



**Commissioner for Children and Young People**  
Western Australia

# **Independent Review into the Department of Communities' policies and practices in the placement of children with harmful sexual behaviours in residential care settings**

September 2021

[ccyp.wa.gov.au](http://ccyp.wa.gov.au)

## **Recognising Aboriginal and Torres Strait Islander People**

The Commissioner for Children and Young People WA acknowledges the unique culture and heritage of our Aboriginal peoples and the contributions Aboriginal peoples have made and continue to make to Western Australian society. For the purposes of this publication, the term 'Aboriginal' is intended to encompass the diverse cultures and identities of the First Peoples of Western Australia and also recognises those of Torres Strait Islander descent who call Western Australia home.

### **Suggested citation**

Commissioner for Children and Young People WA 2021, *Independent Review into the Department of Communities' policies and practices in the placement of children with harmful sexual behaviours in residential care settings*, Commissioner for Children and Young People WA, Perth

### **Alternative formats**

On request, large print or alternative formats can be obtained from:

Commissioner for Children and Young People  
Level 1, Albert Facey House  
469 Wellington Street  
PERTH WA 6000

Telephone: (08) 6213 2297  
Freecall: 1800 072 444  
Email: [info@ccyp.wa.gov.au](mailto:info@ccyp.wa.gov.au)  
Web: [ccyp.wa.gov.au](http://ccyp.wa.gov.au)

## **Privacy**

The names of young people in this report have been changed to protect their identities.

The Review team studied all of the information provided by the Department of Communities from case and other records of two young people and observed information related to numerous other young people within these files.

A brief synopsis of the experiences of these young people has been included to provide context for the findings and recommendations of the Review. The information included in this report does not reflect the full extent of their experiences in out-of-home care.

## **Warning**

This report contains information some may find distressing or uncomfortable. If you experienced abuse as a child or young person at home or in care, it may be a difficult reading experience.

If you find the report's content distressing, please seek support. If you are not sure how or where to access support, contact the Commissioner's office for assistance.

## **Notation**

This report does not purport to make any findings against individual officers involved in the management of specific young people while they were in the care of the Department and the consideration of such matters were beyond the purview of the Commissioner in conducting the Review. The report could not be properly relied upon to ground any examination of the conduct of individual officers.

## Table of contents

Table of contents.....	4
Glossary.....	6
Message from the Commissioner.....	9
Purpose of the Review.....	11
Limitations of the Review.....	11
Historical context.....	12
The young people’s experiences.....	13
Executive summary.....	15
Findings.....	15
Recommendations.....	17
Department of Communities’ response.....	18
Actions the Commissioner will undertake.....	20
Methodology.....	21
Resourcing.....	21
Case file review.....	21
Direct input from relevant agencies, services providers and personnel.....	22
Consideration of other case practice examples.....	22
Review of relevant Department documentation.....	23
Conclusions.....	23
Background to the Review.....	24
Harmful sexual behaviours.....	24
Royal Commission into Institutional Responses to Child Sexual Abuse.....	25
Department of Communities and the role of the CEO.....	28
Children and young people in out-of-home care in WA.....	30
Residential care in WA.....	31
Findings.....	33
Finding 1.....	36
Finding 2.....	40
Finding 3.....	46
Finding 4.....	54
Finding 5.....	60
Finding 6.....	66

Recommendations .....	71
To the Minister for Child Protection.....	71
To the Department of Communities.....	72
Appendix A: Relevant Royal Commission recommendations .....	77
Appendix B: Relevant Better Care, Better Services Standards.....	86
Appendix C: Legislative background .....	91
Appendix D: Department of Communities' policies and documents.....	94

## Glossary

**Advocate for Children in Care:** A position within the Department of Communities whose role is to support children and young people in care to know their rights and to have a say in decisions that affect their lives and in the services provided for them.

**ASSIST:** The client database used by the Department of Communities.

**Care arrangement:** The organisational arrangement that provides out-of-home care for a child. An out-of-home care arrangement can include a family care or foster care arrangement, as well as residential-based care arrangements.

**Care team:** The group of identified people who hold a shared responsibility for the planning and implementation of strategies and services to support a child in their care arrangement.

**Charter of Rights for Children and Young People in Care:** The rights of children in out-of-home care in Western Australia.

**CEO:** The chief executive officer (Director General) of the Department of Communities.

**Child:** A person who is under 18 years of age, and in the absence of positive evidence as to age, means a person who is apparently under 18 years of age.

**ChildFIRST:** A joint unit serviced by staff from the Department of Communities and the Western Australian Police Child Abuse Squad. Responsible for assessing referrals of child abuse and conducting forensic interviews with children, young people and vulnerable adults.

**Community sector organisation (CSO):** A non-government organisation providing out-of-home care services.

**Community services sector:** The collection of non-government organisations that provide the community with services that meet a broad range of needs, including out-of-home care.

**Concerning behaviours:** The Commissioner for Children and Young People defines concerning behaviours as non-sexual behaviours engaged in by a young person with a history of harmful sexual behaviours, sexual abuse, violent behaviours and/or self-harm that should be reasonably expected to raise concern in members of a care team and/or the persons responsible for supervising the work of a care team member. Includes:

- behaviours that may place the safety of the child or another young person or adult at risk; and
- behaviours that cause another child or adult to express fears for their own safety.

**Cottage care:** Residential group homes funded by the Department of Communities and provided through community sector organisations.

**Department of Communities (the Department):** The Western Australian State Government department responsible under the *Children and Community Services Act 2004* for providing and funding a range of child safety and family support services to Western Australian individuals, children and their families. Includes contemporaneous references to the former Department of Community Development, Department for Child Protection (DCP) and Department for Child Protection and Family Support (CPFS).

**District Office (the District):** The local Department of Communities office responsible for the case management of a child in care.

**Family care:** An out-of-home care arrangement with a person(s) who is a 'relative' as defined in the *Children and Community Services Act 2004*. 'Family care' replaces the term 'relative care'.

**Foster care:** A non-family care arrangement where child(ren) are cared for in a place that is the carer's primary residence.

**Harmful sexual behaviours (HSB):** As outlined on page 24 of this Report, HSB is defined as any behaviour of a sexual nature expressed by children under 18 years of age that:

- is outside of what is culturally accepted as typical sexual development and expression; or
- is obsessive, coercive, aggressive, degrading, violent or causes harm to the child or others; or
- involves a substantial difference in age or developmental ability of participants.

**Inappropriate sexual behaviours:** Behaviour of a sexual nature expressed by children under 18 years old that is outside of what is considered developmentally appropriate or that occurs outside the appropriate context.

**Independent assessor:** A role appointed and remunerated by the Department of Communities to inspect residential care facilities.

**Independent oversight:** Oversight processes that are initiated, controlled, conducted and accountable independent of a government department.

**Independent Review (Review):** This report and the work undertaken to compile it.

**In the CEO's care:** A child is in the CEO's care if the child:

- a) is in provisional protection and care; or
- b) is the subject of a protection order (time-limited) or protection order (until 18); or
- c) is the subject of a negotiated placement agreement; or
- d) is provided with placement services under section 32(1)(a).

**Information Management System:** A general term used to describe a combination of database and record management systems. In the context of the Department of Communities, this includes ASSIST and Objective.

**Leaving care:** The planning processes that begin for a child in care when they reach 15 years of age to ensure they are prepared and supported when they leave the CEO's care at the age of 18.

**National Standards for Out-of-Home Care:** The national quality standards that all Australian states and territories are required to measure, monitor and report on for children in out-of-home care.

**Objective:** The Department of Communities' document management system.

**Out-of-home care (OOHC):** The provision of care arrangements outside the family home to children who are in need of protection and care, through the application of the *Children and Community Services Act 2004*.

**Oversight:** The systems, actions, processes and procedures that act to audit, monitor and regulate activities so that they are undertaken correctly and legally.

**Residential care:** In the context of this review, a residential group home operated by the Department of Communities where a child(ren) is cared for in a place that is not the carer's primary residence. Residential care homes typically operated on a rostered basis and care for children with complex and intense needs.<sup>1</sup>

**Royal Commission:** Royal Commission into Institutional Responses to Child Sexual Abuse 2013–2017.

**Residential Care Safety Plan (Safety Plan):** A Department of Communities' document that identifies possible risks posed by a child in residential care to themselves and others, and contains specific strategies to overcome these risks. Safety Plans must be developed when a child who poses a risk to others is placed with other children, and must include the child's views.

**Sexual assault:** A sexual offence as defined under Chapter XXXI of the *Criminal Code Act Compilation Act 1913 (WA)*. Includes offences such as:

- sexual offences against a child under 13
- sexual offences against a child of or over 13 and under 16
- indecent assault; and
- sexual penetration without consent.

**Standards Monitoring Unit (SMU):** A work unit within the Department of Communities that implements a standards monitoring and quality assurance process to monitor the Better Care Better Services Standards.

---

<sup>1</sup> Department of Communities 2020, *Casework Practice Manual*, Section 3.4.24 Residential care services comprise residential group homes, non-government family group homes and the Kath French Secure Care centre. Retrieved October 2020.



## Message from the Commissioner

The United Nations Convention on the Rights of the Child, ratified by Australia decades ago, outlines that a child who is temporarily or permanently deprived of their family environment, or in whose own best interests cannot be allowed to remain in that environment, is entitled to special protection and assistance.

At the time of publishing this Review into residential care placement decisions, there were approximately 5,500 Western Australian children and young people living in out-of-home care, overseen by the Department of Communities. A small percentage of these young people live in residential care.

I acknowledge that any decision to take a child into the Department's care is not made lightly. However, when a decision is made to remove a child from their family in that child's best interests, the Department is accountable for ensuring that the child's best interests continue to be upheld and that all reasonable efforts have been made to provide a safe and supportive care environment that all children are entitled to.

The reports of the Special Inquiry into St Andrew's Hostel Katanning, the Royal Commission into Institutional Responses to Child Sexual Abuse and other similar inquiries have consistently highlighted the vulnerability of children and young people to abuse and harm in institutional settings and the unique barriers they face in speaking up and seeking help.

Throughout my term as Commissioner, I have highlighted the need for stronger independent oversight of out-of-home care in Western Australia.

Three years ago, I recommended that an across-government approach was required in Western Australia by the Departments of Communities, Education, Health, Justice, Police and the Mental Health Commission to bring a strategic focus to the system improvements required for children and young people with harmful sexual behaviours.

This Review was initiated after media reports on the experiences of one young person in the care of the Department of Communities – one young person who spoke up and raised concerns.

I commend this young person's courage in speaking out and their commitment to wanting change for others in care.

I acknowledge the Minister for Child Protection, The Hon Simone McGurk MLA's willingness to explore the issues raised by this young person's experience and for supporting this Review. I also thank the staff at the Department of Communities for their honest cooperation throughout the Review process.

Child protection work is complex and often traumatic for children and young people, their families, and for those working directly with children in care to provide them with care and support.

Comments made within this report about work units and residential care settings are made to highlight the need for change at a system level and are not intended as criticism of any individuals within the Department or the sector.

While this Review was limited in its scope, the issues outlined in this report highlight systemic issues that are still current in 2021 and require urgent attention. I have made a range of recommendations to improve these practices.

To the thousands of Western Australian children and young people in out-of-home care, you all have the right to be safe, to be listened to and to be involved in decisions made about you. It is my aim that this Review is a positive step towards highlighting what is required to ensure your rights as children and young people in care are upheld every day.

Colin Pettit  
Commissioner for Children and Young People

## Purpose of the Review

In October 2020, a young person in the care of the CEO of the Department of Communities (Department) in Western Australia spoke out in the media about her experience of being in residential care<sup>2</sup> and specifically of being placed in the same group home as an older young person who she understood had engaged in acts of harmful sexual behaviour.

On 30 October 2020, the Minister for Child Protection, Hon. Simone McGurk MLA requested the Commissioner for Children and Young People (the Commissioner) conduct an Independent Review (Review) of the Department's policies, practices and services regarding children with harmful sexual behaviours (HSB) in residential care.

The Commissioner agreed to undertake the Review, and the following Terms of Reference were established and accepted by the Minister and the Department:

1. Identify systemic issues arising from the experience of Macie that affect the wellbeing of children and young people in residential care more broadly, including:
  - a. The extent to which the Department's own policy and practice settings regarding HSB and the safety of children and young people in residential care were met in the case of Macie.
  - b. The extent to which any systemic issues, including Departmental policies, practices and services regarding HSB of children and young people in residential care, are consistent with recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission).
2. Identify short, medium and long-term changes that may be required based on the findings of the Review.

## Limitations of the Review

As per the Terms of Reference, the Review focused on the safety of children and young people in residential care and the placement of children and young people with HSB in this part of the out-of-home care system.

While case file records and many of the views shared by stakeholders relate to experiences in the metropolitan region, the findings and recommendations of this Review are relevant to the wellbeing of children and young people across WA.

It was outside the scope of the Review to consider other issues within residential care or the out-of-home care system more broadly (e.g. foster care placements) that

---

<sup>2</sup> Pilat L 2020, *Perth 'sex ring' members 'housed with victims in government care homes'*, WA Today, <https://www.watoday.com.au/national/western-australia/perth-sex-ring-members-housed-with-victims-in-government-care-homes-20201012-p564gb.html#:~:text=Some%20of%20the%20Perth%20men,were%20groomed%20by%20offenders%20online.>

are also potentially pertinent to the safety and wellbeing of children and young people in the care of the CEO.

## **Historical context**

The case files viewed as part of this Review span 2001-2020. The Commissioner acknowledges that some of the content in the case files predate the release of:

- *Children and Community Services Act 2004* and subsequent amendments
- Building a Better Future Out-of-Home Care Reform in Western Australian (released 2016)
- Final Report of the Royal Commission into Institutional Responses to Child Sexual Abuse (released 2017)
- Better Care, Better Services – Safety and quality standards for children and young people in protection and care (released 2006, updated in 2017).

The systemic issues raised through this Review have been assessed in the context of the Department of Communities' current policies and practices, with the aim of providing guidance to the Department on system improvement.

## The young people's experiences

Whilst the Commissioner strongly supports the rights of children and young people to inform reviews, inquiries, and policy and practice development through their views and experiences, the Commissioner believes it is not in the best interests of the two young people whose case files were examined to publicly provide extensive details of their individual experiences. Therefore, the information presented in this report does not reflect the full extent of the experiences of these two young people in out-of-home care. Specific examples, direct quotes or extracts from case file records are provided, where doing so provides relevant context for the findings and recommendations.

### Macie

*"I know from my experience, no one believed me, like DCP didn't really believe me when what happened to me at 12." Macie<sup>3</sup>*

Case records indicated:

- Macie was taken into the care of the Department of Communities at a very young age.
- She lived in a foster care placement for nine years before being placed in a Department of Communities' residential care home early in her teenage years, living in three different residential care placements over a five-month period.
- The Department was aware Macie had been exposed to inappropriate sexual behaviours and HSB both before and while in the Department's care.
- The Department placed Macie in a residential care home with Lee, a male young person who was known to have previously engaged in HSB towards other children and young people.
- Macie spoke up on a number of occasions about HSB and sexual assaults she had experienced.
- Macie repeatedly raised concerns about her safety when around Lee.
- The Department was aware of multiple incidents of inappropriate sexual behaviour or HSB involving Lee and Macie over the period they resided together, including 20 reports from Macie of alleged HSB perpetrated by Lee.

Macie is recorded in her case file as saying:

*"I don't know why they would put me in a house with [him] when they know that I have been sexually assaulted before."*

---

<sup>3</sup> Pilat L 2020, *Perth 'sex ring' members 'housed with victims in government care homes'*, WA Today, <https://www.watoday.com.au/national/western-australia/perth-sex-ring-members-housed-with-victims-in-government-care-homes-20201012-p564gb.html#:~:text=Some%20of%20the%20Perth%20men,were%20groomed%20by%20offenders%20online.>

*"I don't feel safe there. I don't understand why they keep making me go back there."*

## Lee

*"The problem [the Residential Group Home] has is that they didn't look after their traumatised staff, and that the traumatised staff were then not able to look after the kids well." Lee (Case File)*

Case files indicated:

- Lee experienced physical and emotional harm during his early years.
- Lee's mother expressed concerns to the Department of Communities about Lee's behaviours and the safety risk she perceived he posed to other children. Several government and non-government agencies are also recorded as expressing these same concerns to the Department.
- The Department linked Lee and his mother to support services but declined requests to take Lee into care as Lee himself was not seen as being at risk of harm in the care of his mother.
- At the age of 12 Lee engaged in violent behaviours and HSB towards a younger child. As a result of this incident, Lee was taken into the care of the Department.
- An assessment conducted by the Department at this time found that it would be inappropriate to place Lee in a house where there were younger children due to risk issues.
- Lee repeatedly expressed concerns to staff about his sexual urges and the safety of younger children who were living in the same residential care home as him. These were recorded in his case file and included the following:

*"[Lee] feels urges towards other residents occasionally and one in particular."*

*"[Lee] didn't understand why DCP would put him in a house with younger people."*

*"[Lee] expressed that...he is crying for help and no one in the house cares about him anymore."*

- Staff from the Department and other government agencies also expressed concerns about Lee's behaviours and the safety of other children, including Macie in particular.
- Lee and Macie were placed in the same residential care home for almost seven months.

## Executive summary

### Findings

The Commissioner has made six findings relating to systemic issues that affect the wellbeing of children and young people in residential care. These systemic issues were identified through case file materials, review of the Department's legislation, policies and practice guidance, and discussions with experienced Department and CSO professionals from the out-of-home care sector.

Department staff and care teams make difficult decisions on a daily basis about the placements of children in residential care settings. They are required to weigh up the needs and behaviours of individual children and young people as well as the potential risks of harm that occur in the context of trauma, dysregulated behaviours, aggression, physical violence, self-harm, stealing, drug use, criminal behaviours and HSB.

Department staff spoke about leaving children in dangerous or risky situations because there were no other alternatives. They also reflected that often they only have a "fleeting window" to help a child who wants to remove themselves from an unsafe or dangerous situation and that in most cases, if the Department does not have a placement for a young person who is seeking one, then often the young person won't return the next day.

The placement of Macie into a residential care home with Lee, a child with a history of HSB, was not a unique event or even an isolated practice in WA - case records, department policies and the experiences of Department and CSO staff demonstrated that other children and young people with HSB have resided in out-of-home care settings with other children.

As well as being protected from harm in care, promoting the best interests of children and young people includes meeting their physical, emotional, intellectual, spiritual, educational and developmental needs. Macie and Lee both experienced considerable adverse experiences prior to coming into the care of the CEO. They each had a right to receive timely and thorough assessments of their needs and effective therapeutic services. If such services were made available to each individual child in the CEO's care and impacts of their trauma and life experiences were addressed or moderated, there could be positive, life-changing outcomes for each young person.

Providing effective interventions to individual children and young people will also improve the safety in care settings where the children and young people are placed, as effective individual interventions would reduce negative or harmful behaviours towards other children and staff.

There has been minimal change in the policy and practice guidance for Department staff in WA since the Commissioner's project on HSB in 2018 and the *Final Report* of the Royal Commission in 2017. The findings and subsequent recommendations made in this report essentially advocate for the expedited and full implementation of the Royal Commission recommendations that directly relate to the provision of safe

residential care and comprehensive specialist therapeutic responses for children and young people displaying or experiencing HSB.

#### **Finding 1**

The rights of children and young people to be effectively engaged in the planning and decision making that impacts their lives and to be supported and empowered to know their rights, raise their concerns and have these responded to in a timely manner are not routinely upheld.

#### **Finding 2**

The information and knowledge management systems of the Department are not fit for purpose and impede decision making for children and young people and organisational accountability.

#### **Finding 3**

The Department does not have a cohesive or effective framework or policy, practices or services to understand and respond to children and young people with harmful sexual behaviours.

#### **Finding 4**

The Department does not consistently ensure that high quality and safe care by well trained and supported staff and carers is provided to children and young people in the care of the CEO in residential care.

#### **Finding 5**

The Department's risk assessment and management strategies are not effective in consistently preventing, identifying and mitigating risks to children and young people in residential care.

#### **Finding 6**

The Department's internal safeguards and review mechanisms do not contribute effectively to the safety of children and young people in residential care.



## Recommendations

In line with the Terms of Reference, nine recommendations have been made based on the findings of the Review that identify short, medium and long-term changes that are required. Full implementation of these recommendations should ensure the rights and best interests of children and young people in residential care are upheld, that they are safe and that their needs are met.

To the Minister for Child Protection

1. Prioritise the full implementation of the 33 Royal Commission recommendations identified within Appendix A.
2. Establish and resource an independent advocacy function for children and young people in the CEO's care to ensure they are supported to speak out when they feel unsafe, their views are heard and responded to, and they are able to meaningfully participate in decisions about their lives.
3. Commission the scoping of work for the purchase and implementation of an information management system fit for the functions of the Department of Communities required under the CCS Act.

