

FINAL REPORT

Contemporary out-of-home care



Royal Commission
into Institutional Responses
to Child Sexual Abuse

VOLUME 12

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Volume 12

Contemporary
out-of-home care

Content warning

This volume contains information about child sexual abuse that may be distressing. We also wish to advise Aboriginal and Torres Strait Islander readers that information in this volume may have been provided by or refer to Aboriginal and Torres Strait Islander people who have died.

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Preface

The Royal Commission

The Letters Patent provided to the Royal Commission required that it ‘inquire into institutional responses to allegations and incidents of child sexual abuse and related matters’. In carrying out this task, the Royal Commission was directed to focus on systemic issues, be informed by an understanding of individual cases, and make findings and recommendations to better protect children against sexual abuse and alleviate the impact of abuse on children when it occurs. The Royal Commission did this by conducting public hearings, private sessions and a policy and research program.

Public hearings

A Royal Commission commonly does its work through public hearings. We were aware that sexual abuse of children has occurred in many institutions, all of which could be investigated in a public hearing. However, if the Royal Commission was to attempt that task, a great many resources would need to be applied over an indeterminate, but lengthy, period of time. For this reason the Commissioners accepted criteria by which Senior Counsel Assisting would identify appropriate matters for a public hearing and bring them forward as individual ‘case studies’.

The decision to conduct a case study was informed by whether or not the hearing would advance an understanding of systemic issues and provide an opportunity to learn from previous mistakes so that any findings and recommendations for future change the Royal Commission made would have a secure foundation. In some cases the relevance of the lessons to be learned will be confined to the institution the subject of the hearing. In other cases they will have relevance to many similar institutions in different parts of Australia.

Public hearings were also held to assist in understanding the extent of abuse that may have occurred in particular institutions or types of institutions. This enabled the Royal Commission to understand the ways in which various institutions were managed and how they responded to allegations of child sexual abuse. Where our investigations identified a significant concentration of abuse in one institution, the matter could be brought forward to a public hearing.

Public hearings were also held to tell the stories of some individuals, which assisted in a public understanding of the nature of sexual abuse, the circumstances in which it may occur and, most importantly, the devastating impact that it can have on people’s lives. Public hearings were open to the media and the public, and were live streamed on the Royal Commission’s website.

The Commissioners' findings from each hearing were generally set out in a case study report. Each report was submitted to the Governor-General and the governors and administrators of each state and territory and, where appropriate, tabled in the Australian Parliament and made publicly available. The Commissioners recommended some case study reports not be tabled at the time because of current or prospective criminal proceedings.

We also conducted some private hearings, which aided the Royal Commission's investigative processes.

Private sessions

When the Royal Commission was appointed, it was apparent to the Australian Government that many people (possibly thousands) would wish to tell us about their personal history of sexual abuse as a child in an institutional setting. As a result, the Australian Parliament amended the *Royal Commissions Act 1902* (Cth) to create a process called a 'private session'.

Each private session was conducted by one or two Commissioners and was an opportunity for a person to tell their story of abuse in a protected and supportive environment. Many accounts from these sessions are told in a de-identified form in this Final Report.

Written accounts allowed individuals who did not attend private sessions to share their experiences with Commissioners. The experiences of survivors described to us in written accounts have informed this Final Report in the same manner as those shared with us in private sessions.

We also decided to publish, with their consent, as many individual survivors' experiences as possible, as de-identified narratives drawn from private sessions and written accounts. These narratives are presented as accounts of events as told by survivors of child sexual abuse in institutions. We hope that by sharing them with the public they will contribute to a better understanding of the profound impact of child sexual abuse and may help to make our institutions as safe as possible for children in the future. The narratives are available as an online appendix to Volume 5, *Private sessions*.

We recognise that the information gathered in private sessions and from written accounts captures the accounts of survivors of child sexual abuse who were able to share their experiences in these ways. We do not know how well the experiences of these survivors reflect those of other victims and survivors of child sexual abuse who could not or did not attend a private session or provide a written account.

Policy and research

The Royal Commission had an extensive policy and research program that drew upon the findings made in public hearings and upon survivors' private sessions and written accounts, as well as generating new research evidence.

The Royal Commission used issues papers, roundtables and consultation papers to consult with government and non-government representatives, survivors, institutions, regulators, policy and other experts, academics, and survivor advocacy and support groups. The broader community had an opportunity to contribute to our consideration of systemic issues and our responses through our public consultation processes.

Community engagement

The community engagement component of the Royal Commission's inquiry ensured that people in all parts of Australia were offered the opportunity to articulate their experiences and views. It raised awareness of our work and allowed a broad range of people to engage with us.

We involved the general community in our work in several ways. We held public forums and private meetings with survivor groups, institutions, community organisations and service providers. We met with children and young people, people with disability and their advocates, and people from culturally and linguistically diverse communities. We also engaged with Aboriginal and Torres Strait Islander peoples in many parts of Australia, and with regional and remote communities.

Diversity and vulnerability

We heard from a wide range of people throughout the inquiry. The victims and survivors who came forward were from diverse backgrounds and had many different experiences. Factors such as gender, age, education, culture, sexuality or disability had affected their vulnerability and the institutional responses to the abuse. Certain types of institutional cultures and settings created heightened risks, and some children's lives brought them into contact with these institutions more than others.

While not inevitably more vulnerable to child sexual abuse, we heard that Aboriginal and Torres Strait Islander children, children with disability and children from culturally and linguistically diverse backgrounds were more likely to encounter circumstances that increased their risk of abuse in institutions, reduced their ability to disclose or report abuse and, if they did disclose or report, reduced their chances of receiving an adequate response.

We examined key concerns related to disability, cultural diversity and the unique context of Aboriginal and Torres Strait Islander experience, as part of our broader effort to understand what informs best practice institutional responses. We included discussion about these and other issues of heightened vulnerability in every volume. Volume 5, *Private sessions* outlines what we heard in private sessions from these specific populations.

Our interim and other reports

On 30 June 2014, in line with our Terms of Reference, we submitted a two-volume interim report of the results of the inquiry. Volume 1 described the work we had done, the issues we were examining and the work we still needed to do. Volume 2 contained a representative sample of 150 de-identified personal stories from people who had shared their experiences at a private session.

Early in the inquiry it became apparent that some issues should be reported on before the inquiry was complete to give survivors and institutions more certainty on these issues and enable governments and institutions to implement our recommendations as soon as possible. Consequently, we submitted the following reports:

- *Working With Children Checks* (August 2015)
- *Redress and civil litigation* (September 2015)
- *Criminal justice* (August 2017)

Definition of terms

The inappropriate use of words to describe child sexual abuse and the people who experience the abuse can have silencing, stigmatising and other harmful effects. Conversely, the appropriate use of words can empower and educate.

For these reasons, we have taken care with the words used in this report. Some key terms used in this volume are set out in Chapter 1, 'Introduction' and in the Final Report Glossary, in Volume 1, *Our inquiry*.

Naming conventions

To protect the identity of victims and survivors and their supporters who participated in private sessions, pseudonyms are used. These pseudonyms are indicated by the use of single inverted commas, for example, ‘Roy’.

As in our case study reports, the identities of some witnesses before public hearings and other persons referred to in the proceedings are protected through the use of assigned initials, for example, BZW.

Structure of the Final Report

The Final Report of the Royal Commission into Institutional Responses to Child Sexual Abuse consists of 17 volumes and an executive summary. To meet the needs of readers with specific interests, each volume can be read in isolation. The volumes contain cross references to enable readers to understand individual volumes in the context of the whole report.

In the Final Report:

The **Executive Summary** summarises the entire report and provides a full list of recommendations.

Volume 1, *Our inquiry* introduces the Final Report, describing the establishment, scope and operations of the Royal Commission.

Volume 2, *Nature and cause* details the nature and cause of child sexual abuse in institutional contexts. It also describes what is known about the extent of child sexual abuse and the limitations of existing studies. The volume discusses factors that affect the risk of child sexual abuse in institutions and the legal and political changes that have influenced how children have interacted with institutions over time.

Volume 3, *Impacts* details the impacts of child sexual abuse in institutional contexts. The volume discusses how impacts can extend beyond survivors, to family members, friends, and whole communities. The volume also outlines the impacts of institutional responses to child sexual abuse.

Volume 4, *Identifying and disclosing child sexual abuse* describes what we have learned about survivors’ experiences of disclosing child sexual abuse and about the factors that affect a victim’s decision whether to disclose, when to disclose and who to tell.

Volume 5, *Private sessions* provides an analysis of survivors' experiences of child sexual abuse as told to Commissioners during private sessions, structured around four key themes: experiences of abuse; circumstances at the time of the abuse; experiences of disclosure; and impact on wellbeing. It also describes the private sessions model, including how we adapted it to meet the needs of diverse and vulnerable groups.

Volume 6, *Making institutions child safe* looks at the role community prevention could play in making communities and institutions child safe, the child safe standards that will make institutions safer for children, and how regulatory oversight and practice could be improved to facilitate the implementation of these standards in institutions. It also examines how to prevent and respond to online sexual abuse in institutions in order to create child safe online environments.

Volume 7, *Improving institutional responding and reporting* examines the reporting of child sexual abuse to external government authorities by institutions and their staff and volunteers, and how institutions have responded to complaints of child sexual abuse. It outlines guidance for how institutions should handle complaints, and the need for independent oversight of complaint handling by institutions.

Volume 8, *Recordkeeping and information sharing* examines records and recordkeeping by institutions that care for or provide services to children; and information sharing between institutions with responsibilities for children's safety and wellbeing and between those institutions and relevant professionals. It makes recommendations to improve records and recordkeeping practices within institutions and information sharing between key agencies and institutions.

Volume 9, *Advocacy, support and therapeutic treatment services* examines what we learned about the advocacy and support and therapeutic treatment service needs of victims and survivors of child sexual abuse in institutional contexts, and outlines recommendations for improving service systems to better respond to those needs and assist survivors towards recovery.

Volume 10, *Children with harmful sexual behaviours* examines what we learned about institutional responses to children with harmful sexual behaviours. It discusses the nature and extent of these behaviours and the factors that may contribute to children sexually abusing other children. The volume then outlines how governments and institutions should improve their responses and makes recommendations about improving prevention and increasing the range of interventions available for children with harmful sexual behaviours.

Volume 11, *Historical residential institutions* examines what we learned about survivors' experiences of, and institutional responses to, child sexual abuse in residential institutions such as children's homes, missions, reformatories and hospitals during the period spanning post-World War II to 1990.

Volume 12, *Contemporary out-of-home care* examines what we learned about institutional responses to child sexual abuse in contemporary out-of-home care. The volume examines the nature and adequacy of institutional responses and draws out common failings. It makes recommendations to prevent child sexual abuse from occurring in out-of-home care and, where it does occur, to help ensure effective responses.

Volume 13, *Schools* examines what we learned about institutional responses to child sexual abuse in schools. The volume examines the nature and adequacy of institutional responses and draws out the contributing factors to child sexual abuse in schools. It makes recommendations to prevent child sexual abuse from occurring in schools and, where it does occur, to help ensure effective responses to that abuse.

Volume 14, *Sport, recreation, arts, culture, community and hobby groups* examines what we learned about institutional responses to child sexual abuse in sport and recreation contexts. The volume examines the nature and adequacy of institutional responses and draws out common failings. It makes recommendations to prevent child sexual abuse from occurring in sport and recreation and, where it does occur, to help ensure effective responses.

Volume 15, *Contemporary detention environments* examines what we learned about institutional responses to child sexual abuse in contemporary detention environments, focusing on youth detention and immigration detention. It recognises that children are generally safer in community settings than in closed detention. It also makes recommendations to prevent child sexual abuse from occurring in detention environments and, where it does occur, to help ensure effective responses.

Volume 16, *Religious institutions* examines what we learned about institutional responses to child sexual abuse in religious institutions. The volume discusses the nature and extent of child sexual abuse in religious institutions, the impacts of this abuse, and survivors' experiences of disclosing it. The volume examines the nature and adequacy of institutional responses to child sexual abuse in religious institutions, and draws out common factors contributing to the abuse and common failings in institutional responses. It makes recommendations to prevent child sexual abuse from occurring in religious institutions and, where it does occur, to help ensure effective responses.

Volume 17, *Beyond the Royal Commission* describes the impacts and legacy of the Royal Commission and discusses monitoring and reporting on the implementation of our recommendations.

Unless otherwise indicated, this Final Report is based on laws, policies and information current as at 30 June 2017. Private sessions quantitative information is current as at 31 May 2017.

Summary

This volume examines what we learned during our inquiry about institutional responses to child sexual abuse in contemporary (post-1990) out-of-home care. It examines the factors that continue to contribute to child sexual abuse in particular out-of-home care settings, the risks to children associated with different forms of care and some of the barriers for children in identifying and disclosing sexual abuse. While our preceding volume – Volume 11, *Historical residential institutions* – examined the sexual abuse of children in residential institutions of the past, this volume describes the current out-of-home care system.

Given that tens of thousands of Australia’s children are in out-of-home care – and that many of these children are inherently vulnerable – it is critically important to reduce their exposure to further harm. 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 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.

In this volume we consider institutional responses to disclosures of abuse, responses to risks in particular settings and additional risks for particular cohorts of children. Our recommendations are intended to strengthen and enhance existing mechanisms, and to assist governments and out-of-home care service providers to better ensure the safety of Australia’s children.

Contemporary out-of-home care in Australia

The institutional context

Each state and territory in Australia has an out-of-home care system where children who are considered unable to live safely with their families or in informal care arrangements are placed with alternative carers on a short- or long-term basis. These placements usually occur after statutory intervention by the jurisdiction’s child protection system and the courts.

The responsibility for administering, funding and delivering child protection services – including the provision of out-of-home care – rests with the states and territories. The objectives and operation of these systems are broadly similar, but no two systems are wholly alike. Each state and territory has its own array of interconnected legislation – supplemented by regulations, standards, policies and procedures – to meet its social, economic, demographic and geographic circumstances. Although the Australian Government has had a relatively minor role in contemporary child protection, with the adoption of the National Framework for Protecting Australia's Children 2009–2020 it has taken on greater responsibility for promoting a nationally consistent approach to policies and practices.

Australia's systems of out-of-home care have changed enormously in recent decades. Gone are the children's homes, mission dormitories, large disability homes and other historical residential institutions. There is now greater emphasis on placing children in home-based settings, preferably with family or kin. Residential care is still used, but those facilities are typically somewhat domestic in scale and operation. Change is ongoing. In most jurisdictions, day-to-day responsibility for out-of-home care services is being transferred from government to non-government organisations, including a small number of for-profit agencies in some jurisdictions.

Children in out-of-home care

The number of children in the contemporary out-of-home care system is rising. At 30 June 2016, there were 46,448 children in statutory out-of-home care throughout Australia – up from 25,454 children in 2006 and 13,979 in 1996. Currently more than eight out of every 1,000 children are not living at home with their parents.

Although there are variations between jurisdictions, most of these children are in kinship or relative care (48.6 per cent) and foster care (38.7 per cent). Other types of care include residential care, independent living, family group homes and other home-based care, voluntary care and uncategorised placements, such as boarding schools, refuges and hotels/motels. Some of these arrangements are not necessarily under legal orders.

The numbers of Aboriginal and Torres Strait Islander children in out-of-home care are disproportionately high in all jurisdictions. Nationally, the rate of Aboriginal and Torres Strait Islander children in out-of-home care is almost 10 times that for non-Indigenous children. Just 5 per cent of Australian children aged 0–14 years are Aboriginal or Torres Strait Islander, yet they make up 36 per cent of all children in out-of-home care.

Although data is incomplete, we heard that children with disability are also significantly over-represented. One expert witness estimated that at least 24 per cent and up to 30 per cent of children in out-of-home care have some form of disability. Similarly, surveys in Victoria and Queensland suggest that between 20 and 26 per cent of children in residential care have disability. Intellectual, learning and conduct disorders were the most prevalent forms of impairment reported.

Children from culturally and linguistically diverse backgrounds are estimated to constitute 13 to 15 per cent of children in out-of-home care, a significant proportion of whom have refugee experiences. Although no jurisdictions collect relevant data, children of care-leavers also appear to be over-represented, with research suggesting that the risks of intergenerational involvement in out-of-home care are exacerbated by social and economic disadvantage.

The role of contemporary out-of-home care in children's lives

Laws in each jurisdiction set out the role of contemporary out-of-home care, with all states and territories identifying the safety, welfare and wellbeing of children as a primary consideration in decisions made about children. All state and territory jurisdictions stipulate that children should only be removed from their families as a last resort. Where out-of-home care is needed to prevent further serious harm, the child should be protected and nurtured to grow and develop without ongoing disadvantage.

The responsibility to protect children is shared by all Australian governments, institutions and the community, with various policy and legal frameworks making it clear that protecting children is everyone's business. Child protection laws, regulations and policies in each state and territory – including those governing out-of-home care – determine the conditions for placing children in care, recruitment of carers, placement decisions, funding arrangements, and regulation and oversight of services and service providers. At the heart of the contemporary out-of-home care legislative and practice framework is the 'best interests' principle, which requires that decisions made and actions taken concerning children be in their best interests.

The contemporary out-of-home care system is an important component of ensuring children are kept safe and well. Most carers and caseworkers are committed to protecting and supporting the children in their care and we acknowledge that carers and caseworkers often provide sanctuary, stability and healing at critical points in the lives of many children.

Child sexual abuse in contemporary out-of-home care

Nature and extent of child sexual abuse in out-of-home care

Child sexual abuse covers a wide range of behaviours and can take many forms. Its nature is not changed by institutional settings but those settings do give rise to particular risks. Out-of-home care itself appears to present risks to children whose vulnerability is exacerbated by isolation from their families, communities and peers and the instability of the settings in which they live.

Perpetrators may exploit the particular features of out-of-home care settings. It is, for instance, desirable that foster carers, kinship/relative carers and residential care workers become close with the children in their care in order to protect and support them, and provide for their emotional and physical wellbeing. This proximity may present immense risk if a carer is a potential perpetrator as they will have unsupervised access to vulnerable children, usually in private settings.

Our work was informed by our public hearings, research, submissions, roundtable forums and by what we heard from survivors in private sessions and from written accounts about the sexual abuse they experienced as children in out-of-home care. While what survivors told us generally supports the available evidence, we recognise that we cannot know how well their experiences reflect those of victims and survivors who could not or did not attend a private session or provide a written account.

Of the 257 survivors who told us in a private session that they had been sexually abused in contemporary out-of-home care, 170, or 66.1 per cent, said they were abused in home-based care, and 96 (37.4 per cent) said they were abused in a residential care setting. Some told us they were abused in both types of care placements.

Some research suggests that boys are more likely than girls to be victimised by non-family perpetrators (extra-familial) and by multiple male abusers, while girls are more likely than boys to be sexually abused by family members (intra-familial). Information provided to us by survivors in private sessions is reasonably consistent with this research literature. More female survivors (94, or 81.7 per cent) than male survivors (76, or 53.5 per cent) told us about being abused in home-based care. Many female survivors also described abuse by multiple perpetrators.

Most of the survivors of sexual abuse in contemporary out-of-home care who attended a private session told us they were abused by an adult – typically a foster or kinship carer, another adult in the household, a residential care worker, or an adult outside of the care placement.

Some told us they were abused by another child, such as the biological children of their foster carers or other children in the care placement. The risks of harmful sexual behaviours by other children appear to be particularly high in residential care settings.

Factors affecting a child's vulnerability

We learned from research and from private sessions that certain individual circumstances can heighten a child's vulnerability to sexual abuse. In the context of contemporary out-of-home care, factors that most obviously contribute to greater vulnerability may include:

- previous experience of abuse or neglect
- loss of connection to family and culture
- lack of understanding of what constitutes abuse.

All children in out-of-home care are vulnerable to abuse, but their level of vulnerability may depend on their exposure to certain risk or protective factors. In contemporary out-of-home care settings, factors that need to be addressed to increase the safety of children from child sexual abuse include:

- adequate screening, authorisation and training of carers and staff
- ongoing supervision and training on how to keep children safe
- adequate monitoring and supporting of out-of-home care placements – including regularly visiting foster and kinship/relative care placements, creating opportunities to talk with children on their own, and directly observing carers and their interactions with children
- establishing residential care as a safe, supportive and therapeutic environment for children with complex needs, staffed by skilled and experienced workers
- taking sufficient care in placing and supporting children with harmful sexual behaviours, especially in residential care settings.

The impacts of child sexual abuse in out-of-home care

Children in out-of-home care may have been removed from their families of origin because of severe abuse and neglect. If these children are sexually abused while in out-of-home care, the compounding experience of abuse may result in complex trauma and cumulative harm. We heard that victims can experience feelings of betrayal and loss of trust when abused in this context. Sexual abuse can also lead to placement instability, as children may be removed from a placement as a result of disclosing abuse or because carers are unable to manage the ways in which children express complex trauma.

Experiences of sexual abuse, and a poor institutional response to that abuse, can compound other adverse experiences in childhood, setting some children on a pathway to drug and alcohol abuse, homelessness and criminal behaviour. We also heard that experiences of abuse and placement in care can have intergenerational effects. A number of survivors of sexual abuse in out-of-home care told us their parents had been sexually abused in care, or that their own children had been taken into care, or both.

Institutional responses to child sexual abuse in contemporary out-of-home care

In recent decades, out-of-home care services have been transformed by deinstitutionalisation, improved screening of organisations and carers, and stronger regulation and oversight of the out-of-home care sector. Yet during our inquiry we heard that some mistakes of the past continue to undermine the safety and wellbeing of children in care. These include that:

- child protection systems are not sufficiently focused on providing families in crisis with supports when needed, resulting in too many children continuing to enter out-of-home care
- Aboriginal and Torres Strait Islander children remain significantly overrepresented, as do children with disability and children from poor and disadvantaged families
- deficiencies in the care and support provided to children while they are in care are often compounded by the failure to adequately support care-leavers as they transition to independent living.

During our inquiry, we heard that institutional responses to child sexual abuse in contemporary out-of-home care were often compromised by factors such as failure to address systemic risks, incomplete assessment and management of risks, failure to create a culture that supports disclosures, poor responses to child sexual abuse disclosures, and failure to share information.

Addressing systemic risks

Some systemic risks are specific to residential care, such as the challenges associated with caring for groups of vulnerable adolescents in the same facility, and the use of residential care to care for children who have exhibited potentially harmful sexual behaviours, many of whom may have been victims of sexual abuse themselves. Such risks are often compounded by chronic staffing issues such as high turnover and the frequent use of casual labour, workers lacking the right mix of skills and experience, and deficiencies in staff training, supervision and support.

Some systemic risks apply to all out-of-home care settings, such as placement instability, frequently shifting care arrangements and the higher likelihood that children in care, having been separated from their families and friends, will lack external support networks. These factors, together with frequent changes in caseworkers, mean that children in out-of-home care are more likely to be isolated and with few, or sometimes no, adults they can trust. Without a rapport with trustworthy adults, children are less likely to disclose sexual abuse and other concerns.

Assessing and managing risks

While there are many variations in out-of-home care systems across Australia, we identified a number of common failures relating to assessing and managing risks in contemporary out-of-home care. These include:

- not addressing the additional challenges faced by some groups of children in care, including insufficient recognition of the role of Aboriginal and Torres Strait Islander culture in keeping children safe, and the higher vulnerability of children with disability to a range of maltreatments, including sexual abuse
- not identifying, assessing and supporting children with harmful sexual behaviours or referring them to services where they could receive an assessment, and the existence of gaps in the advice provided to prospective carers
- placement instability, adding to the difficulties children often experience in establishing trusting relationships with the array of professionals and carers who come and go in their lives
- inadequate support for many kinship/relative placements, including lower rates of financial reimbursement and limited opportunities for training and casework support
- not adequately protecting children in residential care from sexual exploitation by adults who are able to manipulate children's need for love and attention.

Creating a culture that supports disclosures

During our inquiry we heard of the difficulties that children in contemporary out-of-home care often experience in being heard, feeling safe to disclose sexual abuse, and having their concerns taken seriously. We have learned that two of the key barriers to disclosure for victims of child sexual abuse in out-of-home care are not understanding what constitutes abuse and not having someone they can trust. Making a disclosure can also be influenced by cultural and other factors, for instance, language and literacy barriers. Perpetrator behaviours can also create barriers to disclosure, such as threatening a child that disclosing the abuse may result in them being sent away – separating them from their school, friends, siblings and all that is familiar.

Noting the difficulties children in out-of-home care face in disclosing sexual abuse, it is incumbent on services to create institutional cultures in which children feel safe to disclose and are confident the person they disclose to will respond appropriately. This was confirmed by commissioned research which reported that children generally feel safe in institutions when adults listen to them and respond by taking their concerns and needs into account, including by informing the child about what action has been taken. This requires an organisational culture where adults are aware of and confident about having these difficult conversations.

Responding appropriately to disclosures

We heard about a number of different ways in which caseworkers failed to respond appropriately to a child's disclosure of sexual abuse in contemporary out-of-home care. Given that most current out-of-home care service providers have established policies and procedures for dealing with allegations of abuse, it is not clear whether caseworkers were not following procedures or whether they had not been adequately trained in how to respond when a child disclosed sexual abuse. Whatever the cause, it was clear that in some cases the treatment of the child as described to us was grossly inadequate or, at times, placed the child at further risk.

Improving information sharing

We identified the need for improved information sharing, within and across jurisdictions, to prevent and respond to child sexual abuse in out-of-home care. Of particular relevance is sharing of information about carers and others who have abused or may pose a risk to the safety of children in out-of-home care. While child protection legislation in some jurisdictions provides for sharing information about child safety with carers prior to and during placement, we heard evidence that information provided to protect children in care may sometimes be too little, too late.

Improving safety in contemporary out-of-home care

Making out-of-home care child safe

Volumes 6, *Making institutions child safe*, Volume 7, *Improving institutional responding and reporting* and Volume 8, *Recordkeeping and information sharing* present a national approach to making, improving and supporting child safe institutions. These volumes explain how institutions can be made safer for children by better preventing, identifying, responding to and reporting institutional child sexual abuse. The recommendations in Volumes 6, 7 and 8 are of general application to out-of-home care. The recommendations in this volume for making out-of-home care child safe supplement them.

Child Safe Standards

As part of our Terms of Reference, we were required to inquire into what institutions and governments should do to better protect children against child sexual abuse and related matters in institutional contexts in the future. A key aspect of this task has been to examine what makes institutions ‘child safe’.

In Volume 6, *Making institutions child safe* we recommend that all institutions implement a set of 10 Child Safe Standards we have identified (Recommendation 6.4). We also recommend the Australian Government and state and territory governments ensure the Child Safe Standards are implemented in all institutions that engage in child-related work (Recommendations 6.7, 6.10 and 6.11).

Addressing gaps in the evidence base

During our inquiry, we identified an urgent need to improve the use of information about the extent of child sexual abuse in out-of-home care. Currently only some child abuse is notified, and subsequent reporting about those notifications is limited. The Child Protection National Minimum Data Set has resulted in some recent improvements. However, there are still no reliable estimates of the number of children in out-of-home care who have been sexually abused, the characteristics of those children and who is at greater risk, or who perpetrated the abuse, when and where the abuse occurred, and the adequacy of responses.

As agreement between governments on definitions in relation to child sexual abuse will allow more consistent identification and reporting of child sexual abuse in out-of-home care, we recommend developing nationally agreed terms and definitions for this purpose (Recommendation 12.1).

We also identified enhancements to the Child Protection National Minimum Data Set that will improve the use of existing records about children in out-of-home care and help identify certain risks; and the scope for improved data collection and consistency across governments to enhance reporting on important outcome indicators (Recommendations 12.2 and 12.3).

Accreditation of out-of-home care service providers

In our view, mandatory accreditation for all out-of-home care service providers – both government and non-government – would help protect children in care from sexual abuse by promoting improved standards, transparency and public confidence in the quality of out-of-home care services.

There was broad support for adopting consistent regulation and oversight of all out-of-home care service providers, provided this did not diminish the processes in jurisdictions with more rigorous standards. We recommend each state and territory government establish mandatory accreditation schemes that are based on the Child Safe Standards (Recommendation 12.4).

There is potential for conflicts of interests where the funding agency, usually the child protection department in each jurisdiction, is also responsible for accreditation of non-government providers. As differentiating between the responsibilities of contract engagement/funder and oversight agencies is a valuable step in improving the out-of-home care system, we recommend that accreditation of service providers be undertaken by an agency independent of the lead department (Recommendation 12.5).

Carer authorisation

Carers are the bedrock of contemporary out-of-home care. Sexual abuse by carers, or their failure to support children in their care who have been abused by others, can result in significant harm. Ensuring that carers are the right people to care for children is essential.

Carer authorisation requirements differ between states and territories. Each jurisdiction subjects all types of carers to basic probity checks – usually a National Police Check, Working With Children Check and referee checks. Some jurisdictions conduct more comprehensive screening, and only some require residential care workers to be authorised. Our recommendation for nationally consistent carer authorisation assessments highlights the need for all types of carers to be assessed, and for assessments of carer suitability to – at

a minimum – include community services checks, documented risk management plans to address any risks identified through community services checks, and at least annual review of those risk management plans (Recommendation 12.6).

Foster and kinship/relative carers are, in theory, reviewed annually in most jurisdictions, and at least every two to three years in others. Existing policies indicate that these reviews should be extensive, including discussion and documentation of any changes to the household, the physical environment of the house, any allegations against the carer and the willingness of the carer to continue in the role. Additional needs or support requirements of carers can also be identified during this formal process.

Having regular reviews of authorised carers, including residential care staff, is an important accountability mechanism for ensuring out-of-home care service providers can maintain confidence in the quality and competence of their authorised carers. It is our strong view that interviews with all the children in a placement, including in residential care placements, should, as a matter of course, form part of the annual review of carers (Recommendation 12.7).

In recent years the proportion of children in kinship/relative care placements has increased rapidly in all states and territories. While the standards applied to assessing kinship/relative carers need to be equivalent to those applied to other carers, there are essential differences that must be acknowledged and incorporated into the assessment of kinship/relative carers. We found there was considerable support for the development of specific models for assessing and authorising kinship/relative carers, and note that such models are being tested and evaluated in some jurisdictions. Some of the tools being developed are strengths-based, in that they recognise the strengths of families while aiming to identify supports the family needs to keep the child safe, including building supportive relationships and maintaining community connections. We have recommended the adoption of specific models of assessment that are appropriately tailored for kinship/relative care (Recommendation 12.8).

Child sexual abuse education strategy

There was broad agreement that a strategy is needed to create and guide nationally consistent policy and practice, to prevent child sexual abuse in out-of-home care in Australia and encourage and support the disclosure of child sexual abuse at the earliest opportunity. There was also agreement that this strategy requires the development and evaluation of resources and program implementation. We recommend that all state and territory governments collaborate in developing a sexual abuse prevention education strategy for children in out-of-home care, with input from children in out-of-home care and care-leavers (Recommendation 12.9).

Ensuring the voices of children are heard

We know that complaint processes are not always child-friendly and that the notion of making a formal complaint may be foreign to many children. Some may face additional barriers, including limits on confidentiality, for example in small or remote communities or when the child is in a kinship/relative care placement and the complaint is about a family member. We recommend that state and territory governments, in close collaboration with out-of-home care providers and peak bodies, develop resources to assist out-of-home care providers to implement appropriate mechanisms for children in out-of-home care to communicate, either verbally or through behaviour, their views, concerns and complaints (Recommendation 12.10).

Ensuring all out-of-home care is trauma-informed

There is growing awareness of the need for, and a strong rationale for the value of, a trauma-informed approach to human service delivery. Support for trauma-informed care is driven, at least in part, by an expectation that this approach may reduce the incidence of further abuse.

We recommend that training for foster and relative/kinship carers, residential care staff and child protection workers includes an understanding of trauma, its 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 (Recommendation 12.11).

Children with harmful sexual behaviours

Children in out-of-home care are sometimes sexually abused by other children. We heard from experts, practitioners and survivors who told us about contemporary out-of-home care institutions that failed to protect children from the harmful sexual behaviours of other children. We also heard of institutions that did not respond effectively to the complaints by children or their families of sexual abuse by another child. We were told about institutions that did not provide appropriate support and intervention to either the child who had been sexually abused or the child who exhibited harmful sexual behaviours.

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 (Recommendations 12.12 and 12.13).

Preventing and responding to child sexual exploitation

We heard during our inquiry that strategies to identify and disrupt opportunities for the sexual exploitation of children, including children in out-of-home care, depend on central coordination and multi-disciplinary approaches. In residential care settings, children may be at acute risk of sexual exploitation if the location of residential units becomes known to perpetrators. We identified actions needed in all jurisdictions to prevent children in residential care from becoming easy targets for sexual exploitation – starting with coordinated and multi-disciplinary strategies to disrupt the sexual exploitation of children in residential care (Recommendation 12.14).

We recommend that a nationally consistent definition for child sexual exploitation be adopted to enable state and territory governments to collect relevant data, report on sexual exploitation as a form of child sexual abuse, and evaluate the success of strategies to improve the safety of children in out-of-home care from sexual exploitation (Recommendation 12.15).

Improving the safety of children in particular settings

Through our work, we also identified a number of strategies to improve the safety of children in all out-of-home care settings that need to be taken up by out-of-home care service providers, in collaboration with the child protection departments in each jurisdiction.

Increasing placement stability

The importance of stable placements and consistent care for children in contemporary out-of-home care has been emphasised by witnesses to our inquiry and submissions alike, both for the overall wellbeing of children and as a way of improving the safety of children in care. The need for sharing of information with carers about a child is of particular relevance to preventing and responding to child sexual abuse in out-of-home care. Many submissions highlighted the need for out-of-home care service providers to have access to all relevant information about a child in order to ensure the most appropriate support and placement. We also learned that carers often do not feel adequately supported to provide for the needs of the children in their care.

Out-of-home care service providers should develop practical strategies to assist in ensuring the longer term stability of foster care placements (Recommendation 12.16).

Supporting kinship and relative care

Increasing numbers of children in out-of-home care are being placed in kinship/relative care. Research indicates that children in kinship care have significantly fewer placement changes than children in other types of out-of-home care. Where they are measured, the outcomes for children in kinship/relative care placements are as good as or better than for children in foster care.

We have been told that the needs of grandparents and other kinship/relative carers who care for children who have experienced sexual abuse are not being consistently met or adequately supported, and that this issue requires the attention of all state and territory governments. We recommend that all state and territory governments ensure the financial and other supports provided to kinship/ relative carers are equivalent to those provided to foster carers, that any additional supports identified during carer assessments are funded and that additional casework support is provided to assist with maintaining birth family contact (Recommendation 12.17).

Therapeutic residential care

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. We recommend measures to make the key focus of residential care an intensive short-term therapeutic model designed to meet the complex needs of children with histories of abuse and trauma (Recommendations 12.18 and 12.19).

Improving the safety of certain groups of children

Aboriginal and Torres Strait Islander children

There is insufficient recognition in the child protection system of the essential importance of Aboriginal and Torres Strait Islander culture in keeping children safe, despite legislative and policy requirements to do so. The fundamental goal of the Aboriginal and Torres Strait Islander Child Placement Principle is to enhance and preserve Aboriginal and Torres Strait Islander children's connection to family and community and sense of identity and culture. We recommend that each state and territory government gives priority to developing and implementing plans to support the proper implementation of all elements of the placement principle (Recommendation 12.20).

Children with disability

Improving the safety of children requires mainstream out-of-home care services to develop competence in working with children with disability and high support needs. On the basis of current policies in most jurisdictions, children entering out-of-home care should have individualised care plans. These plans need to be resourced and implemented. Individualised care plans for children with disability in out-of-home care need to be based on adequate assessment upon entry into out-of-home care. Plans should incorporate specific risk-management and safety strategies for individual children, identify trusted adults in the child's life, ensure the availability and provision of therapeutic support, and ensure support for disability-related needs (Recommendation 12.21).

Supporting care-leavers to disclose

Many of the children who leave contemporary out-of-home care each year transition to independent living at a younger age, in a more abrupt manner and with far fewer emotional, social and financial supports than other young Australians. Giving care-leavers reliable and planned access to post-care support services, which are already provided on an ad hoc basis in most jurisdictions, has the potential to provide child sexual abuse survivors with the necessary tools to help them safely transition to adulthood, regardless of whether they have disclosed the abuse. Post-care supports offered to all care-leavers must be made easily accessible. In recognition of the delays in disclosure of abuse and the cluster of factors of disadvantage experienced by this group, we recommend that targeted supports to address the specific needs of sexual abuse survivors should be easily accessible until at least the age of 25 (Recommendation 12.22).

Recommendations

The following is a list of the recommendations made in this volume.

Data collection and reporting (Chapter 5)

Recommendation 12.1

The Australian Government and state and territory governments should develop nationally agreed key terms and definitions in relation to child sexual abuse for the purpose of data collection and reporting by the Australian Institute of Health and Welfare (AIHW) and the Productivity Commission.

Recommendation 12.2

The Australian Government and state and territory governments should prioritise enhancements to the Child Protection National Minimum Data Set to include:

- a. data identifying children with disability, children from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander children
- b. the number of children who were the subject of a substantiated report of sexual abuse while in out-of-home care
- c. the demographics of those children
- d. the type of out-of-home care placement in which the abuse occurred
- e. information about when the abuse occurred
- f. information about who perpetrated the abuse, including their age and their relationship to the victim, if known.

Recommendation 12.3

State and territory governments should agree on reporting definitions and data requirements to enable reporting in the *Report on government services* on outcome indicators for 'improved health and wellbeing of the child', 'safe return home' and 'permanent care'.

Accreditation of out-of-home care service providers (Chapter 5)

Recommendation 12.4

Each state and territory government should revise existing mandatory accreditation schemes to:

- a. incorporate compliance with the Child Safe Standards identified by the Royal Commission
- b. extend accreditation requirements to both government and non-government out-of-home care service providers.

Recommendation 12.5

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:

- a. receiving, assessing and processing applications for accreditation of out-of-home care service providers
- b. conducting audits of accredited out-of-home care service providers to ensure ongoing compliance with accreditation standards and conditions.

Carer authorisation (Chapter 5)

Recommendation 12.6

In addition to a National Police Check, Working With Children Check and referee checks, authorisation of all foster and kinship/relative carers and all residential care staff should include:

- a. community services checks of the prospective carer and any adult household members of home-based carers
- b. documented risk management plans to address any risks identified through community services checks
- c. at least annual review of risk management plans as part of carer reviews and more frequently as required.

Recommendation 12.7

All out-of-home care service providers should conduct annual reviews of authorised carers that include interviews with all children in the placement with the carer under review, in the absence of the carer.

Recommendation 12.8

Each state and territory government should adopt a model of assessment appropriately tailored for kinship/relative care. This type of assessment should be designed to:

- a. better identify the strengths as well as the support and training needs of kinship/relative carers
- b. ensure holistic approaches to supporting placements that are culturally safe
- c. include appropriately resourced support plans.

Child sexual abuse education strategy (Chapter 5)

Recommendation 12.9

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:

- a. input from children in out-of-home care and care-leavers
- 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
- c. resources tailored for children in care, for foster and kinship/relative carers, for residential care staff and for caseworkers
- d. resources that can be adapted to the individual needs of children with disability and their carers.

Creating a culture that supports disclosure and identification of child sexual abuse (Chapter 5)

Recommendation 12.10

State and territory governments, in collaboration with out-of-home care service providers and peak bodies, should develop resources to assist service providers to:

- 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
- 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
- c. regularly consult with the children in their care as part of continuous improvement processes.

Strengthening the capacity of carers, staff and caseworkers to support children (Chapter 5)

Recommendation 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.

Identifying, assessing and supporting children with harmful sexual behaviours (Chapter 5)

Recommendation 12.12

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:

- a. undertake professional assessments of the child with harmful sexual behaviours, including identifying their needs and appropriate supports and interventions to ensure their safety
- b. establish case management and a package of support services
- c. undertake careful placement matching that includes
 - 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
 - ii. rigorously assessing potential threats to the safety of other children, including the child's siblings, in the placement.

Recommendation 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.

Preventing and responding to child sexual exploitation (Chapter 5)

Recommendation 12.14

All state and territory governments should develop and implement coordinated and multi-disciplinary strategies to protect children in residential care by:

- a. identifying and disrupting activities that indicate risk of sexual exploitation
- b. supporting agencies to engage with children in ways that encourage them to assist in the investigation and prosecution of sexual exploitation offences.

Recommendation 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.

Increasing the stability of placements (Chapter 5)

Recommendation 12.16

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:

- a. improved processes for 'matching' children with carers and other children in a placement, including in residential care
- 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
- c. support and training for carers to deal with the different developmental needs of children as well as managing difficult situations and challenging behaviour.

Supporting kinship/relative care placements (Chapter 5)

Recommendation 12.17

Each state and territory government should ensure that:

- a. the financial support and training provided to kinship/ relative carers is equivalent to that provided to foster carers
- b. the need for any additional supports are identified during kinship/relative carer assessments and are funded
- c. additional casework support is provided to maintain birth family relationships.

Residential care (Chapter 5)

Recommendation 12.18

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.

Recommendation 12.19

All residential care staff should be provided with regular training and professional supervision by appropriately qualified clinicians.

Aboriginal and Torres Strait Islander children (Chapter 5)

Recommendation 12.20

Each state and territory government, in consultation with appropriate Aboriginal and Torres Strait Islander organisations and community representatives, should develop and implement plans to:

- a. fully implement the Aboriginal and Torres Strait Islander Child Placement Principle
- b. improve community and child protection sector understanding of the intent and scope of the principle
- c. develop outcome measures that allow quantification and reporting on the extent of the full application of the principle, and evaluation of its impact on child safety and the reunification of Aboriginal and Torres Strait Islander children with their families
- d. invest in community capacity building as a recognised part of kinship care, in addition to supporting individual carers, in recognition of the role of Aboriginal and Torres Strait Islander communities in bringing up children.

Children with disability (Chapter 5)

Recommendation 12.21

Each state and territory government should ensure:

- a. the adequate assessment of all children with disability entering out-of-home care
- b. the availability and provision of therapeutic support
- c. support for disability-related needs
- 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.

Care-leavers (Chapter 5)

Recommendation 12.22

State and territory governments should ensure that the supports provided to assist all care-leavers to safely and successfully transition to independent living include:

- 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
- 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.

1 Introduction

1.1 Overview

This volume examines what we learned throughout our inquiry about child sexual abuse in contemporary (post-1990) out-of-home care and the responses of institutions to that abuse.

The volume describes the current out-of-home care system and the profile of the children who are placed in care. It examines the nature and adequacy of institutional responses to child sexual abuse and draws out common failings in those responses. It also makes recommendations to prevent child sexual abuse from occurring in out-of-home care and, where it does occur, to help ensure effective responses to that abuse.

1.1.1 Why we focused on out-of-home care

The Commissioners selected six types of institution for in-depth examination in the Royal Commission's Final Report: children's residential institutions pre-1990; institutions providing contemporary out-of-home care; schools; sport, recreation, arts, culture, community and hobby groups; contemporary detention environments; and religious institutions. Factors that influenced the selection of these institution types included:

- the number of allegations of abuse we received about them
- the significant role they have played, or play, in children's lives
- children's vulnerability to sexual abuse in the institutions, for instance due to the high-risk nature of the particular environment or the high participation rates of children in those institutions
- the particular regulatory and governance arrangements in place.

Our decision to focus on contemporary out-of-home care was informed by the large and increasing number of children living in care. In 1997, *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*, brought national attention to out-of-home care. When the report was released, there were 14,078 children in out-of-home care, a rate of 3.0 children per 1,000 in the population.¹ By June 2016, the number had risen to 46,448 children, a rate of 8.6 per 1,000 children.²

When a child is removed from their family by a child protection department and placed in care under legal orders, the government assumes responsibility for the safety and wellbeing of the child, directly or indirectly. In doing so, the government takes on a legal and moral obligation to ensure systems are in place to care for and protect that child.

We know that children in out-of-home care are vulnerable to sexual abuse for a number of reasons. The focus of this volume is on identifying predictable and preventable risks in out-of-home care and measures to protect children from risks that arise from the institutional setting itself. It is not acceptable that some of Australia's most vulnerable children, removed from their families of origin in order to better protect and care for them, face an increased risk of sexual abuse while they are in out-of-home care.

1.1.2 Our definition of contemporary out-of-home care

Each state and territory in Australia has an out-of-home care system where children under 18 years who are unable to live safely with their families or in informal care arrangements are placed with alternative carers on a short- or long-term basis. Out-of-home care includes overnight respite and temporary care.

Children are most commonly placed in out-of-home care after statutory intervention by the relevant jurisdiction's child protection system and the courts. Alternatively, parents may make arrangements for an organisation to provide or arrange care for their child, for one or more nights.

When we refer to 'out-of-home care' or 'the out-of-home care system', we include home-based care provided by foster and kinship/relative carers and residential care settings. We examine the risks of and responses to allegations of sexual abuse of children who are in care by carers, by people not connected with out-of-home care and by children with harmful sexual behaviours.

1.1.3 Issues examined

Since 1990 there have been no fewer than six national and at least 18 state or territory inquiries into the effectiveness of child protection systems that included a focus on the treatment of children in out-of-home care (see Table 12.1).

Table 12.1 – The reports of inquiries into child protection systems in Australian jurisdictions since 1990

Jurisdiction	Inquiry /Report title
Commonwealth	<ul style="list-style-type: none"> • Senate Community Affairs References Committee, <i>Out-of-home care</i>, 2015 • Senate Community Affairs References Committee, <i>Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability</i>, 2015 • Senate Community Affairs References Committee, <i>Protecting vulnerable children: A national challenge, second report on the inquiry into children in institutional or out-of-home care</i>, 2005 • Senate Community Affairs References Committee, <i>Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children</i>, 2004 • Senate Community Affairs References Committee, <i>Lost Innocents: Righting the record – report on child migration</i>, 2001 • Human Rights and Equal Opportunity Commission, <i>Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families</i>, 1997
New South Wales	<ul style="list-style-type: none"> • NSW Parliament, Legislative Council, General Purpose Standing Committee No 2, <i>Child protection</i>, 2017 • Special Commission of Inquiry into Child Protection Services in NSW, <i>Report of the special commission of inquiry into child protection services in NSW</i>, 2008 (the Wood inquiry)
Victoria	<ul style="list-style-type: none"> • Commission for Children and Young People ‘Always was, always will be Koori children’: <i>Systemic inquiry into services provided to Aboriginal children and young people in out-of-home care in Victoria</i>, 2016 • State of Victoria, <i>Royal Commission into Family Violence: Report and recommendations</i>, 2016. • Commission for Children and Young People, “...as a good parent would...”: <i>Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care</i>, 2015 • Protecting Victoria’s Vulnerable Children Inquiry, <i>Report of the protecting Victoria’s vulnerable children inquiry</i>, 2012 (the Cummins inquiry) • Victorian Equal Opportunity & Human Rights Commission, <i>Desperate measures: The relinquishment of children with disability into state care in Victoria</i>, 2012

Jurisdiction	Inquiry /Report title
Queensland	<ul style="list-style-type: none"> Queensland Family and Child Commission, <i>When a child is missing: Remembering Tiahleigh – A report into Queensland’s children missing from out-of-home care</i>, 2016 Queensland Child Protection Commission of Inquiry, <i>Taking responsibility: A roadmap for Queensland child protection</i>, 2013 (the Carmody inquiry) Commission of Inquiry into abuse of children in Queensland institutions, <i>Report of the commission of inquiry into abuse of children in Queensland institutions</i>, 1999 (the Forde inquiry)
Western Australia	<ul style="list-style-type: none"> Public Sector Commission, Government of Western Australia, <i>Review of the Commissioner for Children and Young People Act 2006</i>, 2013
South Australia	<ul style="list-style-type: none"> Child Protection Systems Royal Commission, <i>The life they deserve: Child Protection Systems Royal Commission report</i>, Government of South Australia, 2016 Parliament of South Australia, <i>Interim report of the Select Committee on Statutory Child Protection and Care in South Australia</i>, 2015 Children in State Care Commission of Inquiry, <i>Children in state care commission of inquiry: Allegations of sexual abuse and death from criminal conduct</i>, 2008 (the Mullighan inquiry)
Tasmania	<ul style="list-style-type: none"> Parliament of Tasmania, <i>Select Committee on Child Protection: Final report</i>, 2011
Australian Capital Territory	<ul style="list-style-type: none"> Public Advocate of the ACT, <i>Who is looking out for the Territory’s children? Review of the emergency response strategy for children in crisis in the ACT</i>, 2012
Northern Territory	<ul style="list-style-type: none"> Royal Commission into the Protection and Detention of Children in the Northern Territory, <i>Interim report</i>, March 2017 Board of Inquiry into the Child Protection System in the Northern Territory, <i>Growing them strong, together: Promoting the safety and wellbeing of the Northern Territory’s children</i>, 2010

There have also been many reviews by government departments, as well as investigations by oversight and monitoring agencies. Child sexual abuse was first specified in the terms of reference of inquiries in Queensland (1999)³ and South Australia (2008)⁴.

A number of inquiry reports and the data held by relevant state and territory departments indicate a significant risk of child sexual abuse in out-of-home care.⁵ However, there is a lack of accurate and accessible information about the rates of such abuse in Australia.⁶ Further, there is only limited information available as to who commits abuse in out-of-home care and where and how it occurs.

Our national inquiry enabled us to examine how the various out-of-home care systems and oversight regimes in Australia have responded to child sexual abuse, and to make recommendations to increase the safety of all children in out-of-home care. It became apparent through our work that we needed to examine several overarching areas. They were:

1. the nature of contemporary out-of-home care and the roles and responsibilities of institutions and care providers
2. the nature, extent, causes and impacts of child sexual abuse in these environments, and the barriers to disclosing and reporting abuse
3. the nature and adequacy of institutional responses to child sexual abuse in out-of-home care
4. how to make out-of-home care child safe.

This required us to consider several questions, outlined in Table 12.2.

Table 12.2 – Issues and questions for examination of child sexual abuse in out-of-home care

Issues	Questions for examination
Nature of out-of-home care and the roles and responsibilities of institutions and care providers	<ul style="list-style-type: none"> • What is the nature of institutions providing out-of-home care to children? • What governance, management or oversight frameworks exist? • How many children reside in these institutions? • What are the roles and responsibilities of these institutions in keeping children safe?
Nature, extent, causes and impacts of abuse, and barriers to disclosure and reporting	<ul style="list-style-type: none"> • What is the nature and extent of child sexual abuse in these institutions? • Who are the victims? Who committed the abuse? • How and why are children abused in these institutions? • What are the particular impacts on victims of being abused in out-of-home care? • What are the barriers to disclosing and reporting abuse?
Nature and adequacy of institutional responses	<ul style="list-style-type: none"> • How have institutions providing out-of-home care responded to child sexual abuse? • What have been the factors that contributed to poor responses to child sexual abuse?
Making out-of-home care child safe	<ul style="list-style-type: none"> • How can institutions providing out-of-home care, including foster and kinship/relative care, become child safe? • What information and strategies are necessary to support children with harmful sexual behaviours and their carers? • Are the current models of care and staffing arrangements for residential care appropriate to assist staff to support and care for children who put themselves at risk of sexual exploitation?

1.2 Terms of Reference

The Letters Patent establishing the Royal Commission required that we ‘inquire into institutional responses to allegations and incidents of child sexual abuse and related matters’ and set out the Terms of Reference of the inquiry.

In carrying out this task, we were directed to focus on systemic issues, informed by an understanding of individual cases. We were required to make findings and recommendations to better protect children against sexual abuse and alleviate the impact of abuse on children when it occurs.

This volume addresses the future focus of our Terms of Reference. Under paragraph (a) we were directed to inquire into ‘what institutions and governments should do to better protect children against child sexual abuse and related matters in institutional contexts in the future’. Paragraphs (b) and (c) also directed us to consider what institutions and governments need to do to improve their responses to child sexual abuse in institutional contexts and reduce the impact on survivors.

1.3 Information sources

To inform our understanding of institutional responses to child sexual abuse in out-of-home care, we gathered information through public hearings, research and policy work, private sessions with survivors and written accounts they provided, and engagement with the community. Information from these sources informed the development of our findings and recommendations and are referred to throughout this volume.

Following are some of our information sources that were particularly relevant to child sexual abuse in out-of-home care.

1.3.1 Public hearings

Five of our public hearings, held as part of our case studies, examined institutional responses to child sexual abuse that were particularly relevant to contemporary out-of-home care:

- *Case Study 1: The response of institutions to the conduct of Steven Larkins (Scouts and Hunter Aboriginal Children's Service)*
- *Case Study 24: Preventing and responding to allegations of child sexual abuse occurring in out-of-home care (Out-of-home care)*
- *Case Study 41: Institutional responses to allegations of the sexual abuse of children with disability (Disability service providers)*
- *Case Study 51: Institutional review of Commonwealth, state and territory governments (Institutional review of Commonwealth, state and territory governments)*
- *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts. (Nature, cause and impact of child sexual abuse)*

The Royal Commission's case studies on historical residential institutions have also informed our understanding of the institutional measures taken since the 1990s to improve the safety of children in contemporary out-of-home care and of the legacy of risk that remains.⁷

1.3.2 Private sessions and written accounts

Many of the survivors of sexual abuse in out-of-home care whose experiences we heard about in private sessions or through written accounts they provided were abused in residential institutions before 1990 (see Volume 11, *Historical residential institutions*). Of the survivors who attended a private session between 31 May 2013 and 31 May 2017, 257 told us they were sexually abused in out-of-home care since 1990. That we heard about a comparatively small number of allegations of sexual abuse in contemporary out-of-home care is not surprising as it may take many years before a survivor is ready and willing to disclose abuse. (This is discussed in detail in Volume 4, *Identifying and disclosing child sexual abuse*.) Notwithstanding this, the experiences of child sexual abuse in contemporary out-of-home care that we heard about in private sessions are important to this volume because they demonstrate the effects of such abuse and emphasise the need for policymakers and practitioners to focus on what needs to be done to improve the safety of children in out-of-home care.

