD, the child does not initiate and respond to social interactions in a developmentally appropriate manner. It is a disorder of nonattachment and is related to the loss of the primary attachment figure and the lack of opportunity for the infant to establish a new attachment with a primary caregiver. Also, a nonattachment disorder may develop because the baby never had the opportunity to develop at least one attachment with a reliable caregiver who was continuously present in the baby's life"* (eMedicine - Child Abuse and Neglect: Reactive Attachment Disorder, 2006).

eMedicine note that in *"dis-inhibited Reactive Attachment Disorder, the child participates in diffuse attachments, indiscriminate sociability, and excessive familiarity with strangers. The child has repeatedly lost attachment figures or has had multiple caregivers and has never had the chance to develop a continuous and consistent attachment to at least one caregiver. Disruption of one attachment relationship after another causes the infant to renounce attachments. The usual anxiety and concern with strangers is not present, and the infant or child superficially accepts anyone as a caregiver (as though people were interchangeable) and acts as if the relationship had been intimate and life-long"* (eMedicine - Child Abuse and Neglect: Reactive Attachment Disorder, 2006).

Many of the children in care also have other psychological issues related to their upbringing and their subsequent journey through life. Just some of these include: depression and suicidal ideation, anxiety, obsessive compulsive disorder, low self esteem, sexual acting out, behavioural problems, poor impulse and aggression control, poor social skills, poor boundaries, risk behaviour (e.g. unsafe sexual activity), sleep disorder, enuresis, encopresis, eating disorders, fire lighting, cruelty to animals, etc. Please note that this is not an exhaustive list of the psychological issues presenting in some of these children. Nor are they mutually exclusive as many of the young people in care have a range of psychological sequelae.

The very nature of attachment disorder and other psychological presentations mean that for some children Placement Services may be a preferred option as the children do not feel threatened by having to make attachments with one or two people but instead have the opportunity to have superficial relationship with numerous workers.

### 4. Physical Health

A number of children in Placement Service' s care present with a wide range of physical health issues, including Attention Deficit Hyperactivity Disorder and Attention Deficit Disorder. Others present with communicable diseases (e.g. skin conditions) including Sexually Transmitted Diseases (STIs). Some children have eating disorders including anorexia and obesity.

Others due to the nature of neglect can come into the care of the CEO and be placed in Placement Services with the effects of foetal alcohol syndrome and failure to thrive. Many have little or no connection to with local health agencies and as such have not received appropriate medical and dental services. For example, they have not have optometry testing and may have poor eyesight and hearing.

For many of the children in Placement Services a visit to the local GP is often the first opportunity to diagnose a range of medical conditions that were previously undiagnosed (e.g. allergies).

## 5. Educational/Training

A high number of children in the care of Placement Services do not currently access mainstream education systems. They often present with challenging behaviours that are unacceptable or unmanageable within normal classroom settings.

They have often been excluded from the normal education environment and either have no formal education or training programs available to them (because of their behavioural or psychological issues). Other children many have to travel lengthy distances to attend specialised programs.

Lack of educational opportunities means that many of the children enter care behind their peers educationally and due to embarrassment, lack of self respect and self esteem, may either refuse to participate in an educational program or become disruptive to the point of succeeding in being excluded from the system rather than be identified as requiring "educational special needs" .

## 6. Community Connectedness

A significant number of children in Placement Services care are socially isolated and are unable to form acceptable and sustainable community attachments. Multiple placement breakdowns often lead to the children having little community continuity and difficulty in sustaining long-term friendships. Some young people may withdraw from social and community contact due to their perception that their placement is short term and subsequently not worth spending effort on making social connections. This in turn further exacerbates their social isolation.

Due to issues pertaining to their upbringing and subsequent life experience, some lack anger management, formalised social skills and interpersonal skills.

Their attachment issues mean that they sometimes form inappropriate relationships that often endanger themselves and others in the community.