To the Department of Communities

- 4.(a) Implement a new cohesive evidence-informed framework to guide the Department's responses to children and young people with harmful sexual behaviours living at home and for those living in out-of-home care.
- 4.(b) Resource, mandate and deliver children and young people with harmful sexual behaviours training for all staff working directly with children in care, with a priority given to staff who work with children who have been placed in the residential care system in line with the Royal Commission's Recommendation 12.13. Once in place, this training must be continuously reviewed to ensure that the content delivered aligns with contemporary research and best practice and be delivered regularly.
5. Implement a system to ensure that before a child with harmful sexual behaviours is placed in residential out-of-home care, the following occurs:
  - a. comprehensive assessment of the child with harmful sexual behaviours, including identifying their needs, therapeutic interventions and appropriate supports to ensure their safety
  - b. establish clear case co-ordination and review processes and a package of support services
  - c. undertake careful placement matching that includes:
    - i. providing sufficient relevant information to the residential care staff to ensure they are equipped to support the child and additional training as necessary
    - ii. rigorously assessing potential threats to the safety of other children in the placement.
6. Provide comprehensive specialist services to children and young people in out-of-home care who are displaying or have experienced harmful sexual behaviours.

7. Review and align the risk assessment processes of the Department with the Royal Commission recommendations and the National Principles for Child Safe Organisations.
8. Commission and publicly release research regarding best practice in relation to models of residential care to inform the future design, resourcing and implementation of an evidence-based, safe, therapeutic, sustainable model of care for children and young people, including those with HSB.
9. Resource and deliver effective sexual education, protective behaviours, respectful relationships, 'speaking up' training and support to all children and young people in residential care to reduce the risk of abuse and exploitation and to those who care for them in line with the Royal Commission recommendations 12.9, 12.10, 12.11, 12.13.

### **Department of Communities' response<sup>4</sup>**

The Department of Communities (Communities) acknowledges the important role of the Commissioner for Children and Young People in undertaking this review into the systems underpinning the experiences of young people in residential care, triggered by the reports of a particular young person. Communities appreciates the opportunity from the Commissioner to submit a one-page response for inclusion in the final report.

The Review draws on documents including case records from two young people and has identified opportunities that could strengthen policy, practice, workforce and systems affecting young people with harmful sexual behaviours in residential care.

Communities commends the young people involved in the Review, for their courage in sharing their experiences so openly, and for the staff who provided their expertise during the Review process. Frontline staff including those working in residential care work tirelessly and make difficult decisions on a daily basis – meeting the needs of individual children and young people and weighing up the risks that their behaviours may pose to other children and young people in care.

We endeavour to make decisions that are trauma-informed, culturally safe, in the best interests of children and are focussed on meeting their safety and wellbeing needs. In doing so, it is critical that children and young people in care are actively engaged to share their views on decisions that impact on them, as enshrined in the principle of child participation in the *Children and Community Services Act 2004*.

---

<sup>4</sup> In accordance to the Commissioner for Children and Young People's request that Communities' response be limited to one-page only, additional information on reforms and improvements can be provided.

The areas of improvements highlighted in the Review will build on the changes that have already occurred since March 2017, the time of the specific cases referred to in the Review. These include the following:

- Introduction of new practice requirements to improve responses to children exhibiting harmful sexual behaviours in the Residential Care Practice Manual and staff induction package.
- Improving the identification and management of risks where a child in a care arrangement may pose a risk to another child or children, including those who display harmful sexual behaviours, in line with recommendations from the Ombudsman WA.
- In addition to the mechanisms currently in place, implementation of a child-friendly Complaints Management Policy for children and young people in care to speak up when they feel uncomfortable or unsafe or to raise other concerns.
- Implementation of new processes on child safety investigations.
- Use of multi-agency protocol for education options for young people charged with harmful sexual behaviours.
- Implementation of the Traffic Light System in residential care.

Communities is fully committed to its obligation, under the Bennett Duty, to ensure the legal rights of children in its care are protected, and refers young people who have been the subject of reported incidents of abuse whilst in care for independent legal advice. Importantly, Communities is further committed to providing those children and young people with therapeutic supports in a timely manner.

Communities, in partnership with the WA Centre – Pursuit of Excellence in Responding to Child Abuse and Neglect, is contemporising its assessment and responses to harmful sexual behaviours in line with the Royal Commission into Institutional Responses to Child Sexual Abuse recommendations. Communities has developed a draft *Framework for Guiding Responses to Harmful Sexual Behaviours in Children and Young People in the WA Child Protection Service System*. This will be complemented by a workforce development response including evidence-based training modules.

Communities acknowledges the critical importance of taking actions to improve outcomes for the children and young people in our care – we will continue to do this through examining our practice, learning from the experiences of children and young people in care, and being transparent and accountable.

## **Actions the Commissioner will undertake**

Given the gravity of the findings of the Review, the Commissioner will report annually on the implementation of the nine recommendations made in this report.

In addition, the Commissioner will consult more broadly with children and young people in residential care to hear their views about their experiences to support the Department's implementation of the recommendations.

Developing resources and support for staff, volunteers and organisations to assist them to implement and uphold the National Principles for Child Safe Organisations within their workplaces will continue to be a priority work area.

## Methodology

### Resourcing

On 5 November 2020, the Commissioner commenced the Review and established a team of 3.5 FTE staff to review documentation provided by the Department.

The Department provided one staff person (District Director) to work with the Commissioner's team, manage the sharing of information and to liaise with internal work units. The District Director assisted in the identification, analysis and assessment of case records information, and shared knowledge and expertise about the Department's child protection services, policies and practices. This enabled the Review to be thorough and make findings that are fair and balanced. The Department also applied considerable resources to retrieve documents.

In addition, the Commissioner regularly engaged with executive staff of the Department and the Minister for Child Protection's office during the Review.

### Case file review

An examination of the records made by the Department about two young people was undertaken. This process was used to identify potential systemic issues regarding the HSB of children and young people in residential care settings. These issues were then further explored in the context of current policies, practices and services to identify system improvements required to protect children in out-of-home care from harm in the future. The analysis of potential systemic issues was informed by discussions with sector professionals, reviewing the Department's policies and procedures, and examining the findings of internal reports (discussed in more detail below).

Almost 31,000 pages of case file information (hard copy and electronic) were examined. Due to challenges the Department had in retrieving and making the data available, these were made accessible in 'batches' over a seven-week period. The time required to read all of the case file notes with a reasonable level of scrutiny was significant, as case files were broken up by work units, and as a result, there were no clear chronologies across these case files of the significant events in the lives of these two young people or the actions and interventions by the Department over time. Information was dispersed across multiple files within each of the care records. These issues are discussed further in Finding 2.

Other Department records were also reviewed, such as the residential group home staff meeting records, which commented on the experiences of all residents in the group home and interactions amongst these young people.

## **Direct input from relevant agencies, services providers and personnel**

Recognising that the Department is the lead State Government agency amongst a number of agencies and service systems that interact with and support children in out-of-home care, the Commissioner wrote to 14 government agencies and peak bodies advising them of the Review and inviting them to make submissions. Direct meetings were also sought with key work units and personnel within the Department of Communities.

The Review received six written responses and held 26 meetings. These meetings were attended by 47 professionals from the Department of Communities, CSOs, advocacy groups, and other state government departments. The Commissioner also met with both young people whose case studies are outlined in this Report.

Department of Communities staff who participated in the Review process included District Directors, team leaders, case managers, legal officers, specialist unit directors, and senior officers in the advocacy and psychological service areas. The vast majority of the individuals involved in these meetings were senior staff or managers of their work units with extensive experience in the Department. The remaining participants were individuals who had direct involvement with Macie or Lee during their time in care.

Meetings with community stakeholders included CEOs, managers and other senior staff from organisations providing residential care services, HSB services and/or child sexual abuse therapeutic services.

To ensure interview participants felt able to openly and honestly share their views, experiences and expertise with the Commissioner, it was agreed that individuals would not be identified within the final report, and any quotes used would be anonymised.

The Commissioner was assisted in evaluating the information provided by all participants by the Department of Communities District Director who worked with the Review team. The examples and quotes used from the interviews with Department and CSO professionals are illustrative and not exhaustive and provide direct information from their current practice environments.

## **Consideration of other case practice examples**

Through the submissions received and meetings with community sector organisations, external experts and Department staff, the Review sought information on:

- whether there were other children and young people living in (or who had lived in) residential care across Western Australia with similar experiences to Macie and/or Lee
- how relevant policies and practices have been interpreted and applied in similar cases to Macie and/or Lee

- the expected practices when assessing and delivering therapeutic supports to children and young people displaying HSB or who have experienced acts of HSB against them.

## **Review of relevant Department documentation**

The Review examined 55 Department of Communities' policy documents and reports. These documents are listed in full at Appendix D. Information provided by the Department on the progress of implementation of the Royal Commission recommendations in Western Australia, and the Department's out-of-home care reform work was also considered.

The following key documents were used to assess the potential existence of systemic issues relating to the placement of children and young people with harmful sexual behaviours in residential care:

- *Children and Community Services Act 2004*
- Better Care, Better Services Standards
- Casework Practice Manual and linked internal resources for staff (e.g. informational and capacity building resources regarding child sexual abuse)
- Residential Care Practice Manual
- relevant policies, frameworks and documents.

## **Conclusions**

While the case files reviewed contain information spanning a 19 year period, the conclusions reached within this Report are based on an assessment of current Department of Communities' policies, practice guidance and services. Despite some improvements by the Department in recent years, the information provided by the Department, Department staff and community sector organisations clearly identified current systemic issues with regard to children and young people with HSB in residential care settings.

## Background to the Review

### Harmful sexual behaviours

Problematic or harmful sexual behaviours (HSB) can be defined as any behaviour of a sexual nature expressed by children under 18 years old that:

- is outside of what is culturally accepted as typical sexual development and expression
- is obsessive, coercive, aggressive, degrading, violent, or causes harm to the child or others
- involves a substantial difference in age or developmental ability of participants.<sup>5</sup>

When sexual behaviours become problematic or harmful, they can be traumatic both for the children displaying the behaviours as well as any other children who are impacted by the behaviours. It is important that responses are in place within communities and in organisations to provide early intervention, support and treatment that is appropriate to the behaviours displayed and experienced. The safety and wellbeing of all children is of the utmost importance.

During 2017–2018 the Commissioner completed a project aimed at improving the understanding within organisations of children and young people with HSB and enhancing responses to children and young people who may be harming themselves or others. Key issues identified through this project included:

- There is no common definition, language or framework for understanding and responding to HSB is used across government or community agencies in WA.
- The only statewide child sexual abuse prevention strategy in WA is the education of children through the school curriculum. Quality control and monitoring of the implementation of this strategy is not in place.
- There are no readily identifiable statewide educational strategies for parents, community members or professionals about child sexual abuse or HSB.
- There are no specialist services for children with HSB in WA - services are provided by general child sexual abuse counselling services.
- The 2014 Child Sexual Abuse Treatment Services: Service Standards, for agencies funded by the Department to provide therapeutic interventions for children with HSB, do not specifically mention HSB or any principles for therapeutic responses for HSB.<sup>6</sup>
- The current service system is supplemented by many private counsellors who provide services for fees or with government funding.

---

<sup>5</sup> Meiksans J, Bromfield L & Ey L 2017, *A Continuum of Responses for Harmful Sexual Behaviours – An Issues Paper for Commissioner for Children and Young People Western Australia*, Australian Centre for Child Protection, University of South Australia.

<sup>6</sup> Department for Child Protection and Family Support 2014, *Standards for the Delivery of Child Sexual Abuse Therapeutic Services*.



- The quality and effectiveness of the services available statewide was not clear.
- Service providers identified the key issues for the service system as insufficient service availability, inadequate service funding, increasing acuity and complexity of client presentation, how services work with each other, and workforce and development issues.
- The data available within agencies about children with HSB is generally poor, and there is no common data set across agencies to inform service planning.

During this project, the Department also advised that young people with HSB in the CEO's care were placed in residential care with other children if there were no other suitable placements for them. The Department reported that when this occurs, safety plans are put in place, and children and young people with HSB are provided with appropriate therapeutic interventions. The Department also provided an overview of their relevant training on HSB for staff and carers.<sup>7</sup>

Based on the findings of this project, the Commissioner subsequently recommended that a strategic across-government approach be adopted in WA involving the departments of Communities, Education, Health, Justice, Police and the Mental Health Commission to bring a strategic focus to the system improvements required for children and young people with HSB.

## Royal Commission into Institutional Responses to Child Sexual Abuse

Over the course of the five-year inquiry 2013–2017, the Royal Commission conducted public hearings, private sessions, released case studies and an interim report and research to enable organisations to learn, reflect on and improve their own systems well before the release of their *Final Report*<sup>8</sup> and recommendations in 2017.

Throughout the Royal Commission inquiry, the WA Government strongly supported the work of the Royal Commission and presented detailed evidence and submissions, and participated in public hearings, case studies and round tables.<sup>9</sup>

The Royal Commission examined institutional responses to child sexual abuse in contemporary (post-1990) out-of-home care across Australia and found:

*Despite major reforms to out-of-home care in every state and territory in Australia, our work has identified persistent weaknesses and systemic failures that continue to place children at risk of sexual abuse. We learned that sexual abuse by carers, their family members, visitors, caseworkers and other children in care continues to occur in contemporary out-of-home care, and*

---

<sup>7</sup> Department for Children Protection 2016, *Responding to concerning sexual behaviours in children and young people*, workshop information provided to the Commissioner 2017.

<sup>8</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report*, Volumes 1–17.

<sup>9</sup> Government of Western Australia 2018, Royal Commission into Institutional Responses to Child Sexual Abuse *Progress Report*, p. 5.

*that sexual exploitation is a growing concern, especially for children in residential care. We also learned of systemic failings that weaken the safety of children in care, including frequent placement changes, poor information sharing, inadequacies in service providers' responses to children's prior abuse and trauma, and significant gaps in the training and support provided to staff and carers, especially kinship carers. Poor practice by individuals, including failing to listen and respond to children, exacerbates these weaknesses and increases the risks of sexual abuse.*<sup>10</sup>

Despite developments in recent decades, such as smaller residential care homes and improved screening of staff and carers, the Royal Commission found there continued to be deficiencies in the care and support provided to children while they are in care. Further, the responses to child sexual abuse in contemporary out-of-home care were found to often be compromised by factors such as failure to address systemic risks, incomplete assessment and management of risks, failure to create a culture that supports disclosures and poor responses to child sexual abuse disclosures.

Research referred to by the Royal Commission indicates the incidence of child sexual abuse is higher for young people in residential care settings than in other forms of out-of-home care and in the broader general population. Studies comparing residential care and foster care estimated the adult reporting of incidences were 5.0 per 1,000 and 2.0 per 1,000, respectively. Young people's self-reports were considerably higher, with 280 per 1,000 children in residential care experiencing sexual abuse.<sup>11</sup>

The mix of young people placed in residential care has previously been found to increase the risks of harm, particularly when young people who have displayed problematic or HSB are placed with young people who have been sexually abused.<sup>12</sup>

Twenty-seven children and young people (aged between 10 and 20 years of age) were involved in research<sup>13</sup> in 2016 for the Royal Commission that focused on safety in residential care. Key findings from these children and young people were:

- residential care is currently unsafe for most children and young people
- more effort should be put into finding alternate arrangements, particularly for those who were younger and more vulnerable

---

<sup>10</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report Volume 12, Contemporary out-of-home care*, p. 9.

<sup>11</sup> Moore, T., McArthur, M., Roche, S., Death, J., & Tilbury, C 2016 *Safe and sound: Exploring the safety of young people in residential care* Institute of Child Protection Studies, Australian Catholic University. Melbourne, the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney.

<sup>12</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report Volume 12, Contemporary out-of-home care*, p. 119.

<sup>13</sup> Moore, T., McArthur, M., Roche, S., Death, J., & Tilbury, C 2016 *Safe and sound: Exploring the safety of young people in residential care* Institute of Child Protection Studies, Australian Catholic University. Melbourne, the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney.

- children and young people were unsafe because of poor decisions about who they were placed with and wanted more say in how they were matched with their peers
- once placed together in residential care, services should help foster positive peer cultures where young people looked after each other
- residential care staff and services need to develop a better appreciation of the things that can harm children and young people, and have adequate and appropriate discussions with them on the nature of these risks and how to keep themselves safe
- services need to understand children and young people's vulnerability, particularly due to their naiveté about sexual relationships and exploitation, and take on parent-like responsibilities for protecting them from harm
- adequate staffing was considered vital, with many participants believing that they were safer when workers had the time to develop relationships with them, were 'on the floor' and watched out for threats
- staff should be well trained, approachable, available, should act to prevent problems and skilfully respond when issues arise
- staff should be proactive and ask children and young people if they were being harmed rather than waiting for them to disclose
- when children and young people raise concerns, staff need to demonstrate understanding and empathy, even when the concerns seemed insignificant
- children and young people want and need opportunities to partner with workers and services to identify safety risks and develop strategies to prevent and respond to them
- barriers for young people to seeking help included not knowing what to do, fearing consequences and a lack of faith in workers and services.

On 27 June 2018, the Hon. Mark McGowan MLA, Premier of Western Australia, delivered an official apology on behalf of the State Government for the sexual abuse of children in WA government institutions. The Hon. Simone McGurk, Minister for Child Protection, also delivered a speech to Parliament committing to the implementation of the Royal Commission recommendations. In the first progress report on the implementation the Minister stated:

*The McGowan Government is committed to creating a safer Western Australia for children by responding to historical abuse that has occurred, preventing further abuse from happening, and ensuring a swift response to abuse should it occur again... The community has a right to expect that our children are safe, especially within the institutions entrusted to protect, educate, care for and nurture them.*<sup>14</sup>

The State Government is responsible for completing 310 recommendations relevant to WA. With regard to the seven recommendations of the Royal Commission specific to HSB, the WA Government's Royal Commission 2020 Progress Report notes

---

<sup>14</sup> Government of Western Australia 2018, Royal Commission into Institutional Responses to Child Sexual Abuse *Progress Report*, p. 2.

these are being progressed alongside advocacy, support and therapeutic treatment recommendations for victims and survivors of child sexual abuse. The report states the:

*Department of Communities is leading the development of a framework which will guide and support the implementation of a new multi-agency, coordinated approach to the design and delivery of a sustainable and effective therapeutic service system in Western Australia with consultation occurring in the first half of 2021.*<sup>15</sup>

## Department of Communities and the role of the CEO

The Department has a legislative mandate under the *Children and Community Services Act 2004* (the CCS Act) to safeguard or promote the wellbeing of children, individuals, families and communities, and to provide for the protection and care of children in circumstances where their parents have not provided, or are unlikely or unable to provide, that protection and care.<sup>16</sup>

A child is in the Chief Executive Officer's (CEO's) care if the child is in or subject to: provisional protection and care; a protection order (time-limited or until 18); a negotiated placement agreement; or is provided with placement services under section 32(1)(a)<sup>17</sup>. All children and young people in the CEO's care should receive a consistent standard of service that provides for their safety and wellbeing irrespective of where they are placed across the state of Western Australia.<sup>18</sup>

The best interests of the child are required to be the paramount consideration for any decision made under the CCS Act (s.7) and the Department's child protection practices are guided by other sections in the CCS Act.

Section 8 of the CCS Act outlines matters that must be taken into account when determining what is in a child's best interests. These include:

- the need to protect the child from harm
- the capacity of the child's parents, or of any other person, to provide for the child's needs
- any wishes or views expressed by the child, having regard to the child's age and level of understanding in determining the weight to be given to those wishes or views
- the importance of continuity and stability in the child's living arrangements and the likely effect on the child of disruption of those living arrangements
- the child's physical, emotional, intellectual, spiritual, educational and developmental needs
- any other relevant characteristics of the child

---

<sup>15</sup> Government of Western Australia 2018, Royal Commission into Institutional Responses to Child Sexual Abuse *Progress Report*, p. 2.

<sup>16</sup> Department for Child Protection 2011, *Signs of Safety Policy*. Retrieved February 2021.

<sup>17</sup> Western Australia *Children and Community Services Act 2004*.

<sup>18</sup> Department of Communities 2018, *Better Care, Better Services. Safety and quality standards for children and young people in protection and care*.

- the likely effect on the child of any change in the child's circumstances.

Section 10 of the CCS Act states that if a decision under the Act is likely to have a significant impact on a child's life, then steps must be taken to ensure the child is able to participate in the decision-making process. The CCS Act identifies decisions about placement arrangements as one of the decisions likely to have a significant impact on the child's life.

In determining what is in the best interests of the child, the CCS Act also explicitly states that the matters taken into account are not limited to those listed in the Act.

The legislative responsibilities of the Department are primarily enacted through the *Better Care, Better Services Safety and quality standards for children and young people in protection and care* (2018) (the Standards), the policies of the Department, and in the guidance provided to staff in the Casework Practice Manual (CPM) and the Residential Care Practice Manual (RCPM).

The Department has in place a monitoring process through the Standards Monitoring Unit (SMU). The SMU undertakes monitoring visits to assess whether the services provided by the Department through District Offices (and in residential care homes) are meeting the required Standards, to identify excellence in service provision, and to highlight required actions and opportunities for service improvement.<sup>19</sup> The monitoring of the Standards by the Department commenced with District Offices in 2007 and expanded to include CSOs funded by the Department to provide out-of-home care arrangements in 2010.