1.3.3 Policy and research

We commissioned research reports to help us understand child sexual abuse in out-of-home care, and the responses of institutions to the abuse. Table 12.3 sets out the commissioned reports particularly relevant to this volume.

Table 12.3 – Commissioned research related to institutional responses to child sexual abuse in out-of-home care

Report title	Published
<i>Framework for historical influences on institutional child sexual abuse: 1950–2014</i> ⁸	2017
<i>Life journeys of victim/survivors of child sexual abuse in institutions: An analysis of Royal Commission private sessions</i> ⁹	2017
<i>Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings</i> ¹⁰	2017
<i>Aboriginal and Torres Strait Islander children and child sexual abuse in institutional settings</i> ¹¹	2017
<i>Assessing the different dimensions and degrees of risk of child sexual abuse in institutions</i> ¹²	2017
<i>Child sexual abuse in Australian institutional contexts 2008–2013: Findings from administrative data</i> ¹³	2017
<i>A national comparison of carer screening, assessment, selection and training and support in foster, kinship and residential care</i> ¹⁴	2017
<i>Disability and child sexual abuse in institutional contexts</i> ¹⁵	2016
<i>Feeling safe, being safe: What is important to children and young people with disability and high support needs about safety in institutional settings?</i> ¹⁶	2016
<i>Safe and sound: Exploring the safety of young people in residential care</i> ¹⁷	2016
<i>Risk profiles for institutional child sexual abuse: A literature review</i> ¹⁸	2016
<i>The role of organisational culture in child sexual abuse in institutional contexts</i> ¹⁹	2016
<i>Evidence and frameworks for understanding perpetrators of institutional child sexual abuse</i> ²⁰	2016
<i>Scoping review: Evaluations of out-of-home care practice elements that aim to prevent child sexual abuse</i> ²¹	2015
<i>Taking us seriously: Children and young people talk about safety and institutional responses to their safety concerns</i> ²²	2015

Our issues papers, consultation papers, and public and private roundtables provided an opportunity for individuals, organisations and governments to provide us with considered views about institutional responses to child sexual abuse in out-of-home care and proposals for policy reform.

Issues paper 4: Preventing sexual abuse of children in out-of-home care, released on 11 September 2013, sought submissions on preventing child sexual abuse in out-of-home care.²³ Consistent themes from the submissions were taken up in a public roundtable discussion in April 2014. The broad themes for discussion were:

- monitoring and oversight
- recruitment, assessment and training of carers
- prevention through practice
- supporting and responding to children in out-of-home care.

In March 2016, we published *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, which sought submissions on how to address aspects of the out-of-home care system to better protect children against sexual abuse.²⁴

Our research and policy work informed our understanding of institutional responses to child sexual abuse in out-of-home care and our recommendations, which aim to create positive change so that:

- child sexual abuse in institutional contexts, including out-of-home care, is minimised without compromising healthy child development
- perpetrators of child sexual abuse in institutional contexts, including out-of-home care, are prosecuted, convicted and sentenced in line with community expectations
- victims of child sexual abuse in institutional contexts, including out-of-home care, and their families obtain justice and the resources they need to achieve wellbeing and quality of life.

1.3.4 Community engagement

As part of our engagement with children and young people who had experience of out-of-home care, in 2015 Commissioners Justice Jennifer Coate and Robert Fitzgerald attended a conference organised by the CREATE Foundation in Brisbane.²⁵ The Commissioners facilitated a workshop at the conference that focused on how to make out-of-home care safer for children and young people. Key points made by conference attendees informed our examination of institutional responses to child sexual abuse in out-of-home care.

1.3.5 Limitations of our work

We faced several challenges in examining institutional responses to child sexual abuse in out-of-home care.

A lack of accurate and comparable data hindered our ability to identify the extent or specific risks of child sexual abuse in out-of-home care, and the success of strategies and actions designed to prevent or respond to its occurrence. Notwithstanding this, we were able to use information from our private sessions, as well as administrative data from government and non-government stakeholders, to increase our understanding of the issue.

Further, our inquiries into voluntary out-of-home care – arrangements that are often informal – were hindered by the limited information available about this care. We included this type of care in our broad analysis when it was funded by government – for example, overnight respite services for people with disability – but we have not examined it in detail.

1.4 Links with other volumes

This volume is closely related to Volume 11, *Historical residential institutions*, which focuses on institutional responses to child sexual abuse in children’s residential institutions before 1990.

In describing what we learned about child sexual abuse in contemporary out-of-home care, this volume builds on our findings in Volume 2, *Nature and cause*, Volume 3, *Impacts*, and Volume 4, *Identifying and disclosing child sexual abuse*.

This volume should also be read with Volume 6, *Making institutions child safe* and Volume 7, *Improving institutional responding and reporting*, which present a national approach to making, improving and supporting child safe institutions. These volumes explain how institutions can be made safer for children by better preventing, identifying, responding to and reporting institutional child sexual abuse. As protecting children is everyone’s responsibility, these volumes look at the role the community, institutions, government, individuals and other actors can play to create child safe institutions, including in out-of-home care. These volumes address making institutions child safe in all institutional contexts and recommend independent but interrelated initiatives to create child safe institutions.

Recommendations made in Volume 6, *Making institutions child safe*, Volume 7, *Improving institutional responding and reporting* and Volume 8, *Recordkeeping and information sharing* are of general application to out-of-home care and are supplemented by the recommendations in this volume for making out-of-home care child safe.

Also relevant to this volume are our findings and recommendations in Volume 9, *Advocacy, support and therapeutic treatment services* on addressing the advocacy, support and therapeutic treatment needs of victims and survivors and those in Volume 10, *Children with harmful sexual behaviours* on interventions and treatment for children with harmful sexual behaviours.

Volume 16, *Religious institutions* addresses child sexual abuse in religious institutions and makes recommendations for improving their response to institutional child sexual abuse. Noting the ongoing involvement of religious institutions in the provision of out-of-home care services, the recommendations in this volume apply to those institutions, as well as the recommendations from Volume 16.

1.5 Key terms

The inappropriate use of words to describe child sexual abuse and the people who experience the abuse can have silencing, stigmatising and other harmful effects. Conversely, the appropriate use of words can empower and educate.

For these reasons, we have taken care with the words used in this report. Some key terms used in this volume are described below. A complete glossary is contained in Volume 1, *Our inquiry*.

Child safe institutions /child safe organisations

‘Child safe institutions/child safe organisations’ create cultures, adopt strategies and take action to prevent harm to children, including child sexual abuse. The Australian Children’s Commissioners and Guardians (ACCGs) define a child safe institution as one that consciously and systematically:

- creates conditions that reduce the likelihood of harm to children
- creates conditions that increase the likelihood of identifying and reporting harm
- responds appropriately to disclosures, allegations or suspicions of harm.

Child sexual abuse in an institutional context

The term ‘child sexual abuse’ refers to any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. Sexually abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism, and exposing the child to or involving the child in pornography. It includes child grooming, which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child, to lower the child’s inhibitions in preparation for sexual activity with the child. The meaning of this term is discussed in more detail in Volume 2, *Nature and cause*.

Our Terms of Reference specify that child sexual abuse occurs in an institutional context if, for example, the abuse:

- happens on a premises of an institution or where its activities occur, or in connection with its activities
- is engaged in by an institution's official in circumstances where the institution has, or its activities have, in any way contributed to the risk of abuse
- happens in any other circumstances where an institution is, or should be treated as being, responsible for adults having contact with children.

Children with harmful sexual behaviours

We use the term 'children with harmful sexual behaviours' to refer to children under 18 years who have behaviours that fall across a spectrum of sexual behaviour problems, including those that are problematic to the child's own development, as well as those that are coercive, sexually aggressive and predatory towards others. The term 'harmful sexual behaviours' recognises the seriousness of these behaviours and the significant impact they have on victims, but is not contingent on the age or capacity of a child.

Contemporary out-of-home care

We use the Australian Institute of Health and Welfare's definition of out-of-home care, which focuses on the funding of placements for children:

Out-of-home care is overnight care for children aged 0–17, where the state or territory makes a financial payment or where a financial payment has been offered but has been declined by the carer.²⁶

'Contemporary out-of-home care' is taken to be post 1990 in order to focus on current risk factors and the ways in which the safety of children in care can be improved.

Disclosure

‘Disclosure’ is the process by which a child conveys or attempts to convey that they are being or have been sexually abused, or by which an adult conveys or attempts to convey that they were sexually abused as a child. This may take many forms, and might be verbal or non-verbal. Non-verbal disclosures using painting or drawing, gesticulating, or through behavioural changes, are more common among young children and children with cognitive or communication impairments. Children, in particular, may also seek to disclose sexual abuse through emotional or behavioural cues, such as heightened anxiety, withdrawal or aggression.

Foster care

The term ‘foster care’ is used for the out-of-home care setting where a child is placed with a foster carer and is living with the carer and their family in the family home. Foster carers are authorised, supported and supervised by an out-of-home care service provider and an allowance for the care of the child is paid, or at least offered, to the carer.²⁷

Information sharing/information exchange

We use the terms ‘information sharing’ and ‘information exchange’ to refer to the sharing or exchange of information about, or related to, child sexual abuse in institutional contexts. The terms refer to the sharing of information between (and, in some cases, within) institutions, including non-government institutions, government and law enforcement agencies, and independent regulator or oversight bodies. They also refer to the sharing of information by and with professionals who operate as individuals to provide key services to or for children.

Kinship/relative care

‘Kinship/relative care’ is home-based, where the carer is a relative (other than a parent), is considered to be family or is a member of the child’s community (in accordance with their culture). The carer is paid, or at least offered, an allowance to care for the child. These placements are frequently supervised by an out-of-home care service provider.²⁸

Mandatory reporter/mandatory reporting

A ‘mandatory reporter’ is a person who is required by either state or territory legislation to report known and suspected cases of child abuse and neglect to a nominated government department or agency (typically the child protection authority).

‘Mandatory reporting’ refers to where a legislative requirement is placed on an individual to report known and suspected cases of child abuse and neglect to a nominated government department or agency (typically the child protection authority). Mandatory reporting laws are contained in the relevant child protection legislation in each jurisdiction.

Offender

We use the term ‘offender’ for a person who is found by a court to have done something that is prohibited by law.

Out-of-home care service provider

The term ‘out-of-home care service provider’ is used to describe services that are approved, registered and accredited by the relevant government agency to provide out-of-home care services, including a range of types of care and case management of the child in care. An out-of-home care service provider may be a government or non-government agency.

Perpetrator

We use the term ‘perpetrator’ to describe an adult who has sexually abused a child.

Record

A ‘record’ refers to information created, received, and maintained as evidence and/or as an asset by an organisation or person, in pursuance of legal obligations or in the transaction of business or for its purposes, regardless of medium, form or format.

Report

A ‘report’ refers to where concerns relating to child sexual abuse are notified to an authority or agency external to the relevant institution – for example, where a person or institution notifies the police, a child protection agency, oversight agency or a professional or registration authority.

Reportable conduct

‘Reportable conduct’ refers to conduct that must be reported under legislation that obliges designated institutions to report allegations of institutional child sexual abuse to an independent statutory body.

Residential care

The term ‘residential care’ is used when a child is placed in a residential facility, usually a house, and is supported by paid staff rather than an individual carer matched with the child.

Victim and survivor

We use the terms ‘victim’ and ‘survivor’ to refer to someone who has been sexually abused as a child in an institutional context. We use the term ‘victim’ when referring to a person who has experienced child sexual abuse at the time the abuse occurred. We use the term ‘survivor’ when referring to a person who has experienced child sexual abuse after the abuse occurred, such as when they are sharing their story or accessing support. Where the context is unclear, we have used the term ‘victim’.

We recognise that some people prefer ‘survivor’ because of the resilience and empowerment associated with the term.

We recognise that some people who have experienced abuse do not feel that they ‘survived’ the abuse, and that ‘victim’ is more appropriate. We also recognise that some people may have taken their lives as a consequence of the abuse they experienced. We acknowledge that ‘victim’ is more appropriate in these circumstances. We also recognise that some people do not identify with either of these terms.

When we discuss quantitative information from private sessions in this volume, we use the term ‘survivor’ to refer both to survivors and victims who attended a private session and those (including deceased victims) whose experiences were described to us by family, friends, whistleblowers and others. This quantitative information is drawn from the experiences of 6,875 victims and survivors of child sexual abuse in institutions, as told to us in private sessions to 31 May 2017.

Voluntary out-of-home care

The term ‘voluntary out-of-home care’ is used when parents make arrangements for an organisation to provide or arrange care for their child for one or more nights. This includes respite and temporary care.

1.6 Structure of this volume

Chapter 2 describes the institutional context examined in this volume, namely contemporary out-of-home care. It describes the various types of out-of-home care; the contemporary out-of-home care system; the number and profile of children in out-of-home care; the role of out-of-home care in children's lives; and the responsibilities of institutions and society to keep children safe in out-of-home care.

Chapter 3 details what we learned about child sexual abuse in contemporary out-of-home care settings. It discusses the nature and extent of child sexual abuse in out-of-home care; the victims, the perpetrators, and the children with harmful sexual behaviours in out-of-home care; how and where children have been sexually abused in out-of-home care; and the impacts of child sexual abuse on children in care.

Chapter 4 describes what we heard about institutional responses to child sexual abuse in out-of-home care. It details contributing factors to child sexual abuse in out-of-home care, including the barriers to disclosing and identifying sexual abuse. It examines inadequate institutional responses to risks in particular institutional settings and to certain cohorts of children.

Chapter 5 outlines recommendations to improve responses to child sexual abuse in out-of-home care, including referencing relevant recommendations from other parts of this report. The chapter sets out recommendations for increasing the safety of children in out-of-home care; improving institutional responses to child sexual abuse in out-of-home care; increasing the safety of children in particular settings; and supporting certain cohorts of children in out-of-home care.

Endnotes

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- 3 Commission of Inquiry into Abuse of Children in Queensland Institutions, *Report of the commission of inquiry into abuse of children in Queensland institutions*, Queensland Government, Brisbane, 1999
- 4 Children in State Care Commission of Inquiry, *Children in state care commission of inquiry: Allegations of sexual abuse and death from criminal conduct*, South Australian Government, Adelaide, 2008.
- 5 See, for example: Human Rights and Equal Opportunity Commission, *Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children for their families*, Commonwealth of Australia, Sydney, 1997; Commission of Inquiry into Abuse of Children in Queensland Institutions, *Report of the commission of inquiry into abuse of children in Queensland institutions*, Queensland Government, Brisbane, 1999; Australia Parliament Senate Community Affairs References Committee, *Lost innocents: Righting the record – Report on child migration*, Senate Community Affairs References Committee Secretariat, Canberra, 2001; Australia Parliament Senate Community Affairs References Committee, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children*, Senate Community Affairs References Committee Secretariat, Canberra, 2004; Children in State Care Commission of Inquiry, *Children in state care commission of inquiry: Allegations of sexual abuse and death from criminal conduct*, South Australian Government, Adelaide, 2008.
- 6 Royal Commission into Institutional Responses to Child Sexual Abuse, *Institutional responses to child sexual abuse in out-of-home care: Consultation paper*, Sydney, 2016, pp 43–45.
- 7 See, in particular, Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 3: Anglican Diocese of Grafton's response to child sexual abuse at the North Coast Children's Home*, Sydney, 2014; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 5: Response of The Salvation Army to child sexual abuse at its boys' homes in New South Wales and Queensland*, Sydney, 2015; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 7: Child sexual abuse at the Parramatta Training School for Girls and the Institution for Girls in Hay*, Sydney, 2014; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 11: Congregation of Christian Brothers in Western Australia response to child sexual abuse at Castledare Junior Orphanage, St Vincent's Orphanage Clontarf, St Mary's Agricultural School Tardun and Bindoon Farm School*, Sydney, 2014; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 17: The response of the Australian Indigenous Ministries, the Australian and Northern Territory governments and the Northern Territory police force and prosecuting authorities to allegations of child sexual abuse which occurred at the Retta Dixon Home*, Sydney, 2015; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 19: The response of the State of New South Wales to child sexual abuse at Bethcar Children's Home in Brewarrina, New South Wales*, Sydney, 2015; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 26: The response of the Sisters of Mercy, the Catholic Diocese of Rockhampton and the Queensland Government to allegations of child sexual abuse at St Joseph's Orphanage, Neerkol*, Sydney, 2016; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 30: The response of Turana, Winlaton and Baltara, and the Victoria Police and the Department of Health and Human Services Victoria (and its relevant predecessors)*, Sydney, 2016; Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 33: The experience of former child residents at institutions operated by The Salvation Army (Southern Territory) between 1940 and 1990*, Sydney, 2016.
- 8 A Quadara, *Framework for historical influences on institutional child sexual abuse: 1950–2014*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017.
- 9 I Katz, A Jones, BJ Newton & E Reimer, *Life journeys of victims/survivors of child sexual abuse in institutions: An analysis of Royal Commission private sessions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017.
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- 11 P Anderson, M Bamblett, D Bessarab, L Bromfield, S Chan, G Maddock, K Menzies, M O'Connell, G Pearson, R Walker & M Wright, *Aboriginal and Torres Strait Islander children and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017.
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- 17 T Moore, M McArthur, S Roche, J Death & C Tilbury, *Safe and sound: Exploring the safety of young people in residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016.
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- 25 See CREATE Foundation, *Youth for change conference wrap up*, 2015, www.create.org.au/youth-for-change-conference-wrap-up (viewed 8 September 2017).
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- 27 The authorisation and supervision of foster carers has become more regulated since 1990. This Final Report focuses on current arrangements.
- 28 The identification, authorisation and supervision of kinship/relative carers has become more regulated since 1990. This Final Report focuses on current arrangements.

2 The nature of contemporary out-of-home care in Australia

2.1 Overview

Each state and territory in Australia has an out-of-home care system where, after statutory intervention by the jurisdiction's child protection system and the courts, children who are considered unable to live safely with their families or in informal care arrangements are placed with alternative carers on a short- or long-term basis. In these systems, parental responsibility for the children is often transferred to the government minister or the state executive.¹

In this chapter, we discuss the contemporary (post-1990) out-of-home care system in Australia, including: the key developments since the 1990s; the types of care; the number of children in care, including groups who are over-represented; how children are placed in care; the system's legal and administrative framework; and the responsibilities of institutions to keep children in care safe.

While many governments in Australia continue to devolve responsibility for the operation of out-of-home care services to non-government organisations, the system and models of contemporary out-of-home care across Australia have changed significantly in recent decades. One of the most visible changes is the closure of children's homes, mission dormitories, disability homes and other large residential institutions. Instead, there is a greater emphasis on placing children in home-based settings, preferably with family or kin. Although residential care still exists, today's residential care facilities are typically designed to be more 'homelike', and are very different from the earlier models of out-of-home care discussed in Volume 11, *Historical residential institutions*.

The shift away from large institutions, which started in the 1970s, varied between jurisdictions and depended on the type of residential institution. For instance, there were delays in dismantling large institutions for children with disability² and some institutions attached to Aboriginal and Torres Strait Islander missions.³ We learned that still today, children with disability who have high support needs are more likely to live in congregate care facilities than other children.⁴

At 30 June 2016, there were 46,448 children in statutory out-of-home care throughout Australia – up from 25,454 children in 2006 and 13,979 in 1996.⁵ Currently more than eight out of every 1,000 children are not living at home with their parents.⁶ Most of these children are in kinship/relative care (48.6 per cent) and foster care (38.7 per cent).⁷ Other types of care include residential care, independent living, family group homes and other home-based care, voluntary care and uncategorised placements, such as boarding schools, refuges and hotels/motels. Some of these arrangements are not necessarily under legal orders.⁸

The rest of the out-of-home care system is made up of individual carers as well as government agencies and service providers.

2.2 Developments in out-of-home care since the 1990s

Australia's out-of-home care systems have undergone significant reforms in recent decades. In the past, it was common for children to be placed in care because their parents could not afford to care for them, the child had disability, or they were the subject of racially discriminatory laws and policies that sanctioned the forced removal of Aboriginal and Torres Strait Islander children from their families and communities. In many cases care commenced at a young age and continued for years. Parents had limited agency and few rights. In contemporary out-of-home care systems, the 'safety, welfare and wellbeing of the child or young person are paramount', anyone with care and protection responsibilities must focus on the needs of the child, and services are expected to prioritise supports to help families to stay together, and to provide safe and nurturing care.⁹ While reforms are ongoing, these principles underpin child protection law and practice.

The institutional arrangements in today's out-of-home care system are also very different from the pre-1990s institutions described in Volume 11, *Historical residential institutions*. There is now greater awareness of the many risks facing children who have been placed in out-of-home care. Consequently, regulatory and other reforms have been introduced. The key systemic reforms, discussed in the following section, have been the dismantling of large dormitory-style facilities, improvements to the screening of organisations and carers, and stronger regulation and oversight of the sector. Despite this, we have learned that children in today's out-of-home care systems continue to face risks, some of which have their genesis in the flawed systems of the past.

2.2.1 Shifts away from institutional care

While children in contemporary out-of-home care remain vulnerable to sexual abuse, systemic changes to Australia's out-of-home care arrangements have shifted some of the risks associated with these settings. Beginning in the 1960s and 1970s, deinstitutionalisation led to the dismantling of large residential and congregate care facilities such as orphanages and children's homes. Diverting significant numbers of children from these institutional settings reduced the number of children exposed to the unique risks associated with these closed or 'total' institutions of the past.¹⁰

At the same time, the introduction of new pensions and allowances gave more families who were struggling the option of caring for their children at home, reducing the number of children placed in out-of-home care and disability care.¹¹ Other reforms during this era included the repeal of laws that criminalised child vagrancy and the abolition of laws and policies that permitted the forcible removal of Aboriginal and Torres Strait Islander children from their families under racially discriminatory assimilation policies.¹²

Although the progressive closure of large residential institutions was a crucial reform, deinstitutionalisation did nothing to address the risks associated with foster care and other home-based care arrangements. Home-based care had been a significant feature of historical out-of-home care systems, and assumed even greater prominence with the closure of large institutions.

Nor was institutional care completely abandoned. Residential care facilities remain a feature of contemporary out-of-home care systems. Although today's residential care facilities are very different from the residential institutions of the past – for example, units are typically much smaller, situated in community settings and intended to be homelike – some features of past institutional care systems persist. As in the past, contemporary residential care facilities rely on paid workers and care is provided within a framework of institutional rules and procedures. Moreover, there are still some who assert that children in residential care are often regarded as a 'problem' rather than needing and deserving protection, and that residential care settings are institutionalised, with 'uniformity, control and surveillance [prioritised] over care, development and individuality, and the emergence of separate and divisive staff and resident cultures'.¹³

Despite the closure of large institutions and other reforms, contemporary out-of-home care is characterised by a significant over-representation of Aboriginal and Torres Strait Islander children, children of poor and disadvantaged families, and children with disability.¹⁴ For children with disability, we were advised in submissions that the rates of substantiated reports of maltreatment are also higher.¹⁵

2.2.2 Screening of services and carers

Another feature of contemporary out-of-home care is that there are additional formal mechanisms for screening and monitoring of out-of-home care agencies and providers. Similarly, practice standards and accreditation of out-of-home care service providers have developed since the 1990s. While accreditation processes are yet to be standardised across jurisdictions, there is increased recognition of the most prominent risks associated with poorly regulated service providers.

Assessment and authorisation processes for foster and kinship/relative carers have also been formalised in recent decades.

Another area in which risks to children's safety are being addressed is the introduction of the National Framework for Protecting Australia's Children 2009–2020 (the National Framework). Among other things, the framework aims to improve research, information sharing and tools to make practices across jurisdictions more consistent. In Volume 6, *Making institutions child safe* we propose that national child safe standards be incorporated into this framework, and a national plan for child safety be developed to succeed the framework, with the aim of further reducing risks to children.

The introduction of employment screening schemes such as Working With Children Checks, although not without limitations, may have reduced some of the risks to children in out-of-home care. In addition, reforms to criminal justice responses to child sexual abuse may have improved the ability of agencies to effectively screen potential perpetrators of child sexual abuse. As discussed in Volume 2, *Nature and cause*, these reforms include the development of specialist investigative police units,¹⁶ the creation of child protection registers, and the introduction of reportable conduct schemes.

2.2.3 Regulation and oversight

Since the 1990s there has been a marked increase in the number of formal oversight mechanisms of out-of-home care services. In the past, accountability mechanisms often relied too heavily on government inspections. The ‘extent and effectiveness of inspections varied considerably’.¹⁷ When such inspections did occur, they were often superficial and focused mainly on administrative issues, and did not adequately consider the welfare of children in residential care or provide opportunities for them to safely raise concerns.¹⁸

As discussed in Volume 6, *Making institutions child safe*, the welfare of children in care and protection systems is currently monitored by numerous oversight bodies, which vary in presence, nature, scope and power. They include ombudsmen’s offices, reportable conduct schemes, child advocates and children’s guardians, children’s commissioners, and crime and misconduct commissions. Community/official visitor schemes, as described in Section 2.7.1, are an example of attempts to increase the oversight in the out-of-home care sector.

2.3 Types of out-of-home care

Today, relevant government policies state that contemporary out-of-home care, in all its forms, is intended to provide a child with ‘a caring home and experiences that meet the child or young person’s physical and emotional needs’.¹⁹ To that end, since 1990 most out-of-home care has involved children living in the private homes of kinship/relative carers or foster carers, predominantly with four or fewer children in care in each home.

Of the kinship/relative care households at 30 June 2016, 60 per cent had one child in the placement, 38 per cent had two to four children, and 2 per cent had five or more children.²⁰ Of the foster care households, 48 per cent had one child, 48 per cent had two to four children, and the remaining 4 per cent had five or more children in their care. The larger numbers in one household possibly reflect sibling groups.

Residential care facilities today are also intended to create a homelike environment and as a result they are generally smaller, with children having their own bedrooms and staff having their own facilities onsite. The Senate Community Affairs References Committee Inquiry into Out-of-Home Care in 2015 reported that in Victoria, for example, today's residential care units are mainly four-bed units whereas earlier models had an average of six to eight beds.²¹

Table 12.4 lists the types of contemporary out-of-home care in Australia.

Table 12.4 – Institutions providing contemporary out-of-home care^a

Institution type	Description
Kinship/relative care	Home-based care where the carer is a relative (other than a parent), is considered family, or is a member of the child's community (according to their culture). The carer is reimbursed (or has declined an offer of reimbursement) by the state or territory.
Foster care	Home-based care where the carer is authorised and reimbursed (or has declined an offer of reimbursement) by the state or territory and is supported by an approved government or non-government agency.
Other home-based care	Home-based care other than kinship/relative care or foster care, where the carer is reimbursed, such as placement with close family friends.
Residential care	Care is provided in a residential facility where the child is supported by paid staff.
Family group homes	Care is provided by a government or non-government agency in a home with live-in, non-salaried carers who are reimbursed and/or subsidised.
Independent living	Supported accommodation, including private board and 'lead tenant' households, usually for children 16 years and older who are supported financially, but not 'parented'. ^b
Voluntary care	Where parents have arranged for an organisation to provide or arrange care for their child, for one or more nights, including temporary care. ^c
Other out-of-home care	Placements that are not otherwise categorised, including boarding schools, refuges ^d and hotels/motels.

^a Source: Australian Institute of Health and Welfare, *Child Protection Australia: 2014–15*, cat no CWS 57, Australian Institute of Health and Welfare, Canberra, 2016, pp 129–133.

^b Generally for children 16 years and older who are quite independent and are supported financially, but not 'parented'. In many cases, a 'lead tenant' is a live-in volunteer whose primary role is to mentor, support and help create a positive environment for young tenants living in the home together.

^c See NSW Office of the Children's Guardian, *Voluntary out-of-home care*, <http://www.kidsguardian.nsw.gov.au/voluntary-out-of-home-care> (viewed 6 March 2017). Voluntary care can be court ordered and may be supervised/funded by the relevant government agency.

^d Includes youth refuges, but not women's refuges where children are in the care of their mothers.

The length of time a child stays in care varies. Children may be placed in emergency or crisis care for short periods of time because of concerns for their immediate safety. Respite care is usually a short planned break for parents or carers from their caring responsibilities. Short- to medium-term care can last from two weeks to a number of months and up to two years, depending on the jurisdiction. When it is determined that children cannot return safely to their birth family, or when this seems unlikely, they may remain in long-term care until they turn 18.

Despite the contemporary developments in out-of-home care, we have found that children remain at risk of child sexual abuse in these settings, as discussed in Chapter 3.

2.4 Numbers of children in out-of-home care

2.4.1 Net increases every year

As part of its annual report on child protection in Australia, the Australian Institute of Health and Welfare includes information about children in contemporary out-of-home care. In *Child protection Australia 2015–16*, the institute reported that:

- at least 46,448 children were in out-of-home care at 30 June 2016. This equates to 8.6 children per 1,000 children,²² up from 8.1 per 1,000 children at 30 June 2015²³
- more than 11,000 children have been admitted to out-of-home care each year since 2011–12²⁴
- each year the number of children admitted to out-of-home care exceeds the number discharged from care. The 12,829 children admitted in 2015–16 exceeded the 9,794 children discharged – a net increase of 3,035 children. There were 443 more children in 2014–15, 2,676 more in 2013–14, 1,981 more in 2012–13, and 2,936 more in 2011–12.²⁵

The reasons for the increasing numbers of children entering out-of-home care are complex and include socio-economic disadvantage, parental mental health and drug and alcohol use affecting parenting capacity, and domestic and family violence. In 2016, a review of the out-of-home care system that was conducted on behalf of the New South Wales Government (the Tune review) concluded that:

The child protection system responds to immediate crisis, but is not doing enough to address the complex needs of vulnerable children and families to break the intergenerational cycle of abuse and neglect. Vulnerable children and families have needs that cross the boundaries of government agencies. The current approach has not improved the outcomes for children and families with complex needs.²⁶

Definitional and data differences between jurisdictions mean it is impossible to identify complete national figures or fully compare data across jurisdictions. Notwithstanding that, data for 2015–16 shows that:²⁷

- of the children admitted to out-of-home care, 46 per cent were under five years old and 25 per cent were between five and nine years old
- the median age of children entering out-of-home care was six years old and, in line with the general population, just over half of all children in out-of-home care were boys
- children are entering out-of-home care at a younger age and are remaining in care longer – an increasing number of children have been in care for five years or more.

Overall, 93 per cent of children in out-of-home care in 2015–16 were in statutory out-of-home care, under care and protection orders.²⁸ The Productivity Commission's *Report on government services 2017* sets out the overall number of children admitted into different types of out-of-home care. Table 12.5 shows all placements where there have been financial payments by government for overnight care of children (rather than care orders), but excludes placements solely funded by disability services.

Table 12.5 – Children in out-of-home care by type of placement and jurisdiction, 30 June 2016^a

Type of placement									
	Total	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Kinship/relative care	22,592	9,066	5,472	3,839	2,013	1,469	334	348	51
Foster care	17,982	8,036	1,539	4,205	1,718	1,261	473	264	486
Other home-based care	2,896	0	2,211	n/a ^c	8	0	262	91	324
Residential care	2,510	611	438	626	165	479	34	42	115
Family group homes	185	9	0	n/a	162	0	13	0	1
Independent living	144	65	43	n/a	0	34	2	0	0
Other (incl. unknown) ^b	139	13	2	n/a	34	0	32	3	55
Total children	46,448	17,800	9,705	8,670	4,100	3,243	1,150	748	1,032

^a Source: Australian Government Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra, 2017, Table 16A.18. The figures reported for children in each type of care show the relative use of each type of placement, although the types of care are not completely comparable. As 'voluntary out-of-home care' includes an array of respite and other arrangements, calculating the number of voluntary care placements can be difficult.

^b No explanation is provided for 'other' types of placements or how governments can be funding 'unknown' placements.

^c n/a – not available

This table shows that almost 94 per cent of children in contemporary out-of-home care are in home-based arrangements (foster care, kinship/relative care and other home-based care).

Little is known about the number of children in voluntary or informal placements, since the regulation and even recognition of this form of care varies widely between jurisdictions.²⁹ However, we have been told that many children in these placements have disability (see the discussion on children with disability in the following section).³⁰

2.4.2 Over-represented cohorts

Although data is limited, certain groups of children are over-represented in out-of-home care – especially Aboriginal and Torres Strait Islander children and children with disability.

Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander children are significantly over-represented in contemporary out-of-home care and constitute a substantial proportion of children in this institutional setting.³¹ At 30 June 2016, there were 16,846 Aboriginal and Torres Strait Islander children in out-of-home care, which represents about 36 per cent of all children in out-of-home care.³² Yet Aboriginal and Torres Strait Islander children make up only about 5 per cent of all children aged from zero to 14 years in Australia.³³

The numbers of Aboriginal and Torres Strait Islander children in out-of-home care are disproportionately high in all jurisdictions.³⁴ Nationally, the rate of Aboriginal and Torres Strait Islander children in out-of-home care is almost 10 times that for non-Indigenous children.³⁵ The rate has risen steadily since 2012, from 46.2 Aboriginal and Torres Strait Islander children in out-of-home care per 1,000 children, up to 56.6 per 1,000 children in 2016. During the same period, the rate of non-Indigenous children in out-of-home care increased from 5.4 to 5.8 per 1,000 children.³⁶

The Australian Institute of Health and Welfare (AIHW) notes that the underlying causes of the over-representation of Aboriginal and Torres Strait Islander children in child protection systems include:

the legacy of past policies of forced removal, intergenerational effects of previous separations from family and culture, a higher likelihood of living in the lowest socio-economic areas, and perceptions arising from cultural differences in child-rearing practices ...³⁷

The AIHW also reported that substantiated reports of abuse in general (a precursor to children being admitted into care) ‘were more likely to be from the lowest socio-economic areas’ than the highest (36 per cent compared with 7 per cent).³⁸ The same report found that Aboriginal and Torres Strait Islander children ‘were far more likely to be from the lowest socio-economic areas’ (47 per cent compared with 32 per cent for non-Indigenous children).³⁹

AIHW data shows that Aboriginal and Torres Strait Islander children are over-represented in relation to all types of abuse and neglect. Compared with non-Indigenous children, Aboriginal and Torres Strait Islander children were more likely to be the subject of substantiated reports of physical abuse (6.1 per 1,000, compared with 1.1 per 1,000 for non-Indigenous children), sexual abuse (3.4 per 1,000, compared with 0.9 per 1,000), emotional abuse (15.0 per 1,000, compared with 2.7 per 1,000), and neglect (15.2 per 1,000, compared with 5.9 per 1,000).⁴⁰ Emotional abuse⁴¹ (45 per cent of all reports) and neglect (25 per cent) are the most common types of substantiated abuse among all children,⁴² while sexual abuse is the least common type of substantiated abuse (12 per cent).⁴³

Of the 257 survivors who told us in private sessions they had experienced child sexual abuse in contemporary out-of-home care, 80 (31.1 per cent) were Aboriginal and Torres Strait Islander people.

Evidence given to Victoria's Royal Commission into Family Violence noted that family violence is 'one of the predominant contributing factors driving child protection intervention and the removal of children from family'.⁴⁴ The report for that Royal Commission recognised that:

There are multiple complex and diverse factors contributing to the high levels and severity of family violence in Aboriginal and Torres Strait Islander communities. It must be clearly understood that the causes do not derive from Aboriginal culture. Family violence is not part of Aboriginal culture. However, the disadvantage, dispossession and attempted destruction of Aboriginal cultures since colonisation have meant that family violence has proliferated in Aboriginal communities.⁴⁵

Much has been written about Aboriginal and Torres Strait Islander children being at risk of abuse and neglect 'within families that are racked by grief and loss, stress, poor physical and mental health, substance abuse and violence'⁴⁶ and that the removal of Aboriginal and Torres Strait Islander children from their culture comes with a high risk of further entrenching grief and trauma:

The greatest resilient factor for Aboriginal children is culture, and when you take kids away, take children away from culture, from family, you break them down.⁴⁷

The risks faced by Aboriginal and Torres Strait Islander children in contemporary out-of-home care are discussed in Chapter 4.

Children with disability

Although comprehensive data is not available, children with disability are reported to be over-represented in statutory out-of-home care.⁴⁸ The proportion of children with disability aged from zero to 14 years in the general population is estimated to be 6.1 per cent, whereas the proportion of children with disability who are the subject of reportable conduct reports to the NSW Ombudsman is about four times higher.⁴⁹ We have heard a consistent view from disability stakeholders that a significant number of children in statutory out-of-home care have some form of disability.⁵⁰ The Victorian Equal Opportunity and Human Rights Commission's 2012 report, *Desperate measures: The relinquishment of children with disability into state care in Victoria – May 2012*, found that around 20 per cent of children in residential care in Victoria had disability.⁵¹ In both the 2008 and 2009 Queensland Commissioner for Children and Young People and Child Guardian's surveys, *Views of Young People in Residential Care*, about 26 per cent of respondents reported experiencing disability.⁵² Intellectual, learning and conduct disorders were the most prevalent forms of impairment reported.

The peak organisation Children and Young People with Disability Australia suggests that disability is often not recognised and that any reported figures are likely to be an underestimate.⁵³ The 2015 Senate Community Affairs References Committee Inquiry into Out-of-Home Care said:

The committee is concerned by evidence that suggests that children and young people with disability are over represented in the out-of-home care system and that they experience poorer outcomes. In particular, the committee is concerned by evidence that suggests a high proportion of children in out-of-home care have undiagnosed disabilities or chronic health issues such as Foetal Alcohol Spectrum Disorder (FASD).⁵⁴

We understand that many children with disability also use voluntary out-of-home care.⁵⁵ For example, the New South Wales Office of the Children's Guardian reported that in 2015–16, of the 2,174 children who accessed voluntary out-of-home care, 1,872 (about 86 per cent) had disability.⁵⁶ The use of voluntary care can be driven by a lack of adequate support services and families' need for respite.

A CREATE Foundation study of children with disability living in out-of-home care noted the significant over-representation of children with behavioural and/or emotional disorders in out-of-home care.⁵⁷ Mental health conditions appeared to be the most prevalent impairment in out-of-home care followed by intellectual and/or learning impairments.⁵⁸

It is well recognised that children and young people with disability are a particularly vulnerable group who are at particular risk of experiencing abuse or neglect and subsequent entry into the child protection system ... It is less clear whether children with disabilities are predisposed to entering care or whether they are more likely to experience a disability because of past maltreatment and poor parenting practices.⁵⁹

Children from culturally and linguistically diverse backgrounds

Although there is no national data on the number of children from culturally and linguistically diverse backgrounds in contemporary out-of-home care,⁶⁰ data from Victoria indicates that about 13 per cent of children in out-of-home care are from such backgrounds, a significant proportion of whom have refugee experiences.⁶¹

In its submission to the Senate Community Affairs References Committee Inquiry into Out-of-Home Care, Settlement Services International cited 2008 research estimating that 15 per cent of children in out-of-home care in New South Wales were from a family where a language other than English was spoken at home.⁶²

Children of care-leavers

The children of care-leavers also appear to be over-represented in out-of-home care. In *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts*, vice-president of the Care Leavers Australasia Network, Mr Frank Golding, cited a survey of network members in which 15 per cent of respondents reported 'that their parents had been in care or their children were now in care'.⁶³ Although no jurisdictions collect data on this issue, the Victorian Government's Cradle to Kinder early intervention support program prioritises support for, among others, 'women who are or have been in out-of-home care', because 'the parent's previous involvement in child protection and out-of-home care ... [as] a child is an obvious indicator of past abuse or neglect'.⁶⁴

Research suggests that the risks of intergenerational involvement in out-of-home care are exacerbated by social and economic disadvantage.⁶⁵ Many parents of children in out-of-home care 'have often suffered multiple disadvantages, including high rates of childhood physical and sexual abuse and associated trauma, which may have led to their removal from their own parents'.⁶⁶ The fact that many care-leavers become parents at a young age, and often have limited family or social supports when they do so, may also increase the risks of their children being placed in care. A 2009 survey of 471 young people aged 15 to 25 years who were in care or who had recently left care showed that, at the time of the survey, 28 per cent were already parents.⁶⁷ The gaps in supports provided to care-leavers as they transition to adulthood are discussed in Chapter 4.

Overlapping cohorts

In considering why some children may be at higher risk of entering out-of-home care than others, and the underlying factors that may exacerbate these risks, it is important to recognise the overlap between these groups. That is, some Aboriginal and Torres Strait Islander children and children from culturally and linguistically diverse backgrounds may have disability and/or come from a socio-economically disadvantaged background.

The extent of overlap is unknown as the information that state and territory governments contribute to the Child Protection National Minimum Data Set does not yet include data on disability or types of impairments, nor on children's culturally and linguistically diverse backgrounds (see our discussion in Chapter 5). There are significant gaps in what we know about the risks to children in these overlapping groups, such as whether being part of an overlapping group increases a child's vulnerability and their risk of entering out-of-home care, or their risk of being sexually abused while in care.

Chapter 3 discusses vulnerability to sexual abuse in out-of-home care for Aboriginal and Torres Strait Islander children, children with disability, and children from culturally and linguistically diverse backgrounds.

2.5 Administering contemporary out-of-home care

The responsibility for administering, funding and delivering child protection services – including the provision of out-of-home care – rests with the states and territories. The Australian Government has had a relatively minor role in contemporary child protection⁶⁸, although with the adoption of the National Framework for Protecting Australia's Children 2009–2020 it has taken on greater responsibility for promoting a nationally consistent approach to policies and practices.⁶⁹

2.5.1 State and territory administration

The objectives and operation of the child protection systems across Australia's states and territories are broadly similar, but no two systems are wholly alike. Each state and territory has its own complex suite of interconnected legislation – supplemented by regulations, standards, policies and procedures – to meet its social, economic, demographic and geographic circumstances. Table 12.6 lists the principal Acts in each jurisdiction.

Table 12.6 – Child protection legislative framework

Jurisdiction	Principal legislation
New South Wales	<i>Children and Young Persons (Care and Protection) Act 1998</i>
Victoria	<i>Children, Youth and Families Act 2005</i> <i>Child Wellbeing and Safety Act 2005</i>
Queensland	<i>Child Protection Act 1999</i>
Western Australia	<i>Children and Community Services Act 2004</i>
South Australia	<i>Children's Protection Act 1993</i>
Tasmania	<i>Children, Young Persons and Their Families Act 1997</i>
Australian Capital Territory	<i>Children and Young People Act 2008</i>
Northern Territory	<i>Care and Protection of Children Act</i>

The legislation specifies the conditions for placing a child in care, recruiting carers, deciding placements, making funding arrangements, and regulating and overseeing service providers and service delivery.

Laws in each jurisdiction set out the role of contemporary out-of-home care, with all states and territories identifying the safety, welfare and wellbeing of children as a primary consideration in decisions made about children.⁷⁰ This is broadly consistent with the 'best interests' principle, a foundational principle in international and Australian law that requires decisions made and actions taken concerning children to be in their best interests (see Section 2.6, 'Institutional responsibilities to keep children safe in out-of-home care').⁷¹

Australian jurisdictions have adopted broadly similar positions on critical issues for children in contemporary out-of-home care. For example:

- most states and territories are explicit that children removed from their families are to be placed in safe, nurturing, stable and secure environments⁷²
- all states and territories identify the need for children to be protected from harm and living free from violence and exploitation⁷³
- most states and territories express the welfare and wellbeing of children in terms of maintaining language and cultural identity, as well as cultural, spiritual and religious ties⁷⁴
- all states and territories include provisions in legislation to ensure Aboriginal and Torres Strait Islander children can maintain a connection with family, culture, traditions, language and community. These provisions are part of the Aboriginal and Torres Strait Islander Child Placement Principle⁷⁵
- all states and territories identify the need to foster and promote the health and education of children in care, and specify that children in care are treated in ways that respect each child's dignity.⁷⁶

The underlying principle of the state and territory positions is that children who cannot live at home with their families are not disadvantaged by placement in contemporary out-of-home care; rather, in the absence of risk of serious harm, they will thrive. However, as discussed in Chapter 3, this is not always achieved and children are not always safe in contemporary out-of-home care.

2.5.2 Management of care

The trend in most jurisdictions is for governments to transfer responsibility for delivering most contemporary out-of-home care services from themselves to non-government organisations, including a small number of for-profit agencies in some jurisdictions.⁷⁷ This involves engaging non-government organisations to operate residential care facilities, recruit residential care staff and foster carers, and manage children's placements with foster and kinship/relative carers.

The ratio of government to non-government out-of-home care service delivery varies considerably across jurisdictions. In Victoria, almost all foster care and residential care service delivery is managed by non-government organisations.⁷⁸ In Western Australia, South Australia and the Northern Territory, governments manage most out-of-home care service delivery.⁷⁹ Delivery in the remaining jurisdictions varies. The Queensland, Tasmanian and ACT governments have transferred a sizeable portion of out-of-home care service delivery to non-government organisations. Since 2012, New South Wales has been transitioning the management of out-of-home care from a primarily government-run system to primarily non-government.

2.6 Institutional responsibilities to keep children safe in out-of-home care

Governments, institutions and individuals have duties and obligations to protect children under common law as well as under relevant child protection and other legislation.

The Australian Government has various responsibilities at the domestic and international levels to ensure the safety of children. Australia has ratified a number of international human rights treaties, including the International Covenant on Economic, Social and Cultural Rights in 1975⁸⁰ and the United Nations Convention on the Rights of the Child (UNCRC) in 1990, both of which recognise the need to protect the rights of children and to promote their welfare⁸¹ and to be protected from sexual abuse.⁸² Because of these commitments, Australia is obliged to take appropriate measures to ensure that children are protected and able to realise these rights, including in out-of-home care.

The broader responsibility to protect children is shared by all Australian governments, institutions and the community. Various policy and legal frameworks, such as the National Framework for Protecting Australia's Children 2009–2020, make it very clear that protecting children is everyone's business, and place responsibilities on governments, institutions and individuals to keep children safe in out-of-home care.

2.6.1 Relevant policy frameworks

National Framework for Protecting Australia's Children 2009–2020

The National Framework for Protecting Australia's Children 2009–2020 (the National Framework) makes it clear that the Australian Government, state and territory governments, and non-government institutions must work together to protect Australia's children.⁸³ Strategy 3 of the Third Action Plan aims to improve the ways in which institutions respond to children and young people to keep them safe. The National Framework and its Third Action Plan are discussed in detail in Volume 6, *Making institutions child safe*.

The National Framework adopts a public health model 'focused on universal support for all families, with more intensive, or targeted, responses for families that need additional support'.⁸⁴

The placement of children in contemporary out-of-home care is generally considered to be a last resort after all other support and early intervention options have been either exhausted or ruled out.⁸⁵

The National Framework identifies six broad outcomes to be implemented through a series of three-year action plans.⁸⁶ These outcomes are that:⁸⁷

1. children live in safe and supportive communities
2. children and families access adequate support to promote safety and intervene early
3. risk factors for child abuse and neglect are addressed
4. children who have been abused or neglected receive the support and care they need for their safety and wellbeing
5. Indigenous children are supported and safe in their families and communities
6. child sexual abuse and exploitation are prevented and survivors receive adequate support.

Volume 6, *Making institutions child safe* discusses the limitations of reporting against the National Framework and sets out our recommendations to address these deficiencies (see Recommendations 6.1 and 6.15–18 set out in Appendix A).

National Standards for Out-of-Home Care

An outcome of the National Framework's First Action Plan 2010–2013 was the development of the National Standards for Out-of-Home Care, designed to improve and promote a nationally consistent approach to the quality of contemporary out-of-home care.⁸⁸

The National Standards are not mandatory. Further, although the introduction to the Standards states that 'the measurement of and reporting on outcomes is a major feature of the refining and improving of the National Standards over the long term',⁸⁹ neither the *Report on government services 2016* nor *Child protection Australia 2015–16* reports on all the measures in the National Standards.⁹⁰ There are no other accountability mechanisms that ensure or monitor the implementation of the National Standards.⁹¹

2.6.2 Relevant law and regulation

The Australian Government has ratified a number of international human rights treaties that assign it responsibilities to protect children from sexual abuse in all contexts. Of particular relevance, our work on child safe institutions is underpinned by the Convention on the Rights of the Child. In line with these responsibilities, our work is guided by the child's rights to:⁹²

- have their best interests as a primary concern in decisions affecting them
- non-discrimination
- have the responsibilities of parents or carers respected
- participate in decisions affecting them
- be protected from all forms of violence, including all forms of sexual exploitation and sexual abuse, including while in the care of parents, guardians or other carers
- special protection for children with disability.

Consistent with Article 3 of the convention, all institutions concerned with children should act with the best interests of the child as a primary consideration.⁹³ We believe this foundational principle should be at the core of all child-related institutions' purpose and operation. Institutions and their leaders need to make sure it is widely understood and applied by all staff and volunteers. It is discussed further in Volume 6, *Making institutions child safe*.

A range of existing law and regulation is relevant to the responsibilities of institutions and individuals to keep children safe in out-of-home care. Laws and regulations directed specifically to the out-of-home care context include legal and administrative requirements relating to:

- accreditation of out-of-home care service providers
- carer screening and authorisation
- carers registers.

In addition, there are laws applying to institutions and individuals more generally, such as:

- child safe standards (currently in Victoria, Queensland and South Australia)⁹⁴
- Working With Children Checks⁹⁵
- obligatory reporting to external authorities, including mandatory reporting to child protection authorities, and criminal offences for failure to report child sexual abuse
- oversight of institutional responses to complaint handling, including reportable conduct schemes.

Aspects of civil liability under common law are also relevant to the responsibilities of institutions and individuals to keep children safe in out-of-home care.

Accreditation of service providers

Various out-of-home care accreditation schemes require agencies that provide contemporary out-of-home care services to be approved, registered and accredited. In most states and territories, only non-government agencies providing out-of-home care are subject to these requirements. Only in New South Wales is the government department that provides out-of-home care services also required to be provisionally or fully accredited.⁹⁶

In most jurisdictions, out-of-home care service providers are accredited for a set period of time. Accreditation may be subject to conditions and must be renewed when the accreditation period expires.⁹⁷ The renewal process usually requires the provider to demonstrate that it meets the relevant accreditation conditions.

In most jurisdictions, the government departments that fund and administer out-of-home care are also responsible for both assessing and registering out-of-home care service providers. New South Wales is the only jurisdiction where an independent statutory body, the Office of the Children's Guardian, is responsible for the audit and accreditation of out-of-home care services.⁹⁸ To be accredited, the Children's Guardian requires agencies to demonstrate that they comply with the NSW Child Safe Standards for Permanent Care.⁹⁹ These include requirements that a child's health and developmental needs are met, and that carers are

skilled and experienced. The accreditation process provides agencies with an opportunity for self-assessment and review and helps assure the government that standards for out-of-home care are being maintained.

The accreditation requirements for each state and territory are examined in Chapter 4. The importance of mandatory accreditation of all contemporary out-of-home care service providers is discussed further in Chapter 5.

Carer authorisation

Depending on the jurisdiction, individual carers may have to be authorised or registered to provide contemporary out-of-home care.¹⁰⁰ Responsibility for granting and administering their authorisation or registration might rest with the department, an out-of-home care service provider engaging or proposing to engage individual carers, or an independent body such as the Office of the Children's Guardian in New South Wales.

Again, depending on the jurisdiction and the type of care, individual out-of-home carers are subject to varying requirements for authorisation or registration.¹⁰¹

As set out in detail in research we commissioned to compare screening, assessment and selection of carers across jurisdictions, people who apply to be home-based carers must undergo criminal record checks and the relevant Working With Children Checks or Working With Vulnerable People Checks.¹⁰² Home-based carer authorisations are reviewed regularly, usually annually, and criminal record checks are re-run in most jurisdictions at least every three years.¹⁰³

Participants in commissioned research reported that, in some circumstances, the authorisation processes for kinship/relative carers in some jurisdictions may be less stringent than for foster carers.¹⁰⁴ For example, until recently kinship carers in Victoria were exempt from the requirement to have a Working With Children Check if they were 'closely related' to the children they were caring for.¹⁰⁵ This point is discussed in Chapter 4.

In all jurisdictions except Tasmania, some form of probity/criminal record check is also conducted on all household members over the age of 18 years.¹⁰⁶

Background and probity checks on residential care staff are far less rigorous in some jurisdictions. While all jurisdictions require probity checks, the stringency of the checks differ. For example, a criminal history check is required in South Australia but is discretionary in Tasmania, and neither state requires a Working With Children Check or Working With Vulnerable People Check that foster and kinship/relative carers must have.

We were told that generally foster and kinship/relative carers sign a carer authorisation agreement with the out-of-home care service provider with whom they are working. This agreement may or may not include the provider's code of conduct. In at least some cases, carers are also required to sign a code of conduct acknowledging receipt and understanding of the standard of conduct they are agreeing to.

Our recommendation aimed at ensuring minimum requirements for the authorisation of all carers is set out in Chapter 5.

Carers registers

As discussed in our *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, children's safety can be compromised by poorly informed decisions about carer suitability and placement safety.¹⁰⁷ Arrangements for sharing relevant information about risks posed by carers offer an opportunity for authorising agencies to ensure that carers with problematic histories cannot transfer from government to non-government service providers, or move between non-government out-of-home care service providers without detection.¹⁰⁸

Currently only three jurisdictions maintain carers registers – New South Wales, Victoria and Western Australia – and these registers vary in the range and detail of information captured.¹⁰⁹ The registers are a central index of information about people who have applied for authorisation – or who are already authorised – to care for children in the particular jurisdiction's out-of-home care system. These registers allow government agencies and non-government service providers to quickly and easily access information to confirm whether an individual is authorised to provide out-of-home care.

In Volume 6, *Making institutions child safe* there is a detailed discussion of carers registers as a mechanism for contributing to the safety of children in out-of-home care and our recommendation for the adoption of nationally consistent carers registers in each jurisdiction, with inter-jurisdictional access to information.