Data has demonstrated that these children may relate on a superficial level to other children with similar backgrounds. Unfortunately this can also lead to them pursuing high-risk behaviours in an effort to be accepted as part of a clique or "gang". Consequently, they may challenge boundaries, social norms and authority and this can result in negative community perceptions.

## 7. Welfare Issues

As mentioned earlier in this document, a number of the children will engage in extremely high risk behaviours such as criminal activity, including stealing motor vehicles, illicit substance abuse and assaults on public officers. They demonstrate little fear or understanding of the risks involved in their behaviour.

Some of these young people may run away from safe facilities and place themselves at risk living on "the streets" or accepting the hospitality of adults with undesirable expectations. A number of the children are not only victims of abuse but are demonstrating behaviours that further place them at potential risk. These young people may be placed together in group facilities thus increasing the level of need and reducing the level of individualised care offered. This creates a very challenging environment for the children to function within and the staff to manage.

Some children may have exhibited high degrees of self harm or suicidal ideation and a number misuse prescribed medication. They often seek like peers with similar backgrounds to feel a degree of acceptance.

Generally the young people find it difficult to articulate the levels of trauma they have suffered in the past—even in individualised counselling. Such therapy can take a long time for trust to be developed and for these issues to be explored in detail.

## 8. Employment

Very few children in Placement Services are able to gain meaningful stable employment due to the reasons delineated above.

For example, their inability to demonstrate a level of education required to undertake the positions. They are sometimes unable to meet the boundaries, expectations and commitment often associated with working for others. Their risk-taking behaviours and lack of self belief often lead to them being considered unreliable and passed over for employment opportunities.

Many suffer from very poor interpersonal skills and are not able to accept any form of criticism leading to conflict in the workplace and ultimate dismissal from employment.

## 9. Conclusion

While the composite profile provided above has been structured on an ecological systems basis it is by no means exhaustive. Other areas that could be explored include the nature of adult relationships, sexuality, parenting style etc.

This brief snapshot is not intended to be definitive, rather it is intended to provide for the reader an understanding of the nature of the children in Placement Service's care and the challenges facing them and the carers who care for them.

## References

Bromfield, L.M., Higgins, D.J., Osborn, A., Panozzo, S. & Richardson, N. (2005) *Out-of-Home Care in Australia: Messages from Research*. National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32, 513-530

Cashmore, J. & Ainsworth, F. (2004) *Audit of Australian Out-of-Home Care Research*. Association of Children's Welfare Agencies, Sydney.

eMedicine (2206) Child Abuse and Neglect: Reactive Attachment Disorder,  
<http://www.emedicine.com/ped/topic2646.htm>

## Attachment 7. Department for Community Development - Response to Recommendations

### Volume 1 Responses to Recommendations for the Department for Community Development

RECOMMENDATION	RESPONSE
<p>1. The Department develop an appropriate apology which takes into account the inconvenience and anxiety caused to the informant as a result of the inadequacy of the Department’s investigation of the original disclosure, as has been demonstrated by my investigation.</p>	<p>The Department agrees with this recommendation.</p>
<p>2. The Department monitor data on the characteristics of the specific cohort of young people who reside in ACSS facilities to assist it design and review its programs to try to ensure, as far as practicable, that there is a match between its programs and those young people’s needs.</p>	<p>The Department agrees with the recommendation. As far as is practicable there will be a range of treatment services offered to all young people in care matched to each child’s needs (e.g. social skills, mental health support etc). Specialised services for individual needs will be provided by specialists outside of the residential care system.</p> <p>An information system is being developed which will enable the better matching of children and young people with the programs available to meet their needs.</p>
<p>3. In conjunction with the Charter of Children’s Rights, the Department develop posters and other materials for distribution to its residential care facilities outlining the various avenues for children and young people to raise their concerns or complaints; and the Department ensure that this information is included in all induction materials and processes for residential care.</p>	<p>The Department agrees with the recommendation. The Department has developed posters, a CD and other material for distribution to children in its residential care facilities outlining avenues for children and young people to raise their concerns or complaints.</p> <p>A recent innovation of having a suggestion box in residential care facilities has been well received by young people and staff.</p> <p>The Department has included information to staff about the importance of children and young people being supported to raise their concerns and complaints during its Induction Program. This information is provided to children and young people when they are admitted into residential care.</p> <p>Young people in residential care are encouraged to raise any of their concerns with staff however if they feel that they would be compromised by doing so information about independent supports are provided (see below).</p> <p>Information about the avenues for complaints has been provided to young people (e.g. Consumer Advocate, CREATE, Case Manager) in residential care for the last two years. Recently this has been further strengthened by the provision of information about role of the Advocate for Children in Care.</p>