In addition to the direct monitoring by the SMU the Department allocates \$100,000 per financial year to visits by Independent Assessors (Assessors) to residential care facilities. The SMU facilitates inspections of residential care facilities run by the Department and by community sector organisations by Independent Assessors pursuant to the CCS Act.<sup>20</sup> The Assessors are appointed and remunerated by the Department and can at any time visit an out-of-home care facility in order to:

- inspect the facility
- inquire into the operation and management of the facility
- inquire into the wellbeing of any child in the facility
- see and talk with any child in the facility
- inspect any document relating to the facility or to any child in the facility.<sup>21</sup>

Any child in an out-of-home care facility, or a parent or relative of a child, may request that the person in charge of the facility arrange for an assessor to visit a facility and see and talk with the child. Assessors also undertake a process of systematic visiting to residential care facilities. In the Commissioner's report *Oversight of services for children and young people in WA* it was noted that based

---

<sup>19</sup> Department of Communities website, Standards Monitoring Unit, accessed March 2021.

<sup>20</sup> Department of Communities 2020, information provided to the Commissioner.

<sup>21</sup> Western Australia *Children and Community Services Act 2006*.

on the inspection trends and timeframes at that time, each residential care facility will be visited by an Assessor approximately once every six to eight years.

The Department also funds the position of Advocate for Children in Care (Advocate). The Advocate is a role provided internally within the Department to support children and young people in care to know their rights and to have a say in decisions that affect their lives and the services provided for them.<sup>22</sup>

The CCS Act also stipulates the CEO of the Department must prepare a Charter of Rights (Charter), promote compliance with this Charter and give a copy of the Charter to all children in the CEO's care. Age appropriate versions of the Charter and information for children and young people about their rights are on the Department's website. These rights are:

- I have the right to get help with my education, care and health and mental wellbeing.
- I have the right to take part in hobbies, sport, music, dance and/or art.
- I have the right to be kept informed about my care plan and to have my views considered.
- I have the right to be respected.
- I have the right to raise an issue or concern with my case worker, foster carer and/or the Advocate for Children in Care.
- I have the right to privacy and to have my own things.
- I have the right to be heard.
- I have the right to get help and support to go to court about my care.
- I have the right to have contact with my family and friends whenever possible.
- I have the right to be encouraged and supported in my religion and culture.
- I have the right to proper planning before leaving care.
- I have the right to be safe.

All young people in care have these rights, and the CEO may at times be balancing the competing interests and needs of different children and young people in decision making.

## **Children and young people in out-of-home care in WA**

Based on the most recently published data, as at 30 June 2020, there were 5,498 children and young people in the care of the Department, 3,082 of whom are Aboriginal (56.06%).

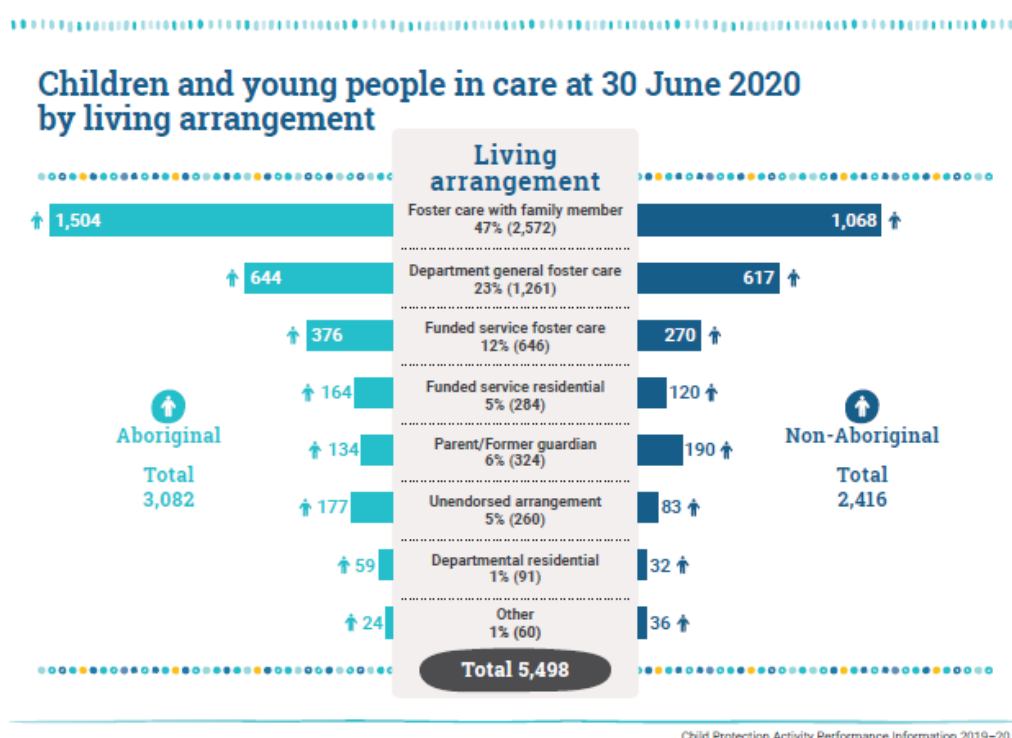
The different living arrangements of the children and young people are outlined below, with 375 children and young people (6 per cent) living in residential care in either a funded community service organisation (284) or a residential home run by the Department (91).<sup>23</sup>

---

<sup>22</sup> Department for Child Protection and Family Support 2015, *Department for Child Protection and Family Support Annual Report 2014–15*, Government of Western Australia, p. 35.

<sup>23</sup> Department of Communities 2020, *Child Protection Activity Performance information 2019–2020*.

The Ford Review<sup>24</sup> noted as at 30 June 2006, there were 2,220 children and young people in care, 851 of whom were Aboriginal (38.3%). Of these, a total of 6.9 per cent of children and young people were placed in residential care, 2.7 per cent in Department facilities and 4.2 per cent in residential care with community sector organisations. While there have been significant changes to the residential care settings since that time and the number of children and young people in care has more than doubled since then, a similar total proportion of the 5,498 children and young people in care (6 per cent), were in residential care as 30 June 2020.



It was not in the remit of the Review to explore the capacity and adequacy of placement availability for young people in either residential care or the out-of-home care system more broadly or the growth (if any) in the number of placements within these care settings since 2006.

## Residential care in WA

*The majority of children and young people in residential care have experienced severe ‘early adversity’ and have diverse previous experiences of sexual or physical abuse and neglect, or complex histories of trauma. Therefore, residential care provides care for some of the most disadvantaged, vulnerable and challenging young people in the out-of-home care system.*

Institute of Child Protection Studies<sup>25</sup>

<sup>24</sup> Ford P 2007, *Review of the Department of Community Development*, Table 2.6, p.32.

<sup>25</sup> Moore T, McArthur M, Roche S, Death J, & Tilbury C, 2016, *Safe and sound: Exploring the safety of young people in residential care*. Institute of Child Protection Studies, Australian Catholic University, Melbourne, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, p. 13.

The Department's residential care services comprise residential group homes (metropolitan and country), non-government family group homes (metropolitan and country) and the Kath French Secure Care Centre. In the metropolitan area, a residential group home will generally accommodate four young people.

The Department is the largest single provider of residential care across the state, with a placement capacity of 117 children and young people. The Department operates 23 group homes, 14 group homes in the metropolitan area (56 placements) and eight houses in regional areas (61 placements). The Department also provides secure care for up to six children and young people at the Kath French Centre.<sup>26</sup>

The Department provides funding to eight community sector organisations who together provide 225 placements<sup>27</sup> across family group homes, residential group homes and cottage care settings.

Royal Commission research noted residential care is considered to be a placement of last resort for children and young people requiring out-of-home care, and is used in circumstances in which other types of out-of-home care are unsuccessful or unavailable. The notion of a place of 'last resort' was affirmed consistently by all Department and CSO professionals in WA who spoke to the Review team.

To apply for a residential care placement for a child or young person, District staff complete a Care Arrangement Referral (CAR), which is an assessment of a child's needs. A Central Referral Team reviews the CAR and considers placement availability across the Department and the community sector organisations. Following consultation, offers of placement are made to the District. This offer includes provision of information and an acknowledgement of the risks in the placement by the District.<sup>28</sup>

The Department's Casework Practice Manual states that residential care services provide time limited therapeutic residential care, which focuses on creating and sustaining care environments capable of healing the traumatic impact of abuse and neglect and the disrupted attachment that ensues. The Casework Practice Manual also states that a care arrangement for a child in a residential care service should be considered a time limited option and generally be for less than two years. However, the Casework Practice Manual goes on to note that in some circumstances, there may be a need for an extension for a child to remain beyond the two-year period.<sup>29</sup>

It was beyond the scope of the Review to evaluate the current residential care settings across WA or the efficacy of the Department's overarching therapeutic care framework<sup>30</sup> within its residential care settings. It was also beyond the Terms of Reference to conduct research into residential care models nationally or internationally.

---

<sup>26</sup> Department of Communities, 2021, Information provided to the Review.

<sup>27</sup> Ibid.

<sup>28</sup> Department of Communities, 2020 *Casework Practice Manual*, Section 3.4.22 Residential care services.

<sup>29</sup> Ibid.

<sup>30</sup> Department for Child Protection and Family Support 2016, *Building a Better Future, Out-of-Home Care Reform in Western Australia*.



## Findings

Systemic issues are those that relate to or affect an entire system, organisation or network and result from problems arising or inherent in the overall system, rather than due to a specific, individual, isolated factor. Ideally, the right changes to the structure, organisation, policies or practices in a system could alleviate systemic problem(s). Such changes might include alteration of performance levels (e.g. quality of supply, workforce development, access to services), development of policy or changes to procedure, or clear regulatory guidelines and monitoring of these.

The Commissioner has made six findings relating to systemic issues that affect the wellbeing of children and young people in residential care. These findings have been generated primarily by utilising the Better Care, Better Services Standards as the expected benchmark set by the Department for its own practice within each District Office and for organisations providing out-of-home care. These Standards outline how organisations should provide safe care to and deliver positive outcomes for children and young people in the care of the CEO.<sup>31</sup> The Standards relevant to the findings are set out in Appendix B.

Royal Commission recommendations relevant to each finding have also been outlined. While acknowledging that the Royal Commission's Final Report was only handed down in 2017, their inclusion in this Report highlights how full implementation could improve the out-of-home care system and the responses to children and young people who have been harmed or exhibit HSB in the present day.

At the time of this Review, it was clearly evident that in the current out-of-home care system, Department staff and care teams make difficult decisions on a daily basis about the placements of children in care settings. They are required to weigh up or juggle the needs and behaviours of individual children and young people as well as the potential risks of harm that can occur between children and young people from dysregulated behaviours, aggression, physical violence, self-harm, stealing, drug use, criminal behaviours and HSB.

Overwhelmingly, Department and CSO professionals who contributed to the Review expressed concern about the current residential care system within WA.

*“The Tier 1 model doesn't really work. Placing four unrelated, traumatised children together, everything we know now about therapeutic care, consistency, predictability, you can't actually physically achieve that in an environment that turns over so many young people on short term contracts...with continuous carer changeover because of the complexity that they're dealing with all the time.”*

---

<sup>31</sup> Department of Communities 2018, *Better Care Better Services. Safety and quality standards of children and young people in protection and care*, p. 5.

*“The system needs to be more flexible and individualised to the young people to meet their needs. If there’s a placement available, that’s where the young person has to go in.”*

*“We have to ask, is the model of having four traumatised strangers together in a house the right way? We’re forcing them to live with people they don’t know and they’ve all got trauma. We don’t have the ability to change it because there just aren’t enough alternatives.”*

The best interests of the child are required to be the paramount consideration for any decision made under the CCS Act. This includes placement decisions made in relation to residential care homes.

It is not in the best interests of any child who has a history of being sexually abused to be placed in an environment where they are at risk of being physically, sexually, psychologically or emotionally harmed by another child.

It is also not in the best interests of any child with a history of violent behaviours and HSB to be placed in an environment where they may harm another child.

Department records examined did not always outline the rationale for making placement offers or decisions, or for maintaining placements where HSB safety risks were not able to be managed. This lack of transparency impeded assessment of how the best interests of children and young people are determined during these processes and why decisions such as these are made.

The placement of Macie into a residential care home with Lee, a child with a history of HSB, was not a unique event or even an isolated practice in WA - case records, internal reports, Department policies and practices, and discussions with Department and CSO professionals demonstrated that other children and young people with HSB are, and are expected to be, residing in residential care arrangements that may place other children at risk.

Department records of discussions that occurred during Macie and Lee’s placement together appear to indicate that retaining each child’s current placement in the house was the primary goal of Macie and Lee’s respective care teams. Whilst stability for children in care is important for their wellbeing and is enshrined in the Standards,<sup>32</sup> the Standards also clearly state that children and young people’s safety needs must be met and that services ask children and young people about their safety needs and are responsive to these.<sup>33</sup> The CCS Act, in determining what is in a child’s best interests, lists the need to protect the child from harm as a mandatory consideration.<sup>34</sup>

Department staff spoke about leaving children in dangerous or risky situations because there were no other alternatives. They also reflected that often they only

---

<sup>32</sup> Department of Communities 2018, *Better Care Better Services. Safety and quality standards for children and young people in protection and care*, Standard 1.

<sup>33</sup> Ibid, Safety Standard.

<sup>34</sup> Western Australia 2006, *Children and Community Services Act*, s8 (1) (a).

have a “fleeting window” to help a child who wants to remove themselves from an unsafe or dangerous situation and that in most cases, if the Department does not have a placement for a young person who is seeking one, then often the young person won’t return the next day.

The decision not to move Macie or Lee from their shared placement was likely indicative of a broader and ongoing Departmental issue regarding a lack of suitable temporary and long term care placements for vulnerable children and young people and/or children who pose a risk to others, and for children and young people in general. Information provided to the Review showed that family, foster care and residential care placements are all limited and insufficient in both numbers and availability. Residential care placement options were described as “fully subscribed and saturated” by one Department officer.

As well as being protected from harm in care, promoting the best interests of children and young people includes meeting their physical, emotional, intellectual, spiritual, educational and developmental needs. Macie and Lee both experienced considerable adverse experiences prior to coming into the care of the CEO. They each had a right to receive timely and thorough assessments of their needs and effective therapeutic services. Their cases highlight the fact that the timely provision of effective support services designed to address the impacts of trauma is critical to achieving positive, life changing outcomes for young people in care.

Providing effective interventions to individual children and young people will also improve the safety in care settings where the children and young people are placed, as effective individual interventions can be expected to reduce negative or harmful behaviours towards other children and staff.

The Review also identified that the Department must place greater emphasis on the views of children and young people in care when making decisions that affect their lives. In order to do so, the Department must have a range of adaptable tools and skill sets at its disposal so that care teams can engage with each child or young person in a manner that feels safe for the child and gives them the confidence to share their honest views in the knowledge they will be listened to.

The Review noted that there has been minimal change in the policy and practice guidance for Department staff in WA since the Commissioner’s project on HSB in 2018 and the *Final Report* of the Royal Commission in 2017.

## Finding 1

**The rights of children and young people to be effectively engaged in the planning and decision making that impacts their lives and to be supported and empowered to know their rights, raise their concerns and have these responded to in a timely manner are not routinely upheld by the Department.**

### Case file review

The following questions were raised through the case file review process for further analysis:

- Are the views of children and young people in residential care being appropriately considered when making key decisions about their safety and wellbeing?
- Are children and young people in residential care supported and empowered to know their rights?
- Do Department policies and/or practices help or hinder children and young people accessing the Advocate for Children in Care and/or independent advocacy services?

### Analysis

#### Consideration of the views of children and young people

Under Article 12 of the UN Convention on the Rights of the Child, children who are capable of forming their own views have the right to express those views freely in all matters affecting them, with their views given due weight in accordance with their age and maturity. This is translated into State law through section 10 of the CCS Act. The CCS Act also requires that the best interests of the child be the paramount consideration for any decision made under the Act. Section 8 of the CCS Act explicitly lists the wishes or views expressed by the child as one of the matters that must be taken into account when determining what is in the child's best interests.

The Department's Standards further reiterate the importance of the child's views stating that in 'performing a function or exercising a power under the Act relating to a child, the considerations of highest priority must be the best interests of the child and child participation'.<sup>35</sup>

Case files show that both Macie and Lee expressed concerns about their out-of-home care arrangements to Department staff. These concerns included fears of being harmed, fears of harming others, that personal Safety Plans were not working, and that the Department was not doing anything in response to the disclosures they were making. Lee is recorded as speaking to Department staff on multiple occasions about his belief that he was at risk of reoffending against younger residents, both before and after Macie was placed in the same residential care home as him. Macie is also recorded as speaking to Department staff 20 times in relation to HSB by Lee.

---

<sup>35</sup> Department of Communities 2018, *Better Care Better Services. Safety and quality standards for children and young people in protection and care*, p. 5.

This included expressing fears within the first six days of sharing a residential care placement with Lee that he was “taking advantage of her” and directly raising her fear of being sexually assaulted with staff six weeks into her and Lee’s shared placement.

Case files contained records of both Macie and Lee being told by their respective care teams that the problems they had raised were the result of their own actions, for example, placing themselves in unsafe situations or not engaging with supports offered. The Department records also indicated that the safety disclosures Macie and Lee made to a variety of Department staff over a number of years independently came to be seen by some staff in their respective care teams as attempts to influence placement decisions and were subsequently discounted when later raised.

The fact that both Macie and Lee had this experience across separate District Office and out-of-home care teams over a number of years suggests there was a systemic issue regarding inconsistent implementation of Quality Standards 2 and 7 of the Department’s Better Care, Better Service Standards. The Review was not provided with information that demonstrated this issue had been rectified in the intervening years.

The Department uses a software program called Viewpoint to assist in understanding the views of children in care.<sup>36</sup> Concerning Viewpoint surveys completed by Macie did not always trigger meaningful change for her, suggesting the Viewpoint results were not consistently used by the Department in case planning and that issues raised through Viewpoint were not consistently responded to. Lee did not always complete his Viewpoint surveys. Case file records did not demonstrate whether alternative methods were used to ascertain Lee’s views about his experience of out-of-home care.

The Auditor General’s 2018 report on young people leaving the care of the CEO noted that:

*To promote participation and engagement, the Department developed a self-interviewing web based program for all children and young people in care called Viewpoint. Support workers are required to invite all children and young people aged 5-17 to complete it as part of their planning process. In just over half (53%) of the cases we looked at, the young person did not complete the Departmental tool. The figures were even lower when compared across all 14-17 year olds in the care of the Department. Only 41 per cent had completed the tool at 31 December 2017. Data was not available for the 15 to 17 year olds.<sup>37</sup>*

---

<sup>36</sup> Department of Communities 2020, *Case Practice Manual*, Section 3.4.4, Viewpoint is a web-based software program introduced in 2011 that promotes participation by children in the development of their personal care plans and in the development of services to meet the needs of all children in care.

<sup>37</sup> Western Australian Auditor General 2018, *Young People Leaving Care*, Report 2: August 2018–19.

Again, this suggests a systemic issue was present regarding the implementation of Quality Standards 2 and 7. As above, the Review was not provided with information that demonstrated this issue has since been rectified.

### Supporting and empowering children and young people to know their rights

As reflected in Better Care, Better Services Standard 7, the Department requires that children in care must first know about their rights in order to be empowered to raise concerns about these rights not being met. The Standard requires that children in care are provided with the Charter of Rights for Children and Young People in Care and that this is reviewed with them annually.

Information available to the Review suggested that while it is likely the majority of children in care are aware of and supported to know and exercise their rights, a significant minority may not be. In 2016 the Commissioner consulted with children and young people in the care of the CEO. The Commissioner found that when asked if they had heard about or seen a copy of the Charter of Rights, 57 (66%) of the 86 children and young people who responded to this question had seen or heard of the Charter, and 29 (34%) had not.<sup>38</sup>

During the Review, numerous Department staff confirmed that not all children and young people in care have access to their care information, and that the Department does not routinely make them aware of their ability to access legal compensation for the damage they suffered, either before, during or after their time in care. In addition, Department staff informed the Review that very few children and young people make a formal complaint in relation to their experiences in residential care.

### Access to the Advocate

The service protocols for the Advocate note that the position 'reflects the Department's commitment to providing our young people in care with meaningful participation in their care'.<sup>39</sup> They also state, 'Advocacy must be responsive and timely: delays in responding to children and young people, for whatever reason, will reduce their trust and confidence in the service and is also likely to prejudice the wellbeing of the child or young person. Children and young people have a different perception of time from adults and the service needs to respond quickly'.<sup>40</sup>

There has been one FTE for this Advocate position since the inception of the role in 2006. In June 2006, there were 1,968 children in care;<sup>41</sup> as at 30 June 2020, that number had grown to 5,498.

Thirteen years into her time in care, Macie sought the involvement of the Advocate for Children in Care to support being heard by the Department. Her case records

---

<sup>38</sup> Commissioner for Children and Young People WA 2016, *Speaking Out About Raising Concerns in Care*, Commissioner for Children and Young People WA, p. 36.

<sup>39</sup> Department for Child Protection 2015, *Advocacy for children and young people in care*, p. 1.

<sup>40</sup> *Ibid*, p. 2.

<sup>41</sup> Commissioner for Children and Young People 2014, *The State of Western Australia's Children and Young People – Edition Two*, 3.19 Out-of-home care, p. 145.

note she requested a referral to the Advocate but that a worker appeared to act as a barrier to accessing the Advocate:

*"[Macie] asked if she can speak with the child advocate [staff person] said this was always an option, but they will ask her what attempts she had made to work out the situation with her Case Manager first."*

Case file records also showed that when Macie sought access to a preferred support person from the Department to help her formally have her views heard in a forensic interview, this was denied.