Our recommendations to strengthen these requirements are set out in Chapter 5.

2.6.3 Child safe standards

Victoria, Queensland and South Australia have implemented mandatory child safe approaches that generally apply to organisations providing services for children, including out-of-home care service providers. A detailed discussion of child safe standards is contained in Volume 6, *Making institutions child safe*.

The particular importance of child safe standards in out-of-home care is discussed in Chapter 5 of this volume.

2.6.4 Working With Children Checks

In Australia, each state and territory has its own scheme for conducting background checks for people seeking to engage in child-related work.

These schemes, commonly known as Working With Children Checks (WWCC) aim to ensure that appropriate people are chosen to work or volunteer with children, including in out-of-home care.¹¹⁰ These schemes aim to do this by preventing people from working or volunteering with children if records indicate that they may pose an unacceptable level of risk to children.

Each state and territory has its own WWCC scheme, and each of the eight schemes operates independently of the others. In our *Working With Children Checks* report,¹¹¹ we found that these schemes are inconsistent and complex, and there is unnecessary duplication across the schemes. The schemes are not integrated, and information sharing and monitoring of Working With Children Check cardholders is inadequate.¹¹²

These problems create a number of weaknesses. Each scheme has a different way of defining who needs a check, meaning that a person engaging in the same type of work might require a WWCC in one jurisdiction but not in another.¹¹³ Despite these differences, all states and territories currently require carers to have passed a WWCC – including a criminal history check – as a condition of authorisation.¹¹⁴

2.6.5 Civil liability

In some circumstances, an out-of-home care service provider may be liable for failing to keep children safe, including from sexual abuse. We discuss the civil liability of institutions in detail in our *Redress and civil litigation* report.¹¹⁵

We learned that in New South Wales support is provided to enable children in out-of-home care to access their civil legal entitlements. Since 2013, Legal Aid NSW's Children's Civil Law Service has provided civil legal advice to vulnerable young people, many of whom have complex needs and are in out-of-home care or are leaving care.¹¹⁶ We were told that a key component of the legal assistance and casework that this service provides to clients 'involves advocacy around the statutory entitlements of young people transitioning out of care' – including ensuring that any entitlements to victims' support have been canvassed, and seeking access to entitlements pursuant to the young person's leaving care plan following discharge from care.¹¹⁷

2.6.6 Obligatory reporting to external authorities

In each state and territory, certain individuals and institutions are legally obliged to report suspicions, risks and instances of child abuse and neglect, including child sexual abuse, to the police or child protection or oversight agencies. This type of reporting is known as ‘obligatory reporting’. The aim of obligatory reporting is to detect, stop and prevent child abuse and neglect by requiring certain individuals and institutions to report to an external government authority.¹¹⁸ Exactly what reporting is required depends on the type of obligatory reporting and varies between states and territories.

The main types of obligatory reporting relevant to out-of-home care are:

- mandatory reporting to child protection authorities
- failure to report offences
- reportable conduct schemes.

Where an institution or an individual associated with an institution does not have any legal reporting obligations, they can make a voluntary report of institutional child sexual abuse to appropriate authorities.¹¹⁹ In most jurisdictions, the appropriate authorities are the police or the child protection authority.

Reporting of institutional child sexual abuse to external authorities is detailed in Volume 7, *Improving institutional responding and reporting*.

Mandatory reporting to child protection authorities

Mandatory reporting laws create an additional duty requiring certain professionals and community members to report any known or suspected child abuse or neglect to child protection authorities.¹²⁰ Upon receiving a mandatory report, a child protection authority assesses the risk of harm, may investigate the risk of harm (usually in collaboration with the police if sexual offences are suspected) and take steps to protect the safety and wellbeing of any affected children.¹²¹

Mandatory reporting laws across jurisdictions have common features, but also differences. The groups of people who are designated as mandatory reporters vary across the states and territories. Groups are generally designated based on their profession. In all states and territories, teachers, doctors, nurses, and at least some members of the police force are mandated reporters.¹²² The inclusion of additional groups varies across jurisdictions. In Western Australia, for example, the only additional mandatory reporters are midwives and boarding supervisors.¹²³ South Australia is the only Australian jurisdiction to expressly include ministers of religion as mandatory reporters.¹²⁴ In the Northern Territory, no groups are mandated. Instead, the obligation to report abuse applies to everyone.¹²⁵ Some jurisdictions, such as New South Wales, designate broad classes of people as mandatory reporters, including any person involved in the delivery of ‘health care, welfare, education, children’s services, residential services, or law enforcement, wholly or partly, to children’.¹²⁶

There is no uniform approach across Australia to help mandatory reporters understand and fulfil their obligations. A serious implication of such inconsistency and exercise of discretion in the enforcement of mandatory reporting around Australia is that the safety of children could be compromised.

In Volume 7, *Improving institutional responding and reporting* we recommend that the mandatory reporting requirements be extended to include certain groups who work closely with children. In out-of-home care, we recommend this include the paid employees of service providers, such as caseworkers and residential care staff. However, we have not proposed that the requirements be extended to foster and kinship/relative carers.

Chapter 2 of Volume 7 contains detailed discussion of, and our recommendations for, strengthening mandatory reporting laws and reporter protections.

Reporting offences

‘Failure to report’ offences impose criminal liability on third parties – that is, persons other than the perpetrator of the child sexual abuse – who know or believe that child sexual abuse has taken place but fail to report this abuse to the police. These third parties must report abuse to the police in order to avoid committing a failure to report offence.

The New South Wales and Victorian governments have both enacted reporting offences that may apply to those working in the out-of-home care sector. Section 316 of the *Crimes Act 1900* (NSW) requires persons ‘without reasonable excuse’ to report to the NSW Police Force serious indictable offences committed, or suspected to be committed, by others.¹²⁷ In Victoria, section 327(2) of the *Crimes Act 1958* (Vic) requires an adult who has information that leads them to form a reasonable belief that a sexual offence has been committed in Victoria against a child by another adult to report that information to Victoria Police unless the person has a ‘reasonable excuse’ for not doing so.¹²⁸

Failure to report offences are considered in detail in our *Criminal justice* report, Chapter 16, ‘Failure to report offences’.¹²⁹

Reportable conduct schemes

Reportable conduct schemes oblige heads of certain institutions, including out-of-home care service providers, to notify an oversight body of any reportable allegation, conduct or conviction involving any of the institution’s employees and oblige the oversight body to monitor institutions’ investigation and handling of allegations. These schemes are described in Section 2.7.3.

Other reporting obligations

Other reporting obligations may require an out-of-home care service provider to report child sexual abuse to a state or territory child protection department or oversight agency with whom the provider has contractual or other reporting obligations.

2.6.7 Direct responsibility for the care of children in out-of-home care

The responsibilities of institutions to keep children safe in out-of-home care start with the day-to-day care of a child. In contemporary out-of-home care, complex structures and systems are designed to support and oversee those who directly care for children.

The principle that the ‘best interests of the child shall be a primary consideration’¹³⁰ is at the heart of the contemporary out-of-home care legislative and practice framework. The embodiment of the principle is the protection of the child’s rights and the promotion of the child’s development.¹³¹

Responsibilities for the direct care of children consist of:¹³²

- parental responsibility
- care responsibility.

Ensuring that children are safe in out-of-home care also involves independent monitoring and review of systems.

This section provides a brief overview of these responsibilities, focusing on their application by institutions to keep children safe in contemporary out-of-home care. As the principles and arrangements for contemporary out-of-home care are broadly similar across jurisdictions, the overall framework is described, rather than the differences between jurisdictions.

Parental responsibility

Parents and guardians have full responsibility for their children until they reach the age of 18, unless a court orders otherwise. This includes all duties, powers, responsibilities and authority for the long-term care, welfare and developmental needs of children, including health and education.¹³³

Parental responsibility includes keeping a child safe from harm. If a child protection department decides that it is no longer safe for a child to remain at home because of substantiated reports of abuse or neglect, an order can be sought from the courts placing the child under the parental responsibility of the relevant government minister or department head (this varies between states and territories).¹³⁴

Court orders can allocate parental responsibility, or specific aspects of parental responsibility, to one or both parents together with the minister/department head, to the minister/department head alone, or to others delegated by the minister/department head to take on this responsibility.¹³⁵ While ‘care responsibility’ for a child (as detailed in the following section) may be given to an individual carer, the minister/department head or their delegate may maintain responsibility for significant decisions about a child – for example, medical treatment.¹³⁶ In taking on parental responsibility for a child, the minister/department head is the person responsible for the overall safety and wellbeing of that child.

Care responsibility

Day-to-day responsibility for the care of children in contemporary out-of-home care is provided by foster carers, kinship/relative carers or residential care staff. A child in statutory out-of-home care will also have an allocated caseworker¹³⁷ – an employee of the out-of-home care service provider who has particular care responsibilities.

Role of caseworkers in out-of-home care

Caseworkers are responsible for reviewing placements and regularly visiting children in care. Their role includes ensuring a child’s case plan is implemented – whether that is permanency planning or reunification with family – and coordinating processes for appropriate care and protection orders as well as all other administrative matters. The role of caseworkers will vary depending on the type of care in which a child is placed.

The responsibilities of caseworkers may include authorisation for the child to take certain medications or change schools, and applications for the child to travel with carers interstate or overseas.

Ensuring a child is able to maintain contact with their birth family is frequently part of a caseworker’s role. Supervision and support of authorised home-based carers may also be the caseworker’s responsibility, including investigation of certain allegations against the carer.

The most significant responsibility of a caseworker is to develop and maintain a relationship with each child who is part of their caseload. Particularly when a child has many different placements, the caseworker may be the most constant, or key, adult in the child’s life. The difficulties arising from high staff turnover in these roles and other organisational cultural issues are discussed in Chapter 4.

Carers

Carers are not given full parental responsibility for a child in statutory out-of-home care, but they are given general authority to make decisions about the day-to-day care and control of a child through agreements reached with the relevant department.¹³⁸ If the child is in voluntary or informal care, the delegation of care and parental responsibility is a matter between the carers and the parents.

While not necessarily having responsibility for long-term decisions about the best interests of the child in their care, carers are required to step into what might be described as an ordinary parenting role. Carers are meant to ensure children are well looked after, fed, clothed, go to school, and so on. Their care is intended to provide a high standard of parenting, as described in the (then) Victorian Department of Health and Human Services Practice Advice:

Children in out-of-home care need the best care that society can provide regardless of whether it is provided by a family member, volunteer or paid staff. Children in out-of-home care are likely to have already suffered abuse or neglect. If they are subjected to further abuse while in out-of-home care, the harm they have already suffered will be further compounded. Rather than experiencing out-of-home care as a safe and protective environment, they will lose further trust in adults and the effect of the abuse will be aggravated.¹³⁹

Departmental guidelines, such as those used in New South Wales, also specify that carers' responsibilities include the emotional wellbeing and mental health as well as the physical wellbeing of children in their care: 'Carers help kids in care feel safe and secure, giving them the stability they need to grow confident and resilient, and develop healthy ways of coping with what they have already experienced'.¹⁴⁰

2.7 Independent monitoring and review

In all states and territories there are statutory schemes in place that are intended to subject the systems and services for delivering out-of-home care to independent monitoring and review. Some of these arrangements, such as official visitor schemes, focus on inspections of specific out-of-home care facilities, and advocating or raising concerns on behalf of individuals encountered through those visits. Others – such as the external oversight provided by children's commissioners or ombudsmen – are expected to identify and recommend systemic improvements.

2.7.1 Official visitor schemes

New South Wales, Queensland and Western Australia have official or community visitor schemes. Under these schemes, officially appointed visitors are empowered to visit children in contemporary out-of-home care placements, inquire into their wellbeing and confirm that their needs are being met.¹⁴¹ The visitors are ministerial appointments independent of the child protection department and out-of-home care service providers.

Queensland has the most established and expansive official visitor scheme – the Community Visitors Program, which is administered by the Office of the Public Guardian. Community visitors are responsible for visiting every child coming into care or re-entering care. The frequency of visits is said to depend on the needs of the child. The community visitor can assist a child:¹⁴²

- by expressing the child's views to their child safety officer
- with education, health or counselling needs
- with concerns about the place where they are living
- with contact with their family or child safety officer
- with legal matters through an Office of the Public Guardian child advocate.

The official visitor schemes in New South Wales and Western Australia are more limited in scope. In Western Australia, the CEO of the Department for Child Protection can appoint 'assessors' to visit residential facilities and secure care facilities only.¹⁴³ Assessors are empowered to enter and inspect facilities, inquire into operation and management practices, and speak to the children including about their wellbeing.

Similarly, in New South Wales, under the Official Community Visitors scheme coordinated by the NSW Ombudsman, visitors can visit children in residential out-of-home care only, which is a small cohort of children.¹⁴⁴ The visitors' role is to promote the best interests of children and young people in out-of-home care, and of children, young people and adults with disability in care. The visitors provide advice to the Ombudsman and relevant government ministers about the quality of services and issues raised by residents. They also help resolve issues at a local level.¹⁴⁵

2.7.2 Oversight agencies

As well as the usual monitoring and oversight of policies, procedures and service delivery conducted by government departments and service providers, each state and territory has at least two independent oversight bodies that are responsible for promoting, representing and defending the rights and interests of children, including children in out-of-home care. In most cases, these bodies are a children's commissioner or guardian, and an ombudsman. Their functions, described in this section, help to ensure decisions affecting children are transparent, and that children's services are high quality and are subject to scrutiny that focuses on continuous improvement.

Children's commissioners or guardians

Children's commissioners or guardians are typically responsible for promoting and monitoring the wellbeing of children; reviewing existing laws, policies and practices affecting children; and providing advice to ministers or the government on services to children (both generally and specifically about out-of-home care).¹⁴⁶ Children's commissioners and guardians may also:¹⁴⁷

- provide advocacy and support for individual children
- receive, investigate and respond to complaints about the care of individual children
- conduct investigations into specific issues (on their own initiative or at the request of the relevant minister)
- issue reports following these investigations, and make findings and recommendations for change or improvement.

Ombudsman

An ombudsman reviews and investigates the administrative actions and decisions of government departments, agencies and public authorities (and those who are engaged by government bodies to act on their behalf – for example, contemporary out-of-home care service providers). In most jurisdictions, this includes the department for child protection.¹⁴⁸ The ombudsman may commence investigations in response to complaints from individuals, or on the ombudsman's own motion.¹⁴⁹ Investigations typically result in recommendations to improve the quality of decision-making and administrative practices.

In every state and territory there are processes for handling complaints of child sexual abuse, including abuse in out-of-home care. The processes and procedures vary across jurisdictions.

2.7.3 Oversight through reportable conduct schemes

In Australia, the only model for independent oversight of institutional responses to complaints of child abuse and neglect across multiple sectors is known as a 'reportable conduct scheme'. Such schemes oblige the heads of certain institutions to notify an oversight body of any reportable allegation, conduct or conviction involving any of the institution's employees.

The schemes also oblige the oversight body to monitor institutions' investigation and handling of allegations. Under existing reportable conduct legislation, reportable conduct includes both sexual offences and 'sexual misconduct'.¹⁵⁰

The only reportable conduct scheme in full operation during the period of this inquiry was in New South Wales. The New South Wales scheme covers parts of the Department of Family and Community Services¹⁵¹ and designated agencies within the meaning of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), including accredited providers of out-of-home care.¹⁵²

The New South Wales legislation provides that an employee of an agency includes ‘any employee of the agency, whether or not employed in connection with any work or activities of the agency that relates to children’ and ‘any individual engaged by the agency to provide services to children (including authorised carers)’.¹⁵³

In July 2017, schemes began in Victoria and the Australian Capital Territory.

The Victorian legislation covers out-of-home care services within the meaning of the *Children, Youth and Families Act 2005* (Vic) and institutions that receive funding under a state contract to provide child protection services.¹⁵⁴ The Australian Capital Territory legislation covers ‘any administrative unit that deals with the safety, welfare or wellbeing of a particular child or class of children’, approved kinship and foster care organisations and approved residential care organisations.¹⁵⁵

The Victorian and Australian Capital Territory legislation contain provisions extending the operation of their respective reportable conduct schemes beyond employees in the ordinary sense.¹⁵⁶ In Victoria, the extended reach applies even if the person is not engaged to provide services to children.¹⁵⁷

Part of the Victorian legislation’s definition of ‘employee’ is intended to ensure that foster care and kinship care arrangements fall within scope, up until the point when a permanent care order is made for the child in question.¹⁵⁸

In New South Wales and the Australian Capital Territory, an adult who stays for at least 21 days at the same premises as an authorised out-of-home carer is also considered to be an employee of the out-of-home care service provider that authorised the carer.¹⁵⁹

Volume 7, *Improving institutional responding and reporting* contains detailed discussion of oversight of institutional complaint handling, including oversight through reportable conduct schemes.

Endnotes

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- 2 G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 15.
- 3 G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016; Human Rights and Equal Opportunity Commission, *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, Commonwealth of Australia, Sydney, 1997, pp 49, 123, 146; Senate Community Affairs References Committee, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children*, Commonwealth of Australia, Canberra, 2004.
- 4 Congregate care, or staffed group care or residential care, 'is provided in community-based residential homes, in which workers provide direct care of children on a rostered or shift-work basis': S McLean, R Price-Robertson & E Robinson, *Therapeutic residential care in Australia: Taking stock and looking forward*, Australian Institute of Family Studies, Melbourne, 2011, p 5.
- 5 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra, 2017, p 16.3.
- 6 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra, 2017, p 16.3.
- 7 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra, 2017, Table 16A.18. Percentages derived from numbers in Table 16A.18.
- 8 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra, 2017.
- 9 'Part 1 Objects and principles', *Children and Young Persons (Care and Protection) Act 1998* (NSW). For similar provisions in other Acts, see *Children and Young People Act 2008* (ACT) ss 7–10; *Care and Protection of Children Act* (NT) ss 4–12; *Child Protection Act 1999* (Qld) s 4–6; *Children's Protection Act 1993* (SA) s 3 (note: this Act will be repealed by the *Children and Young People (Safety) Act 2017* (SA) which is an Act 'to protect children and young people from harm' and 'to provide for children and young people who are in care'); *Children, Young Persons and Their Families Act 1997* (Tas) ss 10A–10G; *Children, Youth and Families Act 2005* (Vic) s 10; *Child Wellbeing and Safety Act 2005* (Vic) s 5; *Children and Community Services Act 2004* (WA) ss 6–10.
- 10 The 'total institution' has four defining characteristics that help explain the role that culture can play in enabling and/or disguising incidents of child sexual abuse in institutional contexts. First, total institutions are made up of staff and 'inmates' including, for example, the residents of regimented children's homes of the past. Second, the staff in total institutions directly or indirectly exert nearly total control over all aspects of the lives of 'inmates'. Third, rigid rules and procedures amplify their control. Finally, while total institutions may have a variety of purposes, their principal objective is the transformation of human beings in line with the purpose of the institution (for example, transforming orphaned children into model citizens). See D Palmer, *The role of organisational culture in child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016.
- 11 The introduction of the Supporting Mothers Benefit in 1973, and the Handicapped Child's Allowance in 1974, significantly enhanced the supports provided by the Australian Government to encourage the care of children at home rather than in institutions. Senate Community Affairs References Committee, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children*, Commonwealth of Australia, Canberra, 2004, pp 72–73; G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 16.
- 12 S Swain, *History of Child Protection Legislation*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2014, p 6.
- 13 T Moore, M McArthur, S Roche, J Death & C Tilbury, *Safe and sound: Exploring the safety of young people in residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 17, citing L Green, 'Analysing the sexual abuse of children by workers in residential care home: Characteristics, dynamics and contributory factors', *Journal of Sexual Aggression*, vol 7, no 2, 2001, p 17.
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- 15 Centre for Excellence in Child and Family Welfare Inc., *Out-of-home care for children with a disability: A literature review*, Centre for Excellence in Child and Family Welfare Inc., Melbourne, 2016, p 3; People with Disability Australia, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, p 10.
- 16 In Australia, these units only exist in NSW and Victoria. N Westera, E Darwinkel & M Powell, *A systematic review of the efficacy of specialist police investigative units in responding to child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 11.
- 17 Senate Community Affairs References Committee, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children*, Commonwealth of Australia, Canberra, 2004, p 176.
- 18 The lack of rigour in historical accountability mechanisms was reflective of the language used in legislation, which could be 'vague to the point where it could have discouraged any reporting of improper behaviour towards children in institutions': Senate Community Affairs References Committee, *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children*, Commonwealth of Australia, Canberra, 2004, pp 84, 177–178.

- 19 See for example: NSW Family and Community Services, *Your rights & responsibilities*, www.community.nsw.gov.au/parents,-carers-and-families/fostering,-guardianship-and-adoption/foster-care/are-you-a-community-services-foster-carer/your-rights (viewed 6 March 2017). In some jurisdictions, including Victoria, these kinds of values are cited as part of a 'Charter for Children in Out-of-Home Care', which lists what children in care 'can expect from all those people who look after you and work with you when you are in care': Victorian Department of Human Services, *Charter for children in out-of-home care*, www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/charter-for-children-in-out-of-home-care (viewed 16 June 2017).
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- 21 Anglicare Victoria submission cited in Senate Community Affairs References Committee, *Out of home care*, Commonwealth of Australia, Canberra, 2015, p 181.
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- 23 Australian Institute of Health and Welfare, *Child Protection Australia: 2014–15*, Australian Institute of Health and Welfare, Canberra, 2016, p 48.
- 24 In this volume a date range, for example, 2011–12 refers to a period of 12 months from 1 July – 30 June, unless otherwise specified. Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, Australian Institute of Health and Welfare, Canberra, 2017, p 60.
- 25 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, Australian Institute of Health and Welfare, Canberra, 2017, pp 60–1.
- 26 NSW Government, *Their futures matter: A new approach: Reform directions from the independent review of out of home care in New South Wales*, NSW Government, Sydney, 2017, p 4. See also: NSW Government, *Their futures matter: A new approach*, www.theirfuturesmatter.nsw.gov.au/_data/assets/file/0004/387292/FACS_OOHC_Review_Summary_171116.pdf (viewed 15 September 2017).
- 27 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, cat no CWS 60, Australian Institute of Health and Welfare, Canberra, 2017, pp 48, 51, 55.
- 28 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, Australian Institute of Health and Welfare, Canberra, 2017, p 55. The proportion varied between jurisdictions from 84 per cent in Victoria to almost 100 per cent in the Northern Territory.
- 29 Association of Children's Welfare Agencies, Submission No 94 to the Senate Standing Committee on Community Affairs, *Inquiry into Out of Home Care*, Commonwealth of Australia, Canberra, 2014, p 1.
- 30 Figures published by the NSW Office of the Children's Guardian show that in 2015–16 there were 167 agencies providing voluntary out-of-home care to 2,174 children, of whom 1,872 (86 per cent) were recorded as having a disability. See NSW Government Office of the Children's Guardian, *Voluntary out-of-home care key statistics*, www.kidsguardian.nsw.gov.au/voluntary-out-of-home-care/key-statistics (viewed 5 September 2017).
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- 32 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra, 2017, Table 16A.18.
- 33 Australian Institute of Health and Welfare, *Child protection Australia: 2014–15*, Australian Institute of Health and Welfare, Canberra, 2016, p 53. Australian Bureau of Statistics, 2016 Census of Population and Housing, percentage derived from Table G07 'Indigenous status by age by sex'.
- 34 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, Australian Institute of Health and Welfare, Canberra, 2017, p 52, table 5.2.
- 35 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, Australian Institute of Health and Welfare, Canberra, 2017, p 52, table 5.2.
- 36 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, Australian Institute of Health and Welfare, Canberra, 2017, p 62, table 5.7.
- 37 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, Australian Institute of Health and Welfare, Canberra, 2017, p 27. AIHW also refers to drug and alcohol abuse and family violence as causes.
- 38 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, Australian Institute of Health and Welfare, Canberra, 2017, p 27.
- 39 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, Australian Institute of Health and Welfare, Canberra, 2017, p 27.
- 40 P Anderson, M Bamblett, D Bessarab, L Bromfield, S Chan, G Maddock, K Menzies, M O'Connell, G Pearson, R Walker & M Wright, *Aboriginal and Torres Strait Islander children and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 25, citing 2014–15 data from Australian Institute of Health and Welfare, *Child Protection Australia: 2014–15*, Australian Institute of Health and Welfare, Canberra, 2016.

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43 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, Australian Institute of Health and Welfare, Canberra, 2017, p 23.

44 Royal Commission into Family Violence, *Volume V: Report and recommendations*, Melbourne, 2016, p 11, citing Victorian Aboriginal Child Care Agency, Submission to the Royal Commission into Family Violence, *Royal Commission into Family Violence*, 2016, p 7.

45 Royal Commission into Family Violence, *Volume V: Report and recommendations*, Melbourne, 2016, p 10, citing Aboriginal Family Violence Prevention and Legal Service Victoria, Submission to the Royal Commission into Family Violence, *Royal Commission into Family Violence*, 2016, p 10.

46 Secretariat of National Aboriginal & Islander Child Care, *Achieving stable and culturally strong out of home care for Aboriginal and Torres Strait Islander children*, SNAICC, Melbourne, 2005, p 8.

47 Transcript of A Jackomos, Case Study 57, 28 March 2017 at 27557:39–42.

48 Senate Community Affairs References Committee, *Out of home care*, Commonwealth of Australia, Canberra, 2015, s 9.60, p 270; G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 28; CREATE Foundation, *Supporting children and young people with a disability living in out-of-home care in Australia: Literature review*, CREATE Foundation, South Brisbane, 2012. See also F Briggs, ‘Safety issues in the lives of children with learning disabilities’, *Social Policy Journal of New Zealand*, no 29, 2006; K Stalker & K McArthur, ‘Child abuse, child protection and disabled children: A review of recent research’, *Child Abuse Review*, vol 21, no 1, 2012; D Higgins, ‘Sexuality, human rights and safety for people with disability’, *Sexual and Relationship Therapy*, vol 25, no 3, 2010, pp 249, 251.

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53 Children and Young People with Disability Australia, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, pp 4–5.

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55 See the following submissions to the Royal Commission into Institutional Responses to Child Sexual Abuse on *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016: National Disability Services, pp 1–2; People with Disability Australia, p 12.

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64 S Couper, A Jackson, N Milburn & C Black, *Victorian cradle to kinder and Aboriginal cradle to kinder: Practice guide*, Victorian Government Department of Human Services, Melbourne, 2013, pp 2–116.

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66 N Ross, J Cocks, L Johnston & L Stoker, ‘No voice, no opinion, nothing’: *Parent experiences when children are removed and placed in care*, University of Newcastle, Newcastle, 2017, p 11.

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- 68 The Australian Government had a role in the child protection systems of the ACT and Northern Territory prior to self-governance. The Northern Territory National Emergency Response (the 'Intervention') is also evidence of the Australian Government's capacity to act in the child protection sphere.
- 69 Senate Community Affairs References Committee, *Out of home care*, Commonwealth of Australia, Canberra, 2015, pp 22–23.
- 70 L Bromfield & P Holzer, *A national approach for child protection: Project report*, Australian Institute of Family Studies, Canberra, 2008, p ix.
- 71 Convention on the Rights of the Child, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990), art 3(1). Article 3(1) states, 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration'. See Australian Law Reform Commission, *Seen and heard: Priority for children in the legal process (ALRC Report 84)*, Australian Government Publishing Service, Canberra, 1997, chapter 16; L Bromfield & P Holzer, *A national approach for child protection: Project report*, Australian Institute of Family Studies, Canberra, 2008, p 18.
- 72 *Children and Young People Act 2008* (ACT) s 7; *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 8; *Care and Protection of Children Act* (NT) s 10; *Child Protection Act 1999* (Qld) s 5B; *Children's Protection Act 1993* (SA) s 3 (note: this Act will be repealed by the *Children and Young People (Safety) Act 2017* (SA) the relevant provisions of which are ss 7–8); *Children, Young Persons and Their Families Act 1997* (Tas) s 10E; *Children, Youth and Families Act 2005* (Vic) s 10; *Child Wellbeing and Safety Act 2005* (Vic) s 5; *Children and Community Services Act 2004* (WA) s 8.
- 73 *Children and Young People Act 2008* (ACT) s 7; *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 8; *Care and Protection of Children Act* (NT) s 4; *Child Protection Act 1999* (Qld) s 5B; *Children's Protection Act 1993* (SA) s 3 (note: this Act will be repealed by the *Children and Young People (Safety) Act 2017* (SA) the relevant provision of which is s 4); *Children, Young Persons and Their Families Act 1997* (Tas) s 10E; *Children, Youth and Families Act 2005* (Vic) s 10; *Child Wellbeing and Safety Act 2005* (Vic) s 5; *Children and Community Services Act 2004* (WA) s 8.
- 74 Where it is deemed to be in the best interests of the child, this is taken to include supporting and encouraging relationships with people significant to the child, including birth or adoptive parents, siblings, extended family and friends. *Children and Young People Act 2008* (ACT) s 9; *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 9(2)(d); *Care and Protection of Children Act* (NT) s 9(2)(b); *Child Protection Act 1999* (Qld) s 5B(m); *Children, Young Persons and Their Families Act 1997* (Tas) s 10C(2)(b); *Children, Youth and Families Act 2005* (Vic) s 10(3)(l); *Children and Community Services Act 2004* (WA) s 8(1)(j). In South Australia s 10 of the *Children and Young People (Safety) Act 2017* (SA), which is yet to commence, makes provision in this regard.
- 75 *Children and Young People Act 2008* (ACT) s 10; *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 13; *Care and Protection of Children Act* (NT) s 12; *Child Protection Act 1999* (Qld) s 5C; *Children's Protection Act 1993* (SA) ss 5–6 (note: this Act will be repealed by the *Children and Young People (Safety) Act 2017* (SA) the relevant provisions of which is s 12); *Children, Young Persons and Their Families Act 1997* (Tas) s 10G; *Children, Youth and Families Act 2005* (Vic) s 13; *Children and Community Services Act 2004* (WA) s 12.
- 76 *Children and Young People Act 2008* (ACT) s 9; *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 8; *Care and Protection of Children Act* (NT) s 10; *Child Protection Act 1999* (Qld) s 5B; *Children's Protection Act 1993* (SA) s 3 (note: this Act will be repealed by the *Children and Young People (Safety) Act 2017* (SA) the relevant provisions of which is s 4); *Children, Young Persons and Their Families Act 1997* (Tas) s 10E; *Children, Youth and Families Act 2005* (Vic) s 10; *Child Wellbeing and Safety Act 2005* (Vic) s 5; *Children and Community Services Act 2004* (WA) s 8.
- 77 For example, as part of New South Wales's *Keep Them Safe* policy to move towards using non-government organisations (NGOs) to deliver all out-of-home care services by 2022, the number of children with an accredited NGO more than doubled from 2,946 in June 2011 to 7,268 in March 2015 – see Audit Office of New South Wales, *Transferring out-of-home care to non-government organisations*, Audit Office of New South Wales, Sydney, 2015, p 3. In Queensland, the use of NGOs in the delivery of out-of-home care has expanded considerably in the past decade and is expected to expand further under reforms proposed by the Queensland Child Protection Commission of Inquiry in 2013 – see Queensland Child Protection Commission of Inquiry, *Taking responsibility: A roadmap for Queensland child protection*, Queensland Government, Brisbane, 2013, p 69. In Victoria, where governments have historically relied heavily on NGOs for the delivery of out-of-home care services, recent statutory and policy reforms have further broadened the already significant involvement of community service organisations in providing care and protection for children in statutory out-of-home care – see Protecting Victoria's Vulnerable Children Inquiry, *Report of the protecting Victoria's vulnerable children inquiry; Volume 2* Victorian Government, Melbourne, 2012, pp 56, 60, 62, 64. Sometimes responsibilities are transferred for some out-of-home care services, but not for others. For example, South Australia's Child Protection Systems Royal Commission recommended against outsourcing 'any [government-run] residential or emergency care service' (Recommendation 151), but nonetheless recommended outsourcing 'assessment and support of kinship carers to appropriately qualified non-government organisations' (Recommendation 102) – see Child Protection Systems Royal Commission, *The life they deserve*, South Australian Government, Adelaide, 2016, pp 245, 297, 301, 349–350, 357.
- 78 Exhibit 24-0001, 'Victorian Government response to the areas to be examined for Case Study 24', Case Study 24, VIC.0007.001.0001, p 11.

79 Exhibit 24-0001, 'Northern Territory Government response to areas to be examined for Case Study 24', Case Study 24, NT.0026.001.0001, p 2; Exhibit 24-0001, 'Government of South Australia response to areas to be examined for Case Study 24', SA.0029.001.0002, p 17.

80 Department of Foreign Affairs and Trade, *Treaties – International Covenant on Economic, Social and Cultural Rights*, 2009, <http://info.dfat.gov.au/Info/Treaties/treaties.nsf/AllDocIDs/CFB1E23A1297FFE8CA256B4C000C26B4> (viewed 21 February 2017).

81 Committee on Economic, Social and Cultural Rights, *General Comment No 13: Implementation of the International Covenant on Economic, Social and Cultural Rights*, 21st session, E/C.12/1999/10 (8 December 1999) para 1; Convention on the Rights of the Child, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990), art 3.

82 Convention on the Rights of the Child, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990), art 19.

83 Council of Australian Governments, *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020 – Second Action Plan 2012–2015*, Commonwealth of Australia, Canberra, 2012, p 9.

84 Australian Institute of Family Studies, *Child abuse and neglect statistics*, 2016, www.aifs.gov.au/cfca/publications/child-abuse-and-neglect-statistics (viewed 15 September 2017).

85 See for example, Council of Australian Governments, *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020*, Commonwealth of Australia, Canberra, 2009, p 25; Senate Community Affairs References Committee, *Out of home care*, Commonwealth of Australia, Canberra, 2015, p 29; Special Commission of Inquiry into Child Protection Services in NSW, *Report of the special commission of inquiry into child protection services in NSW*, New South Wales Government, Sydney, 2008, p 202; Australian Institute of Family Studies, *Child abuse and neglect statistics*, Australian Government, Melbourne, 2016.

86 Council of Australian Governments, *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020*, Commonwealth of Australia, Canberra, 2009, p 11.

87 Council of Australian Governments, *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020*, Commonwealth of Australia, Canberra, 2009, p 11. See also pp 15–33.

88 Council of Australian Governments, *Protecting children is everyone's business: National framework for protecting Australia's children 2009–2020*, Commonwealth of Australia, Canberra, 2009. The standards are: stability and security, participation in decisions, Aboriginal and Torres Strait Islander communities, individualised plan, health needs, education and early childhood, education, training and/or employment, social and/or recreational, connection with family identify development, significant others, carers, transition from care planning.

89 Department of Families, Housing, Community Services and Indigenous Affairs & National Framework Implementation Working Group, *An outline of national standards for out-of-home care: A priority project under the national framework for protecting Australia's children 2009–2020*, Commonwealth of Australia, Canberra, 2011, p 2.

90 The *Report on government services 2017* reports on standard 1.1, 1.2 (although the data is described as 'experimental'), 4.1, 9.1 and partial reporting on 3.1; Child Protection Australia 2015–16 reports on standard 12.1. There are no reports on standards relating to cultural care or leaving care plans. See Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra, 2017; Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, cat no CWS 60, Australian Institute of Health and Welfare, Canberra, 2017.

91 Senate Community Affairs References Committee, *Out of home care*, Commonwealth of Australia, Canberra, 2015, p 56; Transcript of A McLeish, Case Study 24, 30 June 2015, at T14738:8–16 and 14773:15–35.

92 Convention on the Rights of the Child, opened for signature 20 November 1989, 1577 UN 3 (entered into force 2 September 1990), arts 2, 3, 5, 12, 19, 23, 34.

93 Convention on the Rights of the Child, opened for signature 20 November 1989, 1577 UN 3 (entered into force 2 September 1990).

94 See *Working with Children (Risk Management and Screening) Act 2000* (Qld); *Child Safety and Wellbeing Act 2005* (Vic).

95 *Working With Vulnerable People (Background Checking) Act 2011* (ACT); *Child Protection (Working with Children) Act 2012* (NSW); *Care and Protection of Children Act 2007* (NT); *Working with Children (Risk Management and Screening) Act 2000* (Qld); *Child Safety (Prohibited Persons) Act 2016* (SA); *Registration to Work with Vulnerable People Act 2013* (Tas); *Working with Children Act 2005* (Vic); *Working with Children (Criminal Record Checking) Act 2004* (WA).

96 *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 138, 139.

97 See for example: *Children and Young Persons (Care and Protection) Regulations 2012* (NSW) cl 61; *Children, Youth and Families Act 2005* (Vic) s 75.

98 See NSW Government Office of the Children's Guardian, *About designated agencies*, www.kidsguardian.nsw.gov.au/statutory-out-of-home-care-and-adoption/designated-agencies/about-designated-agencies (viewed 21 June 2017). As noted in the discussion on 'Accreditation of out-of-home care service providers' in Chapter 4, Victoria requires service providers to be assessed by a department-approved accreditation body, but the Department of Health and Human Services retains responsibility for deciding on whether the service provider should be registered.

99 NSW Office of the Children's Guardian, *NSW Child Safe Standards for Permanent Care*, Office of the Children's Guardian, Surry Hills, 2015.

100 See for example: *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 136, 137; *Child Protection Act 1999* (Qld) ss 82, 131, 132; *Children, Youth and Families Act 2005* (Vic) ss 73, 75, 77, 119, 120.

101 See for example: *Children and Young Persons (Care and Protection) Act 1998* (NSW) ss 136, 137; *Child Protection Act 1999* (Qld) ss 82, 131, 132; *Children, Youth and Families Act 2005* (Vic) ss 73, 75, 77, 119, 120.

- 102 M Benton, R Pigott, M Price, P Shepherdson, & G Winkworth, *A national comparison of carer screening, assessment, selection and training and support in foster care, kinship and residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 6.
- 103 As detailed in M Benton, R Pigott, M Price, P Shepherdson, & G Winkworth, *A national comparison of carer screening, assessment, selection and training and support in foster care, kinship and residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, in Victoria carers are approved annually, p 49, and police record checks are done every 3 years, p 50. In South Australia there is an annual licence for carers, and NGO providers are subject to annual review of premises, policies, procedures and care standards, p 40. In Tasmania police checks are conducted every 3 years, p 44 and there are annual reviews of carers, p 45. In the ACT carer approvals are reviewed and renewed every 3 years, p 18. See also, annual reviews as supports for carers, p 81.
- 104 M Benton, R Pigott, M Price, P Shepherdson, & G Winkworth, *A national comparison of carer screening, assessment, selection and training and support in foster care, kinship and residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 67–69.
- 105 See *Working with Children Act 2005* (Vic) s 28. Following changes introduced by section 2(2) of the *Working with Children Amendment Act 2016* (to commence on 1 August 2017), kinship carers are no longer exempt from Working with Children Check requirements in Victoria. Section 28 continues to exempt ‘closely related’ family members from having to obtain Working With Children Checks for other child-related work (for example, tutoring), but not for ‘child-related work’ involving a placement in kinship care. See also the following submissions to the Royal Commission into Institutional Responses to Child Sexual Abuse on *Issues paper No 4: Preventing sexual abuse of children in out of home care*, 2013: Life Without Barriers, p 6; NSW Ombudsman, p 6.
- 106 *Child Protection (Working with Children) Act 2012* (NSW), s 10(1); *Children and Young People Act 2008* (ACT) ss 65(1)(h), 514C(a)(ii); *Working with Children (Risk Management and Screening) Act 2000* (Qld) s 14(2); *Children’s Protection Act 1993* (SA) s 44B (note: this Act will be repealed by the *Children and Young People (Safety) Act 2017* (SA), the relevant provisions of which are s 37, s 66); *Children, Youth and Families Act 2005* (Vic) s 148(4)(a); Care and Protection of Children (Placement Arrangement) Regulations (NT) cl 3(e); Children and Community Services Regulations 2006 (WA), cl 4(1)(a)(ii), which requires that carers be able to provide a safe living environment for the child. In hearings for Case Study 24, we heard that the Tasmanian Government has plans to amend the *Children, Young Persons and Their Families Act 1997*. See transcript of C Haire, Case Study 24, 10 March at 12871:16–22.
- 107 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, Sydney, 2016, pp 67–68.
- 108 C Adams & K Lee-Jones, *A study into the legislative – and related key policy and operational – frameworks for sharing information relating to child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, pp 50–51.
- 109 For example, the carers register in Victoria appears to be limited to basic information about registered carers. Information about disqualified carers is not to be recorded on the register, and any entry relating to a disqualified carer must be removed: see *Children, Youth and Families Act 2005* (Vic) s 80; Children, Youth and Families Regulations 2017 (Vic), cl 11. The NSW Carers Register contains significantly more information – see *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 181(1)(d); Children and Young Persons (Care and Protection) Regulation 2012 (NSW) cls 86D–86I. In Western Australia, written protocols issued by the Department of Child Protection note that the Foster Carer Directory of Western Australia ‘records the identifying approval details of foster carer applicants, the outcome of their assessment and the categories of children for whom they are approved to care’. However, a greater range of events trigger a notification to the Directory. See Department of Child Protection, Government of Western Australia, *Protocols for the Foster Carer Directory of Western Australia*, Perth, 2012, p 5.
- 110 Royal Commission into Institutional Responses to Child Sexual Abuse, *Working with Children Checks Report*, Sydney, 2015, p 3.
- 111 Royal Commission into Institutional Responses to Child Sexual Abuse, *Working with Children Checks report*, Sydney, 2015.
- 112 Royal Commission into Institutional Responses to Child Sexual Abuse, *Working with Children Checks report*, Sydney, 2015, p 3.
- 113 Royal Commission into Institutional Responses to Child Sexual Abuse, *Working with Children Checks report*, Sydney, 2015, p 3.
- 114 As discussed in Royal Commission into Institutional Responses to Child Sexual Abuse, *Working with Children Checks Report*, Sydney, 2015, pp 73–4, we believe adults residing in the homes of authorised carers should be required to obtain WWCCs due to the vulnerability of children in out-of-home care.
- 115 Royal Commission into Institutional Responses to Child Sexual Abuse, *Redress and civil litigation*, Sydney, 2015.
- 116 Legal Aid NSW, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, p 4.
- 117 Legal Aid NSW, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016.
- 118 B Mathews, *Mandatory reporting laws for child sexual abuse in Australia: A legislative history*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2014, p 28.
- 119 Noting that in the Northern Territory, all persons are obliged to report child sexual abuse: *Care and Protection of Children Act 2007* (NT) s 26.

120 In every state and territory, mandatory reports can be made to the relevant child protection authority. We therefore
 use the term ‘mandatory reporting to child protection authorities’ in this chapter. We note, however, that in some
 jurisdictions, mandatory reports can be made to other agencies. For example, in Tasmania, a mandatory report can
 be made to a community-based intake service. *Children, Young Persons and Their Families Act 1997* (Tas) s 14.

121 B Mathews, *Mandatory reporting laws for child sexual abuse in Australia: A legislative history*, report prepared for the
 Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2014, p 39. See also: Department of Child
 Protection (WA), *After a report is made*, 2008, www.mandatoryreporting.dcp.wa.gov.au/Pages/FAQ-Afterareportismade.aspx (viewed 22 June 2017); Family and Community Services (NSW), *Reporting suspected abuse or neglect*,
www.community.nsw.gov.au/preventing-child-abuse-and-neglect/reporting-suspected-abuse-or-neglect (viewed
 22 June 2017); Department of Human Services (Vic), *Child Protection*, 2016, [www.dhs.vic.gov.au/for-individuals/
 children,-families-and-young-people/child-protection](http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection) (viewed 22 June 2017).

122 *Children and Young People Act 2008* (ACT) s 356(2); *Child Protection Act 1999* (Qld) s 13E(1); *Children’s Protection Act
 1993* (SA) s 11(2) (note: this Act will be repealed and replaced by the *Children and Young People (Safety) Act 2017*
 (SA) the relevant provision of which is s 30(3)); *Children, Young Persons and Their Families Act 1997* (Tas) s 14(1);
Children, Youth and Families Act 2005 (Vic) s 182(1); *Children and Community Services Act 2004* (WA) s 124B(1)(a).
 While the provisions in New South Wales do not specify particular professions, doctors, teachers, nurses and police are
 all mandated reporters – *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 27(1)(a). Similarly, the
 breadth of section 26 of the *Care and Protection of Children Act 2007* (NT) means these occupations are also mandated
 reporters in the Northern Territory.

123 A ‘boarding supervisor’ is any person who holds an office or position at a boarding facility that provides residential
 accommodation for school students: *Children and Community Services Act 2004* (WA) ss 124A, 124B.

124 *Children’s Protection Act 1993* (SA) s 11(2)(ga) (note: this Act will be repealed and replaced by the *Children and Young
 People (Safety) Act 2017* (SA) the relevant provision of which is s 30(3)(e)).

125 *Care and Protection of Children Act* (NT) s 26.

126 *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 27.

127 *Crimes Act 1900* (NSW) s 316(1).

128 *Crimes Act 1958* (Vic) s 327(2).

129 Royal Commission into Institutional Responses to Child Sexual Abuse, *Criminal justice: Parts III–VI*, Sydney, 2017.

130 Convention on the Rights of the Child, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force
 2 September 1990), art 3.

131 R Miller, *Cumulative harm: A conceptual overview: Best interest series*, Victorian Department of Human Services,
 Melbourne, 2007, p 1.

132 Special Commission of Inquiry into Child Protection Services in NSW, *Report of the special commission of inquiry into
 child protection services in NSW*, New South Wales Government, Sydney, 2008 p 591.

133 *Family Law Act 1975* (Cth).

134 *Children and Young People Act 2008* (ACT) Ch 15; *Children and Young Persons (Care and Protection) Act 1998* (NSW)
 Ch 5, Pt 1, Divs 1–3; *Care and Protection of Children Act* (NT) Ch 2, Pt 2.3; *Child Protection Act 1999* (Qld) Ch 2; *Children’s
 Protection Act 1993* (SA) ss 21, 38 (note: this Act will be repealed by the *Children and Young People (Safety) Act 2017*
 (SA) the relevant provisions of which is s 53); *Children, Young Persons and Their Families Act 1997* (Tas) s 42; *Children,
 Youth and Families Act 2005* (Vic) s 275; *Children and Community Services Act 2004* (WA) Pt 4, Div 2, Subdiv 2.

135 *Children and Young People Act 2008* (ACT) s 17; *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 79;
Care and Protection of Children Act (NT) s 137A; *Child Protection Act 1999* (Qld) s 12; *Children’s Protection Act 1993* (SA)
 ss 21, 38 (note: this Act will be repealed by the *Children and Young People (Safety) Act 2017* (SA) the relevant provisions
 of which is s 53); *Children, Young Persons and Their Families Act 1997* (Tas) s 42(4); *Children, Youth and Families Act
 2005* (Vic) s 275; *Children and Community Services Act 2004* (WA) s 133.

136 *Children and Young People Act 2008* (ACT) ss 516, 518, 520; *Children and Young Persons (Care and Protection) Act 1998*
 (NSW) ss 81, 157; *Care and Protection of Children Act* (NT) s 107; *Child Protection Act 1999* (Qld) ss 51B, 83; *Children’s
 Protection Act 1993* (SA) s 51, (note: this Act will be repealed by the *Children and Young People (Safety) Act 2017* (SA)
 the relevant provisions of which is s 75); *Children, Young Persons and their Families Act 1997* (Tas) s 69; *Children, Youth
 and Families Act 2005* (Vic) ss 172, 173, 282, 285; *Children and Community Services Act 2004* (WA) s 29.

137 The term ‘case manager’ is also used.

138 Special Commission of Inquiry into Child Protection Services in NSW, *Report of the special commission of inquiry into
 child protection services in NSW; Volume 2*, New South Wales Government, Sydney, 2008, p 593.

139 Victorian Department of Health and Human Services, *Practice advice 1466: Abuse in care*, cited in Commission for
 Children and Young People, “...as a good parent would...” *Inquiry into the adequacy of the provision of residential care
 services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst
 residing in residential care*, Commission for Children and Young People, Melbourne, 2015, p 40.

140 ChildStory Caring, *Emotional wellbeing and mental health*, [www.caring.childstory.nsw.gov.au/health-and-wellbeing/
 emotional-wellbeing-and-mental-health](http://www.caring.childstory.nsw.gov.au/health-and-wellbeing/emotional-wellbeing-and-mental-health) (viewed 17 February 2017). See also NSW Department Family and Community
 Services, *Caring for kids: A guide for foster, relative and kinship carers*, 2011 (reprinted 2014).

141 We note that some jurisdictions have visitors programs for children in detention or juvenile justice facilities; children and
 others with disability in facilities established to cater for their needs; and some individuals with mental health concerns
 (Australian Capital Territory, Victoria and Western Australia). Our discussion here is limited to visitors who visit children
 in out-of-home care placements only.

- 142 *Public Guardian Act 2014* (Qld) s 56(1). See also: Queensland Office of the Public Guardian, 'How can your community visitor (CV) help?', Fact sheet for children and young people, www.publicguardian.qld.gov.au/__data/assets/pdf_file/0008/447866/opg-factsheet-community-visitors-children-final.pdf (viewed 25 May 2017).
- 143 *Children and Community Services Act 2004* (WA) s 125A.
- 144 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 8(1); New South Wales Ombudsman, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues paper No 4: Preventing sexual abuse of children in out of home care*, 2013, p 10.
- 145 See New South Wales Ombudsman, *Official Community Visitors*, www.ombo.nsw.gov.au/what-we-do/coordinating-responsibilities/official-community-visitors (viewed 13 April 2017).
- 146 *Human Rights Commission Act 2005* (ACT) s 19B (re the functions of the Commissioner); *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 181 (re the functions of the Guardian); *Children's Commissioner Act 2013* (NT) s 10 (re the functions of the Commissioner); *Family and Child Commission Act 2014* (Qld) s 9 (re the functions of the Commission); Office of the Guardian for Children and Young People South Australia, <http://www.gcyp.sa.gov.au/about-2/> (re the functions of the Guardian); *Commissioner for Children and Young People Act 1997* (Tas) s 8 (re the functions of the Commissioner); *Commission for Children and Young People Act 2012* (Vic) s 8 (re the functions of the Commission); *Commissioner for Children and Young People Act 2006* (WA) s 19 (re the functions of the Commissioner).
- 147 *Human Rights Commission Act 2005* (ACT) ss 19B, 40A; *Advocate for Children and Young People Act 2014* (NSW) s 15(1) (c); *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 181; *Children's Commissioner Act* (NT) s 10; *Family and Child Commission Act 2014* (Qld) s 9; Office of the Guardian for Children and Young People South Australia, www.gcyp.sa.gov.au/about-2/; *Commissioner for Children and Young People Act 2016* (Tas) s 20; *Commissioner for Children and Young People Act 2012* (Vic) s 8; *Commissioner for Children and Young People Act 2006* (WA) s 19.
- 148 The functions of the Ombudsman for the Northern Territory do not extend to a matter that the Northern Territory Children's Commissioner is authorised to investigate under the *Children's Commissioner Act 2013* (NT) (see *Ombudsman Act* (NT) s 10(2)).
- 149 *Ombudsman Act 1989* (ACT) ss 4C, 5; *Ombudsman Act 1974* (NSW) ss 6, 12, 13; *Ombudsman Act* (NT) ss 10-12; *Ombudsman Act 2001* (Qld) ss 5, 6, 12; *Ombudsman Act 1978* (Tas) s 12; *Ombudsman Act 1972* (SA) ss 13, 14A; *Ombudsman Act 1973* (Vic) s 13; *Parliamentary Commissioner Act 1971* (WA) ss 4A, 13, 14.
- 150 *Ombudsman Act 1974* (NSW) s 25A; *Child Wellbeing and Safety Act 2005* (Vic) s 3(1); *Ombudsman Act 1989* (ACT) s 17E.
- 151 *Ombudsman Regulation 2016* (NSW) cl 4(c).
- 152 *Ombudsman Act 1974* (NSW) s 25A(1): see definition of 'designated non-government agency', para (b); *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 139.
- 153 *Ombudsman Act 1974* (NSW) s 25A: see definition of 'employee'.
- 154 *Child Wellbeing and Safety Act 2005* (Vic) Sch 3, cls 9, 10.
- 155 *Ombudsman Act 1989* (ACT) ss 17D(1)(a), (f), (g).
- 156 *Child Wellbeing and Safety Act 2005* (Vic) s 3(1): see definition of 'employee'; *Ombudsman Act 1989* (ACT) s 17D: see definition of 'employee'.
- 157 *Child Safety and Wellbeing Act 2005* (Vic) s 3(1): see definition of 'employee', para (a).
- 158 *Child Safety and Wellbeing Act 2005* (Vic) s 3(1): see definition of 'employee', para (d). See Victorian Government, Explanatory Memorandum, Children Legislation Amendment (Reportable Conduct) Bill 2016 (Vic), p 3.
- 159 *Ombudsman Act 1974* (NSW) s 25AAA; *Ombudsman Act 1989* (ACT) s 17D: see definition of 'employee', para (b).

3 Child sexual abuse in contemporary out-of-home care

3.1 Overview

This chapter describes what we learned about the sexual abuse of children in contemporary (post-1990) out-of-home care. Building on Volume 2, *Nature and cause* and Volume 3, *Impacts*, it discusses:

- the nature and extent of child sexual abuse in out-of-home care
- the victims of child sexual abuse and the adult perpetrators in out-of-home care we heard about
- children in out-of-home care who we heard had sexually abused other children
- where children in out-of-home care have been sexually abused
- how and why children were sexually abused in out-of-home care
- the impacts for children of being sexually abused in out-of-home care.

This volume also incorporates our work in *Case Study 24: Preventing and responding to allegations of child sexual abuse occurring in out-of-home care (Out-of-home care)*, which examined the policies and practices of governments and agencies. During this case study, we heard from witnesses from the government and non-government sectors, advocacy and support organisations, and oversight agencies. We also heard from a panel of young care-leavers about their experiences in out-of-home care.