RECOMMENDATION	RESPONSE
<p>4. The Department, in consultation with Direct Care Workers and other residential care staff, should develop mechanisms to give young people and others confidence in the complaint handling system in ACSS, for example, by developing guidelines which adhere to the principle of procedural fairness and relevant legislative protections for staff but which allow for feedback to young people and others raising concerns or complaints about a staff member.</p>	<p>The Department agrees with the recommendation. The complaints mechanism is being reviewed by Placement Services. It will include a universal and transparent set of guidelines that will be used by both staff and young people. This project should be completed by February 2007.</p>
<p>5. The Department develop guidelines to assist in determining the appropriate placement of staff while the subject of child maltreatment and/or standard of care allegations and give consideration to the frequency of these incidents and impact on staffing requirements when calculating the workforce requirements for ACSS.</p>	<p>The Department agrees with the recommendation. Interim Guidelines for the removal of staff from Placement Services while a child maltreatment allegation against a staff member is being investigated were developed and implemented in November 2005.</p> <p>The guidelines provide for the following to occur:</p> <ul style="list-style-type: none"> <li>• Temporarily transfer the employee to their nearest District Office. The employee would be provided with alternate duties by the District Manager and would continue to receive the commuted allowance until such time as the investigation commenced under the Act and the Department was able to suspend the employee without pay.</li> <li>• Allow the person to use their accrued leave if they wish to do so.</li> </ul>
<p>6. The Department undertake a review of its ACSS Critical Incident Form so that it includes a section for the child or young person to complete about their version of events; or requiring a person not involved in the incident, such as a Team Leader, Case Manager or someone of the young person's choice, to speak with the child or young person about the incident and record their version of events.</p>	<p>Discussions are occurring with the Executive Director Special Projects and senior management to determine the feasibility of an employee remaining within Placement Services but not having any contact with children.</p> <p>The Department agrees with the recommendation.</p> <p>Since March 2006, the revision of the ACSS Critical Incident Form has been prioritised. This work is progressing and will include a section for the child or young person to complete their version of events.</p> <p>Where the child or young person does not have the literacy skills to complete the form or prefers to communicate their concerns in another way, measures have been put in place so that the child or young person can meet with a person they trust such as their case worker or the Advocate for Children in Care.</p> <p>Since January 2006, the Advocate for Children in Care has met with young people in residential care, and followed up with those who have wished to discuss critical incidents. She has supported these individual children and young people throughout resolution of the incidents in question. The</p>