Despite Lee repeatedly raising concerns about his placement and the harm he may cause to other children, the Department's records do not indicate that he was referred to the Advocate, or a non-government independent advocacy service, to assist him in raising his concerns or having his views heard and understood by the Department.

It is not possible to comment on whether Lee and Macie's experiences were isolated or more widespread on the basis of the information available to the Review.

As part of the 2016 consultation by the Commissioner mentioned above, children and young people were asked whether they knew about the Advocate. Of the 81 children and young people who responded, 28 (35%) said they were aware of the Advocate, and 53 (65%) were not.<sup>42</sup>

The resources dedicated to the role of the Advocate (one FTE) and the location of the role (within the Department of Communities), combined with this lack of awareness of the position, collectively represent a systemic issue in terms of children and young people in out-of-home care having access to timely and independent advocacy services.

## Conclusions

The Department does not consistently meet Better Care, Better Services Standards 2 (children and young people, and those important to them, are continuously engaged to participate in planning and decision making that impacts on their lives and their future) and 7 (children and young people are supported and empowered to know their rights, raise their concerns, and have these responded to and resolved in a timely manner). Current policy and practice is not consistent with Royal Commission recommendations 6.4 and 6.6 in relation to the implementation of its recommended Child Safe Standards 2 and 6 in out-of-home care.

The participation of children and young people is articulated in Department standards, policies, practice frameworks and related resources. In line with the research and recommendations of the Royal Commission, the voices of children and

---

<sup>42</sup> Commissioner for Children and Young People 2016, *Speaking Out About Raising Concerns in Care*, Commissioner for Children and Young People, p.37.

young people, their concerns and disclosures of harm must be listened to, heard, responded to and be given greater weight in decision-making processes.

From the analysis conducted, it is apparent that the views of children in out-of-home care are not always heard or acted upon by the adults responsible for making care-based decisions about them.

Internal mechanisms put in place by the Department to support the ability of children in care to raise concerns, such as the Advocate, complaints processes, or Viewpoint cannot on their own address concerns raised by children in residential care. The Department should ensure these tools are easily accessible to and meaningful for children in residential care, and that the information provided by children is being appropriately responded to by case workers and decision makers for the purpose of achieving safety and the best outcomes for these children and their peers.

The information provided to the Review suggests that an advocate, independent of the Department, is required to protect and promote the rights of children in residential care. Complaints and systemic oversight bodies play a valuable role, however the experiences of young people highlight the need for an independent person who can work with individual children and families, the Department and CSOs to protect the children's interests before problems occur.

## **Finding 2**

**The information and knowledge management systems of the Department are not fit for purpose and impede decision making for children and young people and organisational accountability.**

### **Case file review**

The following questions were raised through the case file review process for further analysis:

- What impact is the Department's information management and knowledge systems, policies and practices having on decision making, support provision and/or resource allocation in relation to children in out-of-home care?
- Can children and young people in out-of-home care or previously in out-of-home care easily access their case records that are held by the Department?

### **Analysis**

#### **Information Management System**

The Department's current Information Management System (IMS) is comprised of two separate databases (ASSIST and Objective). Records relevant to a child in residential care can be stored across both databases. Both Assist and Objective are complimentary systems, with Objective as a records storage system and Assist as a data system. Staff use information in both systems when gathering or assessing information.



The case history documentation provided by the Department for Macie was approximately 20,000 pages. Lee's extended to approximately 10,000 pages. In both cases, the young people's case files included records of some unrelated children who were present in shared residential care placements. The Review was informed that case files of this size remain common.

Several Department staff described the difficulty of trying to become familiar with the contents and documents within a child's case file due to the volume of records within a full suite of case files. One staff member described the task as "intimidating".

Department staff recorded in Macie and Lee's case files on a number of occasions that the Department's IMS did not have capacity to place the specific alerts or 'red flags' on the file notes they felt necessary. The Department informed the Review that there is an 'alert' section in Assist where staff can record notes and cross-reference Objective documents that provide case details. However, current department staff across multiple teams informed the Review that the Department's IMS still does not give a comprehensive snapshot of a child's case history and that alerts only relate to a brief case history summary, with one staff member stating "case alerts and flags don't really work".

Within the Department's IMS, there are different filing repositories with different levels of access to information depending on the role of workers. It was only possible in a small number of instances to track relevant information and decision making about responses to the escalation of HSB concerns within the residential care home Macie and Lee lived in.

Department staff advised the Review that routinely some information is not filed in the required IMS databases but is left on local drives or in email folders. Department staff also advised the Review that they often have to duplicate documents across different files (e.g. residential care file; case management file).

The Royal Commission noted in their *Final Report* in 2017 that all state and territory government representatives acknowledged the need for immediate investment in new or upgraded administrative records systems to enhance the ability of child protection caseworkers to access essential information in a timely manner and to enable data to be easily extracted for national reporting.

*The representatives from Queensland, Western Australia, South Australia, Tasmania and the Northern Territory readily acknowledged that the 'legacy' systems they continued to rely on were no longer adequate and needed to be upgraded or replaced and that the insights gained from upgrade projects elsewhere would inform their thinking on how to proceed.<sup>43</sup>*

The Review was not made aware of plans by the Department to address the concerns identified in relation to its current IMS.

---

<sup>43</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report Volume 12, Contemporary out-of-home care*, Commonwealth of Australia, p. 253.

## Record keeping

The Royal Commission found “the creation of accurate records and the exercise of good recordkeeping practices are critical to identifying, preventing and responding to child sexual abuse.”<sup>44</sup> The Royal Commission went on to recommend that all institutions that engage in child-related work implement five key principles that would underpin their records and recordkeeping practices to ensure full and accurate records are created, preserved and accessible (Recommendation 8.4). The Western Australian Director of State Records subsequently provided advice to State Government Departments to assist in their implementation of Recommendation 8.4.

The Review noted that significant Department planning and care documents related to Macie and Lee (e.g. quarterly care reports, placement referrals, care plans) often consisted of copy and pasted information from previous reports. There were also a number of instances where these reports did not reflect current issues or supports in place for the young people or did not present the full set of relevant facts to decision makers. Case records documented Department staff apologising to an external professional for not providing key information in a referral form, noting the “case is so layered and involved that it is very difficult to capture everything in a small document”.

The fact that these issues were observed to have occurred across multiple case workers in separate District Offices and were raised in a contemporary context in discussions with Department and CSO staff, suggests that this remains a systemic issue for the Department today.

The RCPM states that case notes recording all relevant information must be kept in relation to each individual resident. These notes should reflect the child’s current Care Plan and Safety Plan and be detailed and objective. However, in some cases, the Review noted that key information from residential care staff had been inadequately recorded or not recorded contemporaneously. Department staff advised the Review that it remains an issue that residential care workers often do not have time to complete their case notes at the end of their shift.

The Department’s prescribed record keeping practice for staff distinguishes between objective and subjective information, and requires them to be clear if the information they are noting is their own subjective impression or actual observation.<sup>45</sup> This was not always evident in the case records sighted by the Review. Discussions with Department staff suggest that this remains an issue within care records. The impact of this was best illustrated by a senior Department staff member, who told the Review:

*“[a] child can be demonised in the [Care Arrangement Referral] or paperwork”.*

---

<sup>44</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Recordkeeping and information sharing, Volume 8*, Commonwealth of Australia, p. 9.

<sup>45</sup> Department of Communities 2020, *Case Practice Manual and Residential Care Practice Manual*.

Department staff informed the Review that they continue to rely on adherence to specific file naming conventions to find relevant documents. The Department's CPM section 4.1.6 requires staff to adhere to standard naming conventions for documents and identifies the importance of following them. However, the Review was informed that these conventions are not universally known or applied by staff. This, in turn, impacts the ability of care team members and decision makers within the Department to access all relevant information they may require. The impact of not being aware of relevant information for a child was described by an out-of-home care professional:

*“When we don’t have the information and you go ahead and something happens, it’s already too late...a child’s been hurt.”*

### Information sharing

The Royal Commission recommended that when placing a child with HSB in out-of-home care, governments and out-of-home care service providers should provide sufficient relevant information to the potential carers and residential care staff to ensure they are equipped to support the child, and additional training as necessary (Recommendation 12.12).

Successful information sharing processes are reliant on effective information management systems, accurate knowledge of information sharing policies, and appropriate resourcing to facilitate information sharing processes. However, the material analysed by the Review suggests that these factors do not exist at sufficient and consistent levels across the Department.

The Review heard from a number of Department and CSO staff that they did not consistently have timely access to information that should inform placement and management decisions for children with HSB. Feedback included:

*“There is anxiety around sharing information contrary to laws.”*

*“We rely primarily on the [referral] [for information about HSB and risk] which is written by the case manager. The [referrals] vary in quality. It depends on the ability of people to trawl through records and it can be a very time consuming process.”*

*“In reviewing the [Care Assessment Referrals] for [particular children currently in our service] HSB was not put forward as an identified issue in any of the cases and referral information. It has only been after acceptance of referral and placement commencing that we have identified these behaviours.”*

*“That tendency to hold information was seen when we saw a referral go out [from the Department] to other services and none of [the young person’s] information was in there except for a vague, ‘some sexualised behaviour’.”*

The Review also heard from Department staff that while District Office and residential care home staff at appropriate levels have access to each other's records, having sufficient time to regularly review the records of other business areas was a significant challenge in both District Offices and residential care homes.

The Review was informed that having sufficient time to provide appropriate in-person handovers at shift changes remains an issue for residential care staff. This was in addition to residential care staff concerns that they do not have sufficient time to complete full case notes at the end of a shift (as outlined above).

Case records and feedback from Department CSO staff also demonstrated that information sharing between care team members and external support providers remains an issue. In the case of Lee, his care team was not provided with timely or adequate reports by two long-term sources of therapeutic treatment during his time in out-of-home care. Department and CSO staff told the review that this remained a common issue that impacts the ability of care teams to make informed decisions.

#### Access to case records by a child or young person

The Department's CPM sets out the rules for child protection workers stating they must ensure records are accurate, considerate of natural justice and confidentiality, and meet client file management standards.<sup>46</sup> Further, the rights of an individual to seek access to their care records under the *Freedom of Information Act 1992* (FOI Act) and the processes of progressing such requests are also outlined in the CPM.<sup>47</sup> Information about access to case files or records is provided by the Department on their website<sup>48</sup> for children and young people who are or have been in the care of the CEO.

Recent research, inclusive of care leavers, has advocated firmly for a human rights approach to record keeping that includes a child's participation of records being made about them and easy access to their records when they seek them.<sup>49</sup>

The Review's observation of inaccurate documentation, inconsistent record keeping practices, and the difficulties associated with retrieving and collating full case histories for Macie and Lee raises concerns about the ability of children and young people to have access to full and accurate information about their time in care.

### **Conclusions**

The Department does not consistently meet the record keeping and information sharing expectations contained in Better Care, Better Services Standard 9 (Organisations are child focused and accountable) or Royal Commission recommendation 8.4.

For children who have been in care over many years, thousands of documents are filed in this system, and many case workers and other Department staff have

---

<sup>46</sup> Department of Communities 2020, *Casework Practice Manual*, Section 4.2.4.

<sup>47</sup> Ibid, Section 4.1.

<sup>48</sup> Department of Communities <https://www.dcp.wa.gov.au/ChildrenInCare/Pages/Access-to-Information.aspx>.

<sup>49</sup> Golding, F, Lewis, A, McKemmish, S, Rolan G, & Thorpe, K 2021, Rights in records: a Charter of Lifelong Rights in Childhood Recordkeeping in Out-of-Home Care for Australian and Indigenous Australian children and care leavers, *The International Journal of Human Rights*, DOI: 10.1080/13642987.2020.1859484.

contributed to these documents. Being able to easily review and access the key documents, understand a child's case history, and utilise the information to support placement and other decisions is essential.

The Review process itself illustrated that the Department's current IMS has the capacity to impede both data retrieval and information sharing, with lengthy delays experienced in obtaining the case file records for this Review. The Review commenced in November 2020, and initially, a staff person manually searched the database for significant documents to provide information to the Commissioner. Seven weeks after the Review commenced, information from the young people's case files was still being received in batches. In this process, information was received about children and families unrelated to the Review, and documents were found misfiled and mislabelled in both the young people's files. Responses to specific information requests related to the case files were still being received by the Commissioner into February 2021, and some requested information could ultimately not be provided by the Department.

The significant limitations of the Department's IMS and inconsistent record keeping and information sharing practices, combined with the current caseloads of child protection workers, means child protection workers do not have sufficient time to fully avail themselves of the often long and complex case histories of all the children for whom they are responsible. The inability to fully understand a child's case history, combined with an IMS that cannot be relied upon to provide appropriate alerts or flags for key incidents or concerns regarding a child, means the decision-making capacity of child protection workers and the decision makers they advise, is compromised.

Information sharing issues will continue to create problems at key decision points within the Department, within other government agencies and within community sector organisations if not addressed.

For the purposes of this Review, it is important to note that neither the CCS Act nor the *Children's Court of Western Australia Act 1988*, the *Young Offenders Act 1994* or the *Community Protection (Offender Reporting) Act 2004* appear to create a prohibition on disclosure of information between Department officers about the HSB of children in the care of the Department for purposes associated with their care, provided this disclosure is done in good faith and within the course of the duties of the Department officers in question.

Full and complete records should be made available to children in care, and former children in care, via a child-friendly process rather than require vulnerable young people to access their records via Freedom of Information requests.

## Finding 3

**The Department does not have a cohesive or effective framework or policy, practices or services to understand and respond to children and young people with harmful sexual behaviours.**

### Case file review

The following questions were raised through the case file review process for further analysis:

- Do children in out-of-home care have access to appropriate therapeutic supports or treatment to deal with HSB?
- Is there effective coordination and performance oversight mechanisms in relation to HSB or sexual abuse therapeutic services provided to children in out-of-home care, particularly where multiple and/or CSO providers are involved?
- Does the Department have appropriate policies and practices in place to identify and respond to HSB and the risks such behaviour poses to other children and young people in out-of-home care?

### Analysis

#### Access to appropriate and timely therapeutic services

The Royal Commission recommended that governments should ensure timely expert assessment is available for individual children with problematic behaviours and HSB, so they receive appropriate responses, including therapeutic intervention, which match their particular circumstances (Recommendation 10.2).

Expert opinion highlighted by the Royal Commission stated that it is important to identify and respond to all children with problematic behaviours and HSB early. This allows for specialist assessment that can identify and plan interventions tailored to the child's particular needs, background and situation so that the HSB are more likely to cease and less likely to escalate.<sup>50</sup>

The Royal Commission found there was an absence of specialist therapeutic services for HSB in WA.<sup>51</sup> This was reflected in comments made by a Department staff member to the Review:

*“Is the sector equipped [to respond to HSB]? No! Is there knowledge? No!”*

The Royal Commission also noted the WA Government's self-assessment of its responses to children's HSB in a submission to a 2010 study, highlighting that 'the submission stated that professionals, as well as caseworkers, carers and others, often lacked an understanding of children's harmful sexual behaviours'.<sup>52</sup>

---

<sup>50</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report Children with harmful sexual behaviours, Volume 10*, Commonwealth of Australia, p. 80.

<sup>51</sup> Ibid, Table 10.6, p. 180.

<sup>52</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report Children with harmful sexual behaviours, Volume 10*, Commonwealth of Australia.

The Royal Commission further reported the Australian and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA) raised concerns in the 2010 study about assessments being conducted by those with insufficient expertise. The ANZATSA submission stated, ‘the consequences of erroneous judgments may be life-long for the child, young person and, not least of all, vulnerable members of the community’.

Case file records indicated that interventions were provided to Lee after crisis points, rather than at earlier stages when his statements and behaviours should have raised clear concerns for other young people.

The Royal Commission recommended a number of principles that therapeutic intervention for children with HSB should be based on (Recommendation 10.5 – see Appendix A).

For the purposes of this Review, the Commissioner also sought advice on reasonable expectations when engaging a therapist to work with a young person with HSB, which are outlined below.<sup>53</sup> There is no evidence in case files to show that these contemporary expectations were met in Lee’s case, and there was no documentation to demonstrate that a timely expert assessment occurred. If such an assessment did occur, it did not appear to result in the provision of effective therapeutic intervention to Lee.

### **Framework of reasonable expectations when engaging a therapist**

**Pre-requisites:** Any therapist should have appropriate training in a number of areas directly and indirectly related to HSB assessment and treatment. These are HSB theory, Understanding of Child Development, Normative Sexual Development, Trauma Theory, Attachment Theory, Brain Developmental Theory. Furthermore, appropriately qualified and registered psychologists and social workers trained in therapeutic techniques should be engaged, and not unqualified ‘psychotherapists’, as the work is forensic and complex in nature and requires a high level of analytical skills.

**Planning:** Prior to starting the assessment and then possible treatment, the therapist should ensure that an appropriate framework is in place to support the work. No work should commence without an initial report to Child Protection and an assessment of the potential for criminal involvement. Community safety is the number one priority – over and above client confidentiality and client-centred practice, and all involved should be aware of the limitations of confidentiality and the need for the community safety focus.

Recommendations regarding appropriate living arrangements include other children in the home/placement safe; does there need to be statutory involvement, or are the parents/caregivers able to manage the situation? Will the young person attend any assessment and therapy sessions as directed?

---

<sup>53</sup> Pratt, R 2021, *Framework of reasonable expectations when engaging a therapist to work with SAB/HSB issues*, Information provided to the Commissioner.

**Assessment:** The assessor should be aware of current research and thinking regarding the assessment of youth engaging in HSB and also understand important issues such as base rates of recidivism, background factors associated with HSBs, Risk-Needs-Responsivity-Principles (RNR) and have experience and training in psychological testing. The assessor should be aware of and utilise HSB-specific assessment tools and checklists such as the J-SOAP II, ERASOR, PROFESOR and other emerging tools. Assessment should provide information regarding; the basis of the HSBs, who the behaviours were directed towards and why, and what the likelihood of further HSBs occurring is. By the end of the assessment, the clinician should be able to provide a formulation regarding whether treatment is required or not; what the risk of further HSBs occurring is (low, moderate, high), what type of HSBs might occur, who will be targeted (male/female/both, younger/peer aged/older/any, various body shape/hair-colour/skin-colour/other preference) and what setting (stranger assaults/familial assaults/friend assaults).

After this, assessment provides information on; what is to be covered in treatment (Bandwidth), in what amount (weekly, fortnightly, monthly: Dosage), for how long three, six, 12 months or longer: Duration).

Assessment would provide advice on living arrangements, solely based on safety of those in the family/placement, and any other rules or boundaries required. Additionally, assessment would direct whether family work was required and in what form. Finally, assessment would provide some sense of how the clinician would know treatment was working.

**Treatment:** Treatment should be adolescent-appropriate, multi-modal (talk, draw, act, role-play, drama-therapy, art-therapy, narrative-therapy), and the therapist should be aware of and apply current treatment paradigms and models. Models such as the Good-Way, Bad-Way model (Ayland & West) have been used and developed further over the past two decades. The relationship between assessed risk-level and treatment content and duration should be well-understood, from the 'RNR' point of view. Treatment targets should also be understood, as well as how to engage youth in therapy regarding those targets therapeutically. Concerns such as; the impact of pornography on HSB scripts, victimisation's impact on HSBs, ASB, ID, and ADHD and how they impact impulsivity and self-management.

Assessors and therapists should be well aware of the literature and where to access it, as well as where to both access and engage in up-to-date training. Supervision by an appropriate clinical supervisor with knowledge and skills in relevant issues should be a regular part of any clinician's practice.

**Progress reports and care team meeting attendance:** Assessment, progress and treatment exit reports should be expected and provide enough information for a case manager to understand progress. Regular attendance at case management meetings should also be expected.



## Coordination and performance oversight of therapeutic services

The Royal Commission recommended that governments should adequately fund therapeutic interventions to meet the needs of all children with HSB, that these should be delivered through a network of specialist and generalist therapeutic services, and that specialist services should also be adequately resourced to provide expert support to generalist services (Recommendation 10.3). The Royal Commission further recommended governments fund and support evaluation of services providing therapeutic interventions for problematic behaviours and HSB by children (Recommendation 10.7).

The Department's records of the interventions provided to Lee and the lack of positive outcomes achieved by these therapeutic interventions indicate there was not an ongoing quality assurance process in relation to Lee's therapeutic supports.

The Department's records also did not demonstrate a clearly defined therapeutic strategy that all service providers (Department and third-party) were collectively working to implement for the purpose of managing or interrupting Lee's HSB.

Lee was provided with intensive support coordination through the Young People with Exceptionally Complex Needs (YPECN) program when he was almost 17 years of age. YPCEN was introduced by the Department in 2012 and aims to improve the wellbeing of young people with a combination of mental health issues, substance abuse or disability. The program is funded by the Mental Health Commission and the Department, with the Department acting as lead agency.<sup>54</sup> The service targets young people who pose a significant risk of harm to themselves and/or others; require extensive support and would benefit from receiving coordinated services; for whom the existing system is not working as it should.<sup>55</sup> At the time of the Review, YPECN has the resourcing to employ two permanent coordinators and has a maximum capacity of 24 young people at any time. It is not known if this service has been evaluated.