This chapter is also informed by public roundtables, consultations and what we heard in private sessions. Between 31 May 2013 and 31 May 2017, 257 survivors came forward and told their stories of being sexually abused as children in contemporary out-of-home care to one or more Commissioners. In these private sessions, survivors were encouraged to tell their stories in their own way. Some survivors found their experiences easy to recall and relay; some did not know or were uncertain about aspects of their experiences. Some described their experiences of sexual abuse in detail; others chose to or could only give limited information.

The survivors who attended private sessions chose to do so; we do not know whether their experiences reflect those of victims and survivors who did not or could not come forward. However, the information volunteered in private sessions allows us to draw some broad conclusions about children in contemporary out-of-home care.

What we learned about the risks of child sexual abuse in contemporary out-of-home care is also strongly informed by an increasing body of research, which we draw on in this chapter to examine the risks to children that are evident from all the sources identified above.

3.1.1 Limitations of data

The data collected and reported about the extent of child sexual abuse in contemporary out-of-home care in Australia is limited. Despite the heightened risks associated with removing children from their families and placing them in the care of the state, research into the incidence of child sexual abuse in out-of-home care is limited to a few studies, ‘mostly dating back to the early 1990s, when this issue first became prominent’.¹

Recent inquiries and reports indicate that maltreatment (all types of abuse – physical, emotional and sexual – as well as neglect) is ‘widespread for children involved in any area of the child protection system’, yet the issue remains ‘under-researched and under-reported’.² Much of what is known about the risks associated with out-of-home care depends on ‘the availability of data relating to children who have come to the attention of child protection services’.³ As only some abuse is reported, and only select information about that abuse is subsequently made available, there are likely to be significant gaps in what we know about the forms of sexual and other abuse experienced by children in out-of-home care, the duration and frequency of the abuse, and the incidence of grooming. Detailed information may be recorded in case files for individual children but difficulties with extracting this data limit the opportunities for it to be used to monitor systemic issues of abuse in care.

There is also no reliable way to identify the extent of the problem or the overall outcomes of investigations into allegations of sexual abuse in out-of-home care.⁴

The introduction of regulatory regimes, such as the reportable conduct scheme New South Wales introduced in 1999, and efforts to improve the quality of national reporting of child protection data since 2009 are focusing attention on the need for a better understanding of child sexual abuse in out-of-home care. Further, the collection and reporting of a Child Protection National Minimum Data Set, following the endorsement of the National Framework for Protecting Australia’s Children 2009–2020, has broadened the available information about children in out-of-home care. This includes the number of child protection notifications, substantiated reports of sexual abuses per child, and movements in and out of care each year.⁵

While these measures have greatly improved reporting on the number of substantiated incidents of abuse of children in out-of-home care, there is still no national data that would provide reliable estimates of:

- how many children in out-of-home care have been sexually abused
- the characteristics of those children, to help identify whether some cohorts are at greater risk
- who the perpetrators were, when and where the sexual abuse occurred, and the response to the abuse.

The limited capacity of many states and territories to report on child sexual abuse in out-of-home care in turn limits the available information about the nature and extent of the abuse, the risks in this institutional setting, and the effectiveness of strategies and interventions to address the abuse. As we heard during *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts*, ‘This means that we can’t count in Australia. You can’t measure if it’s not counted. More importantly ... you cannot monitor what is happening over time’.⁶

For these reasons, the experiences that survivors of child sexual abuse in out-of-home care shared with the Royal Commission provide important insights into such abuse, which are outlined in this volume.

3.2 The nature and extent of child sexual abuse in contemporary out-of-home care

This section outlines what we learned about the nature and extent of child sexual abuse in contemporary out-of-home care in Australia. However, to fully understand these issues, improved data collection is essential. We heard evidence in *Case Study 51: Institutional review of Commonwealth, state and territory governments* about work being done in all jurisdictions to improve their capacity to collect and analyse information and data. Chapter 5 contains our recommendations for improved data collection.

3.2.1 Nature

Child sexual abuse covers a wide range of behaviours and can take many forms. These are not changed by the institutional settings in which the abuse occurs, but those settings do give rise to particular risks. Unlike other institutions such as schools, out-of-home care itself appears to present risks to children, whose vulnerability is exacerbated by isolation from their families, communities and peers and the instability of the settings in which they are living. Children in out-of-home care make up a substantial proportion of all victims of all types of substantiated reports of abuse and neglect of children in Australia (75 per cent). However, the data does not distinguish between abuse that led to placement in care and abuse experienced while in care.⁷ In Chapter 5 we recommend measures to address gaps in current reports on these issues.

According to commissioned research, few empirical studies have focused on sexual abuse in contemporary out-of-home care. This research notes that studies of the prevalence of abuse in out-of-home care, both home-based and residential, ‘commonly lack specificity regarding the “type” of abuse experienced’.⁸ Notwithstanding this, the experiences of survivors we heard from in private sessions show that children in contemporary out-of-home care can be at risk of all forms of sexual abuse.

Past inquiries into contemporary out-of-home care have considered the risks of child sexual abuse and strategies for preventing it, but have not generally reported on the incidence and types of sexual abuse experienced by children in this institutional setting. A number of survivors came forward to the Commission of Inquiry into Abuse of Children in Queensland Institutions (1999). Their experiences were reported in relation to individual institutions but not as aggregated data, so the scale of the problem was not evident in the report. In 2008, the South Australian *Children in State Care Commission of Inquiry: Allegations of sexual abuse and death from criminal conduct* report noted that of the people who made allegations of child sexual abuse to the inquiry, 242 were children in state care at the time of the alleged abuse. These allegations covered the period from the 1940s to 2004.⁹

In 2015, ‘... as a good parent would ...’: *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care* examined records relating to 281 children who were the subject of sexual abuse client incident reports between 1 March 2013 and 28 February 2014.¹⁰ External predators accounted for 63 per cent of all identified perpetrators, and child sexual abuse by another child made up 31 per cent of reports.¹¹ The inquiry found that ‘more than one quarter (27 per cent) of the Aboriginal children in residential care have been subject to a sexual abuse CIR [client incident report]’.¹²

In 2016, *The life they deserve: Child Protection Systems Royal Commission report* cited data provided by South Australia’s Guardian for Children and Young People, which received 236 notifications of ‘serious sexual abuse’ of 422 children in care in that state between November 2008 and October 2014. The report noted the likelihood of significant under-reporting.¹³

The following section identifies the types of child sexual abuse that we heard about from survivors during private sessions and discusses what we learned about the risks of child sexual abuse in contemporary out-of-home care.

Types of child sexual abuse

The types of child sexual abuse in out-of-home care that we were told about include penetrative and non-penetrative contact abuse, violations of privacy, exposure to sexual acts and material, sexual exploitation, and combinations of these forms of abuse. The *Key terms* section of Chapter 1 provides the definition of child sexual abuse that the Royal Commission adopted.

Of the survivors of child sexual abuse in all contemporary out-of-home care settings that we heard about in private sessions, most (75.5 per cent) mentioned the type of sexual abuse they experienced. Of these:

- 112 (57.7 per cent) said they experienced penetrative abuse
- 111 (57.2 per cent) said they experienced non-penetrative contact abuse
- 47 (24.2 per cent) told us they experienced violations of privacy
- 25 (12.9 per cent) told us they were exposed to sexual acts and material, either in person or online
- 21 (10.8 per cent) told us about being groomed (or entrapped)
- 15 (7.7 per cent) said they had been sexually exploited (that is, manipulated or coerced to participate in a sexual activity in exchange for, or the promise of, an incentive).

Chapter 2 of Volume 2, *Nature and cause* discusses in detail what we learned overall about the nature of child sexual abuse in institutions. The types of sexual abuse are not different in contemporary out-of-home care and our focus in this volume is on the factors that make children in care particularly vulnerable and the risks inherent in the institution.

Commissioned research on the different dimensions and degrees of risk of child sexual abuse in institutions has provided us with a framework within which we can assess the risk of abuse occurring in contemporary care settings. The framework proposes four dimensions of risk:¹⁴

- situational risk, which arises from the opportunities for abuse that the environment offers
- vulnerability risk, which arises from the history and/or characteristics of the children cared for
- propensity risk, which is the risk posed by the greater-than-average clustering of those with a propensity to abuse children
- institutional risk stemming from the characteristics of an institution that may make abuse more likely to occur and less likely to be dealt with properly if disclosed.

The researchers propose that situational and vulnerability risk arise from the nature of the activity undertaken by the institution. They identify out-of-home care and children with physical and intellectual disability in residential facilities as being in the highest category of situational risk¹⁵ and children in care as being in the highest level of vulnerability.¹⁶

How child sexual abuse is carried out in contemporary out-of-home care

The risk framework referred to above focuses on situational risk as the starting point because it deals with the opportunity to sexually abuse children. The risk typology identifies two elements of situational risk: the opportunity ‘to be alone with a child unseen’ and the opportunity ‘to form relationships that could involve physical contact and/or emotional closeness, and which may precipitate crossing acceptable professional boundaries’.¹⁷ The very nature of out-of-home care involves adults having opportunities to be alone with children, primarily in home-based care but also in residential care settings, and to develop supportive relationships with those children.

In private sessions, most survivors who told us they experienced sexual abuse in contemporary out-of-home care described physical (rather than online) abuse, in situations that were created by the institutional setting and relationships.

Grooming

Grooming generally describes a range of manipulative and controlling techniques, behaviours and activities that aim to facilitate and/or conceal child sexual abuse.¹⁸ It usually involves the perpetrator establishing a trusting relationship with the victim in order to introduce and normalise sexually abusive behaviour: ‘The opportunity to be alone with a child makes it much easier to “groom” a child for those who are motivated to do so’.¹⁹ Most grooming techniques are used to disguise interactions with the victim as legitimate activities, and may include many discrete acts that, on their own, are not necessarily criminal or abusive.²⁰ As a result, grooming may not be identifiable until after sexual abuse has occurred because the perpetrator’s motivation is not necessarily evident from their behaviour.²¹

We were told that, as in other institutional contexts, perpetrators in out-of-home care have used a wide range of tactics and strategies, including grooming, to facilitate the sexual abuse of a child. The grooming behaviour we heard about in private sessions from survivors of child sexual abuse in contemporary out-of-home care included grooming of themselves as children, of other significant people in their lives, or of others in their out-of-home care setting, such as carers and caseworkers.

Typically, survivor accounts of grooming in contemporary out-of-home care were not of the elaborate processes that have been described in some other institutional contexts (see, for example, Volume 13, *Schools* and Volume 14, *Sport, recreation, arts, culture, community and hobby groups*). However, as in other settings, survivors told us about being singled out for attention or rewards, and that the attention made them feel special. ‘Conrad Ewan’ described being groomed by a worker in a residential care centre.²² He told us that he had not had much love in his life and the attention from the worker was valuable to him.

What ‘Conrad Ewan’ told us

‘Conrad Ewan’ was sent to a residential centre when he was 11 years old. He told us that a worker at the centre began grooming him, taking him on outings and supplying him with cigarettes and other gifts. The worker then began to sexually abuse him.

‘Conrad Ewan’ said the worker was:

always friendly ... his sexual stuff wasn’t in an angry way. It was making you feel good, making you feel wanted ... let’s be honest, I didn’t know that what he was doing was the wrong thing, because I was young and, you know, the attention ... as a kid that didn’t have much attention, you know what I mean?²³

Where the perpetrator is a carer, grooming can be difficult to distinguish from legitimate caring activities. For example, we heard from several survivors that their experiences of abuse began with perpetrators supervising them while they were in the bath or playing games with them.

We learned that grooming behaviour can inappropriately extend the perpetrator’s relationship with a child or test personal boundaries as precursors to sexual abuse.²⁴ Several survivors of sexual abuse in contemporary out-of-home care told us about being given special favours such as shopping trips, alcohol, drugs or cigarettes and, in one case, driving lessons.

In out-of-home care settings, perpetrators may need to persuade child protection authorities that they are appropriate carers. We heard one account of a girl’s grandfather – allegedly a convicted sex offender – being able to persuade child protection authorities that it was safe for her and her sister to live with him (see ‘Jane’s’ story in Chapter 4). Several survivors of sexual abuse in contemporary out-of-home care told us about situations where perpetrators engaged them in sexual relationships with the apparent endorsement of residential care workers, child protection workers or foster carers.

We heard other examples of children being placed in situations where the risk of sexual abuse was very high²⁵ and was not apparently mitigated by careful oversight and supervision. ‘Annabelle’ told us that before she had reached her teens, in the mid-2000s, she was placed with a single man aged in his mid-twenties.²⁶ She said the man initially groomed her, making her feel ‘cool’ because an older guy liked her. ‘Annabelle’ said that when the physical, psychological and sexual abuse began, she felt trapped (see also Section 4.3.3).

Threats of violence

We also heard from survivors that threats and acts of violence were quite common as perpetrators sought to sexually abuse them and ensure the abuse remained secret.

What 'Tyson Lee' told us

'Tyson Lee' told us the child protection department placed him with a female carer but that he stayed mostly with a woman who was her friend. 'Tyson Lee' said he was sexually abused by this woman almost from the beginning of his four-year stay in the mid-2000s, and by a man who was a religious teacher at the school he attended. He thought each perpetrator knew the other was abusing him because they were friends. 'Tyson Lee' said the woman had once driven him to the site where the body of a murdered child had been found and suggested he might meet the same fate. 'Tyson Lee' told us, 'She said, "You know that young boy that was buried in the pine forest? That shit's going to happen to you if you ever tell anyone"'.²⁷

Another survivor said her sexually abusive foster father threatened to shoot her and her biological mother if she told anyone what he had done to her.²⁸ We also heard from a survivor who said he was raped by a worker in a refuge in the 2000s. He said, '[The worker] was saying that he knew where my grandparents lived. If I said anything, he'd hurt my family and he'd come back and hurt me ... I told no one ...'²⁹

Unsafe online environments

We were told in response to our *Consultation paper: Institutional responses to child sexual abuse in out-of-home care (Out-of-home care)* about the challenges of ensuring the online safety of children in out-of-home care:

we note the challenges associated with internet, including social media, in creating and sustaining a child safe environment. The Consultation Paper correctly outlines how the use of social media to support child exploitation and enable access to pornographic material on the internet, puts children in out-of-home care at risk. The maintenance of safe online environments for children and young people will remain a challenge for providers of out-of-home care. This will continue as technology evolves. Our experience suggests that strategies to manage this risk are not well developed at this time.³⁰

None of the survivors who told us in private sessions that they were abused in out-of-home care settings reported being bullied or sexually exploited through online channels, being groomed online to facilitate abuse in person, or being the subject of sexually abusive material that was distributed online. However, several described 'relationships' with older men, including those who appear to have used the internet to initiate contact and develop connections with children in out-of-home care. These interactions appeared to constitute online grooming, even if the survivors did not recognise or label them as such.

We know that the internet can be a means of social connection, support, information and therapeutic interventions. Being active online is part of the normal social milieu for adolescents today. Strategies to manage the risks inherent in online environments need to be cautiously applied so as not to be so risk averse that they deny children in care ordinary developmental experiences and potential protective factors that can be associated with online environments.

Sexual exploitation

The sexual exploitation of children in out-of-home care, particularly of children in residential care by adult perpetrators, is a major concern for many people and organisations, including some of those who responded to our *Out-of-home care* consultation paper:³¹

Young people in out-of-home care have a pattern of disrupted attachments and are disconnected from familial relationships. The vast majority of young people in residential care have a range of concerning and high risk-taking behaviours that increase their exposure to sexual exploitation. Unfortunately, The Salvation Army's experience confirms that there are many people in the community who are likely to target and take advantage of these vulnerabilities for their own sexual gratification.³²

In 2015 the Victorian Commission for Children and Young People, in its '*...as a good parent would...*' report on sexual abuse in residential care, stated that more than 25 per cent of the 281 children who were the subject of reports of sexual abuse in the 12-month inquiry period were reported as being sexually exploited. Twenty-three per cent of children were the subject of reports classified as 'behaviour sexual'³³ although the reports included incidents of rape, indecent assault and sexual exploitation. The Commission noted that the rationale for this misclassification was unclear. Its analysis indicated that external predators posed the greatest risk to children in residential care.³⁴

A small number of survivors told us about being sexually exploited, from being offered sweets, cigarettes, illicit drugs and alcohol to being set up by a 'friend'. For example, 'Kat' told us she was placed in various hostels and foster homes in the late 1990s, many of which she said were unsafe.³⁵ At one hostel, she fell in with the 'wrong' people, including a girl who:

told me that she was having a dinner with her boyfriend and his mate at his parents' house. It was ... some sort of like double date or something. So I went ... and it turned out that girl conned me and I was actually gang-raped in that house by her boyfriend and his mate while she sat there watching. That's how I lost my virginity ... all you really want is a friend. When that happens, how are you gonna know any better if you haven't seen good?³⁶

Survivors also described being abused in exchange for drugs. 'Caspar' told us he was placed in residential care when he was 12 years old.³⁷ He said he was sexually abused by the manager of this centre, who provided him with drugs in return for sex. 'Caspar' told us another perpetrator, 'Arthur', who did not work at the centre, was allowed to take him out alone on excursions where 'Caspar' was given drugs and sexually abused. 'Caspar' said, 'At first I didn't have a choice. 'Arthur' just used to inject the heroin, hand out aerosols, pot'. 'Caspar' said that when he was high on the drugs, 'Arthur' would sexually abuse him.³⁸

We heard also from survivors who had, at least initially, perceived sexual relationships with older men to be romantic and consensual rather than sexual exploitation.

Duration and frequency of sexual abuse and number of perpetrators

As Commissioners encouraged each survivor in private sessions to tell their stories in their own way, there were great differences in the detail and certainty with which they described their experiences. Of the 257 survivors of child sexual abuse in contemporary out-of-home care we heard about in private sessions:

- 69.3 per cent told us about the duration of abuse. Of this group
 - almost three in five (57.9 per cent) said the abuse occurred for up to 12 months
 - one-third (33.7 per cent) said the abuse lasted between two and five years
 - one in ten said the abuse lasted longer than six years.
- 175 (85.4 per cent) of those who provided information about the number of instances of abuse they experienced told us of multiple instances of abuse in out-of-home care – including multiple incidents of abuse by a single perpetrator or abuse by multiple perpetrators
- 182 (70.8 per cent) of those who provided information about the number of people who sexually abused them told us they were abused by a single adult perpetrator or child with harmful sexual behaviours, while 75 (29.2 per cent) told us they were abused by multiple people.

The accounts of sexual abuse by multiple people and on multiple occasions indicate the vulnerability of children in out-of-home care and support the idea that sexual abuse victims may be more vulnerable to further abuse.³⁹ For more information about factors that increase a child's vulnerability to sexual abuse see Chapter 5 of Volume 2, *Nature and cause*.

Commissioned research suggests that, compared to child sexual abuse in other settings, institutional child sexual abuse is 'more likely to occur over longer periods of time and more likely to involve multiple offenders'.⁴⁰ With reference to abuse of a child by multiple perpetrators, additional research reports that:

children and adults reporting experiences of sexual abuse by multiple perpetrators are more likely to report earlier initiation of abuse, more frequent incidents of abuse, a longer period of abuse, the use of force/threats/drugs and greater severity of abuse.⁴¹

What 'Noah Jeffrey' told us

'Noah Jeffrey' said he was sent to live with an aunt when he was eight years old because his mother, who suffered a mental health condition, had trouble caring for her kids.⁴² 'Noah Jeffrey' said he has intellectual disability, and that his aunt would beat him and tie him to a chair. He said that on one occasion, police were called and found him restrained in this way. He said he was then placed in a foster home in the mid-2000s when he was 10 years old.

'Noah Jeffrey' told us he was sexually abused in this placement by the 18-year-old son of his foster parents. He said the abuse happened 'pretty often', over the few months he lived there. He said he told his foster parents about the abuse, 'but they didn't believe me, because it was their son'.

'Noah Jeffrey' said he was moved to a residential care facility, where an older boy began to sexually abuse him. He said this went on for about two years. Despite being threatened by the older boy with physical violence, 'Noah Jeffrey' said he told a nun what was happening. He said he was then placed in a different house and that he would go up to a priest's house and help him cook. He told us the priest, who was in his sixties, gave him marijuana and money to buy methamphetamines and started to sexually abuse him. He said the sexual abuse went on for about two years. At the time he spoke to us, 'Noah Jeffrey' said he was having nightmares about this man every night, fearing that one day he 'is gonna come and kill me'.⁴³

The duration and multiple instances of sexual abuse a child has experienced are also likely to reflect the length of time they have spent in contemporary out-of-home care. The Australian Institute of Health and Welfare reported that as at 30 June 2016 about 40 per cent of all children in out-of-home care had been continuously in care for five years or more and about 20 per cent had been continuously in care for less than a year.⁴⁴ Research suggests that Aboriginal and Torres Strait Islander children in metropolitan areas remain in out-of-home care for longer periods than non-Indigenous children.⁴⁵

Related forms of child abuse

Child sexual abuse rarely occurs in isolation. Victims are likely to experience other forms of abuse including physical abuse, emotional abuse and neglect. Commissioned research suggests that children in contemporary out-of-home care who experienced sexual abuse before entering care were also likely to have experienced concurrent forms of maltreatment.⁴⁶ This pattern of abuse continues to be evident when children are abused in care. The information provided in private sessions was consistent with research showing that ‘institutional abuse rarely takes one form, and concurrent experiences of sexual, physical and emotional abuse and neglect are common’ – noting, however, that few studies of maltreatment in foster care include details of the types of abuse or neglect experienced by victims.⁴⁷

Of the 257 survivors of child sexual abuse in out-of-home care we heard from in private sessions, 128 (49.8 per cent) described other forms of abuse and neglect alongside the sexual abuse. Of these survivors:

- 87 (68.0 per cent) said they also experienced physical abuse
- 92 (71.9 per cent) told us they were also subjected to emotional maltreatment (emotional and/or psychological abuse)
- 16 (12.5 per cent) described experiencing neglect
- seven (5.5 per cent) told us they also witnessed the abuse of other children

The above information suggests that sexual abuse of children in contemporary out-of-home care seems quite frequently to be accompanied by physical violence and emotional abuse. Of the survivors from all institutional settings who described other forms of abuse and neglect in private sessions, 80.7 per cent said they experienced emotional abuse and 64.4 per cent told us they also experienced physical abuse.

‘Brianna’s’ account of her time in foster care in the early 2000s highlights a number of the themes that were raised through private sessions, including of children experiencing physical and psychological abuse alongside sexual abuse.⁴⁸

What 'Brianna' told us

'Brianna' was a toddler when she and her three siblings were taken into care. When she was five years old, she was reunited with her younger siblings in a foster care placement. 'Brianna' told us the foster parents physically abused the children often. She said that if she wet the bed, she was beaten and forced to eat large amounts of honey as punishment. She described other punishments:

They would make us line up and hit us. They would give us salt and pepper, make us eat soap, or hit us with a wooden spoon or belt ... Having to watch each other get hit, that wasn't good.

'Brianna' remembers her little sister hiding under the table watching while the foster father beat her with a pool cue:

I was crying on my hands and knees. I just looked at her, and I remember putting my hand up to my face and seeing blood on my hand. I just kept looking at my sister ... At that point, after someone hits you so much, you can't feel it.

'Brianna' told us that the foster father began sexually abusing her soon after she was placed with the family. She also said she told a respite carer that when the foster father kissed her, 'he puts his tongue down my throat'. 'Brianna' said he would mostly sexually abuse her in her bedroom at night. 'It got pretty frequent ... I remember I was hurting down there, it hurt.'

'Brianna' said the foster father was charged with indecent assault, pleaded guilty, and was sentenced to periodic detention. She said the children were left with the foster mother, who continued to beat them and treat them cruelly. They didn't report the abuse. She said, 'It wasn't until we got older that we learnt that it was wrong, and that they weren't allowed to do that'.

'Brianna' is still angry that neither foster parent was ever held accountable for the physical abuse, and wonders how she and her siblings could go to school covered in bruises without questions being asked.⁴⁹

In private sessions, survivors commonly told us that sexual abuse by another child took place in a context of bullying and harassment. Often, the bullying and abuse were violent, and the child with harmful sexual behaviours was older and had higher status in the institution than they did. In most cases, the abuse occurred out of view of adults, although other children were sometimes present.

‘Brayden’ told us he was sent to live in a boys’ hostel where most of the boys were between six and eight years old, but where there were also older boys ‘probably about 15 or 16’.⁵⁰ ‘Brayden’ said he and his roommate were laying in their room one morning when one of the older boys came in and lay next to him. He said the older boy, ‘took my pants off and touched me and stuff like that’. ‘Brayden’ said the older boy ‘told me not to say anything otherwise he was gonna bash me ... I was only 11, I think ... We weren’t very supervised at all. It was just ... more or less fend for ourselves’.

3.2.2 Extent

While the full extent of child sexual abuse in contemporary out-of-home care is unknown, several sources provide insights. In all cases, the likelihood of under-reporting needs to be taken into consideration. Given what we learned about the barriers children face in disclosing sexual abuse (see Chapter 4 of Volume 4, *Identifying and disclosing child sexual abuse*), it is highly likely that more children are sexually abused in out-of-home care than report that abuse or whose abuse is identified by protective adults. As discussed in Chapter 2 of Volume 4, many victims of child sexual abuse do not disclose until many years later, often when they are well into adulthood. Of all the survivors who provided information during private sessions about when they disclosed child sexual abuse (88.9 per cent), more than two in five (42.6 per cent) told us they disclosed during childhood and almost three in five (57.4 per cent) told us they did not disclose the abuse until they were an adult. From what survivors told us, it took, on average 23.9 years to disclose the abuse.

Of the 257 survivors of sexual abuse in contemporary out-of-home care, 136 (52.3 per cent) said the abuse occurred in the decade 1990–99, 57 (21.9 per cent) in the decade 2000–09 and 23 (8.9 per cent) said the abuse occurred after 2010.

Information held by the Royal Commission

As noted, Commissioners heard in private sessions from 257 survivors who gave accounts of being sexually abused as children in contemporary out-of-home care. In addition, data provided to us by government and non-government agencies for our *Out-of-home care* case study identified 2,376 reports of child sexual abuse in out-of-home care in Australia in the two years from 1 July 2012 to 30 June 2014.⁵¹ However, this number needs to be treated with caution as the data may contain duplication,⁵² is based on allegations (rather than substantiated cases) of abuse, may include notifications of abuse that occurred earlier than the specified time period, and is not comprehensive.

In 2014, the Deputy NSW Ombudsman informed Commissioners that 55 per cent of all ‘reportable conduct’ matters in that state were ‘generated from the out-of-home care sector’. At 9 April 2014, he was investigating 330 serious reportable conduct matters involving individuals in out-of-home care, which included serious physical and sexual abuse and neglect.⁵³ These are matters under New South Wales’ reportable conduct scheme, which provides independent oversight of institutional responses to allegations against employees of reportable conduct, including child sexual abuse (see Volume 7, *Improving institutional responding and reporting*).

The *NSW Ombudsman annual report 2015–16* states that sexual offences and sexual misconduct notifications accounted for 16 per cent of all notifications of reportable conduct in the out-of-home care sector in that financial year.⁵⁴ No information is provided about the outcome of these notifications. At a forum on reportable conduct held by the Ombudsman in February 2016, the Ombudsman reported that 17 per cent of sexual offence/misconduct allegations made in the out-of-home care sector were sustained for the period 1 July 2013 to 30 June 2015. This is a lower rate than the overall rate for reportable conduct allegations dealt with by the Ombudsman. The Ombudsman further reported that, at November 2015, there were 37 criminal charges arising from notifications of reportable conduct from the out-of-home care sector, 23 of which related to sexual offences.⁵⁵

In commissioned research that explored the use of administrative datasets to estimate the extent of child sexual abuse in institutional contexts, the indicators derived from police data that combined ‘institutional location and extrafamilial (other known) plus person in authority’ were considered the best Australian indicators for child sexual abuse in an institutional context.⁵⁶ However, the research noted the police data’s usefulness in estimating abuse in contemporary out-of-home care was limited, with domestic settings, including private homes where foster and kinship care are provided, presently excluded.⁵⁷ The report concluded that child protection data about abuse in contemporary out-of-home care was not comparable across jurisdictions or able to be used to identify national trends – but did highlight the vulnerability of children in this institutional setting.⁵⁸

Report on government services

Some insights into the scale of abuse in contemporary out-of-home care can be gained from the Productivity Commission’s *Report on government services 2017*, which reports on ‘safety in out-of-home care’ as a measure of the effectiveness of child protection services. The report defines this indicator as the proportion of children in out-of-home care who are the subject of a substantiated notification⁵⁹ of sexual, physical or emotional abuse or neglect, where the perpetrator lived in the household providing out-of-home care.⁶⁰

Table 12.7 shows that there are many children in contemporary out-of-home care and that the substantiation of abuse, including sexual abuse, for children in care is low. As discussed elsewhere, data limitations mean that numbers of substantiated notifications are unlikely to reflect the true extent of abuse in contemporary out-of-home care.

Table 12.7 – Children in out-of-home care who were the subject of a substantiation of all forms of abuse or neglect, 2015–16^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Number of children who were the subject of a substantiated notification	n/a ^b	n/a	163	82	59	7	23	72
Number of children aged 0–17 years in at least one care placement during the year	20,316	12,473	10,709	4,967	3,671	1,300	879	1,299
Proportion of children who were the subject of a substantiated notification, of all children in care (%)	n/a	n/a	1.5	1.7	1.6	0.5	2.6	5.5

^a Source: Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra, 2017, Table 16A.27.

^b n/a – not available. NSW data is not comparable to data supplied by other jurisdictions. Victoria does not record the required data for children who are in out-of-home care.

The data related to the substantiated notification indicator, which the Productivity Commission describes as ‘experimental’,⁶¹ is limited as it does not distinguish between notifications and substantiations of sexual abuse, or identify the type of out-of-home care placement. Moreover, data was not yet available from New South Wales or Victoria, the states with the highest numbers of children in out-of-home care (almost 60 per cent of all children in out-of-home care). New South Wales data has not been comparable to other jurisdictions due to a significantly lower threshold for investigating notifications and a more inclusive set of issues (for example, missing from placement) but it should be able to provide comparable data for 2016-17;⁶² Victoria does not record the relevant data for children who are in out-of-home care.⁶³ Further, there are significant caveats on data that other jurisdictions reported⁶⁴ and the data is not comparable across these jurisdictions due to differing reporting procedures and counting rules.⁶⁵

Additional insights can be gained from a second effectiveness indicator the Productivity Commission reports on – ‘safety in care’. This measures all types of substantiated abuse by someone in the carer household.⁶⁶ In the six jurisdictions that provided data for this measure,⁶⁷ abuse of 445 children by a person living in the household providing out-of-home care was substantiated in the 12 months to 30 June 2016 (see Table 12.8).

Table 12.8 – Children in out-of-home care who were the subject of a substantiation of abuse or neglect and the person believed responsible was living in the household providing out-of-home care, 2015–16^a

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Number of children who were the subject of a substantiated notification	95	163	163	5	n/a ^b	7	12	n/a
Number of children aged 0–17 years in at least one care placement during the year	20,316	12,473	10,709	4,967	3,671	1,300	879	1,299
Proportion of children who were the subject of a substantiated notification, of all children in care (%)	0.5	1.3	1.5	0.1	n/a	0.5	1.4	n/a

^a Source: Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra, 2017, Table 16A.26.

^b n/a – not available.

While this second indicator is an important measure of safety in out-of-home care, the data does not distinguish between abuse that occurred in the child's current placement and abuse that occurred in a previous care placement but was reported after the child was moved.⁶⁸ Also, as with the data in Table 12.7, the figures in Table 12.8 do not distinguish substantiated incidents of sexual abuse from other forms of abuse.

This data indicates that only a small proportion of all children in out-of-home care at the time (1.5 per cent or fewer) were the subject of substantiated abuse. Given the high-risk environment and what we know about the length of time it takes for many victims to disclose abuse as well as the difficulty in identifying and substantiating abuse in out-of-home care in Australia (see Section 3.5 of this volume and Volume 4, *Identifying and disclosing child sexual abuse*) it is likely that this data significantly underestimates the extent of abuse in out-of-home care.

Children in care have been forcibly removed from their families of origin and placed in the care of the state to ensure their safety, and the prevention of abuse in out-of-home care must be a primary concern for state and territory governments. Governments need the best available data and monitoring mechanisms to ensure they have accurate information about the nature and extent of sexual abuse of children in their care.

3.3 Who we heard about in contemporary out-of-home care

Our work has shown that the sexual abuse of children has been widespread in many Australian institutions (see Volume 2, *Nature and cause*). What we heard from the survivors who came forward to tell us about sexual abuse in contemporary out-of-home care has allowed us to understand more about the adult perpetrators and the children with harmful sexual behaviours in out-of-home care, and the settings in which they have operated and continue to operate.

3.3.1 Victims

Between May 2013 and May 2017, Commissioners conducted private sessions with 6,875 survivors of child sexual abuse, or their families, friends and others. As noted, 257 (3.7 per cent) of the accounts we heard were of child sexual abuse in contemporary out-of-home care. Given what we know about delays in disclosure (see Volume 4, *Identifying and disclosing child sexual abuse*), it is unsurprising that we did not hear from more survivors of sexual abuse in contemporary out-of-home care.

Of these 257 survivors:

- 142 (55.3 per cent) were male and 115 (44.8 per cent) were female
- 80 (31.1 per cent) identified as Aboriginal and Torres Strait Islander⁶⁹
- 27 (10.5 per cent) told us they had disability at the time they were first abused.

Of these 257 survivors, 84.1 per cent spoke to Commissioners about how old they were when first sexually abused. We heard:

- their average age at the first instance of abuse was 10.9 years (11.4 years for males; 10.1 years for females)
- 54 (25.0 per cent) were aged between five and nine years old and 123 (56.9 per cent) were aged between 10 and 14 years
- nearly half (49.2 per cent) of those who told us about sexual abuse in home-based care and almost three-quarters (71.7 per cent) of those who told us about sexual abuse in residential care were aged between 10 and 14 years.

More than half (136) of these survivors indicated that the abuse occurred in the 1990s, before many of the current child safety and accountability measures had taken effect. However, we heard during our *Out-of-home care* case study, our public roundtable on prevention, as well as from survivors in private sessions, about significant risks still associated with out-of-home care settings.⁷⁰

As for all children, a range of factors may contribute to the vulnerability of children in contemporary out-of-home care to sexual and other forms of abuse, including age and gender. However, research suggests that children in contemporary out-of-home care may be more vulnerable to further abuse because they may already have 'a history of trauma, psychiatric illness, attachment disorders, substance abuse or maltreatment by their families'.⁷¹

Maltreatment of a child, including attention deprivation and inadequate supervision, may affect psychological development, resulting in attachment difficulties and challenging behaviours which in turn may make the child more vulnerable to exploitation by predatory perpetrators.⁷²

Research also suggests that children with disability and Aboriginal and Torres Strait Islander children may face heightened risk of child sexual abuse in out-of-home care, not least because of their over-representation in contemporary out-of-home care.⁷³

Gender

Although research suggests that girls experience much higher rates of sexual abuse than boys across all settings, including the family and community,⁷⁴ in our private sessions we heard about more male (64.3 per cent) than female (35.4 per cent) victims of child sexual abuse across all institutional contexts and more male (55.3 per cent) than female (44.8 per cent) victims in contemporary out-of-home care.

Age at time of first abuse

As noted, the majority of survivors of child sexual abuse in contemporary out-of-home care who attended a private session and provided the relevant information, told us they were aged between 10 and 14 years when first sexually abused. However, 67 (31.0 per cent) were younger than this, including 13 survivors who were under four years old when they were first abused.

Research indicates 'the age of a child is an important factor in assessing the degree of risk of sexual abuse', and 'the majority of victims, and the higher risk, is clustered in the upper primary and lower secondary age ranges' between about 10 and 15 years of age.⁷⁵ However, there is also research suggesting younger children are particularly at risk and that the age of a victim when abuse begins varies according to institutional settings, related at least in part to the use of different types of institutions for different age groups.⁷⁶ Length of time in care has also been identified as a risk factor, and as children may be placed in contemporary out-of-home care at any age, sometimes very soon after birth, they may spend considerable time in this institutional setting.⁷⁷

We heard from survivors taken into care in their early childhood, who experienced sexual abuse at a young age, and who also experienced difficulties in disclosing or identifying the abuse. For example, 'Ella' told us she and her siblings were placed in care when she was four years old.⁷⁸ 'Ella' said she was about seven when she and her younger sister were sexually abused by their foster father. She said she knew it was wrong at the time, but her sister did not. 'Ella' said she responded to the abuse with deep anger, but her sister became withdrawn and started asking others to touch her genitals. 'Ella' said:

I knew it wasn't right at that age he touched me but, you know, I was only seven. I wasn't at the age where I could have said, 'No' and gone and told someone. But my sister didn't even know it was wrong ... I kept it a secret and she just asked a person to touch her down there.⁷⁹

'Brad Douglas' told us he was taken into care when he was eight months old.⁸⁰ He said his foster mother told him many years later his foster father had sexually abused him at a very young age. 'My foster mum said I was abused by him when I was a baby but I don't remember ... I just ignored her ... But he did go down for abuse of his own daughter, he got nine months for it.' 'Brad Douglas' said when he was about seven years old he was placed in a children's home for two weeks where he was sexually abused by one of the workers. He said that later, at about the age of 11, he was living back with his foster father and was sexually abused by his foster father's friend. 'Brad Douglas' said the man came over frequently and sexually abused him on multiple occasions:

All I know is my foster father said he could sleep in my room ... and that started from there. He abused me while I was asleep and I woke up ... I just thought it was part of growing up ... I didn't tell anyone, I didn't think anyone would believe me.⁸¹

Lack of a capacity to identify abuse and barriers to disclosure are particular problems with very young children. The few reports made of victims of child sexual abuse under the age of four need to be considered in this context. (Barriers to disclosure are discussed in Volume 4, *Identifying and disclosing child sexual abuse*).

Of the 26 survivors who told us they were first sexually abused in out-of-home care when they were aged between 15 and 17 years, 19 gave accounts of being abused in residential care.

Aboriginal and Torres Strait Islander children

The impacts of past laws, policies and practices combined with contemporary systemic failures mean that Aboriginal and Torres Strait Islander children often receive poorer services than other children and face entrenched structural disadvantage in society.⁸² The high rates of Aboriginal and Torres Strait Islander children in contemporary out-of-home care may be, in part, attributable to factors such as these. Aboriginal and Torres Strait Islander children made up 36.3 per cent of all children in care at 30 June 2016.⁸³ Of the 257 survivors of child sexual abuse in contemporary out-of-home care we heard from in private sessions, 31.1 per cent identified as Aboriginal and Torres Strait Islander.⁸⁴

While data is not collected in a way that reveals the extent to which Aboriginal and Torres Strait Islander children are sexually abused in out-of-home care, our commissioned research suggests they face heightened vulnerability.⁸⁵ Not only are Aboriginal and Torres Strait Islander children in out-of-home care in higher proportions than non-Indigenous children, Aboriginal and Torres Strait Islander children in metropolitan areas tend to stay in care for longer periods than non-Indigenous children.⁸⁶ This means Aboriginal and Torres Strait Islander children are more likely than non-Indigenous children to be in an institutional environment characterised by heightened risk for child sexual abuse.⁸⁷

Factors relevant to the placement of Aboriginal and Torres Strait Islander children in contemporary out-of-home care and the resultant risks of sexual abuse are discussed in Section 3.6 and in Chapters 4 and 5.

Children with disability

While there is limited research in Australia, international studies indicate that children with disability are at significantly greater risk of sexual abuse compared to the general population.⁸⁸ Research suggests that certain types of disability – behavioural disorders and intellectual disability, speech and language impairments – can make some children more vulnerable to sexual abuse.⁸⁹

In private sessions, we heard from 27 survivors of child sexual abuse in contemporary out-of-home care who had disability at the time of the abuse. Eight of these survivors identified as Aboriginal and Torres Strait Islander.

As noted in Chapter 2, we understand that many children with disability use voluntary out-of-home care; however, we know very little about the number and the nature of any risks they may experience in this setting. It is also difficult for us to accurately identify how many victims we heard about had disability at the time of the abuse. This is because a person's disability may change over time, may not have been identified when they were abused, or may not have been perceived as relevant or mentioned by the person who recounted the abuse to us.

'Corey' told us about his experience of abuse in foster care as an adolescent in the early 2000s.⁹⁰

What 'Corey' told us

'Corey' has used a wheelchair all his life. He was placed with foster parents when he was an infant. He told us that when he was 13 years old, his foster parents began to physically and emotionally abuse him. He said they would hit and kick him almost every day. He could not move out of the way because of his disability. 'Corey' told us his foster father also physically abused his foster mother, and she would do whatever he told her to. He said that when he was 14, his foster father ordered his foster mother to sexually abuse him: 'My foster mother had sexual intercourse with me, while my foster father masturbated'. 'Corey' believes that the intention was that his foster mother would have a child by him.⁹¹

3.3.2 Adult perpetrators

Most of the survivors who attended private sessions provided us with information on the age of the person who sexually abused them (67.3 per cent). Of these, 3,878 (56.4 per cent) told us that they were abused by adult perpetrators (see Volume 2, *Nature and cause*).

Survivors of abuse in out-of-home care also most commonly told us of being sexually abused by an adult. Of those abused in out-of-home care who mentioned the age of the perpetrator (75.9 per cent), 145 said they were abused by an adult and 65 by another child. As noted, some of these survivors told us they were abused by more than one person.

As discussed in Volume 2, *Nature and cause*, there is no typical profile of an adult perpetrator of child sexual abuse. Research suggests that they have disparate characteristics, motivations and behaviour.⁹² As most available research is based on known (convicted) perpetrators, there is little information about perpetrators who have not been identified, and who may conceivably possess different characteristics. In addition, as there is no diagnostic profile for identifying perpetrators, it is also not possible to predict the likelihood of someone being a perpetrator.⁹³ However, existing research suggests that most known perpetrators of child sexual abuse were characterised by substance abuse (particularly alcohol), violence, and physical and/or psychological impairments⁹⁴ and that they may have experienced higher rates of physical and sexual abuse than other offenders and greater levels of emotional neglect than the general population.⁹⁵

This reflects what we were told in public hearings and private sessions, where we heard about men and women of different ages, backgrounds and circumstances who sexually abused children. As discussed in Volume 2, *Nature and cause*, the majority of perpetrators of child sexual abuse in institutional settings we were told about were male. What we heard from survivors of child sexual abuse in contemporary out-of-home care is consistent with this: 91.8 per cent said they were abused by a male perpetrator. Research suggests that about 89 to 95 per cent of adult perpetrators of child sexual abuse are male.⁹⁶

Across all institutional settings, perpetrators we heard about held a range of positions. They used the trust bestowed on them, their role and their power to access children and sexually abuse them. We heard that some adult perpetrators abused a child once, while others did so repeatedly. Many adult perpetrators abused multiple children.

In the context of contemporary out-of-home care settings, adult perpetrators included foster parents (in most cases foster fathers but there were also instances of sexual abuse by foster mothers); biological fathers during contact visits; relatives or partners of foster or biological parents; friends of foster parents; adult biological children of foster parents; residential care staff (including workers, managers, health workers and teachers, some of whom were also members of religious orders); older 'friends' (including 'boyfriends'); child protection workers; and strangers encountered outside the home, including adults perpetrating sexual exploitation. This list emphasises that 'it is important to distinguish abuse in foster care, from abuse by foster carers'.⁹⁷

Most perpetrators of sexual abuse in contemporary out-of-home care we heard about in our inquiry were in positions of authority and had responsibility for children. Of the survivors of child sexual abuse in this setting who attended private sessions and mentioned the role of the perpetrator (93.8 per cent), 55.2 per cent said they were abused by foster, kinship or relative carers or other adult members of the household, and 7.9 per cent said they were abused by residential care workers. This is consistent with commissioned research that suggests that perpetrators of sexual abuse in contemporary out-of-home care are most commonly adults living in or associated with home-based settings.⁹⁸

As noted, few survivors of sexual abuse in out-of-home care described perpetrators engaging in sustained grooming. Commonly, these perpetrators had ready access to children, and could exploit their positions of adult authority and carer responsibility to abuse children.

We heard from survivors that many perpetrators also used coercion: survivors described being forced to submit to or perform sexual acts, and being threatened after the abuse in order to keep it secret. Some survivors described not being able to say no or not knowing what to do.

When survivors described perpetrators using coercion or threats, the behaviour was often an extension of a controlling and coercive parenting style. Many survivors also gave accounts of being physically abused. 'Renee Clare' said she was placed in the care of her aunt, and recalled being physically abused by her aunt, including being choked and stomped on multiple times.⁹⁹ She said she was scared of her aunt and when caseworkers visited the house she knew that if she disclosed, her aunt would beat her. 'Renee Clare' said that in the mid-1990s when she was still a young child, she was raped and digitally penetrated by an uncle, and later sexually abused by him every day.

While it is self-evident that perpetrating sexual abuse shows a lack of adequate care and empathy for a child, many survivors told us of an unsatisfactory caring relationship and a lack of care in general, in addition to the sexual abuse. ‘Sabrina May’ told us she and her sister were placed with a foster care family where they were physically, emotionally and sexually abused.¹⁰⁰ They were given a small room furnished only with a single mattress, were not allowed to play with the family’s toys or touch their things, and had to sit at a separate table when they ate. They were made to bathe after the family’s children, using the same bathwater.

We also heard about instances of other residents or care workers perpetrating sexual abuse in a residential care setting where the atmosphere was characterised by intimidatory behaviour and a lack of safety. ‘Georgie Helen’, for example, told us she was taken to a refuge in the early 2000s when she was 13 years old, after she had been sexually abused in her foster placement.¹⁰¹ She said she was physically attacked by a male resident in front of a refuge staff member and there was no follow up from staff after the attack. She said she also came into contact with a man at this time who was selling marijuana to the children in the institution. ‘Georgie Helen’ told us she later became pregnant to him, and had a baby at the age of 15, while she was still in care.

While there is no typical profile of an adult who sexually abuses a child in an out-of-home care setting, certain characteristics were relayed to us in private sessions more often than others.

As suggested earlier, in many of the instances of sexual abuse described to us in private sessions the perpetrator took advantage of the unsupervised access to children provided by their role. Perpetrators who were carers could exploit the vulnerability of children in their care. Survivors often described having little power to resist, not necessarily knowing that what was happening was wrong, and having limited or no options to report the abuse. The ability of perpetrators to sexually abuse the children in their care or with whom they were in contact – and to enforce their silence, at times by using force or threats of force – illustrates the power imbalance between perpetrators and victims.

3.3.3 Children with harmful sexual behaviours

As discussed in Chapter 2 of Volume 10, *Children with harmful sexual behaviours*, in most cases of sexual abuse by another child that we heard about in private sessions, the child with harmful sexual behaviours was male. Research suggests that children with harmful sexual behaviours often sexually abuse younger children.¹⁰²

Children in out-of-home care may be at considerable risk of not only being abused by an adult, but by another child. This includes a risk of sexual abuse by the children of foster carers, particularly older, male, biological children of carers.¹⁰³ Other children in a placement under care and protection orders, including the victim’s siblings, may also exhibit harmful sexual behaviours.

The risk of sexual abuse by another child appears to be particularly prevalent in residential care, partly because of the placement of children with harmful sexual behaviours in settings where they may present a risk to others.¹⁰⁴ Indeed, some research suggests that sexual abuse in residential care settings may be more likely by adolescents or peers than by adults.¹⁰⁵

As noted, 75.9 per cent of the 257 survivors of child sexual abuse in contemporary out-of-home care told us the age of the person who abused them. This included 65 (33.3 per cent) who said they were sexually abused by another child. Of this group, 22 (28.6 per cent) told us they were abused by another child while in residential care and 45 while in home-based placements.

Survivors of sexual abuse in contemporary out-of-home care told us that they were the victims of abuse by other foster children in a foster placement (usually older than the victim); other children in a residential care setting; biological sons of foster parents; other relatives such as cousins; friends of relatives; and 'friends', including other peer contacts encountered in social settings such as parties.

For further information about children with harmful sexual behaviours, see Volume 2, *Nature and cause* and Volume 10, *Children with harmful sexual behaviours*.

3.4 Where in contemporary out-of-home care children have been sexually abused

Of the 257 survivors of sexual abuse in out-of-home care we heard about in private sessions:

- 170 (66.1 per cent) told us they were abused in home-based care¹⁰⁶ (94 female/76 male)
- 96 (37.4 per cent) told us they were abused in a residential care setting (22 female/74 male).

Some survivors told us they were abused in both types of care placements.

Some research suggests that boys are more likely than girls to be sexually abused by non-family perpetrators (extra-familial) and by multiple male abusers, while girls are more likely than boys to be sexually abused by family members (intra-familial).¹⁰⁷ Our information from private sessions is reasonably consistent with this research literature: of female survivors, 94 (81.7 per cent) told us about being abused in home-based care compared with 76 male survivors (53.5 per cent). Many female survivors also described abuse by multiple perpetrators.

3.4.1 Home-based settings

Previous inquiries have demonstrated that children removed from, or unable to live with, their parents remain vulnerable to maltreatment in out-of-home care.¹⁰⁸ In the data provided to us by government and non-government agencies for our case study on *Out-of-home care* (see the discussion on ‘Extent’ in Section 3.2.2), the highest number of reports of sexual abuse (39 per cent) came from foster care settings.¹⁰⁹ Children in foster care make up 39 per cent of all children in out-of-home care.¹¹⁰ By contrast, 49 per cent of all children in out-of-home care are in kinship/relative care placements, yet just 20 per cent of the sexual abuse reports were about children in these settings.¹¹¹ Even taking into account the possibility of under-reporting of abuse, the data suggests that the risk of child sexual abuse may be higher in foster care than kinship/relative care settings.

If there are differences in the levels of risk between these two types of home-based care settings, it is not clear from the available research why this might be the case. Researchers have long recognised that ‘biological parenthood is a protective factor in terms of child sexual abuse’, and that ‘the risk of abuse from stepfathers, other men in intimate relationships with mothers and more distant male relatives, is higher than for biological fathers’.¹¹² As removing children from their biological parents appears to remove an important protective factor, any out-of-home care setting that involves children being placed into the care of a non-relative caregiver or together with other non-relative children may elevate their vulnerability to child sexual abuse.¹¹³

Another factor relevant to understanding the risk of child sexual abuse in out-of-home care is whether the settings present ‘opportunities’ for individuals to perpetrate abuse. Research suggests that there are opportunities for child sexual abuse to occur in a particular setting when perpetrators have ‘both time alone with the child and a location for carrying out the abuse’.¹¹⁴ Irrespective of whether abuse is by family members or other people, ‘the most common location in which to perpetrate the abuse was the abuser’s home’.¹¹⁵ Applying these findings to out-of-home care, it appears that there is a very high situational risk in settings ‘where the potential perpetrator and potential victim are together in contexts that offer long or frequent interactions’.¹¹⁶ This would appear to include all home-based care settings.

In private sessions, survivors of child sexual abuse in out-of-home care often did not specify where the abuse occurred. However, in most cases it was implicit in the stories that the abuse occurred in the home or residential care facility, often in private domestic spaces including bedrooms and bathrooms.

3.4.2 Residential care settings

According to Australian Institute of Health and Welfare data, 5 per cent of all children in out-of-home care in Australia were in residential care at 30 June 2016.¹¹⁷ However, data we were given by government and non-government agencies indicated that 33 per cent of sexual abuse reports from 1 July 2012 to 30 June 2014 (where the care type was known) were about children in residential care.¹¹⁸

Despite a lack of Australian data on the incidence of child sexual abuse in residential care, research has identified a number of factors associated with residential care that increase the vulnerability of children to sexual abuse in these settings.¹¹⁹ As discussed in Chapter 4, these factors include high turnover of staff and residents, frequent instability and disruption within many residential care units, and the difficulties children living in unstable units can experience in maintaining 'stable relationships with both their caregivers and their peers'.¹²⁰

Those responsible for providing or overseeing out-of-home care services agreed that the risks of sexual abuse and exploitation were higher in residential care than in other out-of-home care settings. The Chief Executive of South Australia's Department for Education and Child Development told us of the 'high propensity for abuse, neglect or sexual assault in residential care versus that of foster care or next of kin'.¹²¹ The Deputy Secretary, Department of Health and Human Services, Tasmania, spoke of factors that were unique to residential care settings that require 'a high level of monitoring and safety'.¹²² Regarding the risks of sexual abuse and exploitation in the Northern Territory's residential care facilities, the head of the Department of Children and Families' out-of-home care division said:

I think we need to acknowledge that it's occurring ... [we contract] external NGO providers to provide care for 12 to 18-year-old males and females. That is a really high-risk period for behaviours. They are teenagers. When you are mixing genders, that's a difficulty.¹²³

During our private sessions we heard from 'Jaime Allen', who told us that in the late 1990s, he was watching television in his group home when another boy began sexually abusing him.¹²⁴ 'Jaime Allen' said, 'It came as a surprise to myself because one minute we were watching TV, then all of a sudden the abuse started happening'. Commissioned research identifies the elevated risk posed by vulnerable children exhibiting harmful sexual behaviours:

... as children and young people of different ages live together in non-familial environments and without the protective element of having a trusted parent to whom they can disclose abuse. They also have the opportunity to be alone together unobserved.¹²⁵

Although just one in 20 children in contemporary out-of-home care in Australia lives in residential care,¹²⁶ this type of care plays a crucial role as 'a placement of last resort' for some of 'the most disadvantaged, vulnerable and challenging young people in the [out-of-home care] system'.¹²⁷ In all states and territories, residential care is commonly used to care for:¹²⁸

- large sibling groups
- children in need of emergency placements, and
- children with ‘complex and extreme support needs’ who can be difficult to properly support in home-based care settings.