RECOMMENDATION	RESPONSE
7. The Department institute a program to regularly review the ACSS Manual in consultation with Direct Care Workers and other residential care staff with a view to developing a practical and relevant guide for staff working in that environment.	<p>involvement of the Advocate for Children in Care when a critical incident occurs, also provides an independent review mechanism and ensures that prompt advocacy on behalf of the child occurs as a matter of priority.</p> <p>The Department agrees with the recommendation. Work has commenced on reviewing and streamlining the ACSS Manual in conjunction with team leaders, direct care workers (DCW) and other residential care staff to develop a practical and relevant guide for staff working in the residential care area.</p> <p>Placement Services is undergoing a change process, commenced in March 2006, and the manual will be updated over the next 12 months to ensure that new models of working are incorporated.</p>
8. The Department institute a program to regularly review the ACSS Manual to ensure that there is consistency in the articulation of applicable standards of care in all relevant Departmental documentation.	<p>The Department agrees with the recommendation. As per the response provided above for Recommendation 7, the ACSS Manual is currently being reviewed and streamlined. Once this work is completed a 12 month review cycle will be established and team leaders, DCWs and other residential care staff will be involved in the regular review process.</p>
9. The Department increase its efforts to ensure a gender balance amongst Direct Care Workers and generally seek to have a balance in the staff rostered on shift; and a gender mix on shifts be a requirement in those Departmental residential care facilities which accept male and female residents.	<p>The Department agrees with the recommendation and acknowledges the importance of endeavouring to achieve a gender balance of staff to work in residential care and on shifts.</p> <p>The Department has difficulty recruiting female staff to work as either DCWs or in other residential care positions.</p> <p>This is an Australia-wide problem and all jurisdictions have difficulty recruiting female workers to residential care. The Department is exploring innovative recruiting practices such as on the job training and professional development for targeted staff profiles including women, Aboriginal and youth.</p> <p>The Department tries to ensure a gender balance on all shifts, however when this is not possible priority is given to meeting the specific needs of individual children. For example, if a young woman is admitted to residential care with a history of been sexually abused, the Department endeavours to ensure that a female worker is rostered on each shift to provide support to her.</p>
10. The Department set up a system for recording all training provided to its Direct Care Workers and monitoring their training needs, and take steps to ensure that ACSS has capacity to release Direct Care Workers from roster to access ongoing training on the same basis as other Departmental staff.	<p>The Department agrees with the recommendation. Since 2004 the Department has deployed a computerised information system so that data on staff training needs and their attendance at training can be collected. The professional development data base will enable staff to work towards prior recognition of learning, on the job assessment and further study. In the last two months this data base has been reviewed and is currently scheduled for redevelopment in the next 2-3 months.</p>
	<p>A formal induction program has commenced for staff working</p>

RECOMMENDATION	RESPONSE
<p>11. The Department ensure that training on the management of children and young people suffering from mental health issues or intellectual disabilities, and good practice in the management and distribution of high-risk medications, be available for Direct Care Workers.</p>	<p>in the residential care system. Extensive work is underway to improve the skills of staff working in the residential care system.</p> <p>Additional resources provided in the 2006-2007 budget for training will be utilised to establish an integrated approach to training for ACSS staff built on the national competency based framework supported by learning pathways.</p> <p>A skilled workforce will be developed in Placement Services through four components:</p> <ul style="list-style-type: none"> <li>• Entry level training</li> <li>• Core skills development</li> <li>• Advanced skills development</li> <li>• Specialist skills training</li> </ul> <p>Measures have been put in place so that staff can be released from their normal duties to undertake training.</p>
<p>12. ACSS review its performance management program to ensure it is achieving desired outcomes and monitor its ongoing implementation.</p>	<p>The Department agrees with the recommendation. As part of an ongoing training and professional development calendar a range of competencies need to be achieved by Placement Services staff. These include mental health, advanced behavioural management, pharmacological awareness, developmental delay and challenging behaviour to name but a few. It is likely that given the need for this training to be ongoing that the calendar will be an 18-month cycle and involve work place assessment to ensure a high degree of competency.</p> <p>The Department agrees with the recommendation. The Department is currently undertaking a review of the outcomes achieved by Placement Services. Arising from this review will be a change management process that implements a new regime of treatment, assessment and intensive care and support. Further the development of a data base capable of tracking the care journeys of each young person and the services provide as part of their stay will enable a clear delineation of outcome at the individual, unit and system levels. The development of a new residential care system will take up to 18 months due to the complexity of the consultation, design, research and evaluation involved in the delivery of best practice systems.</p> <p>The Department is redeveloping its client information systems over the next 2-3 years through a project called Assist D. The implementation of the new system will modernise the collection of information to enable more comprehensive performance management.</p> <p>Underpinning the overall performance of Placement Services will be the review and strengthening of the Department's staff performance development and supervision processes. This review will ensure that the performance development process established within ACSS meets desired outcomes.</p>