The following comment was provided to the Review by a CSO staff member:

*"[We] know that with HSB it has to be a coordinated approach. A child can't just go and have therapy on their own. It actually needs to be much more of a care team approach where the carer needs to be involved, the school needs to be involved, any other person who has interactions with the child needs to wrap around and respond in a similar way. But that doesn't happen so it's not a coordinated response for the young person."*

The fact that Lee was provided with this intensive service coordination at such a late stage of his time in care meant that he was unable to experience the benefits that may have resulted had it been provided when his HSB first emerged.

---

<sup>54</sup> Department of Communities 2015, *At Risk Youth Strategy 2015-2018*, Appendix B.

<sup>55</sup> Government of Western Australia 2012, *Young People with Exceptionally Complex Needs*, presentation slides.

The Review was informed that the YPECN program continues to only have the resourcing to provide coordination support to 24 young people, and that the level of intensive coordination provided by YPECN is still not broadly available outside of the program for children who have exhibited or have been exposed to HSB and trauma.

Appropriate policies and practices to respond to HSB and the risk it poses

Chapter two of the CPM *Children and young people are safe from abuse and harm (including Children in Care)*<sup>56</sup> provides guidance for staff in responding to concerns for children and young people, critical incidents and allegations of abuse in care. However, case records provided to the Review suggest that this guidance is not always routinely followed.

Case records demonstrated that on a number of occasions, the concerns raised by Macie or Lee regarding HSB were not responded to with the seriousness they were due, with no coherent review of the accumulation of disclosures over time. While it is open to house management, the house psychologist, and District staff to access and review daily notes by residential care workers, this did not always occur, thus incidents and patterns of behaviours diligently documented by these workers can be missed. It therefore appears that instances of HSB or fears of HSB were largely dealt with in isolation.

The case files also contained many examples of disclosures and concerns raised by Macie about her experiences of HSB that were not recognised as HSB and/or not acted upon, or the responses were not proportionate to the risk posed to her or other children and young people in care. After Macie reported one such incident, case records identified:

*“She was scared that he [Lee] was going to rape her...he ... wasn’t taking no for an answer when she was trying to say that she didn’t like him in a boyfriend way.”*

Following this incident, there was no critical incident report made, and while case managers were updated by email, there were no documents that demonstrated any review or changes to the Safety Plans of either young person. Further, there was no record of consultation about this with the Department’s Duty of Care Unit (DOCU), no Safety and Wellbeing Assessment (SWA) initiated, no documented record of District staff following up with the young people and no record of a referral being made to a therapeutic service for Macie. This lack of responsiveness was evident in a number of other incidents.

The fact both Macie and Lee had experiences of this nature across a number of different years, staff members and care settings demonstrates the systemic nature of this issue.

---

<sup>56</sup> Department of Communities 2020, *Casework Practice Manual*, Children and young people are safe from abuse and harm (including Children in Care) 2.1.

During the Review process, the Department advised the Commissioner that:

*In June 2020, in line with recommendations by the Ombudsman of WA, Communities undertook a review of practice guidance within the Casework Practice Manual, completed in collaboration with Residential Care to identify and manage risks where a child in a care arrangement may pose a risk to another child or children, including where a child or young person displays HSB. The guidance includes strategies to enhance collaborative practice across work areas and instructions on how to conduct comprehensive safety planning to mitigate risk. This included strengthen guidance regarding safety planning, risk assessment and use of alerts on ASSIST.<sup>57</sup>*

Despite these improvements, the Department's policy and practice frameworks do not adequately account for responding to HSB, and the risk of harm HSB poses to other children and young people. As of February 2021, the Department did not have a specific policy on HSB or any practice framework guiding its staff in this area. The Review team noted that currently:

- The Department has many policies and considerable practice guidance about sexual abuse, however HSB is not acknowledged in a comprehensive or systematic way in these and particularly not in guidance for residential care settings.
- In manuals where abuse/harm or related concepts were mentioned, there were at best sporadic references to HSB. In many, there was no mention of HSB.
- There is inconsistency between the guidance provided to Department staff around how disclosures of child sexual abuse are made by children and young people (Resources under CPM 2.2.9) and the available critical incident classifications.
- The RCPM indicates what is classified as a critical incident in a group home is at the discretion of house management. It was clear in the case file records that HSB incidents and related patterns of behaviours were not routinely recorded as critical incidents.

Department staff, including senior officers, raised concerns with the Review regarding the current practice of placing children exhibiting HSB in residential care settings with other children and young people.

*“In terms of harmful sexual behaviours in [residential care], we don't get enough say about who we accept and there's no comprehensive safety planning unless there's an incident and then it's too late.”*

CSOs raised concerns with the Review regarding how the Department currently responds to children with HSB:

---

<sup>57</sup> Letter from Department of Communities to Commissioner for Children and Young People, received June 2021.

*“There are no formal mechanisms to respond to [HSB] incidents [in funded residential care placement]...there’s no robust structure in the system. It’s void of structure, process and policy to address issues.”*

*“Quite often when you see serious offending in adolescents who’ve been in care for some time, you’ll find these behaviours have been there for a really long time. You’ll see it early on in foster care, or family-based kinship care and it’s not been identified or captured early on and not appropriately managed. So you get kids who are 15-16 year olds who’ve had no chance of changing their behaviours along the way.”*

## Conclusions

The Department does not consistently meet the Better Care Better Services Safety Standard (organisations provide safe care) or Better Care Better Services Standard 4 (children and young people’s needs are met through individualised assessment and child focused practices, encompassing all aspects of their lives and wellbeing). Current Department policies, practices and services regarding HSB are not consistent with recommendations 9.1, 10.2-10.3, 10.5 and 10.7 of the Royal Commission.

Many senior staff and managers within the Department interviewed by the Review team acknowledged that children are currently at risk within residential care from the HSB and/or other challenging or abusive behaviours of other young people.

At present, the Department does not have a specific policy on HSB or a systematic and cohesive practice framework that provides sufficient guidance to its staff in this area. Specialist practice resources of this nature have been published in other states, for example, the *Adolescents with sexually abusive behaviours and their families*<sup>58</sup> and *Children with problem sexual behaviours and their families* that were released in Victoria in 2012.<sup>59</sup>

The requirement that children and young people’s individualised safety needs are consistently met as per the Standards was not evident in the case records supplied by the Department.

Requests for help from children in residential care and clear statements about fearing they may harm other residents, or be harmed by other residents, must be responded to with due gravity. Staff must also have a strong understanding and awareness of grooming behaviours and what these look like in the context of HSB.

It was evident in the case records that staff did not always act in response to disclosures or calls for help from young people appropriately, even when at times advice was offered by experienced professionals in a CSO or other government

---

<sup>58</sup> Victorian Government Department of Human Services 2012, *Adolescents with sexually abusive behaviours and their families*, Best interests case practice model, Specialist practice resource.

<sup>59</sup> Victorian Government Department of Human Services 2012, *Children with problem sexual behaviours and their families*, Best interests case practice model, Specialist practice resource.

agency. Subjective assessments of a young person's truthfulness were noted in the case records and impacted how the Department responded to their disclosures, particularly while they were living in residential care.

Inadequate responses to concerns raised by children and young people in residential care and noted by staff in their case records contribute to the normalising of HSB. HSB related issues and incidents not being recognised or recorded as a critical incident also meant they were less likely to be promptly escalated to case management teams in District Offices.

Case files also contained records showing that young people had been instructed to either keep themselves safe or to keep others safe by controlling their behaviours. Such a response continues to be ineffective and can lead to self-blaming should a vulnerable young person be harmed.

It is clearly in the best interests of children exhibiting HSB and the best interests of other children that they receive the appropriate type and level of intervention. The advice provided to the Commissioner regarding reasonable expectations when engaging a therapist to work with a young person with HSB should be regarded as the minimum requirement for external therapists providing therapeutic services to address a child's HSB.

While the YPECN program itself may not be the answer to this particular issue of young people with HSB, a YPECN-type coordination approach should be adopted in complex cases, and ideally in relation to all children in the care of the CEO who require coordinated therapeutic responses. Such an approach should be underpinned by ensuring all those within the therapeutic care team are aware of key information (within ethical and legal boundaries), that the care team are brought together on a regular basis, and that one person with the relevant expertise is responsible for coordinating and regularly reviewing the effectiveness of the therapeutic strategy.

The effectiveness of interventions is predicated on the underlying assumption that all those working to implement therapeutic strategies have the necessary qualifications and experience to do so. When interventions are effectively implemented, Australian studies show very low rates of HSB recurring post-intervention.<sup>60</sup> Specialist and 'best practice' therapeutic interventions for HSB are used in a number of domestic and international jurisdictions, including in Victoria and New South Wales. These states also have quality assurance mechanisms for therapists and supervisors working in this area.

---

<sup>60</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Children with harmful sexual behaviours, Volume 10*, Commonwealth of Australia, p. 79.

## Finding 4

**The Department does not consistently ensure that high quality and safe care by well trained and supported staff and carers is provided to children and young people in the care of the CEO living in residential care.**

### Case file review

The following questions were raised through the case file review process for further analysis:

- Do residential care staff have an appropriate level of training and experience to meet the needs of children and young people with HSB and children who have experienced sexual abuse and other forms of trauma?
- Does the Department's management of vicarious and direct trauma experienced by their residential care staff impact their ability to provide the necessary level of support to children in out-of-home care?

### Analysis

#### Training and experience of residential care staff

The Royal Commission recommended that state and territory government and out-of-home care service providers should ensure that training for residential care staff and child protection workers includes an understanding of trauma and abuse, the impact on children, and the principles of trauma-informed care to assist them to meet the needs of children in out-of-home care, including children with HSB (Recommendation 12.11).

The Royal Commission also detailed the training and support needs of caseworkers and all staff and volunteers who care for children or work in support roles in care arrangements. This included:

- Gaining a basic understanding of the normal development of children and young people, attachment theory and practice.
- Identifying harmful sexual behaviours exhibited by children and distinguishing them from healthy sexual development in children.
- Identifying early warning signs and indicators of sexual abuse, including for children and young people who are at high risk of further abuse in care.
- Recognising and responding to grooming behaviours.
- Understanding the obligations of all staff, carers and volunteers to report all suspicions of or concerns about child sexual abuse, including an understanding of laws on mandatory reporting requirements and pathways for reporting.
- Recognising the high prevalence of child sexual abuse in some out-of-home care population groups.<sup>61</sup>

---

<sup>61</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Contemporary out-of-home care, Volume 12*, Commonwealth of Australia, p. 283.

The CPM states that the Department's residential care services provide time-limited therapeutic residential care that 'focuses on creating and sustaining care environments capable of healing the traumatic impact of abuse and neglect and the disrupted attachment that ensues. It is an environment that is intended to be healing for the child, and safe for the child and staff'.<sup>62</sup>

Further, it states, 'effective therapeutic care requires a shared understanding of the child's developmental and therapeutic needs and the best way to respond to those needs', and that residential care staff have a responsibility (shared with child protection workers in District Offices) to 'address the complex interrelated needs of children who have been traumatised by providing unconditional high quality, focused care'.<sup>63</sup>

Macie and Lee's case records both contained a number of examples demonstrating that not all staff possessed the level of skills and understanding expected by the CPM. Their experiences include responses by a number of staff to incidents and behaviours that did not apply trauma-informed practices or indicate an understanding of the developmental and therapeutic needs of Macie or Lee. The fact that many of these experiences occurred across separate care teams, accommodation placements and time frames indicates that this issue is systemic in nature. Information provided to the Review did not demonstrate that this need to build the capacity of staff to the level expected by the CPM had been addressed in the intervening years and that this remains a current issue.

The RCPM lists the core duties of residential care workers and senior residential care workers as including:

- providing group and individual care to children who at times display challenging behaviour
- creating and maintaining a safe, caring and home-like environment for children consistent with the Sanctuary Framework
- planning, coordinating and participating in lifestyle and recreational activities with children to promote positive growth and development
- monitoring and contributing to the daily activities of children
- providing a high standard of care and supervision
- recording events and critical incidents via email, Log Book and case notes
- where a worker has been identified as Key Worker for a child, they are expected to have regular discussions and get to know the child more thoroughly to make sure their individual needs are being addressed by the care team and provide additional support as needed. Key workers also:
  - liaise with other residential care workers, the psychologist and the manager regarding the needs of the child they are the key worker for
  - participate in discussions, planning and reviews involving the child.

---

<sup>62</sup> Department of Communities 2020, *Casework Practice Manual* Section 3.4.22.

<sup>63</sup> *Ibid.*

The RCPM describes some of the above responsibilities of residential care workers in more detail throughout the document:

- Responding therapeutically to a child using the child's trauma profile developed by house psychologists (with input from residential care workers). The RCPM states that this includes non-judgementally accepting and co-regulating the child, discussing with the child when they might be re-enacting trauma script, and coaching the child on ways to avoid conflicts and trauma re-enactments.
- Completing Individual Safety Plans that identify and address risks for all children in their care.
- When potential for self-harm or suicidal behaviour is identified, providing additional supervision and emotional support.
- Be trauma-informed in their responses to critical incidents and able to confidently assess risk, de-escalate heightened emotions, and manage challenging situations.
- After critical incidents, maintaining the physical and emotional wellbeing of other children and staff, and providing immediate emotional first aid to all children.
- Identify problematic and harmful sexual behaviours and respond appropriately.

These responsibilities appear to be aligned to roles requiring advanced qualifications and/or significant professional training and experience.

Residential care workers are required to have a Certificate III or Certificate IV in Community Services (Protective/Residential Care) or approved equivalent or equivalent experience in working with or caring for children and young people who have experienced trauma.<sup>64</sup> Department and CSO staff provided feedback to the Review that frontline residential care staff (i.e. residential care workers and senior residential care workers) do not necessarily have the level of training, resourcing or support required to address the behaviours and complex histories of the children and young people they care for or to address the situations that they are presented with on a daily basis. Senior Department staff also noted the difficulties associated with releasing residential care workers to complete training due to the impact this has on the running of the residential care home.

It was beyond the scope of the Review to fully evaluate all of the training, refresher training and supervision made available to staff in residential care roles, supervisory roles, and in the critical adjacent decision-making roles of District staff.

The Department developed a two day training program for staff and carers in 2016 titled *Responding to concerning sexualised behaviours in children and young people*. The training is not mandatory for any staff groups. The program outline for this

---

<sup>64</sup> Department of Communities 2021, Job Description Form Residential Care Worker – Country, Generic Level 2.



training states, 'Residential Care have advised that they wish for this training to be offered four times a year'.<sup>65</sup>

The Department's 2019–2020 Annual Report indicates that as of 30 June 2020, there were 525 staff in residential care and 3,264 approved foster carers and family carers in WA.<sup>66</sup> The Department provided the following information on the frequency of the concerning sexualised behaviours workshops and participation over the last three years:

Year	Workshops conducted	Number of foster carers who participated	Number of staff who participated	Total participants
2020	2	18	10	28
2019	3	35	24	59
2018	3	53	10	63
<b>Total</b>	<b>8</b>	<b>106</b>	<b>44</b>	<b>150</b>

The Department was unable to advise the specific number of staff from residential care that participated in the workshops, nor the number of staff who have attended the training who are still working with the Department. If each of the 44 staff who attended the training from 2018–2020 were from residential care and remain part of the residential care workforce, this represents about eight per cent (8.4%) of that workforce who have attended the HSB formal training in this time.

Department staff acknowledged the need to improve access to the training and development of staff knowledge in this area:

*“There is a need for more knowledge and training for staff in houses. Their [staff] perspective of harmful sexual behaviours is based on their own personal experiences and how they respond to these behaviours.”*

*“There needs to be refinement of information and knowledge, a depth of understanding about children with sexualised behaviours.”*

*“All areas need specialist knowledge of harmful sexual behaviours.”*

Case records indicate that Department staff involved in forensic interviews at ChildFIRST had a strong understanding of the various ways children and young people may disclose child sexual abuse and HSB and the need to adjust processes to accommodate this. However, information provided to the Review also demonstrated that this understanding was not consistently integrated into practice and awareness across the Department.

<sup>65</sup> Department of Communities 2021, Information provided to the Review.

<sup>66</sup> Department of Communities 2020, *Annual Report 2019–2020*, p.12 and *Child protection activity performance information 2019–2020*, p. 20.

The Department has a psychologist attached to each residential care home whose role is not to provide individual services to young people in the homes, but to provide 'specialist advice and consultative support to residential care workers on the provision of therapeutic care to children'.<sup>67</sup> House psychologists usually work across two residential care homes.

Case records reviewed showed a period of approximately six months when there was no psychologist appointed to the house Macie and Lee resided in, including during the time they resided there together. Case records did not document reasons for this prolonged lack of a dedicated house psychologist, nor did they explain the arrangements made to ensure this support continued to be provided to house staff. Case records showed that some District Office staff were unaware there was no house psychologist in place during this time and assumed someone in this role was actively supporting staff and the young people during this time.

The period during which the residential care home did not have a house psychologist assigned overlapped with both young people experiencing significant psychological stress, including departmental and police investigations into allegations of HSB Macie made against Lee. Staff were instead required to respond to this situation without ready access to the specialist advice and support that a house psychologist would ordinarily be expected to provide.

#### Management of vicarious and direct trauma

Residential care staff often experience vicarious and direct trauma due to working with young people with significant trauma histories and present day behaviours influenced by that history. This was frequently documented in house meeting minutes and critical incident reports:

*"Staff feeling traumatised by recent incidents."*

*"I felt anxious not knowing when the children would let themselves out of the house as there are seven different exits they can access through. This meant while during periods of crisis staff couldn't go to the toilet, get a drink etc. it was difficult to use any self-care strategy other than breathe."*

Department staff advised that vicarious trauma training is available for residential care staff but is not mandatory.

Senior staff also acknowledged that residential care workers experiencing vicarious trauma and/or who have difficulty managing their own emotions would have less capacity to respond appropriately to the challenging behaviours of young people. A senior staff member with experience in psychology explained that when confronted by such challenging behaviours, staff may revert to their own internalised parenting models, including authoritarian approaches.

The Department informed the Review that reflective supervision is part of the staff supervision process, and that it is a goal that reflective supervision occurs routinely

---

<sup>67</sup> Department of Communities 2020, *Residential Care Practice Manual*, Section 1.4.

with each staff member where there is a psychologist attached and available for the residential care facility. The Department also informed the Review that it has tools and templates available to staff to support this way of practice. However, a senior Department staff member shared with the Review the challenges faced by house management in ensuring that quality reflective supervision regularly occurs in practice.

The Department needs to ensure that all residential care staff are provided with regular reflective supervision, and that those who provide this supervision are properly equipped and resourced to do so.

As noted earlier in the report, Lee provided his own thoughts about the residential care environment to a member of his care team while he was still in residential care:

*“The problem [the Residential Group Home] has is that they didn't look after their traumatised staff, and that the traumatised staff were then not able to look after the kids well.”*

### **Conclusion**

The Department did not consistently meet Better Care, Better Services Standard 8 (children and young people are provided high quality and safe care by well trained and supported staff and carers). Full implementation of the expectations set out in recommendation 12.11 of the Royal Commission would ensure that government and CSO out-of-home care providers are adequately equipped with residential care staff and child protection workers with a strong understanding of trauma, abuse, and HSB.

Case records and discussions with professionals indicated that there is not a consistent level of understanding across the Department of the variety of ways children and young people may disclose harm, particularly in relation to young people who have previously experienced sexual abuse or exhibited harmful sexual behaviours.

Limited skills, experience and professional training in the area of HSB, combined with the absence of a clear policy and practice framework and a coordinated, outcomes-focussed approach to therapeutic interventions for children and young people, appears to have impacted the ability of residential care staff to respond appropriately to children and young people with HSB and/or histories of trauma.

The Department should ensure residential care workers have the necessary training, support, skills and experience required to discharge their duties. Residential care workers are a critical component of the residential care system – their ability to successfully and sustainably perform their roles underpins the successful outcomes residential care seeks to achieve. Addressing this matter would also improve the ability of staff to support children and young people through both formal and informal disclosure processes. The Department must ensure that critical staff supports, such as house psychologists, are always available to residential care home staff if they are to be able to perform their duties effectively.

This will require additional investment in the number of residential care workers, the level of training and expertise required, and staff supports that will allow them to effectively perform their duties while maintaining their own mental health and wellbeing. If staff are overwhelmed and under-supported, this could risk dismissiveness of legitimate concerns raised by young people or inappropriate responses to disclosures they may make, as was observed in the young people's case records.

## Finding 5

**The Department's risk assessment and management strategies are not consistently effective in preventing, identifying and mitigating risks to children and young people in residential care.**

### Case file review

The following questions were raised through the case file review process for further analysis:

- Do the risk assessment practices of the Department sufficiently differentiate the levels and types of risk posed by and to different children with harmful sexual behaviours and/or who have previously experienced sexual abuse?
- Are effective and appropriate risk management strategies regularly adopted by the Department in relation to children with HSB and children who are at risk of harm?

## Analysis

### Risk assessment

The Royal Commission recommended that when placing a child with HSB in out-of-home care, governments and out-of-home care service providers should rigorously assess potential threats to the safety of other children in the placement (Recommendation 12.12).