For children whose ‘highly challenging behaviours’ may indicate signs of complex trauma, including experiences of sexual abuse, residential care may sometimes be the only available option for managing the risks of them harming themselves or others.¹²⁹ Because of its role in providing care for children ‘in circumstances in which other types of [out-of-home care] are unsuccessful or unavailable’,¹³⁰ we heard that the majority of children 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’.¹³¹

The risks associated with residential care settings are also noted in international literature.¹³² One prevalence study comparing the incidence of child sexual abuse in residential care and foster care in The Netherlands in 2010 found that ‘child sexual abuse occurs more frequently in out-of-home care, and residential care in particular, than in the general population’.¹³³ In the United Kingdom, a retrospective study of 158 children in foster or residential care in Leeds who were alleged to have been physically and/or sexually abused between 1990 and 1995 noted the higher incidence of reports in these settings and concluded that ‘there are good reasons to believe that these children are at a real risk of increased harm’.¹³⁴ Because most of these children had experienced abuse prior to entering care, and more than half ‘had persistent and significant behavioural or emotional problems’, there were concerns that ‘the harm which children have suffered at home may be compounded by abuse in care’.¹³⁵

In examining the situational risks associated with residential care settings, it is important to note that most Australian residential care facilities are situated in residential neighbourhoods and are intended to provide home-like care, usually for up to four children.¹³⁶ As such, some of the risks associated with home-based care settings such as caregivers having time alone with children and access to private spaces where sexual abuse can occur are also present in residential care settings.

3.4.3 Away from a placement

Sexual abuse of children in out-of-home care is not confined to abuse by carers, other adults in the household or other children in the placement. What we learned from private sessions is that sexual abuse may be perpetrated by friends and acquaintances of the child in care, as well as by adults exploiting the vulnerability of children.

We heard in private sessions that it was fairly common for children who were being sexually abused in care to run away from their placement, putting them at further risk of sexual abuse and exploitation. 'Harry Arthur' told us he and another boy ran away from a children's home and ended up in a house where friends of the other boy lived.¹³⁷ 'Harry Arthur' said he was lured into a bedroom of this house by a man who locked the door and tried to 'sexually penetrate him'.

Another survivor, 'Wyatt', ran away from various state-run residential group homes.¹³⁸ He told us:

I used to run away from these group homes and there used to be these rich old guys that used to frequent these squats that we used to stay at, and they used to buy us shoes and clothes and stuff and take us back to their place. They'd look after us so we at the time, me and my mates didn't think there was nothing wrong with that, but then he would make us, like give us nice clothes, then he'd make us shower and he'd make us do stuff to each other and we'd sleep in the same bed as him, like four of us in one bed.¹³⁹

We heard from survivors who were sexually abused when they accompanied co-residents to the houses of their co-residents' friends.¹⁴⁰ We also heard that sexual abuse occurred in other settings away from the child's placement, including on outings and in transit. We were told of sexual abuse on camping trips by a male staff member of a hostel who was allowed to take the children away,¹⁴¹ in a taxi by a taxi driver who was employed to take a child from his foster placement to a specialist school,¹⁴² and in a caseworker's car when the caseworker collected the child late at night, after the child had run away from his placement.¹⁴³

The 2015 report by the Commission for Children and Young People in Victoria notes that a series of indicators have been developed to assist caseworkers and other staff identify children at risk of sexual exploitation. Being absent from residential care placements, being picked up from the care unit in cars by unknown adults, and experiencing deterioration in mental health after being missing from residential care can all indicate sexual abuse occurring while the child is away from their placement.¹⁴⁴

Commissioned research exploring the safety of children in residential care reported that a number of participants in the research felt that 'outside adults' took advantage of children in residential care and exploited them sexually. The researchers said the children they interviewed:

reported, for example, that there were men who sat outside residential care units waiting to prey on young people (mostly young women) who they knew were vulnerable. Others talked about young women being approached by older men who established relationships with them that appeared to be harmless, but which turned out badly or which were, in retrospect, harmful and inappropriate ... 'we were easy targets, we literally were, we craved the attention and if they could give us what we needed, we did it'.¹⁴⁵

3.5 How and why child sexual abuse occurs in contemporary out-of-home-care

Over the course of our inquiry, we learned that child sexual abuse in institutional settings is not the result of a single factor; rather, it arises out of a complex interaction between diverse factors related to system-wide issues, and between perpetrators and victims in those settings. All children in out-of-home care are vulnerable to sexual abuse, but their level of vulnerability may depend on their exposure to certain risk or protective factors. As discussed, the nature of out-of-home care of itself presents an elevated risk of sexual abuse.

This section focuses on the risk factors we were told have been, and continue to be, present for children in out-of-home care. Understanding the risk factors helps us better understand the reasons why child sexual abuse occurs, as well as how best to prevent it and respond when it does occur.

In describing the situational risks associated with caring for children in home-based care settings, commissioned research notes the importance of identifying ‘modifiable’ and ‘unmodifiable’ risks.¹⁴⁶ Modifiable risks are ‘those in which, with some effort, the inherent situational risk can be reduced’¹⁴⁷ – for example, through close supervision by parents. On the other hand:

An unmodifiable risk arises in activities that, by their very nature, tend to allow more opportunity for a perpetrator to be alone with a child and therefore cannot be modified. Examples include foster care settings in which the nature of family life is such that time alone with children is just a normal part of the family environment.¹⁴⁸

Where a situational risk cannot be easily modified, it is important to consider other strategies that address the inherent risk. Commissioned research on the risk of child sexual abuse in institutional settings identifies the need for situational risk assessment and prevention strategies.¹⁴⁹ While some elements of the situational prevention approach are important in out-of-home care – not leaving a child alone with visitors, for example – it would be impossible, and generally undesirable, for children in out-of-home care to avoid one-to-one contact with an adult carer. It is clearly essential that unmodifiable risks are identified and mitigation strategies put in place. This is discussed in Chapters 4 and 5.

3.5.1 Factors that influence a person to sexually abuse a child

Propensity risk ‘refers to the risk that there will be perpetrators of sexual abuse within the organisation and focuses on the staffing profile of the organisation and associated factors’.¹⁵⁰

Commissioners learned that there was no typical perpetrator profile in out-of-home care settings – a range of adults sexually abused children in these contexts. As in other institutional settings, these people have diverse motivations and behaviours and are influenced by various factors that can change over time.

We have identified three perpetrator typologies that reflect the behaviours and characteristics of perpetrators of child sexual abuse we frequently heard about during public hearings and private sessions. These broad typologies give some insight into perpetrators and their motivations, but are not definitive. Perpetrators may exhibit features from a number of typologies. The perpetrators in contemporary out-of-home care we learned about reflect elements of these perpetrator typologies (for a full discussion on perpetrator typologies see Volume 2, *Nature and cause*). These three typologies are:

- **Fixated and intentional** – These perpetrators tend to have a longstanding sexual attraction to children and are often repeat offenders, abusing multiple children throughout their lives.¹⁵¹ Some fixated, persistent perpetrators may actively manipulate environments to enable them to abuse a child.¹⁵² They may select occupations that facilitate access to children.¹⁵³ They may also take advantage of unplanned situations to abuse.¹⁵⁴ Most perpetrators, however, do not fall within this ‘fixed, persistent’ typology.¹⁵⁵
- **Opportunistic perpetrators** – These perpetrators may not prefer children over adults, but use children for sexual gratification.¹⁵⁶ Opportunistic perpetrators exploit situations where they have access to and authority over children.¹⁵⁷ These situations can arise in institutions that give them access to children and young people.¹⁵⁸ Research suggests that opportunistic perpetrators are less likely than other adult perpetrators to intentionally create situations in which children can be abused, but rather abuse children when the opportunity arises.¹⁵⁹ Consequentially, they are less likely to use grooming strategies.
- **Situational perpetrators** – These perpetrators sexually abuse children in response to ‘stressors’ in their own lives.¹⁶⁰ These may include stress, trauma, grief, social isolation, lack of positive adult relationships and low self-esteem.¹⁶¹ The research tells us that this perpetrator fits the profile of ‘a caregiver or other authority figure who has abused a position of trust and who has ongoing access to the victim’.¹⁶²

Research also suggests that some perpetrators will use their workplace and employment as a cover to target children for sexual abuse.¹⁶³ This group of ‘professional perpetrators’ are often successful in avoiding the suspicion of other staff members because they understand how others perceive their behaviour within an institution and are conscious of the need to adapt their behaviour to changing external environments.¹⁶⁴

Adult perpetrators

For children in out-of-home care, sexual abuse by an adult may be perpetrated by a foster or kinship carer, another adult in the household, a paid worker in residential care, or by another adult outside the care placement.

As noted, out-of-home care presents opportunities for potential perpetrators to have unsupervised, ready access to children, often in private settings. It is, for instance, generally desirable that non-family members (such as a foster or kinship/relative carer and residential care staff members) develop strong personal relationships with the children in their care to provide for their emotional and physical wellbeing.

When these relationships are founded on the best interests of the child, these carers can be enormously protective and supportive of the children in their care. For example, ‘Simeon’ told us that he had a good relationship with the foster parents with whom he was placed at the age of two months.¹⁶⁵ He told us he was sexually abused on several occasions by the taxi driver who drove him to a specialist school placement, and that when he told his foster mother she made a complaint to the relevant child protection service.

In cases where the carer is a perpetrator, the risk to a child in out-of-home care is immense. ‘Carson’ told us he was sexually abused for two years in one foster care placement without the abuse being identified by anyone outside the household.¹⁶⁶

What ‘Carson’ told us

In a private session, ‘Carson’ told us he was nine years old when he went to live with his third foster family, where he was sexually abused by both his foster father and an older foster brother. ‘Carson’ said that the abuse began ‘pretty much straight away’ and happened numerous times in the two years he lived there. He told us that when he tried to stand up for himself, things only got worse with his foster father. ‘When I started making waves and trouble and complaining and stuff, and threatening to run away ... that’s when the physical violence started ... He used to beat me up, grab me by the throat, throw me across the table.’ ‘Carson’ told us that when teachers at his school noticed the bruises, he was able to report the abuse and he was removed from the home.¹⁶⁷

Children with harmful sexual behaviours

In Volume 10, *Children with harmful sexual behaviours* we discussed what we learned about how sexual abuse by children differed from that perpetrated by adults. Some research suggests that harmful sexual behaviours by children under 12 appears more likely to be impulsive than compulsive, compared to adult sexual offending.¹⁶⁸ This is consistent with commissioned research, which found that most harmful sexual behaviour by children is opportunistic.¹⁶⁹

We also learned that complex social and environmental factors may influence a child to sexually abuse another child. These include: adverse experiences in childhood, such as prior sexual or physical abuse and exposure to family violence; interpersonal difficulties; exposure to pornography; and exposure to violence in an institutional context.¹⁷⁰ There is also some indication that harmful sexual behaviours in children are more likely to result from their circumstances rather than personal sexual motivations (see Volume 10, *Children with harmful sexual behaviours*).

In our commissioned research on understanding those who sexually abuse children, we learned that adolescent males with harmful sexual behaviours may show 'greater anxiety, lower self-esteem, social isolation, greater anxious attachment in relationships and atypical sexual interests' when compared to other adolescent offenders.¹⁷¹ This research also suggests that adolescents who sexually abuse younger children may have higher rates of sexual disorders or less-developed relationship skills.¹⁷² Younger children with harmful sexual behaviours were not identifiable by psychological characteristics, but had often experienced domestic violence, physical abuse, sexual abuse, or other family adversity.¹⁷³

In private sessions involving survivors who had lived in households that provided foster or kinship care, we heard numerous instances of an older child in the household sexually abusing younger children. 'Trent James' told us that when he was five years old, his teenage foster brother would put on pornographic movies and get him to act out scenes when his foster parents were out.¹⁷⁴ 'Trent James's' foster brother was able to take advantage of both the limited supervision inherent in family life and 'Trent James's' age to abuse him. Sexual abuse by a foster sibling entails a similar breach of trust as when an adult sexually abuses a child in out-of-home care.

Another survivor, 'Judi', also told us of being sexually abused by the older biological son of her foster carers.¹⁷⁵

What 'Judi' told us

'Judi' described being abused when she was 10 years old by her older foster brother, who threatened her to prevent her disclosing the abuse.

He used to get me to go in his room, we used to play hide and go seek till he jumped in the bed with me ... He'd tell my brother to go out, and keep me in there, and take my clothes off me and try to stick his private into me ... I wasn't allowed to tell anyone and I could get in big trouble too.

'Judi' said that her foster father caught his son kissing and touching her. 'He slapped him and booted him up the arse.' She said her foster father then asked her whether she was okay, but that seemed to be the extent of his response to the abuse.

'Judi' said she ran away to her mother's home a few times but was brought back. She told us her child protection workers never asked her why she was running away and she can't remember any caseworkers visiting the house. She said the abuse did not stop until she moved to a different placement when she was 13 years old.¹⁷⁶

Commissioned research suggests that many children in residential care recognise that behaviours of other children can be driven by 'fear, distress and trauma'.¹⁷⁷ We were told about the risk of bullying and harassment as well as physical and sexual abuse by other children in residential care settings. One participant described seeing sexual harassment by another resident:

I've come across sexual harassment in 'resis' [residential care] between young people. This one guy I lived with, as soon as there was a girl in the house, if he couldn't get with them, he would make their lives a living hell until he could ... [he would] throw mugs at them. Glue their door shut. Break glass in front of their door while they're sleeping. All sorts of stuff.¹⁷⁸

Our commissioned research found that the mix of young people in residential care can increase risks, particularly where children who have displayed harmful sexual behaviours are placed with children who have been sexually abused – noting that the children with harmful sexual behaviours may themselves have been sexually abused.¹⁷⁹ There is a risk of a sexualised culture, in which sex is 'constantly in the air', and in which behaviours that would not be considered acceptable in other environments are permitted.¹⁸⁰ 'Ruth May' told us in a private session: 'I can say about 90 per cent of the places that I was in, there was some sort of sexual activity, which I've never really thought about ... till now. That's really bad'.¹⁸¹ 'Ruth May' also told us that she worked as a stripper at the age of 15, while she was 'in care' in the early 2000s. She said, 'They know about that because I read that in the file'. This appears to be a case of developmentally inappropriate sexual behaviour being permitted.

The harmful sexual behaviours and other problematic behaviours often displayed by children in residential care may lead to further rejection for these children and make it less likely they will receive the protection and nurturing they need.¹⁸²

3.5.2 Institutional factors that enable child sexual abuse in contemporary out-of-home care

In Volume 2, *Nature and cause* we described institutional factors that enable sexual abuse in institutions generally. This section focuses on those institutional factors that increase the risk of child sexual abuse in out-of-home care settings.

Institutional culture refers to the assumptions, values, beliefs and norms of an institution about appropriate and inappropriate attitudes and behaviour.¹⁸³ It includes shared understandings about values, what someone should or should not do, and what is 'good' and 'bad' behaviour.¹⁸⁴ Institutional culture is as relevant for large government departments responsible for child protection as it is for caseworkers and individual carers supervised by small out-of-home care service providers. Its establishment and maintenance are dependent on strong leadership.

The National Standards for out-of-home care were developed:

to ensure children in need of out-of-home care are given consistent, best practice care, no matter where they live ... The national standards are designed to improve the outcomes and experiences for children and young people by focusing on the key areas within care that directly influence positive outcomes.¹⁸⁵

The standards do not explicitly reference institutional culture. However, compliance with the individual standards would make it more likely that poor practice and bad behaviour would be identified and addressed. The Productivity Commission's annual *Report on government services* monitors government investment in programs and initiatives aimed at implementing the standards. However, as discussed in Section 3.1, the high level measures used to report against the standards are limited.

We heard in private sessions of many examples where institutional culture and practices actively enabled or at least failed to prevent instances of child sexual abuse in out-of-home care. Commissioned research reports that, 'sometimes error is due to deliberate malpractice, but more often a series of weaknesses in the system produces the failure'.¹⁸⁶ This is the most important element of situational prevention: 'the best way to avoid harm to children is to avoid dangerous practices, rather than trying to screen out those who may pose a risk to children'.¹⁸⁷

We have identified the following institutional factors as being important in preventing child sexual abuse in out-of-home care:

- an organisational culture that supports children to disclose sexual abuse and adults to respond appropriately
- adequate screening, supervision and training of carers and staff
- regular monitoring and support of out-of-home care placements
- ensuring that residential care is a safe and supportive environment
- carefully placing and supporting children with harmful sexual behaviours.

The absence of these elements of organisational culture and practice may enable child sexual abuse in out-of-home care. The first element is discussed in Chapter 4, which includes a discussion of barriers to disclosure for children in contemporary out-of-home care. The need for cultural safety is discussed in Chapter 5.

Screening, supervising and training carers and staff

Rigorous recruitment and screening policies and practices are essential safeguards against child sexual abuse in contemporary out-of-home care. However, we know that many perpetrators do not have criminal convictions – or have not come to official notice – and, as a result, may pass standard recruitment and screening assessments.¹⁸⁸ We heard during our inquiry that additional steps in the screening and assessment of carers are essential (see Chapters 4 and 5).

The importance of sharing relevant information between institutions¹⁸⁹ and the benefits of New South Wales' reportable conduct scheme¹⁹⁰ in identifying individuals who may pose a risk to the safety of children are discussed in detail in Volume 8, *Recordkeeping and information sharing*.

Institutions that are overly reliant on screening processes to identify perpetrators and risky behaviour, and that do not continue to supervise and train staff and carers in how to keep children safe,¹⁹¹ may enable opportunities for child sexual abuse to occur. One of the elements of a child safe institution we have identified is that staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training. For example, institutional cultures that do not discuss matters related to sex¹⁹² or provide children with age, developmental and culturally appropriate sex education and sexual abuse prevention information may increase the vulnerability of children in their care to sexual abuse.

In our research on safety in residential care, a participant reflected on staff attitudes to sexual relationships between residents and older men – attitudes that are clearly not protective of children:

[I met an older guy] and next thing I know he's rocking up at my resi unit wanting to see me, texted me at 12 o'clock at night that he's next-door at the carpark, and it surprised me and it still surprises me to this day, the encouragement I got from one of the staff members, she was fully encouraging it, 'Yep go see him. You know, have you got something sexy to wear'. It's like she was facilitating it.¹⁹³

The research noted that:

Participants felt the residential care system and individual services and staff need to develop a better appreciation of the risks of sexual abuse and other harm, and inform and educate children and young people about threats, how they are being protected and how to protect themselves. Residential care units were safer when they had clearly articulated expectations of staff and children and young people, and demonstrated their commitment to safety by doing what they said they would do.¹⁹⁴

As discussed in Volume 10, *Children with harmful sexual behaviours*, most people, including staff in child-related institutions, have very little understanding of harmful sexual behaviours exhibited by children, or how to identify and respond to them. We heard in submissions to our *Out-of-home care* consultation paper that out-of-home care service providers recognise the need for training and resources about children with harmful sexual behaviours, but that such training and resources are not consistently available.¹⁹⁵

Monitoring and supporting out-of-home care placements

Carers are potentially in an almost unfettered position to sexually abuse children, given the private domestic setting in which children in out-of-home care are placed. Given that we know pre-employment screening alone is limited in its capacity to identify perpetrators of child sexual abuse, it is essential that caseworkers visit foster and kinship/relative care placements regularly, create opportunities to talk to children on their own, and make observations about the carer and the care being provided to children. Failure to supervise placements and carers may leave children at immense risk.

We heard in private sessions from many survivors whose placements were not adequately monitored. 'Belle Kerry' said she had hardly seen her caseworker.

What ‘Belle Kerry’ told us

‘Belle Kerry’ told us that she was emotionally and physically abused by her foster mother, who was a very violent and controlling woman. She said she was sexually abused by her foster father, who would sit her in his lap and rub or pat her genitals. This continued for the 11 years that ‘Belle Kerry’ stayed with the family. She said she was also sexually abused by a family friend.

‘Belle Kerry’ told us that there was very little monitoring of her foster care placement:

I recall twice ... seeing [the caseworker]. And [with] the [advance] preparation, we were always well dressed ... I used to have nightmares and my whole behaviour changed and nothing was acknowledged.

The caseworker only spoke to ‘Belle Kerry’ in front of her foster mother and ‘she was a very strict lady and we knew not to say nothing’.¹⁹⁶

Similarly, we learned about a failure to adequately monitor a foster care placement from a statement we received from ‘Jordyn’.¹⁹⁷ He told us that he was raped by his foster father, and emotionally abused by other members of the foster family. He wrote: ‘I never really felt able to tell anyone about it. I’m not saying [the child protection department] are bad people, but lots of kids get hurt in care and the Department sweeps it under the rug. I never felt supported and no one came out to see me and see if I was okay.’¹⁹⁸

Research identifies systemic factors that may contribute to child maltreatment in out-of-home care. Heavy caseloads for child protection workers, and a lack of frequent and effective supervision, can impede worker capacity to supervise children in out-of-home care placements.¹⁹⁹ This is discussed in more detail in Chapter 4.

Establishing residential care as a safe and supportive environment for children

Nationally, around one in 20 children in out-of-home care live in residential care units managed by paid staff.²⁰⁰ This form of care is mainly used for children whose complex needs or challenging behaviours can make it difficult to accommodate them in home-based care. Despite a lack of systematic Australian research to identify how many children with disability live in out-of-home care, including residential care settings, we heard that ‘a disproportionate number of children with disability are in residential care placements compared with foster and kinship care’.²⁰¹ In many jurisdictions, residential care also provides a practical option for accommodating large sibling groups.²⁰²

In an article reviewing service trends in Australian residential care, the Northern Territory's Children's Commissioner wrote:

[It is] not unusual for essentially untrained staff members to be caring for children with significant abuse histories, long juvenile justice records, serious substance abuse issues, histories of sexually exploiting other children, and/or frank psychiatric symptomatology, all together in one small and isolated residential unit.²⁰³

There were also concerns raised in submissions about the lack of compatibility between the characteristics of the residential care workforce and the complex needs of children in residential care. One submission to our *Out-of-home care* consultation paper contrasted the 'highly complex' circumstances of children in out-of-home care (many of whom have 'a multitude of co-morbidities'), with the lack of experienced workers 'who aspire to work in child protection'.²⁰⁴ Another submission asserted that 'the lack of professional, specialist and highly trained staff working with and caring for young people with complex needs and a history of trauma' was a factor in the instability of residential care placements.²⁰⁵

We were told that the residential care sector relies on casual and agency staff to fill gaps in rosters and to address the shortage of skilled, permanent staff. We heard that the low pay and complex conditions attached to these contracts contribute to recruitment and retention problems.²⁰⁶ We also heard from many out-of-home care service providers that this instability poses a safety risk for children as well as staff. A transient workforce means that rostered staff may not have the opportunity to develop working knowledge of the children in their care, or be able to identify risks or respond appropriately to them, particularly if they do not receive adequate training and regular supervision.²⁰⁷ 'Cassandra Alice's' story of being sexually abused in residential care exemplifies the risks posed by poorly trained and unsuitable staff.

What 'Cassandra Alice' told us

'Cassandra Alice' has a developmental disorder that makes social interaction challenging for her. She told us she was a difficult and aggressive teenager and in the early 2010s, when she was 13 years old, she wanted to live away from home so elected to go into care. She remained in residential care units for three years. 'Cassandra Alice' told us she was sexually assaulted four times during this period. She said one of the people who sexually abused her was a staff member who took her to his home and kept her there for eight days. We were told that, although other staff knew where 'Cassandra Alice' was, they did nothing. She said that eventually, when her mother threatened to go to the media, an intervention order was sought and charges were laid.

‘Cassandra Alice’ said the second assault was by a co-resident, who climbed through her window as she slept. She told us that although she reported the assault, she doesn’t think the care workers believed her, ‘or if they did I don’t think they found it ... a bad enough situation to do anything about it’. She said the co-resident who was assaulting her remained in the residential care unit for another three months and continually harassed ‘Cassandra Alice’. She said that when she complained to staff, they told her to stay in her room.

We heard that the third assault occurred when ‘Cassandra Alice’ went with a co-resident to visit a friend of his. ‘Cassandra Alice’ told us the two males violently sexually assaulted her. Once again, she said that even though she reported the assault, the co-resident remained in the unit and continued to harass and taunt her. ‘Cassandra Alice’ told us that staff in the unit were aware that the boy had charges pending from a previous sexual assault, but ‘Cassandra Alice’ felt they did nothing to keep other residents safe from him.

‘Cassandra Alice’s’ mother told us staff at the residential care units were ill-equipped to handle a child with her needs. We were told that even though her care order stated that ‘Cassandra Alice’ had to attend both school and counselling, staff told her they could not make her do anything. ‘Cassandra Alice’ told us, ‘If I wanted to go out and get drunk I was allowed to. No one gave a crap’. She said she and other residents frequently ran away from the residential care units to drink and smoke pot. On occasions they returned with goods they had stolen from shops, and ‘Cassandra Alice’ said staff did nothing.²⁰⁸

Commissioned research reported that residential care services may not have adequate numbers of staff to meet the complex needs of children in care.²⁰⁹ Children in residential care often have high support needs and the ratio of staff to children ‘needs improvement’ if staff are to be able to adequately respond to the needs of the children in their care.²¹⁰ There may be a lack of effective and expert behaviour support available in residential care, especially for children with disability.²¹¹

Placing and supporting children with harmful sexual behaviours

According to commissioned research that sought the views of children and young people about safety in residential care, ‘problematic peer sexual behaviour was an intrinsic part of the residential care experience’.²¹²

In *Case Study 45: Problematic and harmful sexual behaviours of children in schools*, criminologist Dr Wendy O’Brien gave evidence that children who exhibit harmful sexual behaviours are likely to have experienced childhood adversity, including:

in no particular order, child sexual abuse, neglect, caregiver substance abuse, social isolation, cognitive delays and profound economic disadvantage ... when a child presents with one, they very often present with many of those issues.²¹³

Several submissions to our *Issues paper 10: Advocacy and support and therapeutic treatment services* and our *Out-of-home care* consultation paper expressed the need for responses to children with harmful sexual behaviours that take into account the trauma these children may have already experienced, and may continue to experience, without intervention.²¹⁴

As discussed in Volume 10, *Children with harmful sexual behaviours*, children with harmful sexual behaviours are often victims of trauma or abuse themselves. Their behaviour can be a result of the harm they have experienced.²¹⁵

A number of common, adverse experiences in childhood have been identified in cohorts of children receiving interventions for harmful sexual behaviours. These include prior sexual or physical abuse, exposure to family violence, interpersonal difficulties, and other influences, such as exposure to and consumption of pornography.²¹⁶ We are aware that the presence of any one or more of these risk factors in a child's life does not mean they will inevitably sexually abuse others. Personal risk factors relevant to an individual child and institutional risk factors in the child's environment combine to contribute to the risk that the child will exhibit harmful sexual behaviours. As discussed in Volume 10 (Chapter 2, at 2.9), the more personal and institutional risk factors are present, the more likely it is that a child will exhibit harmful sexual behaviours.

Experts told us that children who enter specialist therapeutic programs have frequently faced multiple adverse circumstances in their lives.²¹⁷ Therapeutic programs present an opportunity to address these adverse circumstances, as well as the harmful sexual behaviours. In the *Nature, cause and impact of child sexual abuse* public hearing we heard that treatment can reduce the likelihood of a child reoffending.²¹⁸

'Shane Rodney' told us about his experience of being sexually abused in foster care and his subsequent harmful sexual behaviours. We note that children who exhibit harmful sexual behaviours do not necessarily continue these behaviours or become sexually abusive adults.

What 'Shane Rodney' told us

'Shane Rodney' told us he was sexually abused in a foster care placement. He said that later, in a different placement, he touched his foster sister in a sexualised way. 'Shane Rodney' said he was then sexually abused by the female carer who asked him about the incident between him and his foster sister. The carer instructed 'Shane Rodney' to demonstrate with her what he had done with his foster sister.

'Shane Rodney' told us he was over-sexualised from a young age, spending much of his time obsessed with obtaining sexual gratification. At the time he spoke to us, 'Shane Rodney' was in jail for sexually offending against a young man. 'It's cost other people a lot. It's cost my victim, my victim's family ... It's cost a lot of people.'²¹⁹

In our public roundtable discussion on preventing sexual abuse in out-of-home care, Dr Howard Bath, the then Northern Territory Children's Commissioner, described the pressures in the out-of-home care system that contribute to risk of sexual abuse by children with harmful sexual behaviours:

On the question of the child-to-child abuse, one of the issues is that as residential care has become increasingly used for kids with behavioural challenges, and increasingly behavioural challenges have to do with sexualised problems, we are faced with another problem: placements are expensive, there are few of them and there are enormous pressures from the statutory department to oblige agencies to take kids in, to place kids. I remember, as an agency director, on numerous occasions being obliged to take a child who had serious sexual behaviour problems to be with other vulnerable children in a care unit. Talking to other directors these days, that is an ongoing problem.²²⁰

Our commissioned research tells us that staff training about how to identify and respond to the risks posed by the harmful sexual behaviours of children is a significant need. We have been told that distinguishing problematic, harmful, and normal sexual behaviours can be difficult for staff and carers, and that a tendency to downplay harmful sexual behaviours exhibited by a child as normal sexual exploration is problematic.²²¹

3.5.3 Factors that influence a child's vulnerability to sexual abuse in out-of-home care

All children are vulnerable to sexual abuse when a perpetrator is present and the context allows abuse to occur. However, we have learned from private sessions and research that some circumstances heighten the risk for certain children. When a combination of more risk factors and fewer protective factors comes together in a child's life, they may be more vulnerable. This section outlines the key circumstances that contribute to greater vulnerability for those children in out-of-home care.

Previous experience of abuse or neglect

Children who have experienced maltreatment in the past (for example, children already in the child protection system) have an increased vulnerability to further abuse. In addition, most children who have been maltreated experience multiple types of abuse and neglect. Children previously maltreated by a family member are vulnerable to further maltreatment by an extra-familial perpetrator [references omitted].²²²

As discussed in Volume 2, *Nature and cause*, the association between child maltreatment and subsequent victimisation stems from the emotional, cognitive and psychological effects of the maltreatment on the child, which make them vulnerable to being targeted and manipulated by perpetrators.²²³ These effects of prior maltreatment for children may include:

- low self-esteem, a sense of powerlessness and distorted ways of thinking²²⁴
- poor relationships with, social isolation from, or ostracism by their peers²²⁵
- a heightened need for affection and attention²²⁶
- poor interpersonal relationships with family or carers²²⁷
- developmental disorders or cognitive impairments resulting directly from a prior trauma.²²⁸

We have learned that many children in out-of-home care are highly likely to experience one or more of these effects.

Loss of connection to family and culture

Unlike children who are victimised in other institutional settings, many children in out-of-home care face additional disadvantage because they are separated from family and community (although this may not always be the case for children in kinship/relative care).²²⁹ Maintaining positive connections to family, community and culture is an important issue for all children in out-of-home care, as family and culture may provide protective factors.

All children placed in out-of-home care that is not kinship/relative care are separated from their families. Some children placed in out-of-home care are more likely to be separated from their culture as well as their families – Aboriginal and Torres Strait Islander children²³⁰ and children from culturally and linguistically diverse backgrounds in particular.

Accepted parenting roles and practices differ across cultural contexts.²³¹ We heard that poor placement decisions, or caseworker allocations that do not accommodate for these cultural differences or provide choice, may culturally isolate a child or weaken the protective capacity of the carer.²³² We heard that matching children with carers who speak the same language as them is also critical to preserving culture, as is access to cultural community events and traditions.²³³

For Aboriginal and Torres Strait Islander children in out-of-home care, separation from family, culture and community has additional impacts because it builds on the historical legacy of colonisation.²³⁴ As discussed in Volume 11, *Historical residential institutions*, previous inquiries have recorded how the forced removal of children in the Stolen Generations has had traumatic impacts across generations.²³⁵ In 2016, *The life they deserve: Child Protection Systems Royal Commission report* noted that 'Aboriginal people continue to bear the effect of past policies'.²³⁶ In contemporary times these effects underpin complex needs related to poverty, illness, family violence and other forms of social disadvantage.²³⁷ Aboriginal and Torres Strait Islander families are dealing with these effects and for children removed to out-of-home care there is a compounding effect. To be placed without continuity of culture and family connection increases the vulnerability of these children.²³⁸

What 'Maddie Jean' told us

'Maddie Jean', who is Aboriginal, was first placed in care when she was seven years old. She was deemed to have been inadequately supervised by her mother as she and her brother would travel the city on public transport instead of going to school. 'Maddie Jean' told us that over the next 10 years she had about 15 placements, including foster homes, refuges, crisis centres and residential programs, and with extended family members and people she just happened to meet. She didn't stay anywhere for long.

Different issues brought the various placements to an end. 'Maddie Jean' told us that one of the earliest ones ended after she was sexually abused by another foster child in the home. Several of her placements were with Aboriginal carers and, while 'Maddie Jean' appreciates that staff were trying to help her maintain her cultural connections, these arrangements weren't always successful. 'Maddie Jean' said she was sexually abused by the biological older son of a foster carer in another placement. She eventually ran away. She told us there were other sexual assaults after that. 'Maddie Jean' has self-harmed and used drugs: 'I was suicidal and it felt good cutting myself. There was no one that seemed to care'.

'Maddie Jean' told the Royal Commission that her mother had also been abused in care as a child. 'Maddie Jean' now has children and is receiving support herself. She says that it is sad that support wasn't available for her mother. She said, 'My mum just got so abused by everyone, she just thought she couldn't look after us. We weren't going to be good in her care and now you can tell she does regret it'.²³⁹

'Maddie Jean's' story illustrates the critical relevance of culturally appropriate supports and services. The importance of the genuine implementation of the Aboriginal and Torres Strait Islander Child Placement Principle as an approach to addressing such issues for Aboriginal and Torres Strait Islander children is discussed in Chapter 5.

Not understanding what is abusive

Not understanding what is abusive can create vulnerability in children and be a barrier to disclosing abuse. Many children, even older children and teenagers, may not have a good understanding of sexual behaviour and personal safety and so may lack a clear understanding of what constitutes sexual abuse.²⁴⁰ This can be related to many different factors, such as the age of the child, their stage of development, and the child's access to appropriately tailored sex education.

'Tamsin Jane', for example, told us she was placed in her aunt's care where she was sexually abused from the age of five until she was nine or 10 years old by two male cousins in their teens.²⁴¹ 'Tamsin Jane' said for a long time she didn't realise it was wrong, but when she was about 10 she told her aunt what her cousins were doing to her and her aunt took 'Tamsin Jane' to the police to report it.

As discussed in Chapter 5, many factors – such as family crises, the instability of care placements and moving to new schools – can disrupt school attendance for children in out-of-home care and limit their access to school-based sex abuse prevention and healthy relationships education programs.

Research indicates that children with disability often do not receive appropriate education about sexuality and personal safety, including education about their rights, personal relationships, consent and acceptable sexual behaviour.²⁴² This may be because they are often segregated in special classes and miss out on school-based education programs. It may be because the education delivered is often not accessible and may not take into account their cognitive and communication support needs. Research identifies there are still segments of the Australian community that mistakenly assume children with disability are asexual and do not need to know about sex and relationships.²⁴³ In addition, research suggests that 'children with disability whose bodies are frequently touched by non-family carers may find it more difficult to differentiate, or object to, the invasion of private parts of their bodies'.²⁴⁴ Ultimately, through exclusion and lack of tailored approaches, the rights of children with disability to access this knowledge are curtailed.

Issues associated with 'inconsistent or non-existent delivery of sex education' can also adversely affect Aboriginal and Torres Strait Islander children.²⁴⁵ For example, the Northern Territory Government's *'Little children are sacred': Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse* in 2007 highlighted the need to engage with and educate children about sex, relationships and personal safety, including an understanding of 'good touching, bad touching', and for this to be provided in appropriate languages, in gender-specific settings, and delivered through collaboration between senior community men and women, teachers and health clinicians.²⁴⁶ In its submission responding to our *Out-of-home care* consultation paper, the Victorian Aboriginal Child Care Agency identified gaps in the information currently provided to children on these topics. It said there was a need

for specific sexual health education and education that demystified sexual abuse and addressed ‘the particular issues of shame and other cultural nuances that exist for Aboriginal children, families and communities’.²⁴⁷

We heard through submissions and consultations that awareness of child sexual abuse issues can be poor in some culturally and linguistically diverse communities.²⁴⁸ Stakeholders attending our multicultural public forums spoke about how this limited awareness can be linked to shame or taboos associated with talking about sex, both within families and communities and with people outside of communities, including with authorities.²⁴⁹ We also heard how child protection concepts are not always directly translatable across cultural contexts or languages, and that awareness-raising campaigns need to be culturally tailored to be accessible in some communities.²⁵⁰

During our *Nature, cause and impact of child sexual abuse* public hearing, Ms Jatinder Kaur, a social worker and Director of JK Diversity Consultants, stated:

I think when it comes to child sexual abuse ... a lot of parents don’t even know what child abuse, neglect or child maltreatment is or ... that Australia has child protection systems. So that’s your basic starting point. When you go into sexual abuse, it is such a taboo topic that most of the multicultural communities really struggle in talking about sexual abuse, grooming. You wouldn’t be able to get them into the room to have a conversation ... there’s such a taboo [or] stigma still around that topic.²⁵¹

Lack of access to child sexual abuse prevention or sex education programs in their country of origin, or to culturally tailored and appropriate programs in Australia, was identified as a reason for low levels of understanding about child sexual abuse in some communities.²⁵²

Not having a good understanding of what constitutes a healthy and respectful relationship puts some children at risk of sexual abuse and sexual exploitation. In commissioned research on the safety of children and young people in residential care, researchers heard from young people that they were vulnerable to the advances of predatory adults, not least because of their need for love and affection:

At the time I thought nothing of it, I thought yeah I’m getting attention from a guy. I thrived on it, because being in resi [residential care] you literally want attention, you want someone to look at you and you think that they think the world of you when really you don’t understand but clearly the older guy, there’s only one thing they want from you ...²⁵³

The need for a sexual abuse prevention education strategy for children in out-of-home care is discussed in Chapter 5.

3.6 The impacts of child sexual abuse particular to contemporary out-of-home care

As discussed in Volume 3, *Impacts*, the effects of child sexual abuse in institutional contexts can be devastating. These effects, we were told, are different for each victim. Many victims experience deep, complex trauma, which pervades all aspects of their lives. Some do not perceive themselves to be profoundly harmed by the experience. Some impacts are immediate and temporary, while others can last into adulthood. Some emerge only after 'trigger' events or at different life stages, and others accumulate over time.

While each experience shared with us was unique, some impacts were commonly described by survivors. Adverse effects on victims' mental health were the most commonly identified impacts in private sessions. This was followed by difficulties in victims' interpersonal relationships and impacts on their education, employment and overall economic security. Survivors also commonly described to us the impacts on their physical health, social wellbeing, culture, spirituality, sexual behaviour, sexuality and gender identity. Although some survivors told us of one or two of these effects, others described a constellation of impacts, which were interconnected in complex ways. Part of the explanation for this profound and complex web of impacts lies in the detrimental effects that interpersonal trauma can have on the biological, neurological, social and psychological development of a child.

We found that while the effects of child sexual abuse in institutional contexts are similar to those of sexual abuse in other settings, there are often particular impacts of sexual abuse in an institutional context. Mistrust and fear of institutions and authority, and loss of religious beliefs or community were commonly reported impacts of sexual abuse in these contexts. We also found that the way an institution responds to sexual abuse can have a significant impact on a victim, and compound the effects of the abuse. Inadequate responses can leave victims feeling betrayed, ostracised or isolated. This can lead to continued sexual abuse and re-traumatisation, among other things.

The effects of child sexual abuse and institutional responses to that abuse extend beyond victims. Parents, siblings, partners and carers can be significantly affected, as can other children and staff in institutions where the abuse occurred. The effects can be intergenerational and change entire communities.

This section focuses on what survivors told us about the impacts of child sexual abuse in out-of-home care, and the subsequent responses of the relevant institutions, on their lives and wellbeing. We acknowledge that people who, as children, were sexually abused in out-of-home care may experience a range of impacts from sexual abuse, such as self-destructive behaviour. For instance, after being sexually abused in a kinship care placement, 'Tamsin Jane', whose private session story we introduced in the previous section, told us that when she and her carer reported the abuse to police, '[Police] couldn't do anything because I couldn't use the right words...'.²⁵⁴ 'Tamsin Jane' told us she started to self-harm and had become an alcoholic by the time she was 13 years old. These other impacts are detailed in Volume 3, *Impacts*.

As described in Section 3.2, available statistics indicate that the majority of children do not experience abuse in out-of-home care. They may well thrive in settings that are free from abuse. A survey by the Australian Institute of Health and Welfare on the views of a sample of children in out-of-home care in 2015 found, for example, that about 91 per cent reported feeling both safe and settled in their current placement.²⁵⁵ Although it is not the case for every victim of sexual abuse in out-of-home care, what we may see is a compounding series of impacts which may disrupt a child's entire life.

3.6.1 Cumulative harm

Cumulative harm 'refers to the effects of patterns of circumstances and events in a child's life, which diminish a child's sense of safety, stability and wellbeing':²⁵⁶

Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or 'layers' of neglect. The unremitting daily impact on the child can be profound and exponential, covering multiple dimensions of the child's life.²⁵⁷

As discussed, children placed in out-of-home care are likely to have already experienced severe abuse and neglect. Their removal from their families, communities and culture, no matter how abusive or neglectful those families were, may be a further trauma.²⁵⁸

While Aboriginal and Torres Strait Islander communities demonstrate resilience, individually and collectively they face a higher burden of cumulative harm as a consequence of 'the historical legacy of colonisation, racism, deprivation, forced removal of children from their families, and ensuing intergenerational trauma'.²⁵⁹

A child who then experiences sexual abuse while in out-of-home care is more likely to experience the effects of cumulative harm and complex trauma.

Cumulative harm affects a child in many ways that are disruptive to their development and wellbeing. Research on development trauma indicates:

multiple exposures to interpersonal trauma, such as abandonment, betrayal, physical or sexual assaults, or witnessing domestic violence, have consistent and predictable consequences that affect many areas of functioning. These experiences engender intense effects, such as rage, betrayal, fear, resignation, defeat, and shame, and efforts to ward off the recurrence of those emotions, including the avoidance of experiences that precipitate them or engaging in behaviours that convey a subjective sense of control in the face of potential threats. These children tend to re-enact their traumas behaviourally, either as perpetrators (eg, aggressive or sexual acting out against other children) or in frozen avoidance reactions.²⁶⁰

The research suggests that children with complex trauma may not react to situations in the same ways as 'secure' children and unless the caregivers of a child with complex trauma understand 'the nature of such re-enactments, they are likely to label the child as "oppositional", "rebellious", "unmotivated", or "antisocial"'.²⁶¹

Several survivors who attended private sessions talked about their behaviour in ways that indicated they had suffered cumulative harm as children. 'Gav' was one of these survivors.

What 'Gav' told us

'Gav' told us his mother placed him in state care when he was 10 years old because he lashed out at her violent boyfriend. 'Gav' spent four years in many foster homes, institutions and youth refuges, and also lived on the street for a short time. When he was 14 years old, 'Gav' met his new caseworker, who he described as an older man who was quite firm with 'Gav' about his running away. 'Gav' told us that after this caseworker sexually abused him, he 'took off' again and returned to live with his mother. He said he couldn't tell her about the abuse because he was too embarrassed, but that the sexual abuse had changed him and he became angry, violent and disobedient at home and school, experimenting with drugs and always looking for a fight. 'I was misunderstood because no one could work out why I was so angry.'²⁶²

In research exploring connections between child maltreatment, victimisation and trauma, it is acknowledged that:

the child's current and future safety need to be assured, but they also need to be assisted in their short- and long-term recovery to address their psychological, behavioural and developmental needs. In addition, children need to have the adversity in their lives reduced (eg greater family stability, access to support services) and opportunities and strategies to build resilience against future negative events.²⁶³

Due to the growth in the number of children in out-of-home care during the past decade, there is unprecedented pressure to find and support appropriate placements, and to provide experienced practitioners who can visit and build meaningful relationships with children in care. We have been told that limited types and numbers of placements contributes to placement decisions and circumstances that, despite aiming to be in the best interests of children, may ultimately increase their risk of harm.

3.6.2 Placement instability

We received many submissions about the dangers and difficulties posed by placement instability for children in out-of-home care, and yet it remains a significant problem. The New South Wales Government submission in response to our *Out-of-home care* consultation paper stated:

Many of the strategies used for preventing child sexual abuse in out-of-home care are central to addressing the sexual exploitation of children in out-of-home care, whether it be in a foster care setting or in residential care. These strategies include placement stability and the establishment of ongoing relationships with trusted adults and carers who are trained to identify possible abuse and vulnerabilities in the children for whom they care.²⁶⁴

The Life Without Barriers submission stated:

The current system ... is geared to make an attempt – often several attempts – at the cheaper generalist foster care option before consideration will be given to more intensive options. This experience of placement instability can be extremely damaging for children already suffering from the effects of trauma, loss, grief and disconnection and may lead to greater vulnerability to abuse while in care.²⁶⁵

We know that maintaining stable placements for children in out-of-home care is a major challenge.²⁶⁶

One of the impacts of child sexual abuse that is specific to contemporary out-of-home care is that the sexual abuse, and its disclosure, can lead to a child being taken from the placement. Clearly it is appropriate for a child to be taken out of an abusive out-of-home care placement: the change may well improve the situation if a child is given a safe and supportive placement. However, we commonly heard about the disruptive and distressing impact of frequent placement changes, periods of homelessness and stints in residential care.

Research suggests that multiple placements in out-of-home care are of themselves one of the factors in a child experiencing placement breakdown.²⁶⁷ We heard from several sexual abuse survivors from out-of-home care who had experienced multiple placements.

‘Ruth May’, whose private session account is highlighted earlier in this chapter, also told us about experiencing an extreme number of placements.²⁶⁸ She told us that during one 12-month period she was placed in dozens of different foster homes:

They said I was problematic. I was probably acting out. Like, they’re meant to give you care. It doesn’t matter how problematic you can be ... I was in so many homes and because of being passed around ... I felt a sense of no one wanted me and abandonment. And I felt like no one listened to me.²⁶⁹

‘Ruth May’ was not the only victim who told us about having multiple placements. ‘Christian James’ said he was placed in care at the age of seven, and went on to have more than 40 placements, ‘some good, some very good, some horrifying. Some ... cause nightmares still to this day’.²⁷⁰ ‘Christian James’ said that settling down in any of these homes was very difficult: ‘I always ran away ... They used to use the word “sabotage” a lot, mainly because I didn’t know what was going to happen to me’.

Research indicates that children who come into care with significant emotional and behavioural problems are most at risk of placement instability.²⁷¹ Each change of placement may result in further disruption of attachment.²⁷² This in turn affects the child’s development and their vulnerability to further sexual abuse. Research suggests that many of the behavioural problems of children in out-of-home care are not simply the ongoing effects of the abuse, neglect or adverse events that led to them being taken into care. Placement instability may in fact compound existing difficulties²⁷³ and these problems may be related to the instability children experience while in care.

It is difficult to tease apart the impact of the harms that caused these children to enter care from the harms that they experienced in care due to placement instability. Children at risk of placement instability require care that addresses and attempts to heal the harms they have experienced before entering care. They also require care that provides stability.

These children can find it difficult to make and sustain positive connections with family members, friends, their community and their culture.²⁷⁴ Compounding this social isolation and loss of connection that arises from placement instability, we also know that children’s education and attendance at school can be severely disrupted. The poor educational outcomes and subsequent economic and social impact on the adult lives of many care-leavers are well known.²⁷⁵ Poor educational achievement can result in feelings of inadequacy and incompetence, which can compound feelings of guilt and distrust and low self-esteem associated with child sexual abuse.²⁷⁶

Despite the recognition of the importance of placement stability to child wellbeing and the prevention of child sexual abuse in out-of-home care, we have been told that often placements are provided depending on what is available rather than what the child needs.²⁷⁷ Stability and security are not always adequately addressed in practice.²⁷⁸ As discussed in Chapter 4, the systemic failures that cause placement instability can be understood as systemic maltreatment of children in out-of-home care.²⁷⁹

3.6.3 Betrayal and loss of trust

Dr Bruce Perry, a child and adolescent psychiatrist with extensive experience working with people who have been impacted by trauma and abuse, including sexual abuse in institutional settings, gave evidence during our *Nature, cause and impact of child sexual abuse* public hearing.

Everything that we learn, the entire way we heal, is all in context of relationships, and if the very vehicle that we use to learn, to grow, to develop, to heal, to engage, to teach – all the stuff that we do with a parent – if that is corrupted by the process of sexual abuse and you can't trust and don't feel safe, it makes it difficult for you to make your way through life. If ... these institutions are either ignoring, colluding, rejecting or even attacking you because of your disclosure, and you see this and you feel it, it makes you much, much, much less willing to trust.²⁸⁰

A deep sense of betrayal and a distrust of organisations, authorities and institutional settings may pose a significant barrier to victims of institutional child sexual abuse accessing and receiving ongoing support.²⁸¹ We commonly heard from survivors that their experience of sexual abuse in out-of-home care affected their ability to seek help from organisations. 'Belle Kerry' (see also Section 3.5) told us about having to manage the impact of the sexual abuse for the rest of her life:

It doesn't go away ... those memories are there. They are stuck ... trust is a very great issue. It's very hard for me to trust anybody. Especially with the authorities when I ran away. I couldn't trust anybody ... because I didn't want to go back home ... I fought my hardest. Yeah, it really does affect your life afterwards because you're just constantly scared, scared someone is going to try and do something.²⁸²

Similarly, 'Coral' described being too afraid to ask for help – a fear that was a direct result of her previous contact with child protection authorities:

Because you ask for help and then they think that you're unstable and want to take your kids. I've been in welfare. They think that my children should go there because I'm unstable and drug using – they don't ask the reasons why you're drug using and what's happened. They think they've done their job – they push us out and that's it. You don't hear any support, nothing. I asked for support when I was 15 and had my son. But all they said is, 'we can't help you, you need to find someone to look after him or we'll take him'. If they'd helped me then maybe I'd be in a stable house and have my kids.²⁸³

We also commonly heard from survivors that they were unable to form trusting personal relationships because of the sexual abuse they experienced as children in out-of-home care. One survivor told us she had been sexually abused by her older brother while they were in a kinship placement with an aunty.²⁸⁴ She said that when she told her caseworker, 'they didn't really listen to me'. Among the impacts she described was her loss of family connection. 'The sexual abuse has really impacted me now. Because I can't have that same connection with my family as I'd like to.'²⁸⁵

The inability to form or maintain relationships was a common experience that we heard about: 'I can't hold a proper relationship with anyone. I don't trust anybody'.²⁸⁶

3.6.4 Compounding vulnerability

The inability or unwillingness of victims of sexual abuse in out-of-home care to seek assistance from services can, in some cases, put them at increased risk of cascading disadvantage, including vulnerability to homelessness and involvement in crime.

Commissioned research on the impacts of institutional child sexual abuse indicates that if a victim perceives the institution to be complicit in ‘creating situations and settings where abuse can occur, concealing abuse or failing to attend to disclosures in appropriate ways’, it can lead to a sense of ‘institutional betrayal’.²⁸⁷ Where there is a relationship of trust or dependency within the institutional context, and the victim feels betrayed, research suggests the victim may experience increased levels of anxiety, trauma symptoms and dissociation.²⁸⁸ Many survivors of sexual abuse in out-of-home care told us that they experienced ongoing mental health issues, including depression and anxiety. Some victims felt this had led to their criminal behaviour and imprisonment.

Research into the health of young people in custody in New South Wales indicates there may be an association between contemporary out-of-home care and an increased risk of mental health issues, drug and alcohol abuse, and incarceration in later life.²⁸⁹ In the most recent survey of young people in custody in New South Wales, conducted in 2009, 60 per cent of respondents had experienced some form of childhood abuse or trauma and 27 per cent had been removed from their families and placed in out-of-home care during their childhoods.²⁹⁰ In addition, the survey showed that significantly more young women (40 per cent) than young men (25 per cent) and significantly more Aboriginal (38 per cent) than non-Aboriginal (17 per cent) young people had a history of out-of-home care.²⁹¹ Another Australian health survey conducted with an adult prison population in 2009 revealed that almost one-third of the respondents had spent time in out-of-home care.²⁹²

‘Laurin’ and ‘Grantley’, both of whom were in custody when they spoke to us, explained how they had come to commit crimes.

‘Laurin’ told us he was raped by his foster father when he was 12 years old.²⁹³ When he told his caseworker, he was accused of lying and was not offered a medical examination. Instead, ‘Laurin’ said he was simply driven back to the foster home where he promptly had a physical fight with the foster father and the placement then ended. A long period of instability followed, including one month living in motels, because no other foster placements were available. ‘Laurin’ told us that when he came out of foster care he was angry and aggressive and had no trust in adults or in authority generally. He was set up in housing but had no ongoing counselling. He was close to no one emotionally or physically. ‘Laurin’ pleaded guilty to raping a 17-year-old girl when he was in his late teens and had been in custody since the mid-2000s. ‘Laurin’ told us he was diagnosed in prison with post-traumatic stress disorder (PTSD), anxiety, depression and schizophrenia, for which he is on medication.²⁹⁴

‘Grantley’ told us that he had made ‘multiple suicide attempts’.²⁹⁵ ‘I woke up every day and the first thing I did was started drinking and then started with the drugs. I was arrested time and time again.’ ‘Grantley’ was also diagnosed in prison:

I came to prison and ... the doctors in prison figured out that not only did I have PTSD, depression, anxiety, anger management problems, but I also had antisocial personality behavioural disorder. And they put me on some medication because they figured it would help in regards to the flashbacks, the paranoia around people. But it didn’t take too long for me to figure out that it wasn’t helping. It was stopped. Things were tried to be managed differently, but there’s not one day that I wake up and not think about what happened in [residential care]. Not one day.²⁹⁶

3.6.5 Intergenerational impact of abuse and placement in care

Intergenerational trauma is when the impacts of childhood sexual abuse are transmitted from an individual survivor to subsequent generations, such as the survivor’s children or grandchildren. In Volume 3, *Impacts* we discuss how the children of some survivors have been exposed to the debilitating effects of trauma, including mental health and relationship difficulties, alcohol and drug abuse and family breakdown. In some cases, these ‘ripple effects’ of child sexual abuse can be long-lasting and span many generations, perpetuating cycles of disadvantage and trauma.