RECOMMENDATION	RESPONSE
<p>13. In the interests of improving its records management processes, the Department review its policy on the retention of performance management records for its residential care staff to ensure that these are accessible to supervisors and that there is clear guidance to supervisors to ensure that these notes are retained in a consistent manner.</p>	<p>Processes will also be established to monitor the effectiveness of the new system. Performance development will also become a key module in the leadership and management programs which are to be developed for ACSS staff.</p> <p>The Department agrees with the recommendation. Pending the review of the performance management system amendments will be made to existing policies and guidelines to provide clear guidelines on the retention of performance records.</p>
<p>14. The Department clearly elaborate for its residential care staff at all levels the various obligations which attach to the Department and in particular its ACSS Team Leaders, who are neither advocates for young people in care nor representatives of hostel staff, but must take into account the interests of both sides.</p>	<p>The Department agrees with this recommendation. It comments that team leaders are part of Placement Services Management Team and while the role does involve supporting staff its primary function is ensuring that children in residential care receive appropriate standards of care. The role the team leader is clearly understood by staff in Placement Services and this has been the case for sometime.</p> <p>Any lack of clarity has also been addressed through the Placement Services Induction Program recently undertaken by new and experienced staff which reinforces the roles and responsibilities of all staff groups.</p>
<p>15. The Department extend its 24-hour on-call professional response team, on a trial basis, to assist its residential care facilities, incorporating not only professional assistance and support but also including a role in on-the-job training of residential care staff.</p>	<p>The Department agrees with the recommendation. Since the creation of the Executive Director Special Projects a number of initiatives have been undertaken by Placement Services. One such development includes the creation of a paid after hours response team which provides 24 hour professional assistance. Initially this will include team leaders, psychologists and will eventually include senior practice professionals. This team is currently operational and additions to team structure (e.g. psychologists) will be incorporated as they are recruited as a result of the Department's 2006-2007 budget.</p>
<p>16. Given the recent authorisation of DCWs under the C&amp;CS Act to apply restraints to children and young people, the Department undertake regular physical restraint training of all its DCWs to ensure that they are familiar with authorised techniques, restrictions relating to the use of physical restraints against abused young people, and contemporary notions of best practice in these matters.</p>	<p>The Department agrees with the recommendation. Contemporary policy development is also underway which aligns de-escalation techniques and restraint with the new Children and Community Services Act 2004 ensuring consistency with both legal and best practice requirements.</p> <p>The Department recognises the critical importance of training its staff in the administration of Therapeutic Crisis Intervention (TCI). Consequently, earlier this month (June) Placement Services trained 20 of its staff in the TCI program which has now superseded CCM Training.</p> <p>This training was undertaken by Dr Howard Bath from the Thomas Right Institute in Canberra which has close ties to Cornell University where the program was developed and</p>

RECOMMENDATION	RESPONSE
<p>17. The Department undertake research, incorporating the views of children and young people and residential care staff, on the use of brief periods of confinement in a 'time out' room as an alternative to physical restraint and to determine whether it has been successful in other jurisdictions.</p>	<p>evaluated. Dr Bath is regarded as a leading authority (both nationally and internationally) on de-escalation techniques including restraint. Dr Bath is in the process of confirming his next visit to undertake further TCI training of another 20 staff in September.</p> <p>Placement Services has also negotiated with Dr Bath to have four of its staff trained as trainers to deliver the program on an ongoing basis to all existing and new staff within residential care. Dr Bath will provide guidance to the trainers to ensure the integrity of TCI is not diminished and continues to be best practice.</p>
<p>18. The Department include information on how allegations, and the investigation of those allegations, are an integral part of working in residential care, what it means if an allegation is made for an employee, and an outline of the assessment and investigation processes in its induction training for residential care staff and on its intranet.</p>	<p>The Department agrees with the recommendation and will continue to commission and undertake research that incorporates the views of young people and residential care workers.</p> <p>The Department agrees with the recommendation. The recommendation has been implemented. In the most recent induction program conducted in June 2006, staff were comprehensively trained about their duty of care to children in residential care. The areas covered and explored through the training included the obligation of staff to report incidents of abuse in care, the legal and legislative mandate which drives practice in this area, the process for investigating allegations including the various roles and responsibilities of staff and the process should an allegation be made about them during the course of their employment with the Department.</p> <p>The Department's Code of Conduct and Code of Ethics is also included in the Induction to ensure that staff are aware of their responsibilities as an employee and public servant.</p> <p>It is envisaged that training on the above issues will be included during all future induction programs.</p> <p>The Human Resources Division has also developed guidelines for all staff of the Department that outlines the processes undertaken when an allegation is made against them. There are specific references in that guide for staff working in Placement Services. The guide is currently in draft form and once it is finalised, will be made available to all staff.</p>
<p>19. The Department undertake a review of its ACSS Critical Incident Report form so that the forms accommodate a sufficient variety of critical incidents affecting children and young people in care and appropriately reflect the Children &amp;</p>	<p>The Department agrees with the recommendation. Work is currently underway to revise the ACSS Critical Incident Form and the range of critical incident types will be broadened to capture the range of critical incidents which occur in residential care.</p>