The CPM and RCPM state workers "must consider the risks that some children may pose to others who live in...the residence when placing them in any type of care arrangement" and identifies ten risk factors to identify children considered a risk to others, including sexualised behaviours or a history of sexual assault against other children and adults. This guidance captures elements of propensity risk (i.e. the risk a young person may pose to others) however, the Royal Commission identified three other dimensions of risk of child sexual abuse in organisations (situational, vulnerability, and institutional risk).<sup>68</sup> For example, in the case of Macie, vulnerability risk should have been considered in relation to the risk of further sexual abuse on the basis of her past experiences of sexual abuse and HSB.

---

<sup>68</sup> See Appendix A - Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Making institutions child safe, Volume 6*, Commonwealth of Australia p, 262–263.

There was no documentation present in either Macie or Lee's case files that demonstrated a joined-up risk assessment covering these four dimensions of risk had been undertaken or initiated by either of their care teams during their time in care. As the Department does not have a cohesive or effective framework to assess and respond to children and young people with HSB (as outlined previously in Finding 3), it is reasonable to assume that inadequate risk assessment practices in relation to the placement of children with HSB is a systemic issue.

The Department recommends the Signs of Safety approach should be used to 'identify any risks before care arrangements for the child occurs' or after a care arrangement commences for a child.<sup>69</sup> However, the Signs of Safety Policy (2011) does not specifically indicate its use in risk assessment within care arrangements and is more applicable to risk within families. The policy states the approach should be used to determine:

- what supports are needed for families to care for their children
- whether there is sufficient safety for the child to stay within the family
- whether the situation is so dangerous that the child must be removed
- if the child is in the care system, whether there is enough safety for the child to return home.<sup>70</sup>

Risks within residential care settings are not addressed in the Signs of Safety Framework.

Through review of case records and interviews with staff of the Department, it became apparent that children and young people in residential care are commonly viewed as posing undifferentiated high levels of risk to the safety of themselves and others. It appeared that the risks posed by individual children, such as those exhibiting HSB, were not sufficiently differentiated from those posed by children who present with other forms of risk.

Case records included examples of senior staff from the Department documenting the view that safety risks posed to and by children in residential care were undifferentiated across all children in out-of-home care:

*"At present residential care does not have any other placement options for any of the children currently in [house name] and I suspect any new child to the placement could pose another dysfunctional dynamic. Unfortunately, this is the nature of the children who are throughout residential care... All four children in [house name] have their own trauma history and these histories and behaviours exist in every residential care home, even if we had the capacity to move any of the children it would only present itself to another child with similar behaviours to take up the position and hence the challenging dynamic."*

---

<sup>69</sup> Department of Communities 2020, *Casework Practice Manual* Section 2.1.2 Care arrangements for children considered a risk to others.

<sup>70</sup> Department for Child Protection 2011, Signs of Safety Policy, p.1.

To the credit of Macie's care team, her case records showed case management and residential care home staff raising concerns a number of times that the risks posed by Lee to Macie may actually be different to the risks posed by other children in residential care. However, Macie's placement arrangement with Lee went ahead and continued for seven months.

### Risk management

The CPM and RCPM each recognise that it may not always be possible to avoid placing a child who poses a risk to other children in a residential group home, particularly in urgent situations. They both state that a child who has a history of extreme violence or sexual assault should not be placed where there are younger children, children who have developmental delays, or children who are especially vulnerable for other reasons such as previous abuse. If such a placement cannot be avoided, a Safety Plan must be developed.

The RCPM states, 'residential care placements should be able to put more stringent safety plans in place for children who pose a risk to others than is possible in foster care placement. This may include separation from other children and close supervision.'<sup>71</sup> Safety planning is expected to resolve or mitigate the risk of identified safety concerns. Any risks identified as part of a child's assessment process (e.g. HSB) must be considered and the plan must contain specific strategies to 'overcome these risks to self or others.'<sup>72</sup>

Guidance for staff emphasises the individualised nature of safety planning and the specificity of a Safety Plan to 'the specific circumstances of the care arrangement and the individual child'; furthermore that the child's views are included.<sup>73</sup>

The Department's management of risk therefore hinges on individual Safety Plans and collaboration between District Offices and the Residential Care Service to address identified risks. However, case records did not document what, if any, direct collaboration occurred between the District and residential care in producing and revising Safety Plans as per Department guidance.

The effectiveness of Safety Plans is reliant on accurate information. Poor information hindered the successful implementation of Macie's Safety Plan. Analysis of the Safety Plans in place for Macie during the time she shared a residential care placement with Lee, along with discussion with Department staff revealed:

- Macie's history of sexual abuse, as well as concerning situations with male residents in previous residential care placements, were not documented in the initial Safety Plan. This information could have raised specific concerns about placement with Lee.
- In a review of the initial Safety Plan two months into the placement, some brief information about Macie's previous sexual abuse was added, however the identified risk issues and strategies to assure her safety remained largely

---

<sup>71</sup> Department of Communities 2020, *Residential Care Practice Manual*, p. 58

<sup>72</sup> *Ibid*, p. 57.

<sup>73</sup> *Ibid*, p. 57.

unchanged from the initial Safety Plan. No information about incidents or concerns raised by Macie, including fear of being raped by Lee is documented in the plan.

- Residential care staff were not aware of any specific practice requirement for direct contact between a District Office and the leadership group of a child's proposed residential care home prior to placement commencement.

Safety Plans documented for the young people regularly remained unchanged after incidents occurred, indicating they were either not reviewed as per Department policy or the review process failed to recognise that the strategies relied on to keep children safe were inadequate.

As stated under Finding 2, the Department still faces issues in relation to information management, information sharing and record keeping practices. Until these problems have been addressed, there will continue to be a risk that Safety Plans will not be based on full and accurate information.

This reliance on individual Safety Plans for children and young people also becomes problematic if the plans developed include strategies that assume or rely on adequate resourcing (e.g. staff skills and experience, staffing levels) and facilities (e.g. privacy of bedrooms and bathrooms, design that allows for vigilant supervision of children) to enable the strategies to be implemented. For example, Lee's Safety Plans suggest that the main strategy for minimising the risk he posed to other children was that he was not to be left unsupervised with any young people or be provided with opportunities to be alone with young people. These continued as the dominant risk mitigation strategies for Lee's HSB during Lee's time in care despite failing on a number of occasions. Records show that Lee had told staff that he did not feel his Safety Plan was working a number of times.

Department and CSO staff shared with the Review their experiences of unfeasible risk management strategies being put in place without meaningful and ongoing consultation with house staff:

*"[Safety Plans] may contain things that aren't feasible - house staff just have to implement and manage as best [they] can."*

*"Often our concerns are not heeded or looked at early enough in a preventative manner until there's a significant incident and then there's kind of a reaction."*

*"The Safety Plans really vary and staffing's not always consistent. The kids with HSB need eyes on them all the time to keep them safe and other kids safe and that's simply not sustainable in many of our residential care models."*

Department staff and case records also provided examples of security-based responses being employed to address shortcomings in Safety Plans when it became apparent a Safety Plan could not be feasibly implemented. In one case, the Review was told that:

*"[Residential care workers] resort to locked doors, surveillance cameras and alarms in response to unsafe, risky behaviours."*

### 'Transferring' responsibilities for risk management

Department staff are guided by the CPM and RCPM to give special consideration to the placement of children who are vulnerable due to previous abuse with children with a history of sexual assault. The Department provides clear guidance to staff about the impact of trauma on children and young people's development, including anticipating that it may impact a young person's capacity to manage risks to their own safety and wellbeing.<sup>74</sup>

Despite this, case files contained multiple discussions with Macie in which different Department staff appeared to place responsibility on her for managing the risk of sexual abuse or HSB that she faced in the home and from Lee. Responses such as these occurred in the context of Macie having reported to staff alleged coercive behaviours engaged in by Lee towards herself and documented observations by staff members who had witnessed Lee engaging in coercive behaviours towards Macie.

The Department advised the Review that:

- managing risks to children is a shared responsibility across relevant units in the Department, for example, District Office, residential care and psychology services
- when a District is asked to accept the risk before placement is made, it is because case management sits with the District and the District Director is responsible for approving placements
- a child's safety plan is developed collaboratively by the District Office and the residential care unit.

Department staff advised that if a District Office does not accept "generic" information about risks contained in a placement offer email, the placement is not able to proceed. Both Macie and Lee's case files documented multiple placement offers containing these generic paragraphs about placement risks. There was also no documentation within the case files of any escalation processes by the District Offices to executive directors or above about complex or contentious decisions with relation to the risks in residential care placements. In addition, Macie's case files did not demonstrate that her safety plans were consistently developed through the collaborative process expected.

The Review was also provided with information that suggested that CSO's are required to bear significant risk in relation to a child but do not have the decision-making powers they believe necessary to appropriately address that risk. One CSO staff member provided the following feedback to the Review:

*"The Royal Commission has said that the agency that has the child carries the risk but we don't make the decisions, nor do we make the planning [decisions] for that child either. So what happens is we carry the risk but we don't make the decisions to keep them safe."*

---

<sup>74</sup> Department of Communities, undated, *Child development and trauma guide*.



## Conclusion

The Department does not consistently meet the Better Care Better Services Safety Standard (organisations provide safe care) or the expectations set by Royal Commission recommendations 6.4, 6.6 and 12.12.

Risk assessment conducted in the course of making placement decisions must be individualised to the child and the specific placement as required by the Standards. The risk assessment methods used by the Department did not sufficiently differentiate level of risk between different children in care. In addition, the Department did not appear to follow its own guidance to give special consideration to the placement of children who are vulnerable due to previous abuse with children with a history of sexual assault.

The inherent reliance on current information and knowledge management practices as outlined in Finding 2 will continue to create the potential for Safety Plans to be based on incomplete information gaps and for risks to not be adequately accounted for and addressed.

Department staff advised the Review that the number of children in the care of the CEO with a history of sexual offences numbers less than ten. In the case of this small, clearly defined cohort of young people, it should be feasible to thoroughly assess the risk levels for these individual young people and those they reside with and plan to mitigate and manage these risks closely.

Safety Plans cannot remain focused on a single risk dimension (propensity risk based on past behaviour). Safety Plans must be based on a comprehensive assessment of the four risk dimensions as outlined by the Royal Commission occurred.

A thorough (and regularly reviewed) risk assessment examining the four dimensions of risk of child sexual abuse would enable the Department to identify the situational risks the residential care environment poses to individual children and young people, as well as how such risks may be magnified by the propensity and vulnerability risks specific to that child. Current practices should be improved by implementing additional in-depth risk and therapeutic needs assessment processes that assist staff to determine the level of risk and particular needs faced by an individual child and the appropriate way of addressing those risks and needs. Tools for risk assessment and management of HSB in residential care should be reviewed in line with Royal Commission recommendations (including Child Safe Standards one and eight) in order to improve preventative strategies.

The clarity about risk posed to and by children and young people in residential care with HSB, and the management of associated risk is further hampered by other issues outlined in this report, including lack of policy guidance in relation to HSB, lack of training and understanding of HSB by staff; and fragmented information management which undermines well-informed risk assessment.

## Finding 6

**The Department's internal safeguards and review mechanisms do not contribute effectively to the safety of children and young people in residential care.**

### Case file review

The following question was raised through the case file review process for further analysis:

- Do the Department's internal case practice supervision and review processes consistently support outcomes that promote the safety and best interests of children and young people in out-of-home care?

### Analysis

#### Internal review mechanisms

The Department's Better Care Better Service Standards outline clear safety and quality standards for children and young people in protection and care. These Standards aim to:

- protect the children and young people's safety, wellbeing and stability
- meet the needs of children, young people and their families and deliver positive outcomes
- provide a guide to best practice
- increase consumer confidence and expectations, and enhance the sector's image
- provide consistent policy and process information to all staff and carers within the sector
- provide a basis for staff and carer training
- provide a reference model for continuous improvement and evaluation of services
- provide a vehicle for the measurement of achievement in relation to the Standards; and
- provide a means of satisfying government funding and service accountability requirements.<sup>75</sup>

The Standards aim for excellence and to meet the expectations of the community and the Department's legislative role to safeguard and promote the wellbeing of children and young people in the community and in out-of-home care.

The Standards themselves note, 'the Better Care, Better Services Standards represent only one aspect of an effective quality framework. The sector has a range of internal and external processes to examine all aspects of their service provision

---

<sup>75</sup> Department of Communities 2018, *Better Care Better Services. Safety and quality standards for children and young people in protection and care*, p. 5.

and assure the quality of the services they provide. This is done while identifying and implementing opportunities for continuous improvement'.<sup>76</sup>

Previous work by the Commissioner in 2017 assessed the oversight arrangements in the WA out-of-home care system at that point in time. These arrangements remain unchanged to date and were noted by the Commissioner at that time to be insufficiently robust in preventive monitoring and lacking independent individual advocacy support. The Commissioner stated:

*“Proactive mechanisms that actively seek to elicit information from service users, staff and other relevant people about how services are being delivered, are critical in high-risk environments for abuse and maltreatment. This should include a regime of regular, comprehensive inspections and visits, and a network of proactive, well-resourced, trained individual advocates with the cultural competence and expertise to engage with children and young people in out-of-home care.”*

*“Inspection and monitoring of the out-of-home care system should involve an objective consideration of the complete care experience of individual children and young people as well as systematic outcomes monitoring.”*

The Commissioner receives regular reports from the Department’s Independent Assessor reviews and ad-hoc reports from the Department’s the Standards Monitoring Unit. Both of these internal review mechanisms examine individual residential facility experience and not the child’s holistic care experience. As a result, issues that are relevant to the Department in a broader sense, such as case management practice, parental contact, education planning, IT issues, staff training and supervision are not regularly reported on. In 2017 the Commissioner found significant weaknesses in the mandate of the assessors and ambiguity in their role and purpose that restricted their effectiveness.<sup>77</sup>

The effectiveness of these internal mechanisms is also directly related to the ability of the Department to ensure uniformity in the application and completion of these processes, and to subsequently act on the decisions or recommendations made by these units.

The Department’s SMU assesses the application of the Standards and the CPM in District Offices as well as in residential care settings. Recommendations are made by the SMU, but these may not be ‘required actions’. While there is some monitoring of the ‘suggested areas of improvement’, the recommendations do not appear to be enforceable and do not always lead to improvement. Examples include:

- Documents reviewed from two Department review mechanisms note in each review, for the same group home (which both Macie and Lee resided in), concerns about record keeping practices. In 2013 concerns about record

---

<sup>76</sup> Department of Communities 2018, *Better Care Better Services. Safety and quality standards for children and young people in protection and care*, p. 5.

<sup>77</sup> Commissioner for Children and Young People 2017, *Oversight of services for children and young people in WA*.

keeping are first noted, and a 2016 review identifies particular issues with critical incident reporting processes. A review in 2018 notes continuing issues with record keeping and critical incident reporting processes, and again in 2021, some issues are noted with record keeping, including critical incident reports.

- Department internal review of case practice in one of the Districts responsible for the young people noted ongoing issues with adhering to different aspects of child safety investigation procedures across all internal reviews of the District in 2009, 2015, 2018 and 2020. Required actions were listed in each of these reviews for the District to improve practice in this area. The 2020 internal review also required the District to take action to ensure children and young people feel safe and recognise they have the right to feel safe, whilst commending the District for providing information to children about risks, safety and how they can protect themselves from harm.
- It is noted in one of the case file records that an internal work unit with a review role that was consulted by a District office provided important suggestions to the District but that they [the unit] could not direct case practice to compel the District to implement suggestions.
- A Department staff person [from a review unit] stated, “we have to have good faith that required actions are completed”.

Additionally, information provided to the Review indicates the Care Team Approach<sup>78</sup> promoted by the Department was not active and comprehensive for the young people.

As mentioned in Finding 3, there is also no internal oversight and quality assurance process where government and/or non-government providers are engaged to provide therapeutic supports to a young person. Appropriate internal oversight and assurance would ensure that a young person’s supports are coordinated and achieving the global therapeutic and wellbeing outcomes being sought by the Department.

#### Case practice supervision mechanisms

Case files provided by the Department did not contain documentation demonstrating that a regular and objective review of case records was undertaken by the care teams, or a person with the necessary expertise, or an internal oversight mechanism. Such a review would have led to the identification of repeated behaviours or patterns of behaviours indicating likely risks to the safety and wellbeing of Macie and the ineffectiveness of the safety strategies and therapeutic approaches employed in relation to Lee.

It is unclear from the information provided to the Review whether care teams currently required and/or have the resources and capacity to regularly review case notes incident reports, residential care notes and other pertinent records.

---

<sup>78</sup> Department of Communities 2016, *Care Team Approach, Practice Framework*.

It was also evident in case records of the young people that supervision and review processes of case practice decision making, particularly in relation to HSB, did not ensure the safety and best interests of both children. Some examples from case records include:

- Despite Macie disclosing fear of being raped by Lee within six weeks of placement with him, no Department officer determined that a Safety and Wellbeing Assessment (SWA), the precursor to the current Child Safety Investigation (CSI) process used by the Department, was necessary.
- When a DOCU notification (linked to a SWA) was initiated five months into their placement together to assess concerns raised by Macie about Lee, the recorded approval date by senior staff occurred after the point when key decisions affecting the safety of the young people had already been made by staff on the ground.
- Completed SWAs in Macie's case files suggest inconsistent application of the standard of proof (the balance of probabilities) as set out in the CPM. This was not picked up by senior staff who reviewed draft assessments. In turn, this may have impacted the weight given to concerns raised by Macie.

The Review acknowledges that there was more detailed reasoning in assessing allegations of harm against Macie when the SWA process was replaced by the CSI process evident in one record from 2019. This appeared to have the effect of the conclusion of 'substantiated likelihood of harm' being recorded for more of the disclosures and concerns Macie raised.

### **Conclusions**

The Department does not consistently meet Better Care Better Services Standard 9 (organisations are child focused and accountable). Royal Commission recommendations 12.4-12.5 have not been implemented in WA.

There are a number of internal review processes currently in place within the Department intended to ensure the safety and best interests of children and young people, regardless of whether they are in the community or in care. These range from supervision and review of proposed decisions by caseworkers within District Offices through to dedicated organisational units and processes. These include the Complaints Management Unit, the Duty of Care Unit, the Standards Monitoring Unit, the Advocate for Children in Care and the Care Plan Review Panel.

It was not possible to evaluate all these mechanisms in and of themselves. However, it was possible to reflect on processes of review of case practice decision-making and to observe some of these internal Departmental mechanisms in place during the period covered by this Review.

Children and young people in residential care are vulnerable and face challenges in understanding their rights, raising issues and navigating systems as was clearly evident in the experiences of Macie and Lee.

The Commissioner recommended in 2017 that a robust, comprehensive system of independent oversight for all children and young people in out-of-home care be established, and this should include:

- access to an independent advocate to support children and young people to raise concerns about their care
- monitoring of the application of policy and practice
- monitoring of the outcomes for children and young people in care.

Oversight of out-of-home care should be conducted within a transparent, coherent and comprehensive monitoring framework that is focused on ensuring the rights of children and young people are upheld, their needs met and a high standard of care provided. The level of individual advocacy available to children and young people in the care of the CEO is inadequate.

Children should have access to an independent third party advocate with whom they can not only raise issues about their care experience but from whom they can receive support navigating the out-of-home care system generally. The lack of a regular, systematic visiting program by an independent mechanism limits children and young people's right to participate in the making of decisions that affect their lives.

The Royal Commission has since recommended the mandatory implementation of Child Safe Standards and the independent oversight of these standards and out-of-home care accreditation. Such oversight would identify and alert the Department to concerns regarding its internal oversight mechanisms and processes as part of ongoing monitoring and accreditation functions, such as those identified by the Review.

There is benefit of locating an independent individual advocate function within the same oversight body responsible for the Child Safe Standards and accreditation of out-of-home care. Information from working with individual children in care could inform the system oversight activities. It is possible for one body to manage internally and effectively diverse functions such as individual advocacy, systemic advocacy, oversight and regulation.

## Recommendations

In line with the Terms of Reference, these recommendations are based on the findings of the Review and identify short, medium and long-term changes.

The actions and improvements contained within the Recommendations are required for the WA Government, through the Department, to meet the Better Care Better Services Standards.

Most importantly, these recommendations must be implemented fully and as soon as possible to ensure the rights and best interests of children and young people in residential care are upheld, that they are safe and that their needs are met.

### To the Minister for Child Protection

#### Recommendation 1

**Prioritise the full implementation of the 33 Royal Commission recommendations identified below (outlined in detail within Appendix A).**

These recommendations, accepted by the WA Government in June 2018, outline the community expectations with regard to policies, practices and services for children and young people who have experienced sexual abuse or who have HSB and to meet the needs, including safety, of children and young people in out-of-home care.

The 33 identified recommendations are:

- Recommendations 6.8–6.11 (Final Report Volume 6 Making Institutions Child Safe)
- Recommendations 7.6–7.7 (Final Report Volume 7 Improving Institutional Responding, Reporting and Record Keeping)
- Recommendation 8.4 (Final Report Volume 8 Recordkeeping and Information Sharing)
- Recommendations 9.1–9.3, 9.6, 9.8 (Final Report Volume 9 Advocacy Support and Therapeutic Services)
- Recommendations 10.1–10.7 (Final Report Volume 10 Children with Harmful Sexual Behaviours)
- Recommendations 12.4, 12.5, 12.9 -12.16, 12.18, 12.19, 12.21, 12.22 (Final Report Volume 12 Contemporary Out-of-home-care)

Comprehensive implementation of these recommendations will assist the Minister to ensure the Department is meeting the Royal Commission Child Safe Standards.