In private sessions, many survivors of sexual abuse in out-of-home care told us that the abuse they experienced contributed to cascading problems, resulting in their own children being removed into out-of-home care.

‘Spencer James’ told us he was sexually abused in two foster care placements.²⁹⁷ ‘Spencer James’ started using hard drugs at a young age to block things out, he spent little time at school and now struggles to read and write. He also said he has difficulties in his relationships with others. He became involved in criminal activity and now has a young son in foster care. ‘Spencer James’ told us he is now worried this could happen to his son: ‘I’m just worried that something bad could happen like that I’m constantly worried if he’s going to be all right’.

When the concept of intergenerational trauma is used in the context of Aboriginal and Torres Strait Islander peoples, it also encompasses the collective experience of ongoing trauma over multiple generations.²⁹⁸ Due to racially discriminatory ‘protectionist’ and assimilationist policies, many generations of Aboriginal and Torres Strait Islander children were forcibly removed into institutions where they were exposed to abuse, including sexual abuse.²⁹⁹ In consultations and private sessions we heard from survivors many times how this experience has destroyed family and social relationships, disrupted cultural practices that are integral to Aboriginal and Torres Strait Islander children’s wellbeing and denied them positive and loving parenting.³⁰⁰

'Sabrina May's' experience of sexual abuse in foster care was explained in Section 3.3.2. Her family story is an example of the intergenerational cycle of trauma and children placed in care.

What 'Sabrina May' told us

'Sabrina May' told us that her mother was one of the Stolen Generations. In the 1990s, 'Sabrina May' and her sisters were placed in out-of-home care with a non-Indigenous family because her mother was struggling to cope after the death of her husband. 'Sabrina May' would cry and say she wanted to go back to her mother. She and her sisters were physically, emotionally and sexually abused while in foster care. They escaped and were reunited with their mother when an Aboriginal family in the neighbourhood recognised them.

'Sabrina May' said she was charged with a serious crime when she was 17 years old, and went to jail. After she was released 'Sabrina May' had two children, who were then removed into out-of-home care. 'So, it's ... my mother, myself and now my kids are in the system.'

As 'Sabrina May' described it, she and her partner 'just went down the wrong path'. She believes that people turn to drugs and alcohol:

not because it's a poor excuse ... behind those labels are hurt and broken people that do these things to numb themselves ... They use this as a self-medication to numb the pain ... behind those labels is a sore, broken story, that you just don't tend to have the time to even listen to.

Her partner has now turned his life around, and 'Sabrina May' told us:

I went and got myself into therapist counselling through [an Aboriginal organisation]. I undertake anger management courses, loss and grief courses, and drug and alcohol courses ... I've worked like fucking hell to get these little babies back.

After three generations of her family in 'the system', 'Sabrina May' hopes to be 'the person that breaks this cycle. I would love to be'.³⁰¹

Our recommendations aimed at improving institutional responses to child sexual abuse, which may also contribute to breaking this intergenerational cycle, are set out in Chapter 5.

Endnotes

- 1 L Bromfield, C Hirte, O Octoman & I Katz, *Child sexual abuse in Australian institutional contexts 2008–2013: Findings from administrative data*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 24.
- 2 A Uliando & D Mellor, 'Maltreatment of children in out-of-home care: A review of associated factors and outcomes', *Children and Youth Services Review*, vol 34, no 12, 2012, p 2280; see also L Bromfield & D Higgins, 'Chronic and isolated maltreatment in a child protection sample', *Australian Institute of Family Studies: Family Matters*, vol 70, 2005, p 38; M Irenyi, L Bromfield, L Beyer & D Higgins, *Child maltreatment in organisations: Risk factors and strategies for prevention*, Australian Institute of Family Studies, Melbourne, 2006, pp 1–2.
- 3 A Uliando & D Mellor, 'Maltreatment of children in out-of-home care: A review of associated factors and outcomes', *Children and Youth Services Review*, vol 34, no 12, 2012, p 2280; see also L Bromfield & D Higgins, 'Chronic and isolated maltreatment in a child protection sample', *Australian Institute of Family Studies: Family Matters*, vol 70, 2005, p 38.
- 4 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, Sydney, 2016, pp 43–45.
- 5 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, Sydney, 2016, p 44. Developed under the *National Framework for Protecting Australia's Children 2009–2020*, the Child Protection National Minimum Data Set consists of 'de-identified person-level' child protection data from each jurisdiction that the AIHW then compiles and analyses according to nationally agreed rules and methods.
- 6 Transcript of G Llewellyn, Case Study 57, 29 March 2017 at 27686:18–21.
- 7 There were 60,989 substantiated reports of all types of abuse in Australia in 2015–16, and 45,714 involving children in out-of-home care. As abuse can lead to children being placed in care, it is likely that many of these substantiations related to incidents prior to entering care. Australian Institute of Family Studies, *Child abuse and neglect statistics*, 2017, www.aifs.gov.au/cfca/publications/child-abuse-and-neglect-statistics (viewed 16 September 2017).
- 8 T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 35.
- 9 Children in State Care Commission of Inquiry, *Children in state care commission of inquiry: Allegations of sexual abuse and death from criminal conduct*, South Australian Government, Adelaide, 2008, p 24.
- 10 Victorian Commission for Children and Young People, "...as a good parent would...": *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, Victorian Commission for Children and Young People, Melbourne, 2015, p 48.
- 11 Victorian Commission for Children and Young People, "...as a good parent would...": *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, Victorian Commission for Children and Young People, Melbourne, 2015, p 49.
- 12 Victorian Commission for Children and Young People, "...as a good parent would...": *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, Victorian Commission for Children and Young People, Melbourne, 2015, p 53.
- 13 Child Protection Systems Royal Commission, *The life they deserve: Child Protection Systems Royal Commission report*, South Australian Government, Adelaide, 2016, p 294.
- 14 P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 7.
- 15 P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 24–25.
- 16 P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 33.
- 17 P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 23.
- 18 P O'Leary, E Koh & A Dare, *Grooming and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 7.
- 19 P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 23.
- 20 P O'Leary, E Koh & A Dare, *Grooming and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 8.
- 21 P O'Leary, E Koh & A Dare, *Grooming and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 8.
- 22 Name changed, private session, 'Conrad Ewan'.
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- 24 P O'Leary, E Koh & A Dare, *Grooming and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 8.

25 As discussed in P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 45, the great majority of perpetrators of child sexual abuse are male and even though a relatively small proportion of men abuse children, there is an elevated risk associated with male staff. In the example given, the situational risk is also high and the combined risk much elevated.

26 Name changed, private session, 'Annabelle'.

27 Name changed, private session, 'Tyson Lee'.

28 Name changed, private session, 'Evie'.

29 Name changed, private session, 'Calvin James'.

30 MacKillop Family Services, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, p 5.

31 See for example: Victorian Commission for Children and Young People, "...as a good parent would...": *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, Commission for Children and Young People, Melbourne, 2015, p 2. See also the following submissions to the Royal Commission into Institutional Responses to Child Sexual Abuse on *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016: Life Without Barriers, p 2; MacKillop Family Services, pp 1–2; Association of Children's Welfare Agencies, p 23; Centre for Excellence in Child and Family Welfare Inc., p 15.

32 The Salvation Army Southern Territory, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, p 3.

33 Defined by the Department of Health and Human Services, Victoria, as 'behaviour of a sexual nature by a client that places a client's safety and wellbeing at risk'. Victorian Commission for Children and Young People, "...as a good parent would...": *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, Commission for Children and Young People, Melbourne, 2015, p 49.

34 Victorian Commission for Children and Young People, "...as a good parent would...": *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, Commission for Children and Young People, Melbourne, 2015, pp 49–50, 63.

35 Name changed, private session, 'Kat'.

36 Name changed, private session, 'Kat'.

37 Name changed, private session, 'Caspar'.

38 Name changed, private session, 'Caspar'.

39 See for example, I Katz, A Jones, BJ Newton & E Reimer, *Life journeys of victims/survivors of child sexual abuse in institutions: An analysis of Royal Commission private sessions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 49; K Kaufman & M Erooga, *Risk profiles for institutional child sexual abuse: A literature review*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, pp 12, 26.

40 T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 68.

41 M Salter, 'The role of ritual in the organised abuse of children', *Child Abuse Review*, vol 21, no 6, 2012, pp 440–441.

42 Name changed, private session, 'Noah Jeffrey'.

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44 Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, cat no CWS 60, Australian Institute of Health and Welfare, Canberra, 2017, pp 55–56.

45 T Libesman, *Cultural care for Aboriginal and Torres Strait Islander children in out of home care*, Secretariat of National Aboriginal and Islander Child Care, North Fitzroy, 2011, p 53.

46 T Moore, M McArthur, S Roche, J Death & C Tilbury, *Safe and sound: Exploring the safety of young people in residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 16.

47 T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 42. See also B Mathews, K Walsh, M Dunne, I Katz, F Arney, D Higgins, O Octoman, S Parkinson & S Bates, *Scoping study for research into the prevalence of child abuse in Australia*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 20.

48 Name changed, private session, 'Brianna'.

49 Name changed, private session, 'Brianna'.

50 Name changed, private session, 'Brayden'.

51 In addition to states and territories, 13 non-government organisations provided data: Anglicare, Baptcare, Barnardos Australia, Berry Street, CatholicCare, Life Without Barriers, Marymead Child and Family Services, MacKillop Family Services, United Protestant Association of New South Wales, UnitingCare, Victorian Aboriginal Child Care Agency, Wesley Mission New South Wales and Wesley Mission Victoria. The non-government organisations were selected for their diversity in location, size and the type of care provided. Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, Sydney, 2016, pp 28–30.

52 Victoria advised that there was no duplication in its data. The selected non-government organisations provided data on
956 reports of child sexual abuse in out of home care in the same period. As non-government organisations are very
likely to report allegations of sexual abuse of a child in their care to a government agency, data provided by states and
territories may duplicate the non-government data.

53 Transcript of S Kinmond, Out-of-home care public roundtable: Preventing sexual abuse of children in out-of-home care,
Sydney, 16 April 2014 at T10:34–T11:12.

54 New South Wales Ombudsman, *New South Wales Ombudsman annual report 2015–2016*, New South Wales
Ombudsman, Sydney, 2016, p 88.

55 NSW Ombudsman, *Out of home care sector: 16 years of Reportable Conduct Forum*, 2016, [www.ombo.nsw.gov.au/___
data/assets/pdf_file/0010/31699/Forum-OOHC-slides-1April.pdf](http://www.ombo.nsw.gov.au/___data/assets/pdf_file/0010/31699/Forum-OOHC-slides-1April.pdf) (viewed 14 September 2016).

56 L Bromfield, C Hirte, O Octoman & I Katz, *Child sexual abuse in Australian institutional contexts 2008–2013: Findings
from administrative data*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse,
Sydney, 2017, p 14.

57 L Bromfield, C Hirte, O Octoman & I Katz, *Child sexual abuse in Australian institutional contexts 2008–2013: Findings
from administrative data*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse,
Sydney, 2017, p 73.

58 L Bromfield, C Hirte, O Octoman & I Katz, *Child sexual abuse in Australian institutional contexts 2008–2013: Findings
from administrative data*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse,
Sydney, 2017, pp 213–214.

59 Notifications are the reports to the appropriate government child protection department that a child is or may be in
need of protection from harm through abuse or neglect. When notifications are investigated and the child is found to
have suffered abuse or neglect, the abuse is said to be ‘substantiated’.

60 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra,
2017, p 16.14, box 16.5.

61 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra,
2017, p 16.14.

62 In this volume a date range, for example 2016–17, refers to a period of 12 months from 1 July – 30 June, unless
otherwise specified.

63 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra,
2017, Table 16A.27, explanatory notes (a) and (b); L Ockenden & K Goldsworthy, *Children in care: CFCA Resource Sheet*,
Australian Institute of Family Studies, Melbourne, 2016, Table 2, Australian Institute of Health and Welfare data: In 2015
NSW and Victoria combined out-of-home care population = 25,410, all Australian jurisdictions = 43,399.

64 For example, Queensland and Northern Territory data is not comparable with other jurisdictions or across the time-
series for a number of reasons identified in footnotes to Table 16A.27

65 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra,
2017, pp 16.11, 16.14 and Table 16A.26.

66 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra,
2017, p 16.14.

67 Data was not available from South Australia or the Northern Territory.

68 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra,
2017, p 16.14.

69 The status of 29.2 per cent of victims was unknown.

70 Among the ongoing risks associated with out-of-home care settings are those relating to the vulnerability of children in
care (many of whom have already experienced abuse and/or neglect) and the power differential that can exist between
adult caregivers and the children in their care – see M Irenyi, L Bromfield, L Beyer & D Higgins, *Child maltreatment in
organisations: Risk factors and strategies for prevention*, Australian Institute of Family Studies, Melbourne, 2006, p 6;
K Kaufman & M Erooga, *Risk profiles for institutional child sexual abuse: A literature review*, report prepared for the
Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 70.

71 A Uliando & D Mellor, ‘Maltreatment of children in out-of-home care: A review of associated factors and outcomes’,
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73 M Irenyi, L Bromfield, L Beyer & D Higgins, *Child maltreatment in organisations: Risk factors and strategies for
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L Bromfield, S Chan, G Maddock, K Menzies, M O’Connell, G Pearson, R Walker & M Wright, *Aboriginal and Torres Strait
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Responses to Child Sexual Abuse, Sydney, 2017. G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse
in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse,
Sydney, 2016.

- 74 Australian Institute of Family Studies, *The prevalence of child abuse and neglect*, Australian Institute of Family Studies, Canberra, 2017: Studies that comprehensively measured the prevalence of child sexual abuse found that males had prevalence rates of 1.4–7.5% for penetrative abuse and 5.2–12% for non-penetrative abuse, while females had prevalence rates of 4.0–12.0% for penetrative abuse and 14–26.8% for non-penetrative abuse. See also S Smallbone, W Marshall & R Wortley, *Preventing child sexual abuse: Evidence, policy and practice*, Willan, Devon, 2008, pp 11–12: ‘Most victimisation prevalence estimates indicate that girls are much more at risk of sexual abuse than are boys.’ Australian Bureau of Statistics, *Personal safety Australia 2012*, cat no 4906.0, ABS, Canberra, 2013: This study also indicates that many more girls than boys are victims of child sexual abuse in Australia.
- 75 P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 32.
- 76 K Kaufman & M Erooga, *Risk profiles for institutional child sexual abuse: A literature review*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 7.
- 77 K Kaufman & M Erooga, *Risk profiles for institutional child sexual abuse: A literature review*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 28.
- 78 Name changed, private session, ‘Ella’.
- 79 Name changed, private session, ‘Ella’.
- 80 Name changed, private session, ‘Brad Douglas’.
- 81 Name changed, private session, ‘Brad Douglas’.
- 82 P Anderson, M Bamblett, D Bessarab, L Bromfield, S Chan, G Maddock, K Menzies, M O’Connell, G Pearson, R Walker & M Wright, *Aboriginal and Torres Strait Islander children and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 26.
- 83 Productivity Commission, *Report on government services 2017*, Volume F, Chapter 16, Australian Government, Canberra, 2017, Table 16A.18; as at 30 June 2016, 36 per cent of children in out-of-home care were Aboriginal or Torres Strait Islander: see Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, cat no CWS 60, Australian Institute of Health and Welfare, Canberra, 2017, p 52.
- 84 Aboriginal and Torres Strait Islander status was not always volunteered in a private session: 29.2 per cent of private session attendees did not say whether they identified as Aboriginal and Torres Strait Islander or not.
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- 86 C Tilbury, ‘The over-representation of Indigenous children in the Australian child welfare system’, *International Journal of Social Welfare*, vol 18, no 1, 2009, p 61; T Libesman, *Cultural care for Aboriginal and Torres Strait Islander children in out of home care*, Secretariat of National Aboriginal and Islander Child Care, North Fitzroy, 2011, p 53.
- 87 P Anderson, M Bamblett, D Bessarab, L Bromfield, S Chan, G Maddock, K Menzies, M O’Connell, G Pearson, R Walker & M Wright, *Aboriginal and Torres Strait Islander children and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 26.
- 88 G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 44; L Jones, MA Bellis, S Wood, K Hughes, E McCoy, L Eckley, G Bates, C Mikton, T Shakespeare & A Officer, ‘Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies’, *The Lancet*, vol 380, no 9845, 2012; P Sullivan & J Knutson, ‘Maltreatment and disabilities: A population-based epidemiological study’, *Child Abuse & Neglect*, vol 24, no 10, 2000.
- 89 P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 39.
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- 92 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 16.
- 93 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 8.
- 94 M Irenyi, L Bromfield, L Beyer & D Higgins, *Child maltreatment in organisations: Risk factors and strategies for prevention*, Australian Institute of Family Studies, Melbourne, 2006, p 9.
- 95 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 38.
- 96 T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 39; M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 18.
- 97 T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 40.

- 98 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 61.
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- 101 Name changed, private session, 'Georgie Helen'.
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- 103 K Kaufman & M Erooga, *Risk profiles for institutional child sexual abuse: A literature review*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 71. P Parkinson & J Cashmore, *Assessing the different dimensions and degrees of risk of child sexual abuse in institutions*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 71.
- 104 K Kaufman & M Erooga, *Risk profiles for institutional child sexual abuse: A literature review*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 71.
- 105 M Proeve, C Malvaso & P DelFabbro, *Evidence and frameworks for understanding perpetrators of institutional child sexual abuse*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 63.
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4 Institutional responses to child sexual abuse in contemporary out-of-home care

4.1 Overview

In this chapter we outline what we heard about the institutional responses to child sexual abuse in contemporary out-of-home care. It describes what we were told in our case studies, private sessions and policy consultations, along with the findings of our commissioned research and external research, about how children were not adequately protected from sexual abuse in out-of-home care, and the ongoing risks that have not yet been adequately addressed.

Government ministers and departments or non-government agencies are responsible, directly or indirectly, for almost every facet of the lives and wellbeing of the majority of children in out-of-home care, who may be in care for significant periods of their childhoods. As such, all child protection departments and out-of-home care service providers have a unique responsibility to keep these children safe.

As discussed in detail in Volume 6, *Making institutions child safe*, child safe institutions create cultures, adopt strategies and take action to prevent harm to children, including child sexual abuse. We have adopted the Australian Children's Commissioners and Guardians' definition of a child safe institution as one that consciously and systematically:¹

- creates conditions that reduce the likelihood of harm to children
- creates conditions that increase the likelihood of identifying and reporting harm
- responds appropriately to disclosures, allegations or suspicions of harm.

We identified numerous ways that the contemporary out-of-home care system has not adequately addressed the conditions that increase the likelihood of harm to children in care. We examined ways in which the institutional responses to incidents or risk of child sexual abuse in contemporary out-of-home care have failed to encourage the identifying and reporting of sexual abuse, and the need to improve the response to disclosures, allegations or suspicions of abuse.

Many of these responses are common to other types of institutions and are examined in detail in Volume 6, *Making institutions child safe* and Volume 7, *Improving institutional responding and reporting*. However, there are certain features of out-of-home care that have influenced the incidence and identification of child sexual abuse and have magnified the impact of failed responses. These features are discussed in this chapter.

Previous inquiries² and earlier research³ have long identified the risk to children in care from adults in trusted positions of authority and power. Over the course of the Royal Commission, community understanding about the risks of sexual exploitation of children has increased. We note, in particular, the inquiry into child exploitation in Rotherham, England, which reported that perpetrators targeted children's residential units and residential services for care-leavers,⁴ and the inquiry by the Victorian Commission for Children and Young People into the abuse or exploitation of children in residential care.⁵ Our work has extended the knowledge of the risks posed to vulnerable children in institutional settings by exploitative adults. Our work has also demonstrated that child sexual abuse prevention strategies must recognise and address the risks posed by children with harmful sexual behaviours.

4.2 The out-of-home care system response to child sexual abuse

Each state and territory's out-of-home care system – including its regulatory and oversight measures – is complex. We have looked at these systems as they currently operate and considered where they can be strengthened to reduce the risk of child sexual abuse.

There is now greater awareness of the many risks that face vulnerable children who have been removed from their families and communities to be placed in out-of-home care. In recent years, a number of regulatory and other reforms have been introduced to address these risks. However, we have learned that there are deficiencies in at least some jurisdictions that limit the effectiveness of regulatory and oversight mechanisms aimed at the protection of children.

As out-of-home care is the responsibility of states and territories, there will always be some variation in the requirements imposed by each jurisdiction in relation to carers registers, accreditation of service providers, the sharing of information, and the independent oversight of institutional responses to disclosures of child sexual abuse. Nonetheless, the Royal Commission was established with an expectation that all Australian children should be protected from sexual abuse and other forms of abuse, and that our work should include consideration of measures to address systemic failures by institutions to protect children, regardless of where they live. The need for institutions in all jurisdictions to develop and apply minimum standards in relation to keeping children safe is particularly important in out-of-home care, where children are removed from their families of origin and placed in the care of the state.

We examine the factors that contribute to the ongoing risk of sexual abuse of children in out-of-home care, the barriers faced by victims in disclosing abuse, and inadequacies in institutional responses to disclosures. Risks associated with particular institutional settings and certain cohorts of children are also examined.

Our recommendations aimed at improving the safety of children in out-of-home care are set out in Chapter 5. They reflect the Child Safe Standards discussed in Volume 6, *Making institutions child safe*, while addressing issues that specifically apply to children in out-of-home care settings.

4.2.1 Accreditation and authorisation of service providers and carers

Minimum standards of accreditation are essential to ensuring the quality of services and service providers. Since the 1990s, many of the responsibilities for delivering out-of-home care services have been transferred from government to non-government agencies. Consequently, there is a growing need for transparent processes to ensure that these agencies are accountable for the services they have agreed to deliver. As the New South Wales Children's Guardian states:

An accreditation and quality improvement program provides a formal framework based on accepted standards for service delivery. Undergoing accreditation and quality improvement can help agencies to:

- have a common understanding of good practice
- work towards quality improvement
- make systematic judgements about performance against standards
- encourage greater scrutiny of outcomes and quality by service users.⁶

The following case study highlights the importance of ensuring that there are appropriate checks in place to ensure all agencies providing out-of-home care services – and government bodies with responsibilities for overseeing those service providers – understand why service delivery standards are in place. The facts in this case demonstrate the need for agencies that provide out-of-home care services to be active in applying those standards to all aspects of their operations.

The dynamic nature of risk

Case Study 1: The response of institutions to the conduct of Steven Larkins (Scouts and Hunter Aboriginal Children's Service) describes the limitations of the regulatory framework in New South Wales as it was being introduced over a 10-year period. Between 2003 and 2010, it was found that the Hunter Aboriginal Children's Service (HACS) failed to meet new accreditation standards. Despite HACS' failure to meet the standards, the Children's Guardian gave evidence that at the time she could not terminate the interim accreditation of any agency in the Guardian's Quality Improvement Program because of the 10-year transitional arrangements.⁷

Steven Larkins, a senior manager at HACS, was found by the then NSW Department of Community Services 'to be a risk to children on the basis of the information it had on 11 November 2003'.⁸ Yet, as late as July 2010, the Children's Guardian was seeking evidence from HACS about its policies and procedures relating to the board of management, staff supervision and support, and staff training and development. Had appropriate systems been in place, it is likely that the service's management committee would have recognised that Larkins should not have been working directly with children long before his arrest for child pornography offences in 2011.⁹ The Royal Commission found that:

Hunter Aboriginal Children's Service Management Committee members who gave evidence were inexperienced in organisational management and lacked knowledge of governance and legislative and regulatory frameworks relevant to Hunter Aboriginal Children's Service.¹⁰

Those who had authority to subject Larkins's conduct to proper scrutiny missed multiple opportunities to do so, despite at least some members of the management committee later admitting they had concerns about him.¹¹ Full accreditation would have required the agency to demonstrate its management competence and compliance with relevant frameworks.

Accreditation provides a framework to support compliance with relevant legislative and regulatory requirements. In conjunction with training, accreditation can also help staff understand their responsibilities to report concerns about child safety and ensure appropriate action is taken. As noted in Table 12.9, accreditation requirements vary widely from one jurisdiction to the next. The gaps that persist in at least some jurisdictions highlight the need for national minimum accreditation standards to reduce the likelihood of these kinds of problems occurring in other out-of-home care services.

Accreditation of out-of-home care service providers

Submissions to our *Consultation paper: Institutional responses to child sexual abuse in out-of-home care (Out-of-home care)* noted that the states and territories do not have a standardised accreditation process for government and non-government out-of-home care service providers, as outlined in Table 12.9.

Table 12.9 – Jurisdictional differences in accreditation of out-of-home care service providers

Jurisdiction	Accreditation or authorisation requirements for out-of-home care agencies
NSW	An agency must be a ‘designated agency’ to arrange out-of-home care, whether government or non-government. ^a Accreditation as a designated agency depends on satisfying the Children’s Guardian that the agency complies with criteria set by the Minister. ^b
Vic	The Secretary may register a body as a community service (including in the category of out-of-home care service) if it provides certain children’s services and is able to meet applicable performance standards. ^c
Qld	Residential care may be provided in a departmental care service or a licensed care service. ^d A licence may only be granted if criteria are met, including the suitability of applicants to provide care services, compliance with the legislated Working With Children Check requirements and compliance with the required care standards. ^e
WA	No legislative provisions – a child may be placed with a person who has entered into an agreement with the Minister. ^f
SA	A licence is required to maintain a children’s residential facility. Relevant factors for grant of licence include the suitability, qualifications and experience of certain persons, the facility’s system of management and the suitability of the premises. ^g
Tas	None – the Secretary may provide for the care of a child who is under the guardianship, or in the custody, of the Secretary including by placing the child in the care of any person or any body of persons, corporate or unincorporate, the Secretary considers suitable. ^h
ACT	The Director-General may authorise an entity to exercise daily care or long-term responsibility for a child as a residential care service. ⁱ
NT	None – the CEO may enter into a placement arrangement for a child in the CEO’s care as the CEO considers appropriate, but there are no legislative provisions governing arrangements with a residential care facility. ^j

^a *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 138(1).

^b *Children and Young Persons (Care and Protection) Regulation 2012* (NSW) cls 48(1), 49(1). The Minister has approved the *NSW Child Safe Standards for Permanent Care 2015*.

^c *Children, Youth and Families Act 2005* (Vic) s 46. See also the *Human Services Standards*, gazetted as Department of Health and Human Services Standards, under s 58.

^d *Child Protection Act 1999* (Qld) s 82(c) – (d).

^e *Child Protection Act 1999* (Qld) s 126.

^f *Children and Community Services Act 2004* (WA) ss 3, 15, 79(2).

^g *Family and Community Services Act 1972* (SA) s 51(1) – (2).

^h *Children, Young Persons and Their Families Act 1997* (Tas) s 69(1)(b).

ⁱ *Children and Young People Act 2008* (ACT) s 520(1) – (2).

^j *Care and Protection of Children Act* (NT) s 78(1). The Care and Protection of Children (Placement Arrangement) Regulations (NT) do not deal with residential care facilities.

Most jurisdictions do not have licensing or accreditation frameworks in place to formally require out-of-home care service providers to demonstrate their capacity to provide services to a set of agreed minimum standards. The requirements for accreditation vary across jurisdictions, but in nearly all cases a government department both assesses and authorises out-of-home care service providers.

In Victoria, the Department of Health and Human Services (DHHS) requires funded agencies to be assessed against its DHHS standards (primarily focused on service delivery) and governance standards set by a department-approved accreditation body.¹² The service provider contracts an accreditation body to conduct a full assessment against both sets of standards every three years, and a mid-point audit every 18 months. The DHHS uses the results to determine whether to register the service provider. As such, the DHHS remains the registering body as well as conducting 'spot audits' of residential care and, since April 2017, foster care services using sections of the DHHS standards.¹³

In New South Wales, the Children's Guardian, an independent statutory body, is responsible for both audits and accreditation. Provisional accreditation by the Children's Guardian allows agencies to provide statutory out-of-home care services for a period of three years. Full accreditation – available only to agencies that already place children in statutory out-of-home care – can be for one, three or five years.¹⁴

Submissions to our consultation paper on out-of-home care raised the potential for conflicts of interest if funding agencies are also responsible for accreditation. Wesley Mission's submission set out the possible conflicts:

Wesley agrees that there should be an independent body in each state and territory which is adequately resourced to monitor compliance against the standards and assess and grant applications for accreditation. The current situation where government departments have the roles of service provider, funder and regulator gives rise to conflict of interest and does not most effectively promote the best interests and safety of children and young people.¹⁵

There was considerable support in submissions for this proposition.

Submissions also supported the need for government service providers to be accredited to the same standards as non-government agencies.¹⁶ As at 2017, this is only the case in New South Wales.

Submissions indicated that there were gaps in the current systems for accreditation across jurisdictions, and concerns if the National Standards for Out-of-Home Care were to be adopted as the minimum standards. For example, in its submission, Anglicare Northern Territory stated:

A particular concern for service quality in out-of-home care in the NT is the lack of jurisdictional standards and registration requirements for providers; both government and non-government. Agencies are asked to comply with the national out-of-home care standards but these are not designed to be used at the service level. Anglicare NT would like to see the NT develop quality accreditation processes with the same rigour and depth of those used in NSW and Victoria.¹⁷

The Uniting Church in Australia’s submission made a similar point:

UCA supports the accreditation of all OOHC [out-of-home care] providers, including government providers, to a national minimum standard, and believes it is critical that the bar not be set too low in terms of minimum standards (noting that the National Standards for OOHC are quite broad).¹⁸

Our recommendations for mandatory accreditation of all out-of-home care service providers by an independent body are discussed in Chapter 5.

Screening and authorisation of carers

All jurisdictions require fairly extensive screening and authorisation of out-of-home carers although the requirements vary between jurisdictions and across different types of carers. We were told that inconsistent standards and processes can lead to some children being less safe than others. Children and Young People with Disability submitted that:

an important consideration is to ensure consistency of expectations, policies and practice. All children who are involved in organisations and institutions have the right to safety, protection and a high standard of care and this shouldn’t differ depending on the setting or service provider. The roles and responsibilities of the different parts of the OOHC system should therefore be oriented to ensuring consistency and compliance.¹⁹

Foster carers

We commissioned research to compare how each state and territory screens, assesses, selects, trains and supports caregivers. As reported in this research, the screening of foster carers typically includes:²⁰

- an identity check
- a Working With Children Check (WWCC), Working With Vulnerable People Check or similar
- a National Police Check
- a health check
- a referee check.

More extensive screening checks are conducted in New South Wales, Victoria, Western Australia and South Australia where a ‘community services check’ is also required – this being a review of information held by government departments relating to allegations of child abuse. For example, in New South Wales this would include a check for any ‘Risk of Significant Harm reports and allegations of reportable conduct’.²¹ In these jurisdictions, checks are also made of

the carers registers to ‘establish any history relevant to a prospective carer’s abilities to foster a child and, in particular, whether a prospective carer has previously been de-registered by another agency’.²² Participants from other jurisdictions noted the limitations of the WWCC and National Police Check, specifically that the existence of a domestic violence order would not be flagged in the National Police Check unless the order had been breached.²³

Following the initial screening, there is considerable variability across jurisdictions and between different out-of-home care service providers in terms of how the suitability of potential foster carers is assessed. Broadly, these carer assessment processes involved:²⁴

- mandatory use of a particular assessment tool, or
- an assessment tool being stipulated as a minimum, with agencies given flexibility to use other assessment tools, or
- no stipulation of how assessments are to be performed other than that potential carers are to be ‘properly assessed’.

Other variations in the requirements for assessing potential foster carers included differences in the levels of experience and skill of assessors, and some non-government participants reporting carer assessment processes that were much more extensive than the most commonly used tools. Participants in the research viewed the assessment process as ‘a crucial component of ensuring safe, therapeutic and sustainable care for a child in need’.²⁵ Submissions to our consultation paper on out-of-home care, however, noted that current assessment frameworks do not necessarily include the most current knowledge about practices to improve children’s safety, and that regular review and updates of assessment tools is essential.²⁶

There are also cross-jurisdictional variations in whether the relevant child protection department or the out-of-home care service provider authorises carers, and in the requirements for training carers prior to the placement of a child. We have learned, for example, that providers of ‘purchased home-based care’ – which is used in the Northern Territory for nearly one-third of the children in out-of-home care – are only required to hold a Certificate III in Early Childhood Education and Care and that this qualification is required for them to provide long day care services with there being no requirement for training or expertise in the care for children of any age in out-of-home care. Neither are these providers screened or authorised as out-of-home care carers.²⁷

Submissions to our consultation paper on out-of-home care supported the need for nationally consistent minimum standards of screening and authorisation of foster carers as a means of improving the safety of children in out-of-home care. (See Section 5.2.3, ‘Accountability for safety of children in out-of-home care’.)

Kinship/relative carers

In submissions and in evidence for *Case Study 24: Preventing and responding to allegations of child sexual abuse occurring in out-of-home care (Out-of-home care)*, we heard that although kinship/relative carers are expected to undergo screening and assessment procedures similar to those used for foster carers, in practice the checking of kinship/relative carers by those responsible is often far less rigorous. We heard that this is sometimes due to the need of child protection departments to place a child urgently, with kinship/relative placements being preferred, but it appears that follow-up checks are not always done to ensure the ongoing suitability of the carer. For example, as noted in Chapter 2, until recently kinship/relative carers in Victoria were exempt from the Working With Children Check process.²⁸ As one submission commented:

In my experience, I've noticed that there are inadequate checks being undertaken for kinship carers (in culturally and linguistically diverse and Aboriginal and Torres Strait Islander communities) when compared to the processes in place for other carers.²⁹

This approach was not acceptable to those who gave evidence and made submissions to us. Ms Dana Clarke, Chair of the Aboriginal Child, Family and Community Care State Secretariat said:

Quite often kinship placements are used for expedience when, in reality, they aren't suitable. They aren't suitable, but because they have the title 'kinship' in front they are deemed as being suitable and I guess it is quicker to place a child into kinship placement than it is to place them into a foster care placement, which initially you want the children to go to family, but they have to be suitable family, because to keep kids safe, they need to be with safe adults, but quite often family sits in front of safety.³⁰

There was agreement that both in policy and in practice, the same or similar standards should apply to all carers in determining their suitability to become carers, but that there needed to be some flexibility in applying these requirements. For instance, we were told that old criminal convictions for minor offences should not be given more relevance than subsequent years of stable employment and good citizenship.³¹

It has been reported that Aboriginal and Torres Strait Islander people are more likely to provide care than non-Indigenous people³² – 'something that we've done for centuries is foster care'.³³ This is also reflected in data showing that 43.6 per cent of Aboriginal and Torres Strait Islander females reported that they provided unpaid childcare to either their own children and/or other children in the two weeks preceding the 2011 Census, whereas 34.2 per cent of non-Indigenous females reported providing unpaid childcare. While fewer males undertook unpaid caring, the figure was higher for Aboriginal and Torres Strait Islander males (29.1 per cent) than non-Indigenous males (25.8 per cent).³⁴ The researchers also noted that a large proportion of these unpaid Aboriginal and Torres Strait Islander family carers live in regional and remote areas.³⁵

However, despite their importance in the contemporary out-of-home care system, there are not enough Aboriginal and Torres Strait Islander kinship carers available to care for all Aboriginal and Torres Strait Islander children placed in out-of-home care.³⁶

We were told that the assessment of kin in Aboriginal communities in the Northern Territory is problematic partly due to geographic isolation, which means some workers making the assessments do so very quickly as they have no accommodation and want to move on quickly, and partly due to other issues such as people in the community not having ready access to identification documents.³⁷

We were also told that community-based Aboriginal and Torres Strait Islander child welfare agencies were likely to be able to recruit and support kinship/relative carers more readily than mainstream agencies, not least because of their connection to community and their understanding of families in the community.

We know the community ... we actually know who is suitable and who is not within the community. Just because you put your hand up to say you are kin, as I said, doesn't mean that you are a suitable candidate to have children placed with you. So, what – I think the uniqueness of Aboriginal agencies and the uniqueness of us being able to do those assessments is that we have the connectedness to the community. We know what is suitable and who – and to be informed. You know, kids need to be on their community and need to be raised there, but they need to be raised by people who can raise them and give them every life chance. I think having workers and people who come from that community informs that.³⁸

We heard considerable support for the development of specific models of screening, assessment and authorisation of kinship/relative carers from both mainstream out-of-home care service providers and Aboriginal and Torres Strait Islander agencies.

Kinship/relative carers face different challenges than those in general foster care as identified by the Commission. [Northern NSW Local Health District] would support the development of a 'kin-specific' approach to a culturally safe and appropriate kinship/relative carer assessment and recruitment that is differentiated from foster care approaches.³⁹

Our recommendation for this type of approach is discussed in Chapter 5, as is the need for support that is at least consistent with that provided to foster carers, and meets the particular needs of kinship/relative carers. (See also Section 4.4, 'Response to risks in particular institutional settings'.)

What 'Jane' told us about being placed, along with her sister, into the care of her grandparents in 1999 demonstrates the critical importance of ensuring that any minimum standards applied to kinship/relative carer placements include a guarantee that carers will be properly screened and assessed. In the case of kinship/relative care placements that commence as an emergency placement, screening and assessment could be incorporated into follow-up procedures.

What 'Jane' told us

'Jane' told us she was five years old and her sister, 'Taylor', was 12 years old when their mother went to jail in 1999. As their father was unable to look after them, a court ordered that the girls be placed with their grandparents.

'Jane' said that her grandfather was, at the time, a sex offender who had been convicted of sexually abusing one of his own daughters. This may have been 'Jane's' aunt or her mother. The court order stipulated that the child protection department oversee and supervise the placement closely to ensure the grandfather was never alone with the girls. 'Jane' recalled seeing a caseworker only once during the nine years she was sexually abused by her grandfather, a visit that was supervised by the grandmother, who was complicit in the abuse.

'Taylor' left home when she was 16 years old and reported the grandfather's abuse to police, but withdrew the statement before finalising it. 'Jane', then 9 years old, was still living with the grandparents but was not questioned by the police or the child protection department.

'Jane' said her grandfather controlled her activities and did not allow her to spend time with friends. She said he had threatened her and had also told her that no one would believe her if she tried to tell someone about the abuse. 'Jane' didn't disclose the abuse until 2010 when the grandparents were being assessed to be carers for a baby, 'Jane's' niece.

'Jane' was unable to bear the thought of her niece coming to live with the grandparents too, so she walked into an office of the child protection department and disclosed her nine years of abuse. This time the response was prompt and appropriate, with the grandfather being charged, found guilty of sexual assault and sentenced to 12 years' imprisonment.⁴⁰

Residential care

The large residential institutions of the past posed significant risks of child sexual abuse perpetrated by adults, especially adults who held some responsibility for children's wellbeing (see Volume 11, *Historical residential institutions*, for a detailed discussion of these risks and the many accounts given by survivors of child sexual abuse in these settings). Consequently, many prevention strategies have focused on attempting to screen out potential adult perpetrators.

We heard that, since the 1990s, strategies to prevent child sexual abuse in residential care have aimed to reduce the risks of predatory adults obtaining unsupervised access to children in residential care.⁴¹ These include the introduction of systems to screen staff, stricter incident reporting requirements, rules that limit adults' unsupervised access to children, the introduction of complaint handling mechanisms and external scrutiny and oversight, and greater community awareness and understanding of the risks of abuse.⁴²

All states and territories now require residential care staff to undergo basic probity checks. These vary, but usually involve an identity check, a Working With Children Check, National Police Check and referee checks.⁴³ Only a handful of jurisdictions stipulate that residential care staff must be approved as authorised carers. In New South Wales, a designated agency may authorise suitable individuals as 'authorised carers', but only after the person has complied with certain requirements.⁴⁴ In Victoria, out-of-home care services 'must have regard to the prescribed matters before employing or engaging a person as a carer for children placed with the service'.⁴⁵

Despite these and other reforms, significant risks remain. Compared with children in home-based care, children in residential care are often more vulnerable, have higher levels of complex psychological and behavioural problems, and tend to be older, especially if they have a history of multiple placements.⁴⁶ For these reasons, suitability and pre-care assessment and training requirements for residential care staff should be more stringent, not less. In addition, as discussed in Chapter 5, many residential care options are non-therapeutic and not well suited to caring for children with complex needs and behaviours. There is a need for national minimum assessment and training standards to be established for residential care workers. These minimum standards should also be applied to 'emergency' options that allow children to be placed with carers in motels or caravan parks,⁴⁷ or with registered childcare providers.⁴⁸

For carers to be effective in protecting children from sexual abuse in residential care settings, we heard they need to understand the risks posed by:⁴⁹

- potential adult perpetrators within residential care facilities
- problematic and harmful sexual behaviours among young people
- the threat of sexual exploitation by adults outside of residential care.

Through our work, we learned that a comprehensive approach to preventing child sexual abuse in residential care must incorporate strategies to address all three potential sources of harm.

Despite repeated attempts through tighter screening and other preventative measures to exclude adult perpetrators from residential care facilities, risks remain. For example, children have reported that ‘sometimes workers were “creepy” and had poor boundaries (disclosing things that they should keep private)’.⁵⁰ Children also talked about the discomfort caused when staff singled out favourite individuals for special attention, the lack of privacy in some residential care units, and the ongoing risks of potential perpetrators developing inappropriate relationships and taking sexual advantage.⁵¹

In relation to the potential for children to be sexually harmed by other children, children in residential care observed that their peers often engaged in sexual behaviour before they were emotionally equipped to do so. They felt that peers seeking sex was not necessarily problematic, but often became a problem if a young person’s choice to have, or not to have, sex was undermined by intense pressure, violence or threats.⁵² We also learned that the risk of sexual exploitation escalated when adults outside of residential care were able to take advantage of young people’s need to feel as though they were cared for, their naivety about relationships or their vulnerability to being manipulated through gifts and other enticements.⁵³ (See Section 4.4.1, ‘Risks in residential care’.)

4.2.2 An appropriate response to child sexual abuse in out-of-home care

The priority in responding to the sexual abuse of a child in contemporary out-of-home care is that the child be protected from further harm and supported to minimise any ongoing impacts of the abuse. Systems need to be in place to enable the proper investigation of allegations and appropriate action if the abuse is substantiated, including the prosecution of perpetrators.

All states and territories have policies and procedures in place to assist people to report child abuse or neglect and to ensure an appropriate response. We understand that, while the jurisdictions vary in thresholds for reporting suspected abuse of a child and in the required responses of out-of-home care service providers and child protection departments, the overall framework for an institutional response to reports of child abuse in out-of-home care is consistent across jurisdictions.

Table 12.10 synthesises what we have learned from out-of-home care service providers about an appropriate institutional response to a disclosure of sexual abuse by a child in care. Clarifying the different responsibilities of each participant provides a framework in which we discuss what we have learned about institutional responses and where those responses should be strengthened.

Table 12.10 – Framework for institutional responses to a report of child sexual abuse

Person to whom the child discloses	<ul style="list-style-type: none"> • immediately contacts the out-of-home care service provider and directly reports the allegation to the child protection department^a • supports the child, including telling them what action they have taken • supports all other children in the placement.
Out-of-home care service provider – caseworker	<ul style="list-style-type: none"> • reports/records the risk of harm to the child protection department if not already done so • immediately begins to assess ongoing risk to the child and their support needs – for example, medical attention, removal from the placement or therapeutic treatment • provides immediate comfort and support to the child, including telling them what action has been taken and what is likely to happen next • supports carers, where appropriate, and any other children in the placement and assesses risks to these children • reports to their manager • ensures the child's family is informed, as appropriate.
Out-of-home care service provider – manager	<ul style="list-style-type: none"> • contacts the relevant child protection department to coordinate a response • contacts the police and ensures cooperation with any instructions • supports the caseworker to make medical or other appointments, as necessary • makes an internal critical incident report, ensures appropriate investigation and remediation of identified risks, and reports as appropriate to senior management/boards.
Child protection department	<ul style="list-style-type: none"> • assesses the risk to the child and an appropriate response to that risk, including support to the out-of-home care service provider • assists in finding emergency respite for the child and arranging for any immediate treatment, should this be necessary • ensures cooperation with the police • facilitates, where necessary, the exchange of relevant information.
Police	<ul style="list-style-type: none"> • ensure the safety of the child victim, either directly or with the cooperation of the out-of-home care service provider • investigate the alleged sexual abuse and takes appropriate action, including preparing a brief of evidence to assist in the prosecution of the offender, if warranted.

^a All states and territories have identified mechanisms for reporting allegations, risks and/or suspicions that a child is being abused, most of which are centralised intake services.

We have learned that investigations into disclosures, or into other reports of child sexual abuse in out-of-home care, are dealt with inconsistently across jurisdictions. Some investigations are conducted by police, some by investigation units within child protection departments, some by the out-of-home care service provider including a child's case manager, and some with a combination of these. We heard there are benefits to a collaborative, multidisciplinary response and that this approach has been adopted by a number of jurisdictions with a view to ensuring appropriate investigation and minimising the risk of further sexual abuse of children.

We were told, for example, that linking disciplines in the investigation of the sexual exploitation of children in out-of-home care in Victoria has led to the use of intervention orders against potential perpetrators, which were previously available to police, but had not been used for child protection purposes.⁵⁴ We also heard that co-locating police and child protection workers had multiple other benefits. The Deputy Secretary, Service Design and Operations, Department of Human Services in Victoria told us:

Police involved now reflect that they feel they have learnt a lot of social work practice, which has been extremely effective in making the young people feel safe enough to actually disclose more about what has occurred so that police can proceed with their investigation, but that also means that we're in a better position to provide the support that they need after disclosure.⁵⁵

We heard that multidisciplinary centres in Victoria are intended to create 'an environment which provides safety, support and access to justice'.⁵⁶

In New South Wales, the Joint Investigation Response Team (JIRT) involves collaboration between the NSW Police Force, Department of Family and Community Services (FACS) and NSW Health in the investigation of child sexual abuse. We were told JIRT uses staff with specialist training when interviewing children, and care is taken 'to not re-traumatise a child or young person whilst still eliciting disclosures where possible'.⁵⁷ We heard that interviews are conducted in a non-threatening environment intended to make a child feel sufficiently comfortable to disclose sexual abuse, and that techniques are used that allow a child to tell their story without being led. In addition, the child and non-offending family members are offered crisis support from NSW Health clinicians.⁵⁸ We were also told that JIRT would liaise with the child's out-of-home care caseworker during the investigation, 'as they are often the one with a relationship with the child or young person and the best person to provide the ongoing support'.⁵⁹

The Child Protection Systems Royal Commission in South Australia proposed that a unit for investigating abuse and neglect in out-of-home care should:

be staffed by specialist investigators, in a multidisciplinary team encompassing both child protection and law enforcement expertise ... the combined expertise available in a multidisciplinary team should provide a collaborative environment where investigations and decision making are informed both by child protection principles and the investigative principles used in law enforcement.⁶⁰

For further discussion of specialist, multidisciplinary and co-located policing responses, see our *Criminal justice* report.⁶¹ It is our view that combined child protection and law enforcement expertise, complemented by the expertise of health professionals, is a valuable approach to the investigation of allegations of child sexual abuse in out-of-home care.

4.2.3 Oversight of institutional responses

The out-of-home care sector is highly regulated (at least on paper). Because of this, some elements of the required response to reports of child sexual abuse vary according to who is alleged to have committed the abuse. When a child raises an issue of alleged sexual abuse by a carer or youth worker, it is important that independent mechanisms of complaint investigation or oversight are provided for, which sit outside the agency responsible for the child's care. We heard there were benefits to mandatory systems of reporting conduct in out-of-home care, particularly where disclosures are not made directly by victims or by others on their behalf. We heard that reporting mechanisms that open institutional cultures to the scrutiny of external agencies can improve the safety of children in out-of-home care settings. As the Deputy NSW Ombudsman said, the benefit of a mandatory system is that it sends 'a very clear message that this sort of behaviour [child sexual abuse] is unacceptable and it needs to be not swept under the carpet and it needs to see the light of day'.⁶²

Reporting to funding agencies

In addition to any statutory reporting obligations, the contractual agreements between funding bodies and service providers usually require the immediate notification of any suspected or actual evidence of abuse, including requirements to advise the funding body of any complaint or allegation about the health, safety, abuse or risk to a child in care. Contracts often also stipulate requirements to report any allegations about the governance, financial accountability or criminal activity of the service provider, any failure to meet basic service standards or client needs, or any serious concerns about the management or financial viability of the service provider.⁶³

Reporting to external/oversight agencies

All states and territories have established independent bodies, such as children's guardians or commissioners, to oversee out-of-home care systems. The regulatory responsibilities of these bodies vary, ranging from accreditation and monitoring of out-of-home care agencies in New South Wales and monitoring of out-of-home care arrangements in South Australia, to more general monitoring, protection and advocacy in other jurisdictions. In the Australian Capital Territory, the Public Trustee is also responsible for investigating complaints about the care provided to children and young people.

The Senate Community Affairs References Committee's 2015 report on out-of-home care recommended that the Council of Australian Governments (COAG) develops and implements nationally consistent powers for independent child commissioners and guardians to:⁶⁴

- review individual out-of-home care cases
- address complaints and concerns by children and young people
- ensure the voice of children and young people is heard in all decision-making processes about placements and case planning
- provide community visitors to visit all out-of-home care placements.

In Australia, independent oversight of institutional responses to complaints of child abuse and neglect across multiple sectors is provided by reportable conduct schemes in New South Wales, Victoria and the Australian Capital Territory.

This scheme is discussed in detail in Chapter 4 of Volume 7, *Improving institutional responding and reporting*, in which we recommend that all state and territory governments establish nationally consistent reportable conduct schemes based on the New South Wales model.

4.3 Factors contributing to child sexual abuse in contemporary out-of-home care

While we acknowledge that much work has been done since 1990 to improve the safety of children in contemporary out-of-home care, we know that systems can fail, and incidents and accidents can occur. This can be the result of unsafe acts by individuals – whether deliberately or in error – or else arise due to the failure of preventative measures.⁶⁵ No systems are perfect and even the most competent individuals can make mistakes – there is, however, little room for error when caring for some of our most vulnerable children.

Certain features of institutions and institutional roles can facilitate or enable sexual abuse of children to occur. As discussed in Volume 2, *Nature and cause*, children are more vulnerable in institutions where multiple risk factors exist, as these factors can be interrelated and can also accumulate, increasing the levels of risk to children.⁶⁶ The level of risk within a particular institutional context is influenced by the types of activities and services provided, the physical environment, the characteristics of children in the institution and the management style and structure of the organisation. It is evident that there are high levels of risk inherent in all out-of-home care settings.

Most of the identified risks arising from institutional roles and activities/services are apparent in out-of-home care precisely because of the private settings in which the children live and the close personal relationships carers are intended to develop with the children in their care.

Identified risks include:

- unsupervised, one-on-one access to a child
- providing intimate care to a child or an expectation of a certain level of physical contact
- the ability to influence or control aspects of a child's life
- authority over a child, particularly in situations with significant control such as a residential setting
- responsibility for young children
- opportunities to become close with a child and/or their family.

There are risks that apply to all out-of-home care settings – home-based and residential care. These include a number of factors that disrupt the opportunities for children to develop stable and safe relationships with people they can trust: placement instability; frequently shifting care arrangements; and the higher likelihood that children in care, having been separated from their families and friends, 'lack external support networks and have a tendency toward nondisclosure of their negative experiences'.⁶⁷ Some risks are specific to residential care, such as: higher child-to-caregiver ratios; issues associated with managing groups of children with complex needs and histories of abuse and trauma in the same facility; and the likelihood that victims of violence in residential care may have 'round-the-clock exposure to their aggressors'.⁶⁸

The children placed in these sometimes volatile and risky situations are often those with a greater vulnerability to abuse, including sexual abuse. As discussed in Chapter 3, children in out-of-home care can have an increased vulnerability to sexual abuse due to:

- the impact of previous maltreatment on a child's self-esteem, heightening their need for affection and attention, and undermining their capacity to trust others and develop relationships
- loss of connection to family and culture as a protective factor
- not understanding what is abusive or what constitutes a healthy and respectful relationship.

The additional risks for certain cohorts of children in out-of-home care are discussed in Section 4.5.

The risks represented by the inherent power imbalances and complex institutional environments that face children in out-of-home care need to be addressed through organisational management and culture as well as through the selection of appropriate carers. This section focuses on what we have identified as some of the key organisational elements of out-of-home care that need to be addressed.