RECOMMENDATION	RESPONSE
Community Services regulation requirements relating to the recording and reporting of any incident in which an officer 'restrains' a child.	
20. The Department maintain statistical data on the use of restraints in its residential care facilities; and consideration be given to the implementation of an independent review function which might, for example, be based on the Canadian model, involving an independent board consisting of community-based and professional members.	<p>The Department agrees with the recommendation. As described above in Recommendation 12, work is occurring to develop a new information system for recording data about children and young people in residential care. This will incorporate information about the use of restraints.</p> <p>Consideration is occurring about an independent review process being established which will involve the Advocate for Children in Care and CREATE.</p> <p>The Department had sought clarification about which "Canadian model" was referred to in this recommendation.</p>
21. The Department, after consultation with direct care staff, field staff, relevant managers and Human Resource experts, develop guidelines about the responsibilities of Residential Care Managers and Case Managers in assessing the conduct of residential care workers. Based on those responsibilities, the Department provide guidelines on what information is to be passed on to field staff by Residential Care Managers about the conduct of individual hostel workers.	<p>The Department agrees with the recommendation and is working towards developing enhanced guidelines for Residential Care Managers to assist them assess the conduct of residential care workers. As a part of the revised guidelines, information will be incorporated in the Field Workers Guidelines to make certain field staff understand their responsibility and the process involved if they have concerns about the conduct of a Direct Care Worker.</p>
22. The Department take steps as a priority to streamline and rationalise policies and procedures on the handling of child maltreatment allegations against Departmental staff and to ensure that its practice is consistent and is reflected in these documents.	<p>The Department agrees with the recommendation. The Department is currently reviewing and re-developing its Concern for a Child's Wellbeing Report (which supersedes the Child Maltreatment Allegation). This redevelopment will be consistent with the new legislation and the <i>Public Sector Management Act 1994</i> and provide clear guidelines and responses to staff and management. This policy will be developed, finalised and implemented by December 2006.</p>
23. If the Department is to continue to apply child protection investigative processes within its residential care facilities, it should review its policies and processes so that there are practical guidelines for investigators articulating how child protection investigations and outcomes are to be managed in a workplace, and the clear allocation of responsibilities to specified officers.	<p>The Department agrees with this recommendation. It is still uncertain whether the Corruption and Crime Commission and the Crown Solicitor have been consulted in relation to this recommendation.</p> <p>The Department agrees that there are some issues with the requirements under the <i>Public Sector Management Act 1994</i> in relation to discipline processes and its ability to accommodate the interests of third parties in investigations. The ability of the Department to take into account the nature of its own work in imposing penalties on staff has also raised some concerns from recent investigations.</p> <p>The Department would be eager to participate in any forum that assists in resolving the limitations placed upon it by the current processes contained in the <i>Public Sector Management</i></p>

RECOMMENDATION	RESPONSE
	<i>Act 1994.</i>
24. If the Department is to continue to apply child protection investigative processes within its residential care facilities, it should provide guidelines to investigators of allegations against Departmental staff so that their conduct of the investigation does not compromise the opportunity for the Department to pursue <i>Public Sector Management Act 1994</i> disciplinary action if required.	The Department agrees with the recommendation. Please see the response to Recommendation 22.