#### Recommendation 2

**Establish and resource an independent advocacy function for children and young people in the CEO's care to ensure they are supported to speak out when they feel unsafe, their views are heard and responded to, and they are able to meaningfully participate in decisions about their lives.**

The Department's Better Care Better Service Standards 2 and 7 require that children and young people in care be supported to express their views and are made aware of individual bodies and/or agencies, including the Advocate for Children in Care, who can assist them in resolving concerns. These standards align with the rights afforded to children and young people under Articles 12 and 20 of the United Nations Convention on the Rights of the Child.

The resourcing of independent advocacy supports for children and young people in out-of-home care will support the implementation of Royal Commission recommendations 6.4–6.5 and 6.8.

### **Recommendation 3**

#### **Commission the scoping of work for the implementation of an information management system fit for the functions of the Department required under the CCS Act.**

The Department's information system must enable coherent storage of information and enforce consistent document management and naming system across all work units. Such a system is required to provide all decision makers with reliable, accurate and current information to inform decision making and planning for children and young people in the CEO's care. Implementation of the system must also include training and accountability measures to improve the recording of information by staff and monitoring of data accuracy.

The information system should also be informed by contemporary research on the lifelong rights in record keeping of children in out-of-home care.

This recommendation will assist the Department to meet its existing obligations under the *State Records Act 2000* and also meet the Royal Commission recommendations 6.5, 6.6, 6.9, 8.4.<sup>79</sup>

## **To the Department of Communities**

### **Recommendation 4**

- a) **Implement a new cohesive evidence informed framework to guide the Department's responses to children and young people with harmful sexual behaviours living at home, and for those living in out-of-home care.**
- b) **Resource, mandate and deliver harmful sexual behaviours training for all staff working directly with children in care, with a priority given to staff who work with children who have been placed in the residential care system in line with Royal Commission Recommendation 12.13. This training must be continuously reviewed to ensure that the content aligns with contemporary research and best practice and be delivered regularly.**

---

<sup>79</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Children with harmful sexual behaviours, Volume 10*, Commonwealth of Australia p. 14.



The Royal Commission Final Report stated:

*Institutions should have clear policies on how to deal with harmful sexual behaviours in children. These policies should support adults within institutions to react to these behaviours when they occur and respond to incidents in an appropriate, informed and calm manner, while prioritising the safety of all children involved.<sup>80</sup>*

In relation to children and young people in care who exhibit HSB, the Royal Commission commented:

*There is a need to better protect children from, and respond to, abuse by other children in out-of-home care. In particular, there is a need to ensure professional assessments of any child who exhibits harmful sexual behaviours, followed by case management, appropriate support services, and careful placement matching – ensuring carers have the information needed for them to properly support the child, while taking steps to protect other children in the placement.<sup>81</sup>*

## **Recommendation 5**

**Implement a system to ensure that before a child with harmful sexual behaviours is placed in residential out-of-home care, the following occurs:**

- a) comprehensive assessment of the child with harmful sexual behaviours, including identifying their needs, therapeutic interventions and appropriate supports to ensure their safety**
- b) establish clear case co-ordination and review processes and a package of support services**
- c) undertake careful placement matching that includes:**
  - i. providing sufficient relevant information to the residential care staff to ensure they are equipped to support the child, and additional training as necessary**
  - ii. rigorously assessing potential threats to the safety of other children in the placement.**

This recommendation directly arises from the Royal Commission Recommendation 12.12. Undertaking such assessments will allow for informed decision making with regards to placements, particularly residential care. All Districts responsible for the children in the placement with the child with HSB should be fully informed of relevant information, risks and be included in safety planning for all the children in the home.

---

<sup>80</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Children with harmful sexual behaviours, Volume 10*, Commonwealth of Australia p. 14.

<sup>81</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Contemporary out-of-home care, Volume 12*, Commonwealth of Australia p. 20.

Placements will also need to be fully resourced in response to the particular needs of residents and specialist and therapeutic services arranged for children and young people who need them.

### **Recommendation 6**

#### **Provide comprehensive specialist services to children and young people in the care of the CEO who experience or exhibit harmful sexual behaviours.**

The Royal Commission found:

*The trauma of institutional child sexual abuse can have profound, long-lasting and cumulative impacts on victims and survivors. Many survivors face a complex set of challenges throughout their lives. At various times, depending on the circumstances, victims and survivors seek support from a range of mainstream and specialist services to help manage the detrimental impacts of abuse on their mental health. They may also need support for legal, education, housing, health, employment and financial issues, and for assistance with reporting abuse. The services used by victims and survivors span several sectors and can be difficult to navigate.<sup>82</sup>*

The Department advised that it has a legal obligation under the ‘Bennett Duty’<sup>83</sup> to ensure the legal rights of children and young people in its care are protected. The Department has a process for referring children in care to independent legal advice regarding possible legal claims for incidents that have occurred in care, which aims to ensure those legal rights are protected and the Department is safeguarded from breaching its obligations. The process for referral is managed by the Duty of Care Unit and Legal and Business Services.

The Department must ensure all children and young people in care have timely access to independent legal advice in relation to potential civil claims or other opportunities to seek compensation or redress, and that young people participate in the decision making about these actions (in accordance with their wishes).

---

<sup>82</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Advocacy, support and therapeutic services, Volume 9*, Commonwealth of Australia, p. 9.

<sup>83</sup> The Department of Communities has a duty (known as the Bennett Duty following a 1992 High Court of Australia case) to children in its care to take reasonable steps to avoid their suffering, loss and damage in consequence of a legal right, typically an entitlement to damages or compensation, not being pursued on their behalf. If there is a conflict or potential conflict with the Department due to a potential claim against the State for loss or injuries suffered in care, a child or young person is referred for independent legal advice.

## Recommendation 7

### **Review and align the risk assessment processes of the Department with the Royal Commission recommendations and the National Principles for Child Safe Organisations.**

The Royal Commission Child Safe Standards were designed to help institutions address the multiple risks that can arise for them and provide a systemic framework for them to address all the cultural, operational and environmental risks that may arise.<sup>84</sup> The Department will need to consider each standard, take time to identify related risks across all of its services, including residential care settings, and develop ways to mitigate or manage those risks.

The Royal Commission's Child Safe Standards are embedded in the National Principles for Child Safe Organisations endorsed by the Premier of Western Australia in February 2019. Whilst all the Principles are important in promoting safety and minimising risk, Principle 1 specifically states, child safety is a shared responsibility at all levels of the institution and risk management strategies focus on preventing, identifying and mitigating risk to children. Principle 8 focuses on the importance of considering physical and online environments (e.g. in residential care settings when promoting safety and wellbeing and minimising the opportunity for children and young people to be harmed). Consideration of the four dimensions of risk considered by the Royal Commission (situational, vulnerability, propensity and institutional) should be integrated into the implementation of the National Principles.

The efficacy and capacity of the Department's internal review mechanisms such as the Standards Monitoring Unit, Independent Assessors, Complaints Management Unit, and Advocate for Children in Care should also be reviewed. Recommendations, required actions, or suggestions for improvements made by these units have the potential to contribute to risk assessment and management and continuous improvement.

## Recommendation 8

### **Commission and publicly release research regarding best practice in relation to models of residential care to inform the future design, resourcing and implementation of an evidence based, safe, therapeutic, sustainable model of care for children and young people, including those with HSB.**

The Royal Commission found that while there are multiple risks commonly associated with residential care, it also presents crucial options for some of the most vulnerable and complex children in the out-of-home care system. When properly managed and resourced, residential care can bring skilled and experienced staff together with the children who most need their support.<sup>85</sup>

---

<sup>84</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Making institutions child safe, Volume 6*, Commonwealth of Australia, p. 140.

<sup>85</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Contemporary out-of-home care, Volume 12*, Commonwealth of Australia, p. 22.

The provision of residential care services both directly and through contracts is a responsibility of the Department. The commissioned research would assist the Department to specifically consider the needs of children and young people with HSB in care settings and should include meaningful participation from children and young people in residential care in WA.

### **Recommendation 9**

**Resource and deliver effective sexual education, protective behaviours, respectful relationship, ‘speaking up’ training and support to all children and young people in residential care, and the staff who provide them with support, to reduce the risk of abuse and exploitation and to those who care for them in line with Royal Commission Recommendations 12.9, 12.10, 12.11, 12.13.**

The Royal Commission stated that given the particular vulnerability of children in out-of-home care, a tailored education strategy is necessary for these children, their carers and caseworkers. Carers and practitioners often do not know how to educate children in out-of-home care about healthy relationships and to help them recognise and protect themselves from child sexual exploitation and abuse. Furthermore, the children in out-of-home care are:

- more likely to miss out on school-based education programs because of frequent disruptions to schooling as a result of family crises and care placement instability
- often have ‘limited knowledge or education about sex, sexuality and healthy relationships to draw on’
- may appear ‘worldly’ and knowledgeable about sexual matters but can lack basic knowledge of human development sexual functioning and what constitutes sexual abuse.<sup>86</sup>

---

<sup>86</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Contemporary out-of-home care, Volume 12*, Commonwealth of Australia, p. 284.

## Appendix A: Relevant Royal Commission recommendations

### Royal Commission into Institutional Responses to Child Sexual Abuse Final Report 2017

Royal Commission into Institutional Responses to Child Sexual Abuse 2017 Final Report Volume 6 Making institutions child safe	
Rec no.	Recommendation
6.4	Institutions should implement the Child Safe Standards identified by the Royal Commission.
6.5	<p>The Child Safe Standards are:</p> <ol style="list-style-type: none"> <li>1. Child safety is embedded in institutional leadership, governance and culture.</li> <li>2. Children participate in decisions affecting them and are taken seriously.</li> <li>3. Families and communities are informed and involved.</li> <li>4. Equity is upheld and diverse needs are taken into account.</li> <li>5. People working with children are suitable and supported.</li> <li>6. Processes to respond to complaints of child sexual abuse are child focused.</li> <li>7. Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training.</li> <li>8. Physical and online environments minimise the opportunity for abuse to occur.</li> <li>9. Implementation of the Child Safe Standards is continuously reviewed and improved.</li> <li>10. Policies and procedures document how the institution is child safe.</li> </ol>
6.6	<p>Identifies components core to each of the ten Child Safe Standards. Notably in relation to risk:</p> <p>Standard 1: Child safety is embedded in institutional leadership, governance and culture [including] (c) Risk management strategies focus on preventing, identifying and mitigating risks to children.</p> <p>Commissioned research by the Royal Commission identified the following dimensions of risk to support assessment of different levels of risk of child sexual abuse in institutions<sup>87</sup>. These included:</p> <ul style="list-style-type: none"> <li>• situational risk – focuses on characteristics of the physical and online environments found in the activities of given settings</li> <li>• vulnerability risk – focuses on characteristics of potential victims</li> <li>• propensity risk – focuses on characteristics of potential perpetrators</li> </ul>

<sup>87</sup> Commonwealth of Australia 2017, Royal Commission into Institutional Responses to Child Sexual Abuse *Final Report, Making institutions child safe, Volume 6*, Commonwealth of Australia, p. 262–263.

	<ul style="list-style-type: none"> <li>• institutional risk – focuses on characteristics of the organisational environment.</li> </ul>
6.8	State and territory governments should require all institutions that engage in child-related work to meet the Child Safe Standards.
6.9	<p>Legislative requirements to comply with the Child Safe Standards should cover institutions that provide:</p> <ol style="list-style-type: none"> <li>accommodation and residential services for children</li> <li>activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children</li> <li>childcare or child-minding services</li> <li>child protection services, including out-of-home care</li> <li>activities or services where clubs and associations have a significant membership of, or involvement by, children</li> <li>coaching or tuition services for children</li> <li>commercial services for children</li> <li>services for children with disability</li> <li>education services for children</li> <li>health services for children</li> <li>justice and detention services for children</li> <li>transport services for children, including school crossing services.</li> </ol>
6.10(a)	State and territory governments should ensure that an independent oversight body in each state and territory is responsible for monitoring and enforcing the Child Safe Standards. Where appropriate, this should be an existing body.
6.11	<p>Each independent state and territory oversight body should have the following additional functions:</p> <ol style="list-style-type: none"> <li>provide advice and information on the Child Safe Standards to institutions and the community</li> <li>collect, analyse and publish data on the child safe approach in that jurisdiction and provide that data to NOCS</li> <li>partner with peak bodies, professional standards bodies and/or sector leaders to work with institutions to enhance the safety of children</li> <li>provide, promote or support education and training on the Child Safe Standards to build the capacity of institutions to be child safe</li> <li>coordinate ongoing information exchange between oversight bodies relating to institutions' compliance with the Child Safe Standards.</li> </ol>

**Royal Commission into Institutional Responses to Child Sexual Abuse 2017  
Final Report Volume 7 Improving institutional responding and reporting**

Rec no.	Recommendation
7.6	<p>State and territory governments should amend child protection legislation to provide adequate protection for individuals who make complaints or reports in good faith to any institution engaging in child-related work about:</p> <ul style="list-style-type: none"> <li>a. child sexual abuse within that institution or</li> <li>b. the response of that institution to child sexual abuse.</li> </ul> <p>Such individuals should be protected from civil and criminal liability and from reprisals or other detrimental action as a result of making a complaint or report.</p>
7.7	<p>Consistent with Child Safe Standard 6: Processes to respond to complaints of child sexual abuse are child focused, institutions should have a clear, accessible and child-focused complaint handling policy and procedure that sets out how the institution should respond to complaints of child sexual abuse. The complaint handling policy and procedure should cover:</p> <ul style="list-style-type: none"> <li>a. making a complaint</li> <li>b. responding to a complaint</li> <li>c. investigating a complaint</li> <li>d. providing support and assistance</li> <li>e. achieving systemic improvements following a complaint.</li> </ul>

**Royal Commission into Institutional Responses to Child Sexual Abuse 2017  
Final Report Volume 8 Recordkeeping and information sharing**

Rec no.	Recommendation
8.4	<p>All institutions that engage in child-related work should implement the following principles for records and recordkeeping, to a level that responds to the risk of child sexual abuse occurring within the institution.</p> <p><b>Principle 1:</b> Creating and keeping full and accurate records relevant to child safety and wellbeing, including child sexual abuse, is in the best interests of children and should be an integral part of institutional leadership, governance and culture.</p> <p>Institutions that care for or provide services to children must keep the best interests of the child uppermost in all aspects of their conduct, including recordkeeping. It is in the best interest of children that institutions foster a culture in which the creation and management of accurate records are integral parts of the institution's operations and governance.</p>

**Principle 2:** Full and accurate records should be created about all incidents, responses and decisions affecting child safety and wellbeing, including child sexual abuse.

Institutions should ensure that records are created to document any identified incidents of grooming, inappropriate behaviour (including breaches of institutional codes of conduct) or child sexual abuse and all responses to such incidents. Records created by institutions should be clear, objective and thorough. They should be created at, or as close as possible to, the time the incidents occurred, and clearly show the author (whether individual or institutional) and the date created.

**Principle 3:** Records relevant to child safety and wellbeing, including child sexual abuse, should be maintained appropriately.

Records relevant to child safety and wellbeing, including child sexual abuse, should be maintained in an indexed, logical and secure manner. Associated records should be collocated or cross-referenced to ensure that people using those records are aware of all relevant information.

**Principle 4:** Records relevant to child safety and wellbeing, including child sexual abuse, should only be disposed of in accordance with law or policy.

Records relevant to child safety and wellbeing, including child sexual abuse, must only be destroyed in accordance with records disposal schedules or published institutional policies. Records relevant to child sexual abuse should be subject to minimum retention periods that allow for delayed disclosure of abuse by victims, and take account of limitation periods for civil actions for child sexual abuse.

**Principle 5:** Individuals' existing rights to access, amend or annotate records about themselves should be recognised to the fullest extent.

Individuals whose childhoods are documented in institutional records should have a right to access records made about them. Full access should be given unless contrary to law. Specific, not generic, explanations should be provided in any case where a record, or part of a record, is withheld or redacted. Individuals should be made aware of, and assisted to assert, their existing rights to request that records containing their personal information be amended or annotated, and to seek review or appeal of decisions refusing access, amendment or annotation.

**Royal Commission into Institutional Responses to Child Sexual Abuse 2017  
Final Report Volume 9 Advocacy, support and therapeutic treatment services**

Rec no.	Recommendation
9.1	The Australian Government and state and territory governments should fund dedicated community support services for victims and survivors in each jurisdiction, to provide an integrated model of advocacy and support and counselling to children and adults who experienced childhood sexual abuse in institutional contexts. Funding and related agreements should require and enable these services to:



	<ul style="list-style-type: none"> <li>a. be trauma-informed and have an understanding of institutional child sexual abuse</li> <li>b. be collaborative, available, accessible, acceptable and high quality</li> <li>c. use case management and brokerage to coordinate and meet service needs</li> <li>d. support and supervise peer-led support models.</li> </ul>
9.2	The Australian Government and state and territory governments should fund Aboriginal and Torres Strait Islander healing approaches as an ongoing, integral part of advocacy and support and therapeutic treatment service system responses for victims and survivors of child sexual abuse. These approaches should be evaluated in accordance with culturally appropriate methodologies, to contribute to evidence of best practice.
9.3	The Australian Government and state and territory governments should fund support services for people with disability who have experienced sexual abuse in childhood as an ongoing, integral part of advocacy and support and therapeutic treatment service system responses for victims and survivors of child sexual abuse.
9.6	<p>The Australian Government and state and territory governments should address existing specialist sexual assault service gaps by increasing funding for adult and child sexual assault services in each jurisdiction, to provide advocacy and support and specialist therapeutic treatment for victims and survivors, particularly victims and survivors of institutional child sexual abuse. Funding agreements should require and enable services to:</p> <ul style="list-style-type: none"> <li>a. be trauma-informed and have an understanding of institutional child sexual abuse</li> <li>b. be collaborative, available, accessible, acceptable and high quality</li> <li>c. use collaborative community development approaches</li> <li>d. provide staff with supervision and professional development.</li> </ul>
9.8	The Australian Government and state and territory government agencies responsible for the delivery of human services should ensure relevant policy frameworks and strategies recognise the needs of victims and survivors and the benefits of implementing trauma informed approaches.

**Royal Commission into Institutional Responses to Child Sexual Abuse 2017  
Final Report Volume 10 Children with Harmful Sexual Behaviours**

Rec no.	Recommendation
10.1	The Australian Government and state and territory governments should ensure the issue of children's harmful sexual behaviours is included in the national strategy to prevent child sexual abuse that we have recommended (see Recommendations 6.1 to 6.3).

	<p>Harmful sexual behaviours by children should be addressed through each of the following:</p> <ol style="list-style-type: none"> <li>a. primary prevention strategies to educate family, community members, carers and professionals (including mandatory reporters) about preventing harmful sexual behaviours</li> <li>b. secondary prevention strategies to ensure early intervention when harmful sexual behaviours are developing</li> <li>c. tertiary intervention strategies to address harmful sexual behaviours.</li> </ol>
10.2	The Australian Government and state and territory governments should ensure timely expert assessment is available for individual children with problematic and harmful sexual behaviours, so they receive appropriate responses, including therapeutic interventions, which match their particular circumstances.
10.3	The Australian Government and state and territory governments should adequately fund therapeutic interventions to meet the needs of all children with harmful sexual behaviours. These should be delivered through a network of specialist and generalist therapeutic services. Specialist services should also be adequately resourced to provide expert support to generalist services.
10.4	State and territory government should ensure that there are clear referral pathways for children with harmful sexual behaviours to access expert assessment and therapeutic intervention, regardless of whether the child is engaging voluntarily, on the advice of an institution or through their involvement with the child protection or criminal justice systems.
10.5	<p>Therapeutic intervention for children with harmful sexual behaviours should be based on the following principles:</p> <ol style="list-style-type: none"> <li>a. a contextual and systemic approach should be used</li> <li>b. family and carers should be involved</li> <li>c. safety should be established</li> <li>d. there should be accountability and responsibility for the harmful sexual behaviours</li> <li>e. there should be a focus on behaviour change</li> <li>f. developmentally and cognitively appropriate interventions should be used</li> <li>g. the care provided should be trauma-informed</li> <li>h. therapeutic services and interventions should be culturally safe</li> <li>i. therapeutic interventions should be accessible to all children with harmful sexual behaviours.</li> </ol>
10.6	The Australian Government and state and territory governments should ensure that all services funded to provide therapeutic intervention for children with harmful sexual behaviours provide professional training and clinical supervision for their staff.
10.7	The Australian Government and state and territory governments should fund and support evaluation of services providing therapeutic interventions for problematic and harmful sexual behaviours by children.