4.3.1 The need to invest in prevention and early intervention

During our *Out-of-home care* case study, questions were posed about the best strategies for preventing sexual abuse of children in contemporary out-of-home care. Through our public hearings, submissions to our inquiry and our commissioned research, we heard the most effective way to protect children in out-of-home care is to keep them out of this institutional setting:

The best thing that we do and that we can do is to create stability and permanency with the natural family. To the extent that we put effort into really seriously looking at keeping that family together where possible, acknowledging that there are times where that's not possible, I think that's the best prevention.⁶⁹

I think the first thing about risk is we need to be clear about – I think we're not necessarily clear about children coming into care and that we don't do enough work there. Have we got the right children in care? Have we done absolutely everything with this family to ensure that they are able to provide permanency and safety for this child before bringing them in?⁷⁰

The reasons why so many children continue to enter out-of-home care are complex. Although placing children in out-of-home care may sometimes be the only safe option, it appears that some children continue to be removed from their families in circumstances where the timely provision of appropriate supports might have been enough to help the family ensure the safety and wellbeing of the child.⁷¹ For example, we have learned that the failure to properly consider additional supports before removing a child can disproportionately affect families who have a child with disability or a parent with mental illness or other disability, many of whom would greatly benefit from easier access to much-needed services.⁷²

The Australian Institute of Health and Welfare reports that children who were the subject of substantiated reports of abuse in 2016 were more likely to be from the lowest socio-economic areas (36 per cent of all reports) and from geographically very remote areas (23.5 per 1,000 children compared with 6.2 per 1,000 children in major cities).⁷³ In addition, disproportionately high numbers of children and adults with disability are concentrated in low socio-economic areas.⁷⁴

As reported by the Queensland Child Protection Commission of Inquiry, while underlying social problems are not predictive of child abuse and neglect, the strong links support 'the need for a public health approach to child protection'⁷⁵ and an expansion of early intervention and prevention services to reduce the number of children in out-of-home care services.⁷⁶

A recent New South Wales review of out-of-home care highlights some of the systemic issues that can increase the numbers of children entering out-of-home care:

The child protection system responds to immediate crisis, but is not doing enough to address the complex needs of vulnerable children and families to break the intergenerational cycle of abuse and neglect. Vulnerable children and families have needs that cross the boundaries of government agencies. The current approach has not improved the outcomes for children and families with complex needs.⁷⁷

We heard that the lack of a government-wide commitment to early intervention and intensive family support results in a crisis-driven approach and the involvement of the statutory child protection system, which focuses on the removal of children. This applies to child protection services for all children but is particularly evident in the way child protection systems often respond to concerns in Aboriginal and Torres Strait Islander communities.

A 2012 report, *Not one size fits all: Understanding the social and emotional wellbeing of Aboriginal children*, focuses on the need to look at the whole child and not just the presenting problem, particularly in the context of intergenerational and collective trauma:

It is therefore sound child welfare policy to seek active interventions in the social environment which take account of the effects of cultural and societal pressures on children and their environment. Rather than merely treating symptoms, child welfare and therapeutic interventions need to be involved in prevention and providing societal supports and resources to address negative social environments. Such supports need to look at the functionality of the family and the family's community.⁷⁸

In 2016, the Child Protection Systems Royal Commission in South Australia found that 'poor knowledge of culture and parenting practices may lead many non-Aboriginal practitioners to identify child protection concerns where there are none'.⁷⁹ It also found that some child protection practitioners may intervene too late with Aboriginal and Torres Strait Islander families because their fear of being seen as racist prevents them from intervening early and providing intensive family supports.⁸⁰ We heard during our *Out-of-home care* case study that the current focus is on removing children when something goes wrong rather than on supporting families: 'Why can't we put money at the end where we are strengthening families so children aren't removed?'⁸¹

We know that Aboriginal and Torres Strait Islander people are under-represented in universal⁸² and early intervention services, not least because of the limited availability of services that are culturally safe for Aboriginal and Torres Strait Islander peoples dealing with the legacy of the racially discriminatory legislation, policies and practices that created the Stolen Generations.⁸³ We also note the general lack of drug and alcohol, mental health and general health services in regional and remote areas – and sometimes even in outer metropolitan suburbs.

The lack of early intervention and intensive support for families where children are at risk increases the likelihood of Aboriginal and Torres Strait Islander children being taken into care. In its submission to the Royal Commission, the Victorian Aboriginal Legal Service (VALS) identified the risks to Aboriginal and Torres Strait Islander children that increase merely by their removal into out-of-home care:

This increased rate of Aboriginal children that are removed ... axiomatically leads to a risk that they will experience institutional child sexual abuse. There is therefore an impetus to curb the rate of removal in favour of evidence-based policies and programs that aim to support the family to stay together, while acting in the best interests of the child. It is VALS's view that the fewer children that are in out-of-home care, the fewer instances of institutional child sexual abuse that may arise.⁸⁴

Fixing systemic issues that result in Aboriginal and Torres Strait Islander children being removed inappropriately, or removed but not in adherence with the Aboriginal and Torres Strait Islander Child Placement Principle, is a key safety issue. As the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse found in 2007, the fear of the possible removal of a child from the community has been identified as a barrier to reporting child sexual abuse.⁸⁵

In private sessions, we heard from some survivors of child sexual abuse who felt the child protection departments had intervened prematurely in taking them away from their parents when services could have been provided to assist and support their parents.

We heard from 'Shekinah', who believes the physical and sexual abuse she experienced in foster care could have been avoided had more been done to help her parents. She told us her father had been given custody of her and her siblings, but he lost the custody because he kept seeing their mother, which was not allowed. 'Because of that stupid little rule, I went through all the shit I went through. You know what I mean? Parents aren't always bad ... Sometimes people need to look a bit deeper ...'⁸⁶

4.3.2 The need to train and support caseworkers

Systemic factors such as inadequate resourcing of services, insufficient staffing levels, high turnover of staff, and limited staff training and support are risk factors for the sexual abuse of children in out-of-home care.⁸⁷ Using data from the Victorian Department of Human Services, a review of factors associated with risk to children in out-of-home care reported on:

the importance of administrators providing staff with clear expectations and training in how children and adolescents in out-of-home care should be treated, how to manage challenging situations, and how to get support or supervision if required.⁸⁸

We heard in our *Out-of-home care* case study that the challenge of managing the increasing numbers of children in out-of-home care has contributed to inadequate responses to child sexual abuse. Of concern is the reported high turnover of staff in government – and increasingly non-government – out-of-home care services, which means that children in out-of-home care do not uniformly have an allocated or consistent caseworker. A caseworker should be a significant protective adult in the life of a child in out-of-home care. Only by having an understanding of the child and a decent level of rapport would a caseworker be able to identify behavioural changes that may indicate sexual abuse, including grooming, of the child. A known and trusted caseworker would also be in a position to support a child through any investigative or court processes where sexual abuse is identified.

The importance of consistency and continuity in relation to caseworkers is highlighted in the *Report on government services*, which includes proposals to measure the ‘continuity of caseworker’ as ‘an indicator of governments’ objective to provide quality care’.⁸⁹ The report notes criticisms that there is often a high turnover of staff responsible for supervising individual placements, and that ‘a productive, stable working relationship between the caseworker and the child assists to deliver quality out-of-home care services’.⁹⁰ The proposed indicator is yet to be defined but has been ‘identified for development and future reporting’.⁹¹

Caseworkers are central to a child’s care team, and advocate for the child’s safety and development. Research indicates that the quality of the relationships that professionals and carers form with children in care may be key to good outcomes for children.⁹² This was confirmed to us in submissions to our *Out-of-home care* consultation paper⁹³ and in evidence from witnesses in our *Out-of-home care* case study. A member of the Youth Movement Initiative told us:

there’s a lot of worker turnover, which means it’s hard for the young people to build a rapport with the workers, the people who they are involved with on a professional basis. It takes a lot of time to get to know and trust these workers, and then the workers leave and you get a new one and you have to start from scratch which makes it very, very difficult.⁹⁴

The 2017 report of the NSW Legislative Council inquiry, *Child protection*, canvassed issues with recruitment and retention of caseworkers, workload and welfare concerns, organisational culture and the need for a broad workforce strategy to improve the health, safety and wellbeing of the child protection workforce.⁹⁵ The review of the British child protection system conducted by Professor Eileen Munro in 2010–11 contains similar themes. Her reflections on the high turnover of skilled and experienced social work staff focus on high caseloads, the need for cohesive and supportive workplaces and the importance of opportunities for reflective practice.⁹⁶ In addition, Professor Munro’s report states:

Evidence from studies of high turnover amongst social workers indicates that the problem would be reduced if staff were better supported and provided with more opportunities to engage in direct work with children and families rather than referring on to others and being left with burdensome administrative tasks.⁹⁷

Many submissions to the *Out-of-home care* consultation paper noted the particular need to improve the residential care workforce. One submission summarised this challenge:

There are significant challenges in the recruitment and retention of quality staff in the sector due to the relatively low status, difficult conditions and insufficient wages for frontline staff. We would suggest that addressing these issues is a key element of improving retention and will make the meeting of targets around reduced reliance on casual staff much more achievable.⁹⁸

In residential care settings where residents often have higher levels of complex needs and behaviours, children need someone they know and trust, and can turn to, when they are unsafe. In a public hearing for our *Out-of-home care* case study, one young care-leaver told us that it was hard for those in residential care to build rapport with workers who do not stick around.⁹⁹ Another said the instability that children experience in residential care was also evident in other parts of the out-of-home care system: ‘You’ve got worker changeover, you’ve got schools changing, everything keeps changing, the kid ends up not trusting anyone’.¹⁰⁰

In its inquiry into the adequacy of services for children who have been sexually abused or exploited while in residential care, Victoria’s Commission for Children and Young People reported that children in some residential care units can experience up to 22 different direct-care staff in one week.

The ability for any child to form a meaningful relationship in such a setting is highly compromised – let alone a vulnerable child who is living away from family and friends and has a significant abuse and trauma history.¹⁰¹

Several submissions to our consultation paper on out-of-home care expressed concerns about residential care services using ‘labour-hire’ staff (employed by a third party and contracted as necessary to cover shifts or temporary vacancies), many of whom are not necessarily properly trained.¹⁰² Submissions also noted that casual staff can be valuable workers, particularly if an out-of-home care service provider maintains a ‘pool’ of suitably selected, trained and supported workers.¹⁰³ Nonetheless, the use of casual workers may compromise the capacity of service providers to notice changes in behaviour that may indicate sexual abuse.¹⁰⁴

Participants in commissioned research on safety in residential care stated that stability, including low turnover of staff, provided a level of predictability that helped them feel safe. They knew what to expect and felt more at ease with workers they knew.¹⁰⁵

Community and academic groups that made submissions to our *Issues paper 4: Preventing sexual abuse of children in out-of-home care* told us that training in preventing child sexual abuse and responding appropriately to indications of sexual abuse should be mandatory for all staff and volunteers who care for children or work in support roles in care arrangements. We also heard from individuals that training and support for out-of-home care caseworkers, as well as carers, is very important and often under-resourced.

Training needs to be delivered across sectors and jurisdictions to increase the shared language and understanding on issues surrounding child sexual abuse such as grooming, child exploitation etc. Ideally this training would be done at all levels of the organisations so issues are addressed at the frontline and practice, through to policy and standards.¹⁰⁶

As one in every three children in out-of-home care are Aboriginal or Torres Strait Islander, the training that out-of-home care agencies provide to their staff should also equip workers with the knowledge and skills to work effectively with Aboriginal and Torres Strait Islander children and families. Our commissioned research showed that a strong connection to culture and maintaining a positive relationship with a child's biological family can both increase the protective factors for Aboriginal and Torres Strait Islander children.¹⁰⁷ Effective cultural competency training can help agencies to embed cultural safety into their operations, ensure that staff recognise the strengths of diverse family forms, promote empowerment, and create avenues for safe disclosure of abuse.

The Victorian Aboriginal Child Care Agency told us that a child safe organisation provides cultural competency training to: ensure the institution is welcoming; celebrate the cultural identities of children and their families; and actively support strong relationships between children and their extended families, and between Aboriginal and Torres Strait Islander families and the institution.¹⁰⁸ Organisations that employ Aboriginal and Torres Strait Islander workers can support their workers by first acknowledging they carry a 'heavier weight through high rates of personal trauma as a result of pervasive racism and high rates of interpersonal violence' and then by carefully planning supervision and mentoring.¹⁰⁹

The Australian Children's Commissioners and Guardians, *Principles for Child Safety in Organisations* tell us that a child safe organisation 'that respects cultural difference:

- thinks about safety and wellbeing concepts from a cultural perspective
- takes steps to develop cultural competence within the organisation so staff and volunteers can respond in a culturally appropriate manner
- takes guidance from experienced others (for example, seeks advice from recognised Aboriginal or Torres Strait Islander organisations in regards to the needs of children from these backgrounds), and
- approaches family cultural contexts with sensitivity'.¹¹⁰

The Victorian Aboriginal Child Care Agency also told us about the skills required by those who manage child safe organisations:

in a broad framework for safety, those on boards or in management positions should be required to demonstrate respect for Aboriginal culture and an understanding of how a strong cultural identity acts to safeguard Aboriginal children.¹¹¹

The importance of caseworkers being both culturally competent and sensitive to the needs of families was emphasised to us by survivors in our private sessions. ‘Trish’ told us how her childhood experiences of out-of-home care in the 1950s and 60s impacted on her role as a child protection worker as an adult. ‘Trish’ said when she was two years old she was taken from her Aboriginal mother, who was grief-stricken at the time after just losing a baby to illness. ‘Trish’ said she was placed with a non-Aboriginal foster family where she was sexually abused from the age of eight. She said, ‘Mum used to be sitting there at the bus stop, right out the front of the school just waiting for me to arrive so that she could see me’. Her mother was not allowed to approach her.

‘Trish’ stressed the need for caseworkers to treat families with compassion and respect.

I used to always say to the [departmental] officers when I worked with them, ‘When you are walking away with that child on your hip from that woman over there ... look behind and just have a look at that mother. Have a look in her eyes. Just look at her. When is she going to see her kids again? That woman’s got no idea when she’s going to see her kid again. No one believes her, no one listens to her’.¹¹²

4.3.3 The need for a culture that supports identification and disclosure of child sexual abuse

As discussed in Volume 4, *Identifying and disclosing child sexual abuse*, identifying child sexual abuse in institutional contexts – including in out-of-home care – is a critical step in protecting children from ongoing or potential sexual abuse, providing support to children in need, assessing and addressing any harmful sexual behaviours by other children, and holding adult perpetrators accountable. It can also be an important part of the healing process for victims.

Child sexual abuse in institutional contexts can be identified by a victim’s disclosure or by another person identifying either the abuse or indicators of the abuse.

Disclosure can take many forms and occur at any stage in the life of a victim. It can be verbal or non-verbal, accidental or intentional, partial or unclear. Disclosure is rarely a one-off event, and many victims will disclose in different ways to different people throughout their lives. Some victims never disclose. There is often a significant delay between the abuse and disclosure, and many survivors disclose for the first time when they are adults.

Identification, like disclosure, can take many forms. It can occur through the disclosure of another victim of the perpetrator, a witness observing the abuse, a person noticing physical or other evidence of abuse, disclosure of abuse by an adult perpetrator or by a child with harmful sexual behaviours, finding other evidence (for example, child pornography) or adults recognising non-verbal or behavioural clues that a child is being, or has been, sexually abused.

The Royal Commission was told about many significant barriers that needed to be overcome before victims could disclose their experiences of child sexual abuse to another person. We also heard about barriers that needed to be overcome before adults could recognise abuse or indicators of abuse in victims, as well as barriers arising from perpetrator behaviours. Building on our work in Volume 4, *Identifying and disclosing child sexual abuse*, this section focuses on the barriers to disclosing and identifying child sexual abuse in out-of-home care that were commonly reported to us. Some of these barriers are unique to the out-of-home care context, while others are common to at least some other institutional contexts we heard about.

The barriers to disclosing and identifying child sexual abuse that were commonly reported to us can be divided into:

- barriers for the victim
- perpetrator behaviours that create barriers
- institutional barriers.

A positive child-focused culture in an organisation is key not only to protecting children, but also to facilitating identification of abuse and disclosures.

Barriers for the victim

We have learned that some of the key barriers to disclosure for victims of child sexual abuse in out-of-home care are:

- not understanding what constitutes abuse
- not having someone they can trust with their disclosure of abuse
- not feeling safe to disclose
- ambivalence arising from being made to feel special or cared for (by the perpetrator)
- fear of being removed from a placement
- fear of not being heard or believed
- fear of not being treated with respect and dignity.

We also know that children in out-of-home care frequently experience poor self-esteem and that perpetrators actively contribute to the low self-esteem of vulnerable children (this is discussed in more detail in Volume 4, *Identifying and disclosing child sexual abuse*). We acknowledge this as a barrier to children talking generally about their needs and wishes. Much support is required to enable children in contemporary out-of-home care to feel safe in disclosing child sexual abuse.

Not knowing what abuse is

Not knowing what sexual abuse is can increase the vulnerability of children to abuse and may be a barrier to disclosing.

Commissioned research tells us that children in out-of-home care may have limited knowledge about sex and healthy sexual relationships and may not immediately know that what they have experienced is abuse.¹¹³ Studies indicate that a lack of discussion or formal recognition of sexual development in residential institutions can lead to a lack of clarity among children about their sexuality and their own boundaries, given there may be little contact with the ‘normal’ world outside.¹¹⁴ For victims of previous sexual abuse, the effects of prior abuse can also result in heightened vulnerability to further abuse.¹¹⁵ This is consistent with what we heard from victims of abuse in historical residential institutions and is also supported by many of the stories we heard in private sessions from survivors who had not experienced healthy and respectful relationships before their placement in out-of-home care.

In addition, carers may avoid discussing sex and sexual abuse with children because they view it as inappropriate. The research suggests that ‘taboos around frank discussions of sex may create an environment where children are uncertain about what is and what is not appropriate or abusive’.¹¹⁶

In a private session, ‘Jane’ told us that she wished a caseworker had taken her aside and spoken to her, or that someone at school had asked her how things were going:

We had sex education classes, but it never went into abuse. If there’s that knowledge that it does happen and you’re not a disgusting person and it’s not your fault, then it might have been easier for me to talk.¹¹⁷

A participant in commissioned research on safety in residential care pointed to the need for education about sexual abuse for residents so they knew to disclose abuse:

It just comes down to educating them on what sexual assault is because some kids might not understand it or what consent is, so inform them of – if you don’t want it and they do it, they’ve broken the law – so [cut] all the jargon: talk in a language they understand.¹¹⁸

A young woman from the same group in this research project said children in residential care don't know enough about sex and relationships, and needed sex education:

the problem becomes worse because 'resi' don't actually have sex [education]. Kids who aren't really in 'resi' usually either have their parents or a family member or school, so there's always more options. In 'resi', staff don't really want to talk about it. [Kids] don't necessarily have family round, and they're either not attending school or the schools don't do the education. So where is the learning coming from? And we're so easy to please.¹¹⁹

In addition, children may not have the language or cognitive capacity, or the knowledge or experience from healthy relationships, to name what is happening to them. Children who have been sexually abused can also become traumatised and dissociative, shutting down emotionally.¹²⁰ Without information from safe and trusted adults who can speak authoritatively about the approaches and behaviours that perpetrators use to groom and/or sexually abuse children, the child is often isolated by and more vulnerable to the perpetrator's deception. Volume 4, *Identifying and disclosing child sexual abuse* contains more information on barriers to disclosure.

In Chapter 5 we discuss the need to develop a child abuse sex education strategy for children in contemporary out-of-home care.

Not having someone to trust

Volume 11, *Historical residential institutions* documents the accounts of survivors of pre-1990s children's residential care. Many of these survivors told us in private sessions of the sense of powerlessness they felt when they reported their experiences of sexual abuse and were disbelieved or not heard. We have learned that institutions with a higher power differential between adults and children, as was common in historical residential institutions, are more likely to silence children and diminish their ability to raise safety concerns and disclose abuse.¹²¹

Commissioned research explored the views of children and young people in contemporary residential care about safety and ways to make out-of-home care environments safer. This research emphasised the importance of building trusting relationships between children and staff.¹²² At our public roundtable session on prevention, we were also told that children and young people were more likely to disclose abuse, or other concerns, to people with whom they had daily contact.

We have commonly heard from children about the importance of having access to an independent person whom they trust and to whom they can disclose sexual abuse, and a process that they know and trust. As we were told by a recent care-leaver during our *Out-of-home care* case study, 'you need to be safe and secure to reveal ... and feel as though you're going to be believed'.¹²³

We heard that the reality in contemporary out-of-home care is that a ‘passing parade of strangers’¹²⁴ move through the lives of children in out-of-home care.

We don’t ask how many workers has a child had during their care ... if a child has been in care for quite a number of years, we put a lot of strangers in front of them ... What we see as result of that system is that our children in out-of-home care are not raised with the stranger-danger type sense. We don’t monitor the numbers of strangers [passing through a child’s life].¹²⁵

Fear of not being heard or believed

Qualitative commissioned research that was conducted with a sample of private sessions attendees found that all survivors who disclosed sexual abuse that occurred in the period 1990 to 2015, while they were children, reported being more likely to be believed than those who disclosed abuse that occurred before the 1990s. Survivors who disclosed abuse that occurred after 1990 were also less likely to report that they encountered physical punishment as a result of disclosure.¹²⁶ In more recent times, fewer survivors reported having no one to tell, fear of not being believed and fear of retribution – but disclosure as a child was still difficult, with deep shame and a fear of being blamed for allowing the abuse to occur remaining as barriers.¹²⁷ Some children are fearful about who would believe them, or what others would think about them if they did disclose.¹²⁸

‘Cohen’, who told us that he was sexually abused in residential care, said that he never told anyone about the abuse because he was certain that ‘people would’ve just thought we were making lies or just trying to cause trouble’. Because he was often in trouble with his cottage parents for minor misdemeanours, ‘Cohen’ assumed ‘they would’ve just thought “Well you’re making it up” or “you’re just trying to cause trouble”’.¹²⁹

We also heard from survivors who told us of their experiences disclosing to professionals who either dismissed the disclosure or paid no attention to it. ‘Caspar’ told us that by the time he was 10 years old, he had spent time living on the streets, and when he was 11, he was in statutory care. ‘Caspar’ recalled seeing a court-appointed child psychologist and telling her about the sexual abuse he had experienced while in the care of relatives. ‘They just sort of dismissed it’, ‘Caspar’ told us, and no further action was taken. ‘Caspar’s’ later sexual abuse, when he was placed in a children’s home, is described in Chapter 3. Unsurprisingly, ‘Caspar’ did not tell anyone else about the subsequent abuse, except his aunt.¹³⁰ ‘Larissa’ gave a statement to police about being sexually abused by the son of her respite carer. When she later saw the statement, she said it documented her as saying, ‘There is no point in making a statement given that people usually believe adults and children are not believed’.¹³¹

Not feeling safe to disclose

We understand that victims of child sexual abuse often significantly delay disclosing. However, many survivors told us that they would have spoken out earlier, or tried to, but the adults with whom they had contact were neither sensitive nor responsive. We were also told that it was

primarily the responsibility of adults to notice a child's discomfort or changes in behaviour and to take opportunities to talk to a child about their wellbeing. Commissioned research involving participants who had experience of residential care reported them as saying that it was hard to disclose abuse or harm. The research said that participants:

felt that it would be easier for workers to ask children and young people if they were being harmed, rather than waiting for them to disclose. When children and young people raised concerns, they needed workers to demonstrate understanding and empathy, even when the concerns seemed insignificant.¹³²

Participants also said they were rarely given opportunities to talk about issues such as child sexual abuse or to give their advice on how best issues might be handled.¹³³

Children need easy access to an adult they can talk to, and a complaint handling system that is accessible and in which they can have confidence. Where children do not feel listened to, they are less likely to report abuse. If they do disclose, the disclosures need to be taken seriously.

As a 16-year-old boy said during another research project which sought children's views:

If my life was made into a movie I wouldn't be allowed to watch it. There'd be drugs, alcohol, adult themes, violence, language ... Most people think we can't cope talking about this stuff but they need to hear it and we need to say it.¹³⁴

In private sessions, we heard that some caseworkers did not create a safe culture for children to disclose. Survivors in foster and kinship/relative care commonly told us that caseworkers did not speak with them alone. One survivor told us she was desperate to leave her foster family because of the sexual abuse she was subjected to; she looked forward to her caseworker's visits so she could disclose the abuse. However, the worker would always ask how everything was going in front of her foster parents.¹³⁵ Some survivors told us they were rarely visited by caseworkers and had no one to tell.

What 'Annabelle' told us

'Annabelle' told us about her caseworker visiting frequently but never speaking to her. 'Annabelle' said the caseworker 'never came into the house', and she was not able to disclose the sexual abuse she was suffering from the man in whose care she had been informally placed. 'Annabelle' said the child protection department approved the man as her foster father despite the fact he was only in his mid-20s, and the caseworker who visited every week would see her covered in bruises. 'Annabelle' became pregnant to this man and gave birth in the mid-2000s. She was in her early teens. She said the department took no action until it removed her baby following her being hospitalised as a result of being violently assaulted by the same man.¹³⁶

Ambivalence from being made to feel special or cared for

Given that most reported sexual abuse of children in out-of-home care is perpetrated by known adults, a victim is likely to be enmeshed in a complex relationship with the perpetrator, and the dynamics of that relationship may restrict the child's freedom to speak out.

The susceptibility of some children to any kindness or special attention can make them vulnerable to grooming and sexual abuse, and can also make disclosing such abuse more difficult. This is a particular risk for children in out-of-home care with prior experiences of sexual abuse. One survivor said of the sexual abuse he experienced by a residential care worker: 'It was making you feel good, making you feel wanted ... as a kid that didn't have much attention, you know what I mean?' Consequently he refused to make a statement to police about the sexual abuse.¹³⁷

Survivors told us about situations in which they were offered care and support by people in authority who subsequently sexually abused them. 'Cohen' told us about a culture of bullying at a boys' home in the mid-1990s, where he was subjected to physical and sexual abuse by other residents and religious brothers. He said a computer teacher at the home approached him and asked him whether he was experiencing any bullying from the other boys. 'Cohen' said that after he confided in the teacher about the abuse, the teacher began fondling him under his shirt and trousers, telling him, 'You don't have to tell anyone. I can make it go away 'cause I can get the older boys to back off'.¹³⁸

'Cassie' told us that she was sexually abused by a male officer she knew from a detention centre, after accepting a lift from him out in the community. 'Cassie' said, 'I wanted someone I could trust, someone to look out for me but instead I was taken advantage of by him'. She said she rarely saw her [child protection] caseworkers, other than in court. 'Cassie' said she believes the sexual abuse she suffered may have been curtailed if there were:

more trusting people around, or someone who came in on a regular basis monitoring us and our wellbeing. I feel that if someone was actually looking out for us kids, what was happening might have been uncovered sooner.¹³⁹

Fear of being removed from a placement

During our *Out-of-home care* case study, care-leavers described their difficulties in talking about their experiences of danger and harm:

I think a lot of children in care are afraid the placement is going to break down if they say anything, or they are not going to be believed, and there's a lot of other things that come into it as well. Like there's heaps of other stuff. I think it's also ... And I think for me I felt like everything that I went through I deserved.¹⁴⁰

We heard that some children did not report the sexual abuse they were experiencing because they feared being separated from their siblings and their peers. As discussed in the following section, some perpetrators take advantage of this fear, threatening children with this outcome. 'Chas' told us about his experience of this threat.¹⁴¹

What 'Chas' told us

When 'Chas' was eight years old in the early 2000s, his father was badly injured and 'Chas' and his siblings were placed into a foster home for about six months. 'Chas' told us that while he was in the home, the foster father often came into his room at night and sexually abused him. He said, 'Probably in the first three weeks ... started ... the dad ... come in the room. Started playing with himself. Then he started playing with me ... I didn't understand what that all meant to me'.

'Chas' told us that during the day, his foster father would send the other children to the shops or the park, and tell 'Chas' he had to stay home to help clean the house. The abuse went on for the whole time 'Chas' and his siblings were in foster care. 'Chas' is unsure whether the foster mother was aware of the abuse, or whether any of his siblings were also sexually abused.

'Chas' told us his foster father threatened him, saying that if he told anyone, the children would be split up and sent to different foster homes. This was very worrying for 'Chas', so he kept quiet.

Not being treated with respect and dignity

One of the most important things we have learned about out-of-home care is that children should be given a voice, and their rights should be recognised and respected.

A lot of children don't get heard. A lot of things that happened to me where I always told the truth ... I was actually denied, never listened to, hit, beaten ... my truth was not a truth ... And that's the very sad thing about it because a lot of children do tell the truth and no one hears them.¹⁴²

Additional barriers for Aboriginal and Torres Strait Islander children

We heard that when Aboriginal and Torres Strait Islander children do not have a trusted Aboriginal or Torres Strait Islander adult in their lives, it is more difficult for them tell someone that they do not feel safe or that they are being abused. Ms Sue-Anne Hunter, Deputy Chair of Child Protection, Secretariat of National Aboriginal and Islander Child Care, affirmed this in evidence during our *Out-of-home care* case study:

Who is going to believe a little black boy over a white person with authority? One of the things is we talk about culture and protection. If these children had connection some way to culture, to an Aboriginal person, to an Aboriginal agency, they have stated they would probably be more likely to disclose. So how do we do that with our kids in out-of-home care? How do we have an Aboriginal agency or community or support person involved in that child's life?¹⁴³

As we heard from the Victorian Aboriginal Child Care Agency, the importance of cultural care, recognised in the National Standards of Out-of-Home Care, is a protective mechanism for Aboriginal and Torres Strait Islander children, regardless of placement type.

A child who is strong in their cultural identity is more likely to have a voice. A key principle of creating a child safe organisation is to ensure the voice of the child is heard and that children actively participate in the services provided by the organisation. Therefore, ensuring children are strong in their identity will ensure they are better able to have a voice and participate in communicating when they feel safe and importantly when they do not feel safe.¹⁴⁴

'Colin John' told us, 'I don't want this happening to any more people, especially my kind, I'm ... Aboriginal, and it's a big thing ... it hurts metaphysically when we are sexually abused'. 'Colin John' said of disclosing his sexual abuse:

It's taken me ages ... I don't talk to nobody. The only person I've really spoken to about all this is my partner and she knows a lot about me. I've bottled this up for years and I said to her I need to release some of this anger.¹⁴⁵

Some Aboriginal and Torres Strait Islander survivors described 'shutting down' after attempting to disclose the sexual abuse to disbelieving caseworkers. 'Hume' told us he was sexually abused by his foster father in the early 1990s, a man he described as 'very sadistic'. 'Hume' remembered caseworkers visiting the home, but they never saw anything wrong. 'They would inform the people, the carers, when they were coming out, so [the carers] made everything look happy and all that. And the bruises on me they blamed my brother for.' 'Hume' said he tried to report the abuse to his caseworkers, but all it did was make his foster father act with further cruelty. 'They confronted the carers and obviously they would deny it. And then I learned the hard way it was best to keep my mouth shut.'¹⁴⁶

In Chapter 5 we discuss the key role played by Aboriginal and Torres Strait Islander workers and community-based child welfare organisations in creating a safe culture for children in out-of-home care.

Additional barriers for children from culturally and linguistically diverse backgrounds

We understand that barriers to making a disclosure can also be influenced by the child's cultural context. This is discussed in detail in Volume 4, *Identifying and disclosing child sexual abuse*.

Children from culturally and linguistically diverse backgrounds are likely to face additional challenges when they enter out-of-home care. These challenges may limit opportunities to disclose sexual abuse, and may include: language and literacy barriers; not understanding the role of child protection systems; and limited access to culturally appropriate placement options and support services.¹⁴⁷

At one of our public multicultural forums we were told about a child who spoke Farsi and was learning English who was placed with a family that did not speak either language. The family forced the child to learn their language. This child would face huge difficulty if they needed to disclose sexual abuse.¹⁴⁸

We also heard in public multicultural forums that taboos associated with talking about sex can impede disclosures of sexual abuse in some communities. These taboos can affect discussions within families and communities, and between communities and outsiders, including authorities.¹⁴⁹ We heard that without appropriate cultural training or advice, disclosures may go unnoticed or be misunderstood.¹⁵⁰

Sufficient culturally appropriate supports are needed to enable children from culturally and linguistically diverse backgrounds to disclose sexual abuse in out-of-home care settings, whether outside or within their communities.

Additional barriers for children with disability

As noted in Chapter 3, children with certain types of disability may face barriers in developing knowledge about sex, protective behaviours and safety, which can heighten their risk of sexual abuse in out-of-home care. We have also been told that children with disability may be 'denied any sexual behaviours, denied support to learn about sexuality, and/or denied even basic mainstream sexual education'.¹⁵¹

Our commissioned research suggests that some of the strategies used by children with disability when they feel unsafe – such as keeping quiet and trying to avoid danger¹⁵² – may in fact also be barriers to them disclosing sexual abuse. 'Anya', for example, told us she has an acquired brain injury which has made it hard for her to communicate the sexual abuse she suffered at the hands of her foster father. 'At the time, I was too frightened and too scared to tell anyone. I couldn't even tell the police about it.' 'Anya' said she thrived at the local college she attended – she loved her teachers, friends and the subjects she studied – but that life in her foster placement was very different, and she ran away after completing her school studies.¹⁵³

This is not to suggest that children with disability are incapable, but rather that they may need specific support to develop their safety skills. Practices that stereotype children with disability as less capable, more dependent and less sexual than their peers can lead to ‘over-protection’ and greater vulnerability for the children. In fact, in a supportive setting, children with disability can build capacity, including protective behaviours.¹⁵⁴

Chapter 5 discusses our view that policies and procedures are required that recognise and respond to the diverse communication needs of children with disability.

Perpetrator behaviours that create barriers to disclosure

We heard about numerous ways in which perpetrators of child sexual abuse create barriers for children to disclose sexual abuse.

Where the perpetrator is the child’s carer (or is a friend or relative of the carer), children may be concerned that if they disclose sexual abuse they will be moved from the placement. This can be a major dilemma for a child who, despite the abuse they have suffered, wants to remain in a familiar environment, maintaining their contacts with schools, friends and siblings. As already noted in the earlier discussion on ‘Fear of being removed from a placement’, we heard of perpetrators threatening children with this disruption should they report the abuse.¹⁵⁵

We heard of perpetrators threatening children with violence if they were to disclose abuse. We also heard from survivors that they were told they would not be believed – because as children in out-of-home care they were not valued or considered valuable. ‘Sabrina May’, for example, whose private session was also discussed in Chapter 3, told us that when she and her sister were physically, emotionally and sexually abused by their foster family, they were told by their foster father that no one would believe them.¹⁵⁶

Children may also remain silent because they are ashamed, particularly when perpetrators have manipulated them into believing that they are responsible for the abuse, or when they fear that others will think they deserved or encouraged the abuse, or were ‘willing participants’. ‘Rolf Andrew’ told us he didn’t tell anyone for fear of being looked down on, and for fear of being perceived as having ‘deserved it’.¹⁵⁷

What 'Rolf Andrew' told us

'Rolf Andrew' lived with many different foster carers in Victoria, New South Wales and South Australia. In the early 1990s, when he was 12 or 13 years old, 'Rolf Andrew' was placed with a single middle-aged man in his home in central Victoria. He told us, 'I thought it was pretty suss straight away. He'd always come into the shower and always be inquisitive on me about what I was doing and wouldn't let me out of the house'.

'Rolf Andrew' was with this man for only a few days. The sexual abuse began straight away – the man touched 'Rolf Andrew's' genitals many times. Eventually he grabbed the boy and tried to rape him. 'Rolf Andrew' threatened the foster carer with a knife and ran away.

'Rolf Andrew' lived on the streets for two months before the police picked him up. He then entered the juvenile justice system in Victoria, and was frequently in trouble on stealing and assault charges all through his teen years.

'Rolf Andrew' described himself as 'care less' at that time. 'The government and everyone gave up on me so I gave up on myself. I didn't feel like I belonged, then.'

He felt he could not reveal the sexual abuse to his caseworkers at the time. 'I thought they would look down on me for it ... I've been thinking I deserved it. I've always asked myself, "Why? Why me?"'¹⁵⁸

Institutional barriers to disclosure

Noting the difficulties that children in out-of-home care face in disclosing sexual abuse, it is clearly incumbent on services to create institutional cultures in which children feel safe to disclose, and in which they have someone to disclose to who will respond appropriately. This was confirmed by commissioned research that found that children generally feel safer in institutions when adults listen to them and respond by taking their concerns and needs into account, including by informing the child about what action has been taken in response to a disclosure.¹⁵⁹ This requires an organisational culture where adults are aware of and confident about having these difficult conversations.

During our *Out-of-home care* case study, recent care-leavers gave evidence of the many barriers to making a disclosure or complaint about sexual abuse, including:¹⁶⁰

- the power imbalance between the child and the institution or the individual to whom the complaint might be made. This barrier is perhaps the most challenging in the out-of-home care context, where the child is often dependent on the person, employee or organisation that they are seeking to complain about
- lack of trust in the process
- the victim's lack of knowledge about the complaint handling process or their rights.

The national peak consumer body representing the voices of children in out-of-home care, CREATE Foundation (CREATE), stated in its submission to our *Issues paper 3: Child safe institutions* that:

fostering an organisational culture which recognises the barriers children and young people may face in being aware of their own rights and enabling them to speak up is an important step to addressing organisational factors which may have provided opportunities for harm to be undetected.¹⁶¹

The need for a skilled and careful response

We heard during our *Out-of-home care* case study that high demand for out-of-home care services has contributed to responses to child sexual abuse being inadequate. Despite the fact that caseworkers play a central role in a child's care team, including advocating for their safety and development, children in out-of-home care do not all have an allocated or consistent caseworker. Caseworkers should be able to form a relationship where the child feels able to talk about everything that is happening to them, not just sexual abuse.

Out-of-home care service providers and carers have a responsibility to develop and foster a culture that encourages disclosure and promotes safety for all children in their care. Research we commissioned on the different dimensions and degrees of risk of child sexual abuse in institutions indicates:

A crucial issue in institutions ... is the denial of voice to children. This reflects a culture in which children are not listened to, and their views are not respected. This goes well beyond having an accessible complaints mechanism. Even if the institution has a complaints mechanism that children are aware of, they may not be confident that they will be listened to and not victimised if they make a complaint. The more pervasive underlying problem is when the staff members are not accessible and not trusted by children to be sensitive and responsive, and to meet their needs.¹⁶²

This view is supported by research we commissioned on children's views of safety in residential care which reports that these children 'felt abandoned by workers and institutions that did not have the knowledge, skills or experiences to provide appropriate support to help them deal with the ongoing impacts of abuse and the disclosure process'.¹⁶³ Services need to have processes in place that identify changes in children's behaviours, and sensitively respond to individual children. As we heard from Ms Maree Walk, then Deputy Secretary of the New South Wales Department of Family and Community Services in evidence during our *Out-of-home care* case study, 'You really need to listen to children, and by that I mean listen to what their behaviour tells you as well'.¹⁶⁴

In commissioned research, Professor Eileen Munro emphasised the need to provide mechanisms for staff to talk through any ambiguous information they are working with because judgments about child safety are subject to errors of reasoning.¹⁶⁵ Her report on child protection systems in Britain noted:

abuse and neglect can be hard to see, with many of the indicative signs or symptoms being ambiguous and possibly having other benign explanations. Moreover, some parents go to extreme lengths to conceal the truth. There is a degree of uncertainty about recognising that children and/or young people are suffering significant harm that cannot be eliminated, though training helps professionals to know what to look for and procedures help them know what to do with their concerns. Managing this inescapable uncertainty is a problem that bedevils child protection services around the world ...¹⁶⁶

The report also emphasises the importance of workers seeing children regularly and providing opportunities for children to talk freely about their concerns.¹⁶⁷ This is consistent with what we heard about children needing someone to trust.

Perceptions that children are a ‘problem’

A legacy of past mistakes in the institutional care of children is that too often children in out-of-home care are ‘still regarded as a “problem” rather than needing and deserving protection’.¹⁶⁸ ‘Cultural norms and beliefs that labelled children as undeserving and deviant, and in need of moral reform gave children a low social status and low credibility’, and this legacy continues for children in the contemporary out-of-home care setting.¹⁶⁹ As one witness told us:

I think a stigma is still attached to children who are either wards of the state or who are taken into care, that there is some sort of tacit and subtle assumption by the community that somehow they deserve what they get in some way. So there’s still this nexus that operates between welfare and justice. It is a sort of form of punitive welfare, and I think the community has a sort of blind eye that it turns towards children in out-of-home care.¹⁷⁰

This is especially true for children in residential care, where ‘perceptions that residential care is the worst option and “resi kids” are the worst kids’ often still prevail.¹⁷¹

A related factor is the persistence of some aspects of the ‘closed’ institutional cultures of the past that tend to increase the risks of perpetuating a harmful ‘us and them’ mentality.

A key issue is how the institution conceptualises its primary goal. So if the primary goal is control, that sets up a series of other interactions. If the primary goal is to control children who are offenders, then there’s a sharp distinction between staff and those who are being controlled, and there tends to be stereotyping on both parts. Children, for example, look at staff as untrustworthy. Staff look at children as not worthy of their trust, needing control. That sets up a distinction of perceiving oneself as morally superior and others as less superior.¹⁷²

This is still sometimes a problem, even in out-of-home care organisations ostensibly focused on child development rather than child control.

Concerns about the persistence of old attitudes and growing recognition of the need for greater clarity of purpose in parts of the statutory care system have helped drive interest in ways to apply therapeutic models of care to residential care settings. In 2010, a landmark meeting of the National Therapeutic Residential Care Alliance brought practitioners and service providers together with researchers and government policymakers.¹⁷³ A key objective of this forum was to examine how best to support a move away from residential care as a place focused on the ‘containment’ of ‘hard cases’, and instead promote the use of ‘therapeutic residential care’ that actively facilitates ‘healing and recovery from the effects of abuse, neglect and separation from family’.¹⁷⁴ The scope to apply therapeutic models of care to all residential care services is discussed in Chapter 5, Section 5.4.3.

Inadequate responses to disclosures

Not supporting children

We heard that children more often disclose sexual abuse through their behaviours rather than with words.¹⁷⁵ We also heard that children who were sexually abused in out-of-home care settings were sometimes not provided with sufficient support, particularly where attempts made by the child to disclose involved challenging behaviours.

Some survivors of sexual abuse in home-based settings told us their attempts to disclose sexual abuse non-verbally went unsupported. ‘Alannah’ said she was too terrified to say anything to her caseworker about the sexual abuse she was experiencing in foster care, and would attempt to communicate non-verbally with her caseworker in front of her foster parents:

I used to stare at him and at one stage I grabbed his knee and he said, ‘Oh sorry’, and he moved to the other side of the table. And I thought, ‘You could give me a break here’... One time I ran out the front to walk with him to his car. And the foster mother was screaming at me to get back inside. And he said, ‘Look, I promise I’ll come talk to you soon’. But he never did.¹⁷⁶

We heard support for children who are displaying difficult or abnormal behaviours may involve providing an environment to help facilitate their disclosure. As the Acting Director, Office of Professional Practice, Department of Human Services Victoria, Ms Robyn Miller told us:

We need [caseworkers] to be creative and think outside the square and use the moment in the car, because that is when a child is more likely to disclose rather than the formal interview. We need them to create opportunities. Rather than asking the children 20 questions, they can create a space where they are hanging out with them and they are more likely to talk about something that is embarrassing or they are not sure of, because patterns of disclosure are really important for our caseworkers to understand.¹⁷⁷

A child not being given sufficient support following a disclosure was another common theme that we heard about. ‘Dani’ told us that she moved from foster care into a youth shelter, where she was raped by one of the other residents.

What ‘Dani’ told us

‘Dani’ told us about the very limited assistance the workers in the youth shelter gave her after she had been raped while out with other residents.

I tried to fight him off but he ended up assaulting me and then they called the police and the police took me to the hospital, but I freaked out at the hospital so I just walked home. And then I tried to kill myself a couple of days later but another one of my friends, she convinced me to call the workers from the shelter, and I told them and they just kind of seemed like they were bothered by it. I told them I wanted to go to the police.

The youth workers initially didn’t want to respond to ‘Dani’s’ call but eventually one came to pick her up and drive her to the police station. ‘She took me to the police station but dropped me off’, ‘Dani’ said. ‘I was confused why she didn’t come in with me. I didn’t want to go in by myself.’

The youth shelter organised a unit for ‘Dani’ to stay in, but she wasn’t there long when friends of the boy she’d reported to police started intimidating her. As well as following her around town, they’d break into the unit and destroy things. Because of the damage they caused, ‘Dani’ was told by the youth workers that she’d have to vacate the unit.

‘They said I didn’t know anybody so they didn’t think it was a good idea to give me the unit and I’d be better somewhere else, but they didn’t do anything, they just kicked me out.’¹⁷⁸

Children with experience of residential care who participated in commissioned research about safety in residential care reported it was hard to raise concerns and disclose abuse in that setting.¹⁷⁹ In particular, these children felt residents needed appropriate information about risks, such as unsafe adults who might exploit or take advantage of them. They felt residential workers ‘were not always aware, available or competent to prevent harm or to intervene when residents were at risk’.¹⁸⁰

Participants in this research expressed a need for workers to respond effectively to make it clear that violent, bullying or harassing behaviours were unacceptable, rather than dismiss or downplay what occurred. Where worker responses were ineffective, these children said they ‘felt unsure about what to do when they felt pressured [into sexual activity], when they were “tricked” into having sex with peers or felt uncomfortable with the way their relationships were progressing’.¹⁸¹

Availability of residential workers to disclose abusive behaviours was also an issue for participants in this research. In particular, children said that workers became unavailable to respond to their concerns at night, when the behaviour was most likely to occur, because the workers were asleep.¹⁸²

Complaint handling processes

Volume 7, *Improving institutional responding and reporting* discusses in detail the handling of complaints of sexual abuse of children in institutional settings.

We heard about different ways in which caseworkers failed to respond appropriately to a child's disclosure of sexual abuse in contemporary out-of-home care. As discussed, some survivors told us in private sessions that they were not believed, or that no action was taken. In some cases, the response placed the child at further risk. Given that out-of-home care service providers generally have policies and procedures for dealing with child protection matters, it is not clear whether caseworkers were simply not following procedures or whether they had not been adequately trained in how to respond.

'Alisha' told us she went to a meeting with child protection authorities and her foster parents after it was known that her foster father had sexually abused her when she was 16 years old. She said the departmental officer berated the foster father, but nobody said a word about her psychological or physical wellbeing.¹⁸³

We were told about the inadequate response of residential care workers and of instances where it appeared they endorsed, or at least ignored, abusive behaviour by other residents.

'Augie' told us that at the boys' home he lived in during the early 2000s, the older boys bullied and abused the younger children, and that staff at the home were aware of this and in fact endorsed the authority of the older boys, despite knowing that the younger boys were being sexually abused.¹⁸⁴ Another survivor told us when he was being physically assaulted by older boys in a boys' home, 'the staff used to sit back on the couch, and they'd laugh about it and tell me to stop being a wimp and toughen up'.¹⁸⁵

We heard in submissions that independent oversight of complaint handling systems was essential to ensure children felt their complaints would be heard and addressed. CREATE told us their research found children may see complaint handling systems located in child protection departments or with non-government service providers as biased or compromised.¹⁸⁶ In addition, children felt concerned their complaint may result in repercussions to their safety, or may harm their relationship with their care provider.

Surveys conducted by CREATE, regarding knowledge and use of complaints by children in out-of-home care, found only about half of the respondents knew how to complain if they needed to, and about 19 per cent had made a complaint. Of those who had made a complaint, 45 per cent reported being at least quite satisfied with the outcome, compared with 24 per cent who were quite dissatisfied.¹⁸⁷

We were also told that confidence in complaint handling systems among children in out-of-home care may be influenced by cultural factors, particularly for Aboriginal and Torres Strait Islander children. As Professor Muriel Bamblett, CEO of the Victorian Aboriginal Child Care Agency told us:

There are some children, particularly Aboriginal children, who, once we tell them they have to talk to DHS and the police, they will not talk. From our point of view we would like to have Aboriginal people trained in forensics and understanding because I think sometimes DHS says you are guilty until proven innocent.¹⁸⁸

We also heard that complaint handling systems need to be accessible to children from their perspective.

We must look at the way that as adults we allow them to disclose and that we have mechanisms for them to disclose. The processes for making a complaint, for example, are not child friendly. Our whole framework has to change so that we can start looking through the eyes of the child at how easy is it to disclose and how willing are adults to hear that?¹⁸⁹

4.3.4 The need to share information

Information sharing, as part of a collaborative approach to child protection, is necessary for effective, integrated and therapeutic responses to risks and incidents of child sexual abuse. Information sharing should occur:

- between agencies concerned with child protection
- with carers
- with children in out-of-home care.

The importance of information sharing has been highlighted by other inquiries and reviews, as well as in the commitments and initiatives of Australian governments under the National Framework for Protecting Australia's Children 2009–2020.¹⁹⁰

However, in our case studies we heard evidence and received submissions indicating that:

- inadequate information sharing between institutions results in missed opportunities to identify, prevent and respond to incidents and risks of child sexual abuse in out-of-home care contexts¹⁹¹
- weaknesses in inter-jurisdictional information-sharing arrangements create risks for the safety of children in out-of-home care¹⁹²
- inadequate information sharing with carers about the sexual abuse histories of children in their care may place children in care and other children in carer households at risk.¹⁹³

In Volume 8, *Recordkeeping and information sharing* we discuss what we have learned about barriers to sharing information for the purpose of preventing, identifying and responding to child sexual abuse in institutional contexts. Our discussion addresses the need for improvements in information exchange between institutions within and across a range of institutional contexts, including out-of-home care.

In this chapter and Chapter 5 we consider the need to improve the exchange of information between out-of-home care institutions, between out-of-home care agencies and carers, and between children and those who are responsible for their care.

Exchanging information between institutions

We heard in submissions that improvements are needed in information sharing, within and across jurisdictions, to prevent and respond to child sexual abuse in out-of-home care.¹⁹⁴ The sharing of information about carers and others who have sexually abused, or who may risk the safety of, children in out-of-home care is essential.

In the *Scouts and Hunter Aboriginal Children's Service* case study,¹⁹⁵ we learned that the risks identified by the then New South Wales Department of Community Services in a Working With Children Check (WWCC) assessment of Steven Larkins in 2003 were not reported to the Hunter Aboriginal Children's Service (HACS) management committee, but directly to Larkins himself as he had nominated himself as the contact person. Larkins concealed his WWCC assessment from HACS and continued to be employed by the agency.

In February 2004, Larkins sought a review of his WWCC because he had never been charged or convicted of any of the alleged offences that had resulted in his negative assessment. By this time the Commissioner for Children and Young People had taken over the administration of WWCCs. Larkins provided false documents saying his role did not have direct and unsupervised contact with children. The Commission for Children and Young People did not check Larkins's representations with the HACS chairperson or management committee and did not exchange information with the Office of the Children's Guardian about Larkins's position with HACS. The Commissioner for Children and Young People wrongly withdrew Larkins's WWCC assessment in June 2004.

Larkins was eventually prosecuted in 2012 for offences he had committed 15 years earlier – aggravated indecent assault, possessing child abuse material and dishonesty offences (swearing a false statutory declaration and forging documents). The lack of important communication between agencies allowed Larkins to deceive the then Department of Community Services, the Commission for Children and Young People and Hunter Aboriginal Children's Services for many years.

In private sessions we also heard about the apparent failure by agencies to share sufficient, relevant information, which placed children in care at risk of sexual abuse. 'Jane', whose story we highlighted earlier in this chapter, told us she and her sister were placed in kinship care with their grandfather who had been convicted of sexually abusing one of his daughters. It is difficult to understand how this placement could have been made if all relevant information about the risks posed to 'Jane' and her sister was communicated and considered as part of the assessment of the suitability of the placement.¹⁹⁶

Keeping carers informed

While child protection legislation in most jurisdictions provides for sharing information with carers before and during the placement of children into out-of-home care,¹⁹⁷ evidence before us suggests that information provided to carers about children in their care may sometimes be too little and too late.

We were told during our *Out-of-home care* case study, in submissions to our consultation paper and in private sessions about the importance of sharing information with carers regarding the history and needs of children placed in their care, including any information about harmful sexual behaviours. The overall emphasis of submissions was that carers need more information than is usually provided. Better information sharing with carers is required to ensure the safety of children, to give the carer the best chance of supporting the child and to ensure the most suitable placement. The Northern NSW Local Health District submitted:

The experience of clinicians supporting children in out-of-home care in our health district is that many carers receive little or no background information in relation to children coming in to their care. Carers report a frustration in not having this information. Health clinicians routinely make recommendations following assessment of a child's emotional and behavioural wellbeing that includes better sharing of information of a child's trauma history with carers. The rationale for this information sharing is to assist carers with better understanding the child's behaviour. A greater understanding of a child's life experience is likely to enhance the carer's ability to provide reparative care.¹⁹⁸

The sharing of sufficient relevant information with carers is integral to ensuring placement safety and stability for children. The Victorian Aboriginal Child Care Agency (VACCA) emphasised the connection between information sharing with carers and placement stability for Aboriginal children:

If we do not provide accurate information about the abuse and trauma history of a child, including any behavioural challenges including engaging in harmful sexual behaviours, there is a high risk of setting the carer and child up for failure. Many of our children have already experienced far too many changes in placement and it is VACCA's view that full disclosure in relation to these issues is imperative.¹⁹⁹

We note that the Child Protection Systems Royal Commission in South Australia identified a ‘high level of concern’ about inadequate sharing of information by the South Australian child protection agency:

This concern is not isolated to the information required at the start of a placement; it applies to information relevant on an ongoing basis to the carer’s capacity to parent. In particular carers felt excluded from comprehensive information about children’s trauma histories. This left carers to their own devices to navigate the child’s special needs.²⁰⁰

We learned that, especially where a child has displayed sexualised behaviours, inadequate sharing of information with carers may undermine the stability of the placement, compromise the care provided for that child, and jeopardise the safety of other children in carer households.²⁰¹

As the 2015 decision of the Queensland District Court in the matter of *ABC & Ors v State of Queensland & Anor* indicates, even where they are required to do so by legislation, out-of-home care service providers might not share relevant information with carers.