## Volume 2 Responses to Recommendations for the Whole of Government

RECOMMENDATION	RESPONSE
25. A review be conducted of the adequacy of the existing powers available to Departmental officers for managing children and young people in care who engage in extremely high-risk behaviours affecting themselves and others. Such a review should include giving consideration to whether a ' <i>secure welfare</i> ' option is necessary, or whether there are other and better alternatives available.	<p>The Department agreed in principal to an earlier version of this recommendation, starting that a 'Secure welfare' would broaden the options available to the Department to manage high-risk children and young people and also protect the safety of other children and young people in residential care units.</p> <p>The Department reiterates that there is no plan for the Department to cease providing residential care to children and young people. Residential care forms part of a continuum of care responses to the needs of children and young people and it is envisaged that this service will continue for the foreseeable future.</p>
26. Government establish a mechanism to provide for the monitoring and evaluation of relevant government and non-government agencies' employee disciplinary processes where allegations of child maltreatment are involved.	<p>The Department agreed in principle with an earlier version of this recommendation and would support a dialogue in an across government to enhance the protection of children.</p> <p>The Department already has specifications and standards in place with each of its funded not for profit residential care agencies which relates to incidents of child maltreatment.</p>
27. Government give consideration to externally allocating the function of monitoring both Departmental and non-governmental residential care facilities.	<p>The Department agreed in principle with an earlier version of this recommendation. The Department has already established a number of independent review mechanisms to ensure that children and young people in residential care are able to their voice concerns and action is taken to address their issues. Amongst these are the Advocate for Children in Care, the Consumer Advocacy Service and the Executive Director Special Projects.</p> <p>Both the Advocate for Children in Care and Executive Director regularly visit residential care facilities on an unscheduled and informal basis, so that they can meet and</p>

RECOMMENDATION	RESPONSE
<p>28. Government consult with key stakeholders and relevant experts to develop an appropriate legislative, policy and administrative framework to allow for timely and effective management responses to allegations against staff in the area of child protection; and that departments with child protection responsibilities develop a comprehensive and consistent Public Sector response to allegations of child abuse against staff.</p>	<p>build relationships with children and young people. These conversations with young people have highlighted areas for improvement in residential care which the Department is incorporating into its current change process.</p> <p>In addition all critical incidents are now independently reviewed by the Duty of Care Unit, and where concerns are identified regardless of the initial classification, the Executive Director Special Projects, Executive Director and the Director General all review the actions to investigate and ensure the child's safety and well being is paramount.</p> <p>The Department accepts that the Ombudsman does not wish to be prescriptive in recommending a particular model however views that considerable work would be required to determine the most appropriate independent monitoring model for children residential care. The Department is aware that some other Australian jurisdictions, such as Queensland and Victoria, are in the process of, or have recently reviewed their model of independent monitoring of children in care.</p> <p>With respect to the second part of the recommendation which deals with legislative protection for witnesses and informants the Department remains uncertain about this is envisaged as being different from the protection afforded through the Corruption and Crime Commission.</p> <p>The Department agrees with this recommendation but notes that it is uncertain whether the Corruption and Crime Commission and the Crown Solicitor have been consulted in relation to this recommendation.</p> <p>The Department agrees that there are some issues with the requirements under the <i>Public Sector Management Act 1994</i> in relation to discipline processes and its ability to accommodate the interests of third parties in investigations. The ability of the Department to take into account the nature of its own work in imposing penalties on staff has also raised some concerns from recent investigations.</p> <p>The Department would be eager to participate in any forum that assists in resolving the limitations placed upon it by the current processes contained in the <i>Public Sector Management Act 1994</i>.</p>