**Royal Commission into Institutional Responses to Child Sexual Abuse 2017  
Final Report Volume 12 Contemporary Out-of-home care**

Rec no.	Recommendation
12.4	<p>Each state and territory government should revise existing mandatory accreditation schemes to:</p> <ul style="list-style-type: none"> <li>a. incorporate compliance with the Child Safe Standards identified by the Royal Commission</li> <li>b. extend accreditation requirements to both government and non-government out-of-home care service providers.</li> </ul>
12.5	<p>In each state and territory, an existing statutory body or office that is independent of the relevant child protection agency and out-of-home care service providers, for example a children's guardian, should have responsibility for:</p> <ul style="list-style-type: none"> <li>a. receiving, assessing and processing applications for accreditation of out-of-home care service providers</li> <li>b. conducting audits of accredited out-of-home care service providers to ensure ongoing compliance with accreditation standards and conditions.</li> </ul>
12.9	<p>All state and territory governments should collaborate in the development of a sexual abuse prevention education strategy, including online safety, for children in out-of-home care that includes:</p> <ul style="list-style-type: none"> <li>a. input from children in out-of-home care and care-leavers</li> <li>b. comprehensive, age-appropriate and culture-appropriate education about sexuality and healthy relationships that is tailored to the needs of children in out-of-home care</li> <li>c. resources tailored for children in care, for foster and kinship/relative carers, for residential care staff and for caseworkers</li> <li>d. resources that can be adapted to the individual needs of children with disability and their carers.</li> </ul>
12.10	<p>State and territory governments, in collaboration with out-of-home care service providers and peak bodies, should develop resources to assist service providers to:</p> <ul style="list-style-type: none"> <li>a. provide appropriate support and mechanisms for children in out-of-home care to communicate, either verbally or through behaviour, their views, concerns and complaints</li> <li>b. provide appropriate training and support to carers and caseworkers to ensure they hear and respond to children in out-of-home care, including ensuring children are involved in decisions about their lives</li> <li>c. regularly consult with the children in their care as part of continuous improvement processes.</li> </ul>

12.11	State and territory governments and out-of-home care service providers should ensure that training for foster and relative/kinship carers, residential care staff and child protection workers includes an understanding of trauma and abuse, the impact on children and the principles of trauma-informed care to assist them to meet the needs of children in out-of-home care, including children with harmful sexual behaviours.
12.12	<p>When placing a child in out-of-home care, state and territory governments and out-of-home care service providers should take the following measures to support children with harmful sexual behaviours:</p> <ul style="list-style-type: none"> <li>a. undertake professional assessments of the child with harmful sexual behaviours, including identifying their needs and appropriate supports and intervention to ensure their safety</li> <li>b. establish case management and a package of support services</li> <li>c. undertake careful placement matching that includes <ul style="list-style-type: none"> <li>i. providing sufficient relevant information to the potential carer/s and residential care staff to ensure they are equipped to support the child, and additional training as necessary</li> <li>ii. rigorously assessing potential threats to the safety of other children, including the child's siblings, in the placement.</li> </ul> </li> </ul>
12.13	State and territory governments and out-of-home care service providers should provide advice, guidelines and ongoing professional development for all foster and kinship/relative carers and residential care staff about preventing and responding to the harmful sexual behaviours of some children in out-of-home care.
12.14	<p>All state and territory government should develop and implement coordinated and multi-disciplinary strategies to protect children in residential care by:</p> <ul style="list-style-type: none"> <li>a. identifying and disrupting activities that indicate risk of sexual exploitation</li> <li>b. supporting agencies to engage with children in ways that encourage them to assist in the investigation and prosecution of sexual exploitation offences.</li> </ul>
12.15	Child protection departments in all states and territories should adopt a nationally consistent definition for child sexual exploitation to enable the collection and reporting of data on sexual exploitation of children in out-of-home care as a form of child sexual abuse.
12.16	<p>All institutions that provide out-of-home care should develop strategies that increase the likelihood of safe and stable placements for children in care. Such strategies should include:</p> <ul style="list-style-type: none"> <li>a. improved processes for 'matching' children with carers and other children in a placement, including in residential care</li> <li>b. the provision of necessary information to carers about a child, prior to and during their placement, to enable carers to properly support the child</li> </ul>

	<p>c. support and training for carers to deal with the different developmental needs of children as well as managing difficult situations and challenging behaviour.</p>
12.18	<p>The key focus of residential care for children should be based on an intensive therapeutic model of care framework designed to meet the complex needs of children with histories of abuse and trauma.</p>
12.19	<p>All residential care staff should be provided with regular training and professional supervision by appropriately qualified clinicians.</p>
12.21	<p>Each state and territory government should ensure:</p> <ul style="list-style-type: none"> <li>a. the adequate assessment of all children with disability entering out-of-home care</li> <li>b. the availability and provision of therapeutic support</li> <li>c. support for disability-related needs</li> <li>d. the development and implementation of care plans that identify specific risk-management and safety strategies for individual children, including the identification of trusted and safe adults in the child's life.</li> </ul>
12.22	<p>State and territory governments should ensure that the supports provided to assist all care leavers to safely and successfully transition to independent living include:</p> <ul style="list-style-type: none"> <li>a. strategies to assist care leavers who disclose that they were sexually abused while in out-of-home care to access general post-care supports</li> <li>b. the development of targeted supports to address the specific needs of sexual abuse survivors, such as help in accessing therapeutic treatment to deal with impacts of abuse, and for these supports to be accessible until at least the age of 25.</li> </ul>

## Appendix B: Relevant Better Care, Better Services Standards

The following outlines the relevant safety and quality standards from the Department of Communities' *Better Care, Better Services - Safety and quality standards for children and young people in protection and care*

### Safety Standard

Organisations Provide Safe Care	
No.	Indicators of compliance with the safety standard
1.	<p>Children and young people's safety is embedded in the services' leadership, governance, and culture.</p> <ul style="list-style-type: none"> <li>a) Coherent child safe policies and frameworks are applied in day-to-day practice to address safety concerns and protect children and young people from harm while in care.</li> <li>b) Policies and procedures are child focused, easily accessible and clearly understood by staff, carers, children and young people, and families. Processes are in place for regular reviewing of policies, procedures, and practices.</li> </ul>
2.	<p>People working with children and young people are suitable and well supported.</p> <ul style="list-style-type: none"> <li>d) Services provide staff and carers with ongoing development and training to respond to children and young people's needs and behaviours in a safe and therapeutic way.</li> </ul>
3.	<p>Children and young people's individualised safety needs are met. Services provide a child safe environment for children and young people, and proactively minimise the opportunity for harm to occur.</p> <ul style="list-style-type: none"> <li>a) Services ask children and young people about their safety needs and are responsive to these.</li> <li>b) Services provide information to children and young people about risk and safety, and how to protect themselves and others from harm.</li> <li>c) Services deliver trauma informed care and provide therapeutic supports that respond to the complex needs and behaviours of children and young people.</li> <li>d) Services identify and assess risk and protect children and young people who are at risk of harming themselves or others.</li> <li>e) Services mitigate risk in physical and online environments to keep all children and young people in a care arrangement safe.</li> <li>f) Strategies are in place, maintained and reviewed, to support the safety of children and young people in line with their diverse social, emotional, and developmental needs.</li> <li>h) Services document safety concerns for a child or young person in a written safety plan that clearly identifies risk and specific strategies to mitigate the identified risk. The Service is to have a review process for the safety plan.</li> </ul>

## Quality Standards

### Standard 2 - Children and young people, and those important to them, are continually engaged to participate in planning and decision-making that impacts on their lives and their future

No.	Indicators of compliance
2.1	Children and young people are consulted, are listened to, and have their opinions considered when services make day to day or longer-term decisions that affect their lives.
2.2	Services, case managers and key workers support children and young people to express their views, consider these views in decision making, and respond to their needs.

### Standard 4 - Children and young people's needs are met through individualised assessment and child focused practices, encompassing all aspects of their lives and wellbeing

No.	Indicators of compliance
4.2	<ul style="list-style-type: none"> <li>a) Children and young people have their physical, developmental, and mental health needs assessed and managed in a timely manner.</li> <li>e) Children and young people are provided opportunities to engage in activities that promote learning and have access to resources to support their educational development and potential.</li> <li>i) Children and young people are assessed and offered appropriate treatment and counselling to address the effects of trauma.</li> <li>j) Children and young people report they feel cared for and are provided with emotional support to assist with recovery from the effects of trauma.</li> <li>k) Children and young people have a plan that addresses their therapeutic needs, which is reviewed regularly.</li> </ul>

### Standard 7 - Children and young people are supported and empowered to know their rights, raise their concerns, and have these responded to and resolved in a timely manner

No.	Indicators of compliance
7.1	Children and young people understand their rights in care, have a copy of the Charter of Rights, know where to access it, and have the purpose and meaning explained to them; at a minimum on an annual basis.
7.2	Children and young people know they have a right to share their concerns and are provided with regular opportunities to do so, through child friendly mechanisms.
7.3	Children and young people understand how their views have been taken into account when decisions are made about their lives. Where their wishes or

	concerns are not acted upon, children and young people are helped to understand the reasons why.
7.4	Children and young people know they will be listened to and believed, without fear of any consequences, when raising concerns. The boundaries of confidentiality will be considered and carefully explained to children and young people to avoid breaches of trust.
7.5	Children and young people can identify at least one trusted adult with whom they can raise their concerns, who will advocate for them, and will help them make sense of the decisions that have been made about their lives.
7.6	Children and young people know how to make a complaint, are provided with information about how to raise their concerns through a number of child friendly mechanisms, and are supported through the complaints process.
7.7	Children and young people are aware of individual bodies and/or agencies, and the Advocate for Children in Care, who can assist them to resolve concerns about their care and decisions made about their lives.

**Standard 8 - Children and young people are provided high quality and safe care by well trained and supported staff and carers**

No.	Indicators of compliance
8.2	<p>Staff</p> <ul style="list-style-type: none"> <li>b) Staff employed are suitable and have appropriate skills or qualifications for their role to respond to the needs of children and young people in a safe, therapeutic, and culturally appropriate way.</li> <li>c) Staff receive orientation and induction that equips them to perform their duties.</li> <li>d) Staff have access to support and advice, and are provided with regular supervision by appropriately qualified and experienced staff.</li> <li>e) Staff receive regular performance appraisals that identify strengths and areas for improvement to support them to continuously develop.</li> <li>f) Staff receive ongoing professional development opportunities, and are given training in the appropriate documentation of file notes and incident reports.</li> <li>g) Staff apply contemporary and evidenced based practice in line with the organisation and the Department's frameworks and models of therapeutic care.</li> <li>h) Staff model professional behaviour abiding by relevant codes of conduct, and have strong ethics and boundaries.</li> <li>i) Staff use professional judgment in a transparent and accountable manner and all decisions are made in the best interests of the child or young person.</li> </ul>



## Standard 9 - Organisations are child focused and accountable

No.	Indicators of compliance
9.1	<p>Management</p> <ul style="list-style-type: none"> <li>a) All relevant policies, procedures, codes of conduct and processes are written in language that is accessible and understood by children, young people, and carers.</li> <li>b) Services adhere to requirements and principles contained in legislation, and demonstrate diligence in the adoption of policies and processes, in the pursuit of the best outcomes for children and young people in care.</li> <li>c) Services maintain sound practice informed by literature, research, legislation, policies, and procedures as well as professional ethics and values. Case practice is evidence based and complies with contemporary community standards.</li> </ul>
9.2	<p>Accountability</p> <ul style="list-style-type: none"> <li>a) Services maintain clear, relevant, concise, timely, and up-to-date records, including electronic and hard copy case records, file notes, and incident reports. Records are maintained at all times.</li> <li>b) Services will ensure that original records are provided to the Department. The Department will keep these records in the child or young person's Child History folder.</li> <li>c) The rationale for decisions made in cases are clearly documented and endorsed by the appropriate staff.</li> <li>d) Services review the quality of documentation on a regular basis and continuously improve methods of recording.</li> <li>e) Services comply with relevant legislation and regulations for the protection of the confidentiality and privacy of the children and young people in care, and keep all documentation in a secure environment.</li> </ul>
9.3	<p>Child Focused</p> <ul style="list-style-type: none"> <li>a) The best interests of the child or young person is the paramount consideration for the service.</li> <li>b) Services, staff, and carers promote child safety awareness.</li> <li>c) Services develop and implement strategies to promote the participation and inclusivity of children and young people.</li> <li>d) Services recognise and respond to the specific needs of those who may experience barriers due to their cultural background, religion, spiritual beliefs, disability, identity, or sexual orientation.</li> <li>e) Services are aware of and responsive to new challenges and remain child focused through continuous improvement.</li> <li>f) Information about how to make a complaint is made available to carers, staff, and external stakeholders.</li> <li>g) Services maintain a register of complaints and disputes.</li> </ul>

- |  |  |
|--|--|
|  | <ul style="list-style-type: none"><li>h) Services encourage an environment where complaints are seen as an opportunity for service improvement and will be taken seriously, without judgment or blame</li><li>i) Services undertake a thorough review at the earliest opportunity when a complaint has been made and is finalised to identify the cause of the problem, systemic issues and errors, organisational risks and areas for improvement.</li><li>j) Services implement initiatives that support staff and carers to facilitate children and young people's safety and wellbeing particularly during times of stress and crisis, such as Employee Assistance Programs, vicarious trauma training, and promoting self-care practices.</li></ul> |
|--|--|

## Appendix C: Legislative background

### Commissioner for Children and Young People

The Review has been conducted according to the functions and powers afforded by the *Commissioner for Children and Young People Act 2006* (the CCYP Act). Under the CCYP Act one of the primary functions of the Commissioner is to monitor and review written laws, draft laws, policies, practices and services affecting the wellbeing of children and young people (section 19(g) of the CCYP Act).

The Review occurred under the authority of section 19(g) of the CCYP Act, and supported the Commissioner's function to monitor the way in which a government agency investigates or otherwise deals with a complaint made by a child or young person and the outcome of the complaint (section 19(d)).

This report has been drafted pursuant to the following legislated functions of the Commissioner for Children and Young People:

- To advocate for children and young people (section 19(a)).
- To promote the participation of children and young people in the making of decisions that affect their lives and to encourage government and non-government agencies to seek the participation of children and young people appropriate to their age and maturity (section 19(b)).
- To promote public awareness and understanding of matters relating to the wellbeing of children and young people (section 19(h)).

Section 20 of the CCYP Act obliges the Commissioner to act in specified ways when performing a legislated function, including requirements to:

- Give priority to and have special regard to the interests and needs of Aboriginal children and young people and Torres Strait Islander children and young people;
- Give priority to and have special regard to the interests and needs of children and young people who are vulnerable or disadvantaged for any reason;
- Have regard to the United Nations Convention on the Rights of the Child;
- Adopt work practices that encourage the participation of children and young people in decision making by the Commissioner; and
- Work in cooperation with, and consult with, other government agencies and non-government agencies.

Under section 21 of the CCYP Act, the Commissioner has the power to do all things necessary or convenient to be done for or in connection with the performance of the Commissioner's functions.

Section 23(2)(c) of the CCYP Act permits the Commissioner to investigate or otherwise deal with a matter affecting the wellbeing of children and young people generally which is raised through a matter related to a particular child or young person. In compliance with this limitation, the terms of reference of the Review and content of this report have been focused on the identification and remedying of

systemic issues impacting children and young people living in residential out-of-home care that were initially brought to light through the experiences of Macie.

Section 3 of the CCYP Act requires the Commissioner to regard the best interests of children and young people as the paramount consideration in the performance of their functions (The Macquarie Dictionary defines 'paramount' as 'above others in rank or authority').

Section 4 of the CCYP Act contains four principles that must be observed in the administration of the CCYP Act.

Of particular relevance to the Review are:

Section 4(a) – children and young people are entitled to live in a caring and nurturing environment and to be protected from harm and exploitation, and

Section 4(c) – the views of children and young people on all matters affecting them should be given serious consideration and taken into account.

Both sections 3 and 4 of the CCYP Act were observed in the design and execution of the Review process and the development of this report.

### **United Nations Convention on the Rights of the Child**

The United Nations Convention on the Rights of the Child (UNCRC) is the foremost international treaty on the civil, cultural, economic, political and social rights of children and young people. Australia ratified the UNCRC in 1990. As previously stated, the Commissioner for Children and Young People is required by section 20 of the CCYP Act to have regard to the UNCRC in the performance of their legislated functions.

Of particular relevance to this Review, the UNCRC affords all children and young people the following rights:

- Article 3 - in all actions concerning children, the best interests of the child shall be a primary consideration.
- Article 9 - a child shall not be separated from their parents against their will except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child.
- Article 12 - a child who is capable of forming their own views has the right to express those views freely in all matters affecting them, with their views being given due weight in accordance with their age and maturity.
- Article 19 – all appropriate legislative, administrative, social and educational measures shall be taken to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation (including sexual abuse) while in the care of parents, legal guardians or any other person who has the care of the child.
- Article 20 – a child temporarily or permanently deprived of their family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance.

- Article 34 – children have the right to be protected from all forms of sexual exploitation and sexual abuse.
- Article 39 – children have the right to have governments take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation or abuse, and that such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

## Appendix D: Department of Communities' policies and documents

Policies and related documentation provided by the Department as current at the time of the Review

- *Children and Communities Services Act 2004*
- Department of Communities Better Care, Better Services Standards (2017)
- Department of Communities Child Protection Casework Practice Manual (current as at January 2021)
- Department of Communities Residential Care Practice Manual (current as at January 2021)
- Department for Child Protection and Family Support Policy on Child Sexual Abuse (2013)
- Department of Communities Complaint Management Policy (2014)
- Department of Communities Complaint Management Policy for Children and Young People (2020)
- Department for Child Protection Residential Care (Sanctuary) Framework (2012)
- Department for Child Protection Signs of Safety Child Protection Practice Framework (2011)
- Department for Child Protection Signs of Safety Policy (2011)
- Department for Child Protection and Family Support Care Planning Policy (2010)
- Department for Child Protection and Family Support Care Team Approach Practice Framework (2016)
- Department of Communities Completing the Needs Assessment Tool Guidance for Child Protection Workers and Care Team Members (undated)
- Department of Communities Needs Assessment Tool Level Descriptors (undated)
- Department of Communities Care Arrangement Matching Framework (2017)
- Department of Communities Rapid Response Fact Sheet (Undated)
- Department for Child Protection Western Australia Participant Handbook – Responding to Concerning Sexual Behaviours in Children and Young People: A learning resource for carers and staff (Undated)
- Department for Child Protection Responding to Concerning Sexual Behaviours in Out-of-home care (Residential Care) Program Outline (undated)
- Department of Communities Residential Care Workers Orientation Checklist (2017)
- Department of Communities – Risk Assessment Table (undated)
- Department of Communities – Residential Care Services Learning Pathway (undated)
- Department of Communities - Responding to concerning sexual behaviours in residential care (undated)

- Department of Communities Child Safety Investigation Flowchart (undated)
- Department of Communities Critical Incident Reporting Policy (2020)
- Department of Communities - Building a Better Future OOHRC Reform Program Roadmap 2019-2023
- Department for Child Protection and Family Support Out-of-home care Reform in WA - Building a Better Future (2016)
- Department of Communities Building Safety When Harm is Denied (2020)
- Department of Communities Child Development and Trauma Guide (undated)
- Department of Communities Treatment Needs for Children and Families Affected by Child Sexual Abuse (2020)
- Department of Communities and Community Service Organisations Protocol for Standard of Care and Allegations of Abuse in Care for Children in the CEOs Care (2020)
- Department of Communities Critical Incident Reports (2018)
- Department for Child Protection and Family Support Indicators of child sexual abuse (undated)
- Department for Child Protection and Family Support Child Sexual Abuse Accommodation Syndrome (Undated)
- Department for Child Protection and Family Support Misconceptions of child sexual abuse and types of child sexual offenders (undated)
- Department for Child Protection and Family Support Medical and forensic examination (undated)
- Department for Child Protection and Family Support Analysing the child assessment interview, forensic interview and the child's behaviour (undated)
- Department for Child Protection and Family Support Assessing behaviour and responding to the child's needs (undated)
- Department of Communities Sexual behaviours of children (undated)
- Department for Child Protection and Family Support Prompts for assessing and responding to child sexual abuse when the alleged perpetrator is a child (undated)
- Department for Child Protection and Family Support How to intervene in sexual behaviours (2012)
- Department for Child Protection and Family Support Holly-ann Martin's Protective Behaviour parenting tips (2012)
- Department for Child Protection and Family Support Preventing false allegations checklist (2012)
- Department for Child Protection and Family Support Guidelines for a safe and healing home (2012)
- Department for Child Protection and Family Support Other Matters in Planning an Investigation (undated)
- Department of Communities Flowchart Residential Care Services Critical Incident Reporting Process (undated)
- Department for Child Protection and Family Support Flowchart Summary of Actions When A Child is Missing or has Absconded (undated)

- Department of Communities Residential Care Critical Incident Summary Template
- Department of Communities Residential Care Critical Incident Report Template
- Department of Communities Residential Care Services Referral Process Map (undated)

Internal review reports – provided to the Commissioner by the Department prior to the Review

- Standards Monitoring Unit Reports regarding the [redacted] Group Home (2018)
- Independent Assessment Report and a follow-up report regarding the [redacted] Residential Group Home (2016)
- Independent Assessment Report regarding [redacted] Residential Group Home (2021)
- Standards Monitoring Unit Reports regarding [redacted] and [redacted] Districts (multiple reports)
- Department of Communities – Standards Monitoring Cycle 5 Review
- Department of Communities – Annual Assessor Review 2019/2020