In that case, the Queensland District Court considered whether the Department of Child Safety had provided carers with adequate information to make an informed decision to accept placement of a foster child, after three plaintiff sisters were sexually abused by a foster child in their family’s carer household. The court noted:

Certainly, she [the plaintiff’s mother and foster child’s carer] knew that the foster child had committed earlier serious sexual offences but there is no evidence that she was provided with such information as was necessary for her and her husband to make the informed decision [to accept placement] for the purposes of section 83A of the [*Child Protection Act 1999* (Qld)]. Of necessity, that information had to include matters relevant to ensuring the safety of the three plaintiffs [her children].²⁰²

The court found that, by failing to provide the carers with ‘all of the information that was reasonably needed’ to make a fully informed decision to accept the placement, the department had breached its duty of care.²⁰³

In our *Out-of-home care* case study, the President of the Australian Foster Carers Association highlighted the importance of sharing information with carers to keep all children in carer households safe:

Just from a very personal perspective, I can remember at one stage there was a child brought to us late on a Saturday night by a stepfather, and when I went to the door to greet the stepfather and the child, I was carrying a baby in my arms and the stepfather said, ‘Oh, you’ve got a baby? He can’t be anywhere near babies. That’s why he’s being put into care now’, and then went on to explain why. So we did take the child over the

weekend; the child could not stay after the Monday, though, because we couldn't put the baby, who was also in care, at risk, or the other young children we had in our home. It's about this sharing appropriate information to keep all children safe, not just the child who is coming into care, so there is a big issue around that sort of work that needs to be done within the sector.²⁰⁴

We heard about a number of incidents of children being sexually harmed by other children. We were told that child protection agencies and out-of-home care service providers had not given carers adequate information about the harmful sexual behaviours of children placed in their care.²⁰⁵

In a private session, foster carer 'Mariel' told us she did not want to foster a child older than her biological son, 'Jayke', because of some previous experiences where foster children had displayed highly sexualised behaviours. However, the child protection department asked the family to take a boy who was five years older than 'Jayke' – which they did despite strong reservations.

'Jayke' told us, '[the child protection department] wouldn't take no for an answer ... Mum said no three times and they kept calling'. The older boy raped 'Jayke' when 'Jayke' was nine years old but 'Jayke' did not disclose the assaults until he was a teenager and began to suffer anxiety disorders. His mother, 'Mariel', told us she strongly believes the department and foster care agencies owe foster families the same duty of care that they provide to children in their care. She said:

I understand from [the department's] point of view that they don't know and can't run around saying everything about the child. But I do feel they should give you enough information to make an informed decision about it. 'Cause this is your life, you know.²⁰⁶

We understand the challenges of placing children with complex behaviours. However, without sufficient information to be able to support the child and manage difficult or risky behaviours, carers are unlikely to be able to protect other children in a placement or provide long-term stable care for the child with harmful sexual behaviours. This leads to further instability and risk for children with harmful sexual behaviours in out-of-home care.

Involving children in decisions that affect their lives

The rights of children to express their views and participate in decisions that affect their lives are generally recognised and well accepted in the out-of-home care sector.²⁰⁷ However, we heard that more needs to be done to share information with children in care when decisions that affect them are being made. Ms Bev Orr, President of the Australian Foster Care Association, highlighted the need to consider how children should be informed 'about the decisions that are being made about their life at the time':

Somebody within the system – and I don’t necessarily believe it should be the carer, I think it should be the decision-maker – should be explaining this to the child, whether it be, say, by writing a letter, or having a conversation, but somebody needs to explain to them what the decision is and why, and listen to their response, because that is where you get improvement in practice and better safety for children.²⁰⁸

‘Ella’ told us that she and her siblings were sexually and physically abused by her foster father. She remembers having a short interview with police, and apart from that cannot remember anyone asking her about the abuse or affirming to her that what happened to her was wrong.²⁰⁹

We have also learned that the failure to share information related to child sexual abuse with children may adversely affect their sense of safety. In recent research on institutional responses to children’s safety concerns, the Australian Catholic University’s Institute of Child Protection Studies found that children ‘recognised that adults often did not share information with them about sensitive issues [such as sexual abuse] in an attempt to protect them, but [the children] felt that sometimes this was counterproductive’.²¹⁰

4.3.5 Identification, assessment and support of children with harmful sexual behaviours

In Volume 10, *Children with harmful sexual behaviours* we describe the failure to identify children’s harmful sexual behaviours – including not recognising these behaviours as serious and therefore requiring intervention – and the subsequent failure to respond to the risks associated with these behaviours. We heard that in many instances institutions did not refer children who had exhibited harmful sexual behaviours to services where they could receive an assessment. Assessment is necessary to better understand these behaviours, to identify any needs and safety concerns for the children and those around them, and to determine the appropriate interventions.

In Chapter 3, we describe a failure of out-of-home care service providers to take sufficient care in placing and supporting children with harmful sexual behaviours. We were told in submissions to our consultation paper on out-of-home care that there are systemic failings that result in increased risk of sexual abuse by other children, especially for children in residential care.

The information provided by children who participated in commissioned research about safety in residential care indicated that harmful sexual behaviours were ‘an intrinsic part of the residential care experience’. Reflecting on children’s feedback about the nature of the risks in residential care, the researchers observed:

They believed that by having groups of young people with high sex drives and limited knowledge or education about sex, sexuality and healthy relationships to draw on; many young people engaged in sex, both appropriately and inappropriately.²¹¹

‘Inappropriate sex’ was described by the children as sex that resulted from significant and ongoing pressure, and sex without consent. We heard that the younger children in the study ‘felt strongly that inappropriate sex rarely occurred in residential care’.²¹² On the other hand, the older participants observed that young people in residential care ‘often engaged in sexual behaviour, often before they were emotionally equipped to do so’.²¹³ These observations highlight the need for sexual abuse prevention education for children in contemporary out-of-home care, which is discussed further in Chapter 5.

Despite the risks posed by peers – and especially those engaging in physical violence or exhibiting problematic or harmful sexual behaviours – there was recognition that peers could also be a protective factor for children and young people in residential care. Participants in the study stressed ‘the need for enhancing positive peer cultures and to help young people help each other’.²¹⁴

In submissions to our consultation paper on out-of-home care, we were told that there are insufficient specialised placements and services for children with harmful sexual behaviours,²¹⁵ and that the pressure for children with harmful sexual behaviours to be placed may compromise the safety of other children, especially in residential care.²¹⁶ We heard that there is a need to pay more attention to placement matching,²¹⁷ and that groupings in accommodation can be inappropriate.²¹⁸

Being placed in care with older children with harmful sexual behaviours was an issue for some survivors we heard from. ‘Mikel’ told us he was placed in short-term residential units with groups of older children because he was physically and sexually abused by his father. He told us the older children sexually abused him in these settings. ‘I was put with kids that were 10 years older than me. I was forced to do things that you could never imagine.’²¹⁹

‘Dana Maree’ told us her biological brother was sexually abusing her when they were both placed in foster care. She said she reported the abuse but they were not separated. She said they were kept together through different placements, which was the worst thing that could happen. Even when her foster parents were provided with respite care, ‘Dana Maree’ and her brother would be sent to this together, meaning she never had any time away from him.²²⁰

We also heard that assessment and specialist interventions for children with harmful sexual behaviours in out-of-home care are at times unavailable or inaccessible,²²¹ and that delays in accessing intervention can contribute to placement instability.²²² We also heard concern about the lack of Aboriginal or Torres Strait Islander-specific treatment services for children with harmful sexual behaviours, and the need to increase the availability of culturally safe services.²²³

Our commissioned research tells us that there is an inconsistent national response to children with harmful sexual behaviours.²²⁴ In submissions, we were told about initiatives by service providers and administrators to increase training for staff, carers and children on identifying and responding to harmful sexual behaviours.²²⁵ However, there is a need for national leadership to increase the availability and consistency of this training. This discussion is taken up in Chapter 5.

4.4 Response to risks in particular institutional settings

4.4.1 Placement instability

We have consistently heard that improving the stability of placements for children in out-of-home care is essential to ensuring their wellbeing and better protecting them from risks of child sexual abuse.

We heard from many survivors in private sessions about their experience of regularly moving between different foster care and residential placements during their childhoods. During our *Out-of-home care* case study, young care-leavers linked the instability of out-of-home care placements with vulnerability to further sexual abuse.

We've worked with somebody who has moved like 22 times across the state. He said he was moving every six months at one stage and he was never able to form a support system with a carer and with an agency worker, or with a school, even. He always knew he was going to be moved on and that's a common story. You do that and that isolates you as a person. Then if you don't have the support system either, you've got no one to fall back on.²²⁶

Young care-leavers also spoke about the key role that having nurturing relationships played in helping them deal with their experiences of child sexual abuse. Recurring themes in the information we received – and in the evidence provided by witnesses – included the importance of connection and belonging to a community, attending the local school, making and keeping friends, and being able to visit siblings and family.

A lack of stability in a placement and seeing many professionals and carers – including caseworkers and the residential care workforce – come and go is likely to exacerbate problems for children in out-of-home care who may have trouble trusting and forming healthy connections with adults. There is a need for ongoing and familiar carers, professionals and staff members who can build rapport with children and to whom children feel safe in disclosing abuse.

For some survivors, placement instability was linked with behavioural issues, which in turn were a response to child sexual abuse. 'Holly Jane' told us that after a male relative started to sexually abuse her while she was in kinship care, she:

started mucking up at school and teachers reported to [the child protection department] and then I went to other foster homes. I've been to 36 foster homes all up. After the first foster care [placement], I didn't really have tolerance for anyone else. So I just misbehaved.

'Holly Jane' said she didn't know how to tell anyone about the sexual abuse and no one ever asked her why she was misbehaving.²²⁷

For other survivors, being sexually abused in a placement was the reason for being moved on. 'Maddie Jean' told us that in one of her earliest placements when she was about nine years old, she was sexually abused by another of the foster children in the home; he was 18 years old. She told a teacher about the abuse, the teacher notified the child protection department and 'Maddie Jean' was removed from the home. 'Maddie Jean' said she had been happy at the home until then, and wished that the perpetrator had been relocated instead of her. 'Maddie Jean' told us that some 15 placements followed and she didn't stay anywhere for long.²²⁸

Our recommendations for addressing obvious factors that contribute to placement instability are discussed in Chapter 5.

4.4.2 Risks in home-based settings

Some of the general risk factors for child abuse and neglect in a family context are clearly relevant to home-based placements of children in contemporary out-of-home care. Research into the interaction of risk and protective factors in families indicates that these risks include:²²⁹

- individual child factors (of relevance being the child's history of abuse and neglect, their temperament or behaviour, and whether they have disability)
- family/parental factors (of relevance being whether the carers perceive the child as a problem, and the carers' temperament and exposure to stress).

Identified protective factors for a child in care that can be missing from home-based placements include a strong parent/child relationship, family cohesion and positive social connection and support.²³⁰

Screening and authorisation of foster carers and kinship/relative carers are processes that aim to ensure that people who present obvious risks to children are not given the responsibility to be an out-of-home carer. From what we were told by survivors of child sexual abuse in contemporary out-of-home care, these processes are not foolproof and, in fact, do not always address obvious risks posed by people applying to be foster carers.

As noted, we heard in submissions and in evidence during our *Out-of-home care* case study that there is less rigorous checking of kinship/relative carers than of foster carers. In relation to emergency placements into kinship/relative care, it is crucial that any carer screening and assessment procedures not conducted at the time of the placement (because of the demands of the circumstances), are incorporated into follow-up assessments.

Foster care

In private sessions we heard from some survivors who had been placed in foster care arrangements with carers who would not appear to be suitable and posed a high risk to children.

We heard from survivors who were placed with single male foster carers in situations that were not sufficiently well screened or supervised. ‘Elliott’ told us that when he was 13 years old, he was placed with a single man who lived in a caravan park.²³¹ ‘Elliott’ said, ‘That, to them, was acceptable ... He picked me up and drove me straight out there. First night in, he opens the fridge up and it’s full of VB [beer] cans. He goes, “That’s what we live on”’. ‘Elliott’ said the man made threats and was physically violent towards him. ‘Elliott’ was also sexually abused by the man. ‘Nothing was off limits, you know, full penetration, the whole thing, over a few weeks.’ Another survivor, ‘Percy Scott’, told us he was placed with a single male foster father in the early 1990s.²³² He said the man sexually abused him by masturbating him and digitally penetrated him. ‘Percy Scott’ said he ran away from this placement.

‘Alisha Lee’ told us she was placed with a foster family in the mid-2000s where she was sexually abused by the foster father.²³³ She said she has since learned that the foster father had been incarcerated for domestic violence against his wife prior to ‘Alisha Lee’ moving in with the family. She told us she thinks the authorities should have known not to place her there.

Our recommendations aimed at strengthening existing screening and authorisation of carers are discussed in Chapter 5. We know, however, that it is not possible for screening to exclude all potential perpetrators of sexual abuse – regular supervision of placements by skilled and experienced caseworkers is an essential means of mitigating risks in home-based settings. We heard many stories about sexual abuse in out-of-home care that may have been prevented, or at least stopped sooner, had there been consistent and diligent supervision of the placements.

‘Evie’ told us she was placed with foster carers when she was about nine years old. She said that soon after she started living there, the foster father began to sexually abuse her. When ‘Evie’ disclosed as a teenager, she also reported her fears for two young sisters who were being fostered in the same family. These girls were removed, and the foster carers lost their carer authorisation and their gun licence. The carers’ biological daughters then came forward to disclose that their father had sexually abused them. The man was charged with the sexual abuse of his daughters but not of ‘Evie’. Less than a year later, ‘Evie’ was placed with one of the man’s daughters.

They stuck me with their daughter, that lived on the same block ... And she’d become a foster carer. How can they let her become a foster carer? ... It does my head in every day ... Your system to get foster parents definitely needs to change.²³⁴

Reports of risk of harm to individual children can be made by any concerned person. However, a system response to mitigate the risks of home-based placements must include regular supervision of placements by skilled and experienced practitioners (see Section 4.3) and ensuring that children know how and to whom they can safely talk about their experiences in these placements. ‘Evie’ told us that she wasn’t able to tell her caseworker about the abuse because they would sit on the verandah and drink coffee with the carers, so she wrote to her caseworker. ‘It just said “I don’t want to live here anymore. Get me out of here”.’ ‘Evie’ said the letter was never acknowledged. She was only able to disclose the abuse when she was in respite care and could then talk to her caseworker.²³⁵

Our recommendation addressing the need to ensure the voices of children in out-of-home care are heard is set out in Chapter 5.

Kinship/relative care

The continued growth in the numbers of children being placed in kinship/relative care is clear and for many children this may be the best option.

Research suggests that children in kinship/relative care have fewer placement changes and were more likely to be placed with their siblings and have more positive perceptions of their placements.²³⁶ The philosophy of kinship care is that the loss experienced by a child who has been removed from their parents is likely to cause significant trauma in itself.

Placing a child with kin may help offset some of this psychic trauma, providing the child with a familiar environment with known caregivers and maintaining the perceived warmth and safety of a family during the placement process.²³⁷

As we were told in evidence during our *Out-of-home care* case study, placing a child with relatives or kin increases the likelihood that he or she:

will grow up and know that they’re loved, they’re claimed, they belong ... that essential human need we have to be anchored, to belong, to be claimed, to have someone who delights in you ...²³⁸

We were also told about the protective factors that can arise from maintaining strong family and social connections:

Children who are part of a broader community with an interest in their wellbeing are more likely to be noticed when they are in danger and have networks of support to draw upon when they feel unsafe.²³⁹

There are nonetheless risks in such placements that need to be identified through the assessment of suitable carers and managed by out-of-home care service providers. Risks identified by survivors of sexual abuse in kinship/relative care placements include decisions by child protection departments to place children with family, apparently without regard to known risks. We also heard about the difficulties faced by some survivors who had ongoing contact with perpetrators of sexual abuse because they were family members.

‘Shayna’ told us she was sexually abused by multiple people in her family during her time in kinship care. She became pregnant at the age of 11, with DNA tests revealing her uncle was the father of the baby. She said that she later discovered her mother had made sexual assault allegations about the same uncle years before. ‘Shayna’ told us that she was not placed with this uncle – although there was regular family contact – but her brothers and sisters were. ‘Shayna’ said:

And what makes that whole situation worse is that [the child protection department], who is an organisation to help children who, you know, are being abused, they knew what type of person he was, they knew that there was previous allegations against him, and they allowed me to go and live with somebody who was having regular contact with him. And not only me, my brothers and sisters as well.²⁴⁰

Research indicates that ‘kinship care placements receive less and, in some instances, no monitoring, training and support’.²⁴¹ Concerns about the adequacy of financial and other supports provided to kinship/relative care placements were also noted in the 2005 Senate Community Affairs References Committee report, *Protecting vulnerable children: A national challenge*. Although many kinship/relative carers (and foster carers) remain committed to assisting children who cannot live at home, we know that the financial costs of caring for a child can make it unviable to be a carer in the longer term.²⁴² We also know that the demographics of kinship/relative carers often indicate the need for additional support of kin placements.

Kinship care is often provided by individuals with the following characteristics: female (regularly grandparents), single, older, unmarried, less educated, lower socio-economic status, unemployed or out of the workforce and, have health issues.²⁴³

Commissioned research comparing support in foster, kinship/relative and residential care reports that ‘the provision of support to kinship carers was widely acknowledged to be inadequate’.²⁴⁴ The most significant barrier was reported to be the capacity of caseworkers to provide effective individualised support to kinship/relative care placements – noting that in some jurisdictions, significant numbers of kinship placements did not have an allocated caseworker.²⁴⁵ This is notwithstanding that the needs of a child in a kinship/relative placement are likely to be no less than a child in foster care.

What ‘Emma Leanne’ told us

‘Emma Leanne’ told us she was taken into kinship care with an aunty because her mother suffered a mental illness and could not look after her and her siblings. There were many children in her aunty’s house, and ‘Emma Leanne’ did not receive a great deal of care or attention.

Her brother, ‘Blake’, who was 10 years older than her, lived on and off in the garage for a while. ‘Emma Leanne’ was about 11 years old when one day ‘Blake’ called her into the garage and raped her. She was too scared to disclose the sexual assault to her aunty, as ‘she used to flog us all the time. No one really listened’.²⁴⁶

Other inquiries have raised the challenges of kinship/relative care.²⁴⁷ Submissions to us²⁴⁸ indicate ongoing issues including that kinship/relative carers:

- tend to have fewer social and economic resources than other carers²⁴⁹
- are generally older, more financially disadvantaged and in poorer health, and more likely than foster carers to be single.²⁵⁰

We heard in evidence and from submissions of the need for more, rather than less, support for these carers and placements.

Life Without Barriers submitted that:

children and young people in kinship care should receive increased casework support and oversight – we believe that children in family and kinship placements are just as likely to need casework and other supports as children placed in other types of care.²⁵¹

We were also told that a targeted approach to supporting kinship/relative care is necessary rather than treating it in the same way as foster care. Particular attention was drawn to the needs of kinship carers in managing complex family dynamics.²⁵²

The kinship-specific assessment tools mentioned in Section 4.2 provide an opportunity to identify the need for additional support for a placement. This discussion is taken up in Chapter 5.

We know that removal into out-of-home care is likely to be a traumatic experience for any child separated from their family of origin. We know that many of their birth parents also often experienced time in out-of-home care when they were children, and acknowledge that having a child removed in these circumstances may compound histories of significant trauma.

The holistic approach that is ‘fundamental to Aboriginal community-controlled child and family services organisations’²⁵³ could provide interventions to Aboriginal and Torres Strait Islander families that are appropriate for those families. We were told that holistic, evidence-based Aboriginal or Torres Strait Islander models are more likely to contribute to community healing more broadly.

[The Victorian Aboriginal Child Care Agency] is well aware of the challenges for kinship care recruitment and assessment of our families ... we would like to see a 'shared family care' model of kinship care developed that would provide community care in culture for our children. Funding to Aboriginal services to enable them to provide culturally safe support to families is required. In Victoria, the large majority of kinship care placements are managed by child protection and this is culturally insensitive and ineffective for our families.²⁵⁴

What we have been told is that all kinship carers would benefit from a different model of support. Several submissions made this point – for example:

If supporting kinship carers and the children in their care was treated more like targeted family support, working in partnership with the family would very likely mean that carers would be welcoming of advocacy, practical and educational supports, and therapeutic interventions.²⁵⁵

4.4.3 Risks in residential care

The nature and structure of the residential care system can increase the risk of child sexual abuse (see Chapter 3).²⁵⁶ A focus group participant in a study on children's perceptions and experiences of safety in institutions said, 'Resi care will never be safe. When you're in resi care, you're just fighting for survival'.²⁵⁷

We heard that the systemic factors that can increase children's vulnerability in residential care include:

- inconsistent and limited access to therapeutic support for children, young people and carers
- staffing issues – including the use of staff who lack the skills and experience to work with adolescents; deficiencies in staff training, supervision and support; high staff turnover and the use of casual labour
- frequent turnover in both staff and residents, making it hard for children to maintain 'stable relationships with their caregivers and peers'²⁵⁸ and 'decreasing the likelihood that [children] will have someone they know and trust, who they can turn to when they are unsafe'²⁵⁹
- challenges associated with children who have exhibited harmful sexual behaviours being placed in residential care facilities that also house children who have a particular vulnerability, including children who have a history of sexual abuse²⁶⁰
- a tendency among some in the out-of-home care sector to regard children in residential care as a 'problem' to be managed, rather than children 'needing and deserving protection'²⁶¹

- the form of institutional care itself, with ‘uniformity, control and surveillance over care, development and individuality, and the emergence of separate and divisive staff and resident cultures’.²⁶²

The serious and systemic nature of the risks associated with living in residential care was detailed in an inquiry by Victoria’s Commission for Children and Young People in 2015. The inquiry examined the adequacy of services provided to 166 children and young people (25 of whom were Aboriginal) who were alleged to have been sexually abused or sexually exploited while in residential care. The inquiry found that those in residential care were ‘reporting an alarming level of sexual abuse and sexual exploitation’²⁶³ and that the residential care system:

- ‘creates opportunities for the sexual abuse of children and young people’²⁶⁴
- ‘does not prevent sexual abuse or offer consistent responses when it occurs’.²⁶⁵

Similarly, the 2016 Child Protection Systems Royal Commission in South Australia noted that the increased risks of child sexual abuse in emergency care and residential care settings had been well known ‘for many years’ and that action to mitigate these risks ‘is long overdue’.²⁶⁶ It identified an urgent need for South Australia to end its reliance on emergency care where poorly trained staff from ‘commercial agencies’ are ‘deployed in shifts to care for children in locations such as motels, caravan parks, bed and breakfast cottages, and short-term rentals’, often ‘for much longer than the term “emergency” implies’.²⁶⁷

These and other inquiries identified a number of serious and systemic flaws, particularly the ‘poverty of options for the individual care needs of children’.²⁶⁸ As the Victorian inquiry observed, a form of care that is intended to provide children with ‘safety and sanctuary from the abuse and trauma that led to their placement away from their families’²⁶⁹ instead ‘creates the opportunity for sexual abuse and sexual exploitation to occur’.²⁷⁰

It is simply intolerable to continue propping up this flawed model of ‘care’. Children are channelled through a system that is not equipped to heal them of past abuses, let alone provide them with the most basic physical and emotional protection and care.²⁷¹

According to children who live in residential care facilities, safety is something that they hope for but do not always experience. In the commissioned study that invited those living in residential care to share their perceptions of safety, most participants ‘reported that they were not safe and did not feel safe within residential care’.²⁷² We were told that it can be difficult to establish and sustain a sense of safety in these settings:

Unfortunately, due to the often chaotic and unstable nature of residential care, the constant churn of adults and children and young people through a facility, and the pervasive risks that were present, most of the participants did not characterise residential care as being a safe place. Instead, it was somewhere where they had to protect themselves from multiple interpersonal risks.²⁷³

The few individuals who reported feeling safe usually had not been in residential care for long, and also tended to have workers taking an active interest in ensuring their care and safety.²⁷⁴

In addition, there can be a culture among children in residential care that is highly sexualised. Our research indicates, 'As many of the young people have had past experiences of child sexual abuse and are developing sexually, young people's peer cultures are often hyper-sexual'.²⁷⁵ In this environment, there is an increased risk of children engaging in sexual behaviours that are not likely to be permitted in other environments.²⁷⁶ Residential care staff must be alert to the need to identify and respond to potentially harmful sexual behaviours such as sexual aggression, which is sometimes passed off as 'a normal component of male sexuality'.²⁷⁷ We heard that 'mislabelling this behaviour as normal or biological enabled staff to allow, and even promote, these behaviours'.²⁷⁸

As noted in the following section on sexual exploitation, there is also a growing recognition that children in residential care settings may be vulnerable to this type of abuse by adults outside residential care facilities. We learned that 'significant drug and alcohol misuse or mixing with people involved in these activities' can be a factor in children in residential care engaging in risk-taking behaviours that increase their susceptibility to sexual exploitation.²⁷⁹ As part of its review of cases involving children alleged to have been sexually abused or sexually exploited in residential care, Victoria's Commission for Children and Young People highlighted the difficulties associated with caring for groups of vulnerable adolescents in residential care settings, noting the particular risks associated with alcohol and other drug use.

Direct-care staff spoke about the challenges of keeping the children in their care safe. Other children in the same residential unit may persuade or coerce each other into engaging in high-risk activity offsite. Many staff spoke of 'contamination', where a younger child is placed with older children who are engaging in high-risk behaviours.²⁸⁰

Elsewhere in the report, the Commission observed:

The current four-bed residential unit model is unfortunately a perfect setting for learning dangerous behaviours. Only one of the 87 staff interviewed by the Commission thought that the current system of residential care provided adequate safety to children and young people.²⁸¹

The additional risks associated with residential care highlight the need to pay close attention to the needs of all children affected by the placement decision – the child or children entering the placement and those already living there.

What we were told about 'Chris'

We received a written submission from a clinician, 'Karen Michelle', who worked in a child welfare program, about the sexual abuse of adolescent 'Chris' in residential care, and subsequent institutional responses.²⁸² 'Karen Michelle' told us that the abuse happened in this decade.

'Karen Michelle' told us that 'Chris' had been living in residential care for some years, when at 14 he was referred to a child welfare program for assessment and treatment of mental health concerns including symptoms of depression and anxiety, threats of self-harm, school refusal and alcohol use. 'Karen Michelle' said she was then told that 'Chris' had been recently sexually abused by another resident, 'Kyle', over a period of a few days, that the abuse included forcing 'Chris' to perform sexual acts, including oral sex, and that the abuser bullied and harassed 'Chris'.

'Karen Michelle' told us that 'Chris' was removed from the residential care placement and placed in emergency foster care for one night, but then returned to the residential care placement despite his wish not to return there. She told us that some weeks later, another resident, who had had contact with 'Kyle', harassed 'Chris' about the abuse by 'Kyle'. 'Karen Michelle' said she also learned of an allegation that 'Chris' had been sexually assaulted by another resident, 'Lucas', who she understands had a history of sexualised behaviours.

We were told that 'Chris' then experienced a number of changes of placement. He spent two months in a youth detention centre at the age of 17, and was told that the only option for him when he left youth detention was to return to the placement where he had been abused by 'Kyle'. 'Karen Michelle' said she was concerned that 'Chris' would feel unsafe at this placement, and could be traumatised if obliged to go there. She heard that 'Chris' stated that he did not want to go there, and cried at the prospect. She attended a meeting where the residential service provider acknowledged 'Chris's' trauma, but could offer no alternative placement. Karen was concerned that statements by the residential service provider – that 'Chris' would not be placed in the same room as 'Kyle' and that the building had been painted – did not adequately understand or address 'Chris's' trauma. Child protection services then directed that 'Chris' should not return to that placement, and 'Chris' was then given a foster care placement from which he ran away after one night. 'Karen Michelle' told us that 'Chris' eventually returned to another residential care placement where he felt attached to the staff, and subsequently transitioned to a kinship placement as part of his leaving care plan.

'Karen Michelle' told us that 'Chris's' right to safety was compromised when he was sexually abused in care and returned to the same environment, despite his objections to this, and was subsequently sexually abused again. She told us that the principles of making decisions in the best interests of the child, and of listening to the child, were not followed, due to pressure on the out-of-home care system to place children. She suggested that children like 'Chris' need an independent advocate.²⁸³

4.4.4 Sexual exploitation and risky behaviours

As noted, there is growing recognition that young people in residential care may be vulnerable to being sexually exploited by adults outside the care facility. We heard that sexual exploitation typically involves adults outside residential care taking advantage of children and young people's need to feel as if they are cared for, their desire to have things bought for them or their naivety about relationships.²⁸⁴

We heard that, until recently, misunderstandings by carers, practitioners and police have influenced institutional responses to child sexual exploitation in residential care settings. Common misunderstandings include characterising child sexual exploitation as 'adolescent sexual experimentation', or in some cases wrongly labelling this exploitation as 'prostitution'.²⁸⁵ In writing about the Rotherham child sexual abuse scandal in Britain, the authors make the following observation about the language of sexual exploitation:

From one perspective, the term 'child sexual exploitation' does describe what happens: it involves children, it involves sexual acts and it is exploitative. But we believe that the term intellectualises and normalises what is, in reality, the abuse and rape of vulnerable children and young people by skilled and predatory adults ... we use the term 'organised child sexual abuse' in conjunction with 'child sexual exploitation'.²⁸⁶

We were also told there was a mistaken view among some that the unwillingness of a child to fully disclose or to make a sworn statement to police rendered the system powerless to intervene to stop perpetrators.²⁸⁷

We heard of children in residential care engaging in sex for gifts or money. This included some cases where children recognised the risks involved in such sexual encounters (including the risk of sexually transmitted infections, or being raped or otherwise assaulted) and also recognised that the encounters were exploitative – but they said it was something they had done regardless.

'Jimmie' told us he was sexually abused by a worker at a residential home while being taken on trips, such as picnics and concerts, or being taken to the mall. 'Jimmie' said, 'It was like a favour because he'd let me pick certain stuff ... You don't sort of understand that. And because it had happened at a young age at my house ... I didn't worry too much that these things were happening to me ...'²⁸⁸

The observation was made by children who participated in commissioned research that children in care sometimes initiated these relationships and that they believed these relationships only became problematic when the (usually male) adults manipulated them or put pressure on them to have sex.²⁸⁹

We heard that children's risky behaviours, such as running away, are sometimes viewed by caregivers merely as antisocial or adolescent behaviour, but that trauma-informed work practices are improving the responses to such behaviour, viewing it as a result of trauma or current sexual abuse or exploitation.

Mr Tony Kemp, then Deputy Secretary, Department of Health and Human Services, Tasmania, told us:

I think we are still light years away from actually understanding behaviour in a residential context. Even the language of 'absconding' is deficit saturated – even the word is wrong. They are absent or they are missing or whatever it may be, but we have not even got that bit right.²⁹⁰

Other inquiries have also considered how the risks associated with 'missing from placement' incidents are assessed and responded to.

The inquiry by Victoria's Commission for Children and Young People in 2015 reported the case of a 15-year-old girl with intellectual disability who disclosed that someone in her residential care unit had entered her bedroom and sexually abused her. Residential care unit and departmental staff discussed whether the girl's disclosure referred to a current event or something that had happened in the past. They offered no support to the girl but rather focused on safety planning for staff – having two active staff on duty overnight 'to protect staff at the unit'.²⁹¹ Following her disclosure, the girl was absent from the unit for long periods of time. No one knew her whereabouts. However, she did make contact with a worker, stating that 'she was fearful of returning and that she was suicidal'.²⁹² The plan for responding to her calls was documented in a case note:

[the worker] should respond to [the girl] by stating that [the worker] is unable to talk at this time due to tending to something else and that [the worker] will call [the girl] as soon as they can talk. This response should be enough to hold [the girl]. The ... worker then consulted with a manager ... and it was agreed that 'there is no immediacy to [the worker] seeing [the girl] this afternoon'.²⁹³

The 2016 whole-of-government systems review undertaken by the Queensland Family and Child Commission (QFCC) of responses to children 'missing' or 'absconding' recommends that the language of 'absconding' not be used, in part because of the implication that children 'are to blame for their absence':

A reason for changing the term or the perception of the term is in consideration of residential facilities being children's homes and, generally a child would not be regarded as having 'escaped' from home.²⁹⁴

The QFCC recommended that all agencies cease using the term and ‘adopt a single standard definition in all policies and procedures using the terms “missing” and “absent from placement”’.²⁹⁵ It said clear language will assist responsible agencies to decide whether a casework response is required, including whether child safety officers should develop a ‘safety plan’ in response to frequent absences, or whether to report the child as a missing person and to update policies and procedures accordingly.²⁹⁶ Adopting this approach would be useful for all agencies providing out-of-home care services.

The need for all staff and carers working with children in out-of-home care to have trauma-informed training to ensure that their work with children is always focused on the child’s safety and wellbeing is discussed in Chapter 5.

Responding to ‘missing from placement’ reports

We heard that children in residential care who are being sexually exploited are frequently missing from their placement for extended periods of time and on multiple occasions. ‘Missing from placement’ may be a ‘red flag’ indicator of sexual exploitation for service providers and child protection authorities.²⁹⁷

Despite the recognised risks, under-resourced child protection systems can be slow to follow up on unexplained absences. Jurisdictions typically rely on interagency protocols to provide a coordinated response when children in residential care are reported missing. However, in submissions we were told that adherence to these protocols can be patchy.

While protocols exist regarding reporting children who have gone missing from placement etc, sadly the volume of numbers of children and the overstretched nature of all the systems involved does lead to oversights in protocol adherence and timely responses to children who have left or not returned to their placement.²⁹⁸

In South Australia, the protocol involving the child protection department (formerly known as Families SA), South Australian Police and non-government organisations for responding to ‘missing from placement’ reports included assessments of ‘baseline risk’ and ‘dynamic urgency’ that guide the service response.

The level of urgency – extreme, high, medium or low – determines the response by SA Police and/or Families SA. GCYP [the Office of the Guardian for Children and Young People] has questioned whether [the protocol] has increased the safety of children and young people in out-of-home care. There is no data or evidence available to draw any conclusions.²⁹⁹

We also heard that it was common for some services to minimise the risks associated with unexplained absences. In cases where the child has returned to their family or community, the ability of residential care staff to provide follow-up support can be ‘extremely limited’.

A key issue for us is minimising the risk of young people who run away from the residential unit, particularly vulnerable young Aboriginal women. With an overworked child protection system providing case management, staff in residential facilities are extremely limited in their ability to respond to young people who abscond and return to family or community. It is critical that therapeutic services are able to provide 24/7 care, assertive follow up, case management away from the facility, and family support.³⁰⁰

One challenge is that children who are victims of sexual exploitation are highly unlikely to volunteer information about where they have been when they have been ‘missing from placement’, making it difficult to prosecute offenders. The executive director of services and strategy at the Victorian Aboriginal Child Care Agency praised the initiative shown by police and child protection services in coordinating an effective response to sexual predators targeting children in residential care in Victoria. ‘I think the idea of looking at it [child sexual exploitation] as not an individual child’s responsibility but more the responsibility of state agencies is really very critical.’³⁰¹

Care is needed in interpreting the reasons for children and young people running away from placements. As highlighted in *Case Study 30: The response of Turana, Winlaton and Baltara, and the Victoria Police and the Department of Health and Human Services Victoria to allegations of child sexual abuse*, one reason is to escape the sexual abuse to which these children are being subjected. Returning a runaway child to the institution may be placing them at further risk.³⁰² Some of the submissions also highlighted this risk, noting that there was a need:

to be mindful of some of the difficulties relating to children leaving or being ‘missing’ from a particular placement. It is important to recognise that in some circumstances, seeking a way to escape a care setting is one of the only ways a child has for expressing protest or dissatisfaction with being there. This may be for a variety of reasons, both innocent – such as missing friends that they have moved away from – and problematic – such as the presence of a perpetrator within a care setting.³⁰³

4.5 Response to risks for certain cohorts of children

Research suggests that exposure to risk factors is cumulative and that ‘the more risk factors in a child’s life, the greater the chance that they will experience maltreatment’.³⁰⁴ We heard that particular cohorts of children face additional risks and that targeted institutional responses are necessary.

4.5.1 Additional risks for Aboriginal and Torres Strait Islander children

One of the risks of removing Aboriginal and Torres Strait Islander children and placing them into out-of-home care is that their connection to family, community and culture can be severed, or at least compromised.³⁰⁵ Although all jurisdictions have legislation and policy requiring the Aboriginal and Torres Strait Islander Child Placement Principle to be applied, we heard from many sources that there is insufficient recognition in all state and territory child protection systems of the important role played by Aboriginal and Torres Strait Islander culture in keeping children safe.

The importance of cultural care³⁰⁶ for all Aboriginal and Torres Strait Islander children in out-of-home care, regardless of their placement type, is of particular concern because many Aboriginal and Torres Strait Islander children in out-of-home are placed outside of their culture. Research tells us that when Aboriginal and Torres Strait Islander children are placed with non-Indigenous families, they are less likely to have contact with their families and less likely to be restored.³⁰⁷ Aboriginal and Torres Strait Islander survivors commonly told us that they could not disclose their sexual abuse because they were separated from their family, and were sometimes the only Aboriginal and Torres Strait Islander person in their town. Barriers to disclosing sexual abuse are discussed in detail in Volume 4, *Identifying and disclosing child sexual abuse*.

In Chapter 5 we discuss the importance of the diligent implementation of the Aboriginal and Torres Strait Islander Child Placement Principle in addressing poor institutional responses and risks to the safety of Aboriginal and Torres Strait Islander children.

Submissions and evidence given to our *Out-of-home care* case study emphasised the importance of cultural safety for an Aboriginal and Torres Strait Islander child's safety and wellbeing.

[The Victorian Aboriginal Child Care Agency] was pleased to see the Royal Commission acknowledge in their consultation paper the importance of connection to culture and community and the role this plays in healing trauma for Aboriginal children in out-of-home care. Embedding a culture of child safety also means embedding a culture of cultural safety for Aboriginal children. Culture enhances an Aboriginal child's safety and therefore should be a key component of all policies and practices.³⁰⁸

Connection to culture is 'associated with better emotional, social and physical health of Aboriginal and Torres Strait Islander peoples'.³⁰⁹ Research we commissioned suggests that positive cultural connection can 'increase the protective factors available to Aboriginal and Torres Strait Islander children by helping them to develop their identities, fostering high self-esteem, emotional strength and resilience'.³¹⁰ Positive cultural connection also indirectly increases protective factors by supporting the social conditions necessary for all adults in a kinship placement to be available, responsive to and protective of children in the community.³¹¹

As noted in Volume 3, *Impacts*, Dr Graham Gee, a registered psychologist with the Victorian Aboriginal Health Service, explained that connection to culture is an important source of resilience for communities that are managing the negative impacts of forced removal of children from communities over many generations:

With my mob of Stolen Generations members in particular, it has been the fact that, despite being institutionalised and experiencing abuse, they've somehow managed to maintain a connection to their cultural connections and to their family members and communities. That's a massive source of resilience that sometimes differentiates between those who have been really damaged and are on really long journeys of recovery.³¹²

Maintaining a positive connection to culture is not easy in the context of high levels of racism and the 'cumulative impact over generations of the denial of Aboriginal history and its effective invalidation of the lived experience of Aboriginal peoples'.³¹³

When the culture of a people is ignored, denigrated or, worse, intentionally attacked, it is cultural abuse. It is abuse because it strikes at the very identity and soul of the people it is aimed at; it attacks their sense of self-esteem, it attacks their connectedness to their family and community. And it attacks the spirituality and sense of meaning for their children.³¹⁴

'Shaun' told us that Aboriginal and Torres Strait Islander people need to be included in any discussions about their children. 'Let the [Aboriginal and Torres Strait Islander] people take care of their own people. Give them the respect they need. Let the leaders have their say.'³¹⁵

While stressing the importance of a strong connection to culture, family and community, all sources – including reports by Aboriginal and Torres Strait Islander agencies³¹⁶ and expert evidence to our *Out-of-home care* case study – emphasise that the child's safety is always the paramount consideration in any placement decision.³¹⁷ As noted in the discussion on the need for greater investment in prevention and early intervention in Section 4.3.1, ongoing safety concerns include the failure to address systemic issues that may result in inappropriate removal of Aboriginal and Torres Strait Islander children, or removal for good reason but failure to adhere to all elements of the Aboriginal and Torres Strait Islander Child Placement Principle.

What makes institutional care particularly risky for Aboriginal and Torres Strait Islander children is that they are much more likely than non-Aboriginal children to be raised outside of their culture because of inadequate implementation of the Aboriginal Child Placement Principle and adherence to the National Standards. When they are separated from culture, they are separated from the protective factors associated with being strong in culture – including a strong identity, high self-esteem, and many and strong attachments.³¹⁸

All children in out-of-home care face heightened risk of child sexual abuse. Aboriginal and Torres Strait Islander children, who are already over-represented in out-of-home care, are likely to face more risk factors and less protective factors than non-Indigenous children.³¹⁹ Within frameworks that prioritise the safety of children, there is a need to reduce the over-representation of Aboriginal and Torres Strait Islander children in out-of-home care – starting with adherence to legislation that requires the diligent implementation of the Aboriginal and Torres Strait Islander Child Placement Principle.

4.5.2 Additional risks for children with disability

There is limited research in Australia about the prevalence of abuse of children with disability. However, international research indicates that children with disability – and particularly those with behavioural disorders, intellectual disability, and speech or language communication impairments – are at significantly increased risk of a range of maltreatments, including sexual abuse, in some institutional settings.³²⁰ We understand from our commissioned research that children with disability can often spend more time in institutional contexts, relative to other children. While some institutional settings (such as mainstream schools) are the same for all children, other settings (such as specialised support and respite care for children with disability) are different.³²¹

Despite the lack of disability data in Australia’s Child Protection National Minimum Data Set,³²² we were told in submissions that children with disability are significantly over-represented in out-of-home care.³²³ Children in care are removed due to abuse and neglect in their families of origin. We know from research into the impacts of abuse and neglect that abuse and neglect can be the cause of physical and mental health disability, and cognitive and sensory disability. In *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts*, the director of the Centre for Disability Research and Policy, Professor Gwynnyth Llewellyn, estimated that at least 24 per cent and up to 30 per cent of children in out-of-home care are children with disability.³²⁴ As noted in Chapter 2, it is not clear whether children with disability are over-represented because they are predisposed to entering care or because past maltreatment and poor parenting mean children in care are at greater risk of experiencing disability.³²⁵

One factor that increased the number of children with disability being placed in out-of-home care in the past, and which may still be an issue today, was the inability of families to access appropriate supports to care for their children at home. Research commissioned by the Australian Government in the late-1990s to identify why parents continued to place their children on waiting lists for residential care, despite the growth in services and supports for home-based care, found that most families wanted help to keep their children at home, but in the absence of assured help, sought places in residential care.³²⁶

‘Tim Luke’ told us he was sexually abused by an uncle before being taken into care, and subsequently sexually abused while living in a children’s home. ‘Tim Luke’ said after his uncle abused him, he was taken by the child protection department, and

they got their own psychologist to diagnose me ... as an abused child ... I couldn’t get along at school, I didn’t have any friends ... I couldn’t sit in a classroom, couldn’t do anything really. It was just difficult.

He said he was diagnosed with attention deficit hyperactivity disorder (ADHD) and suspects that he also suffered from undiagnosed Asperger’s syndrome. ‘Tim Luke’ became very emotional recalling this period of his life. He said, ‘I sort of feel like it ... it was my fault I got taken away from Mum. All Mum was asking for was help’.³²⁷

We have been told that children with disability are more vulnerable to sexual abuse than their peers without disability.³²⁸ Research estimates the risk of sexual abuse of children with disability to be about three times that of the general population, with some estimates being considerably higher.³²⁹ There is certainly a need to better understand the particular circumstances in which children with disability are at risk in out-of-home care, with particular attention to the higher risk one-to-one interactions that occur in disability-specific institutional settings.³³⁰

Non-normalised and segregated settings have been associated with the highest risk of sexual abuse for children with disability³³¹ and the segregated nature of the disability-specific institutions in the voluntary out-of-home care sector may increase this risk of abuse.³³² On the other hand, it is essential that staff in general residential institutions are trained and supported to provide the highest standard of care for children with disability.

It is likely that children with disability are still over-represented in residential care settings compared with foster care or kinship/relative care because a home-based carer may not have sufficient resources to care for the particular needs of a child.³³³ Given that residential care is associated with a greater risk of sexual abuse than home-based care, it is possible that children with disability are at an increased risk of sexual abuse simply through the greater likelihood of their placement in this out-of-home care setting.³³⁴ Similarly, children with disability spend more time in institutional contexts as a result of policies designed to provide additional supports – for example, respite care services, disability transport, and education schemes to give children with disability or developmental delay more intensive programming and opportunities for socialisation.³³⁵

Submissions to our out-of-home care consultation paper also told us that placement in residential care may separate children with disability from their existing support networks and contribute to their loss of connection to family, especially when parents have been obliged to relinquish their child with disability through the child protection system.³³⁶ This loss of connection may add to the barriers for children with disability in disclosing sexual abuse, as discussed in the section that follows.

‘Harry Arthur’ told us he was diagnosed with a hyperactivity disorder, was in constant trouble at school, and was taken into care to give his family a break from his behaviour. He said that while he was in residential care he was raped by another resident in a locked television room. ‘Harry Arthur’ told us he was subsequently placed in different residential institutions where he was also sexually abused. He said he was sexually abused by a priest in a boys’ home when he was attempting to disclose the abuse he’d been subjected to by others. ‘Harry Arthur’ told us:

There are so many kids that are in state care now, I feel that, in that dark and closed environment and space there that I was in ... shut out from the world, so to speak. Believe me, it’s probably the worst, darkest place you could ever been in.³³⁷

The National Disability Insurance Scheme (NDIS) presents opportunities for improved collaboration between the disability and child protection sectors.³³⁸ Dr Sally Robinson, a disability researcher, told us in *Case Study 41: Institutional responses to allegations of the sexual abuse of children with disability* that work is underway to establish a framework that formalises links between disability and child protection service providers, but that this work is in the early stages: ‘To be bringing together child protection and disability is incredibly important, but it is new. It is a new disability conversation’.³³⁹

For those who do qualify for NDIS assistance, the scheme can provide continuity of disability support services if children’s caring or living arrangements change due to a child protection order. For children already participating in the NDIS, a child’s individual plan would be reviewed, including consideration of whether the child’s support needs have changed because of entry into out-of-home care.³⁴⁰ The NDIS Quality and Safeguarding Framework aims to provide an overarching protective framework for children participating in the NDIS.

On the other hand, even when the NDIS is fully rolled out, some people estimate that the scheme will only include about 10 per cent of those Australians who have disability. As NDIS assistance will only be made available to people with significant and permanent, or likely to be permanent, disability, most of the children referred to in this section are unlikely to be eligible for support.

4.5.3 Risks for care-leavers

In Australia, 'leaving care is legally defined as the cessation of legal responsibility by the state for children living in out-of-home care'.³⁴¹ Nationally, there were 9,794 children discharged from out-of-home care during 2015–16.³⁴² Of these, 3,134 or 32 per cent were aged 15 to 17 years.³⁴³ We heard that some of these older care-leavers continue to live in their existing foster or kinship care placements, some return to their family of origin, and 'many ... go on to live independently'.³⁴⁴ As no states or territories keep records or monitor the progress of care-leavers, 'there are no figures to indicate how many young people fall into each category'.³⁴⁵ In 2016, one care-leaver study found just over one-fifth of respondents continued living with their carers after turning 18, 'while 27 per cent moved in with family members, mostly relatives other than parents or siblings'.³⁴⁶

Care-leavers have long been recognised as among 'the most vulnerable and disadvantaged' groups in Australia.³⁴⁷ Compared with most young Australians leaving home, care-leavers' transition to independent living usually occurs at an earlier age, in a more abrupt manner and with far fewer emotional, social and financial supports.³⁴⁸ We heard that the abrupt cessation of out-of-home care, combined with deficiencies in the supports provided as care-leavers transition to independence, can particularly affect those children who have been sexually abused – both in terms of being supported to disclose abuse and in establishing positive life trajectories.³⁴⁹

Among the care-leavers who are more likely to need extra assistance or specialist supports as they transition to adulthood are:

- children who were sexually abused while in out-of-home care, and who have already disclosed the abuse
- children who were sexually abused in care, and who are yet to disclose the abuse
- children who were not sexually abused themselves, but who may have witnessed or been affected by the abuse of others.

For children who have already disclosed the sexual abuse they experienced in care, governments and service providers have a duty of care to assist them to access therapeutic treatment to deal with any impacts of that abuse – at the time they choose to access such support, noting that this might not be immediately.

While there is also a duty of care to support the other two groups, there is not necessarily an easy way to identify these cohorts. The challenge in providing post-care supports targeting the specific needs of care-leavers is finding ways to ensure that those who want or need help to deal with the impacts of child sexual abuse are supported to disclose the abuse and can subsequently access therapeutic treatment when needed. The public health literature suggests this could be achieved by ensuring existing universal service systems for all care-leavers are

capable of providing a platform for the ramping up of post-care supports targeting the specific needs of child sexual abuse survivors.³⁵⁰ Deficiencies in universal services may compromise the ability of more vulnerable care-leavers to identify and access therapeutic treatment and other targeted supports. This section discusses the potential for both universal and targeted services to help care-leavers deal with the sexual abuse they experienced in care.

Accessing sources of post-care support

Care-leavers who have been sexually abused in out-of-home care, or as they are leaving care, are less likely to report the abuse unless there are appropriate supports in place as they transition to independence. For all children, moving out of home and into self-supported living arrangements is a key milestone in their lives. Even after turning 18, most young Australians continue to rely on their families for some level of support – including shelter, financial assistance and advice – as they complete their education and move into adulthood.³⁵¹ In 2012–13, 60 per cent of all 18- to 24-year-olds were still living with their families, up from 50 per cent of this age group just 15 years earlier.³⁵² Even after leaving home, many in the 18 to 24 age group return home ‘at least once’ and ‘others will require ongoing support and help’.³⁵³

For care-leavers, transitioning to independence can be a period of fear and uncertainty.³⁵⁴ As one young care-leaver explained during our *Out-of-home care* case study:

a lot of children who live with their parents, they pretty much live with their parents until they are 25 or older. When you’re in care, you stop being a ward of the state when you’re 18, you stop getting help, you stop getting anything, so suddenly you’re on your own and there’s a fear behind that. You’re in the big bad world by yourself.³⁵⁵

Although ‘most states and territories say that support is provided to young people until the age of 21 years, and in some cases to 25 years’,³⁵⁶ in practice, assistance quickly tapers off and is often only available to those who ‘seek out support if they need it, which can be difficult’.³⁵⁷ The differing levels of support immediately before and after leaving care starkly illustrate this point. In the 12 months to 30 June 2016, Australia spent between \$28,000 and \$40,000 on each home-based care placement, and between \$217,000 and \$639,000 for each child in residential care.³⁵⁸ While actual spending on post-care support is difficult to quantify, the \$11 million that the Victorian Government allocated in 2013–14 to help 18- to 21-year-old care-leavers access housing, training, employment and other opportunities was the equivalent of just over \$5,000 for each of the estimated 2,000 or more care-leavers who were eligible to seek help.³⁵⁹ Additionally, the Australian Government offers a one-off Transition to Independent Living Allowance grant of up to \$1,500 to care-leavers. However, as discussed in the following section, this scheme is heavily undersubscribed, in part because many care-leavers don’t know about the grants, are uncertain whether they are eligible, and have difficulties in accessing payments.³⁶⁰

As the onus is on individual care-leavers to identify and request help from various sources, in practice those who experience a 'volatile pathway' from out-of-home care are less likely to seek out and receive help. A 2010 study of care-leavers aged between 18 and 25 years found that 77 per cent of care-leavers 'have a volatile or problematic transition from care'.³⁶¹ A volatile transition is associated with multiple placements in care, physical and/or sexual abuse before or while in care, leaving care at a younger age and with little planning, and a lack of appropriate accommodation upon discharge.³⁶² Of those surveyed, 47 per cent reported having been physically or sexually abused prior to or while in care, 53 per cent had a substance abuse problem and 25 per cent were currently homeless.³⁶³ Similarly, Anglicare Victoria estimated that:

50 per cent of those who are terminated from state care at 18 years [in 2016] will either be homeless, unemployed, a new parent or in a correctional facility within their first 12 months of leaving care.³⁶⁴

Another impediment is not knowing what post-care supports are available and who is eligible to access them. A Victorian study of care-leavers with disability – all of whom were struggling financially – found that more than half received no funding support when leaving care.³⁶⁵ Even after two-thirds of this group later accessed Victorian Government post-care brokerage funding for items such as school supplies, accommodation costs, dental bills and public transport cards, most had difficulty in understanding their entitlements and how to access them.³⁶⁶

One young person who did not find out about the post-care funding until he was too old to access it, stated that [the department's] approach seems to be: 'If you don't ask what's available, we won't tell'.³⁶⁷

The administrative requirements imposed by some schemes can also deter applicants. Care-leavers applying for the Australian Government's \$1,500 Transition to Independent Living Allowance grant to offset leaving care expenses must have an approved 'transition to independence plan', provide quotes for the goods and services to be purchased, and have a caseworker to apply for, receive and spend the funds on their behalf.³⁶⁸ Those who have already left the out-of-home care system must first ask their state or territory child protection department to assign them a caseworker and develop a plan.³⁶⁹ A 2016 survey of 369 young people who had 'aged out' of out-of-home care in the previous year found that 57 per cent of respondents either did not know about the allowance or had not applied for it.³⁷⁰ Some care-leavers who had submitted applications said that 'quotes were hard to get' and were then lost by the department processing the application, and there was confusion about whether the allowance was additional to or instead of state and territory supports.³⁷¹

Although state and territory governments sometimes try to minimise red tape by funding agencies to provide user-friendly services directly to care-leavers,³⁷² locating prospective clients can be difficult. When the CREATE Foundation tried to send government-funded resource kits to all Australian care-leavers in 2016, it found that the state and territory child protection departments that had funded and agreed to distribute the kits could not find most of the young people who had exited statutory care in the previous year.³⁷³

Overall, 64 per cent of the group of young people who left care in 2015 were not locatable. This is not the same as the young people choosing not to engage. These young people could not be found, and no one was able to provide information on their whereabouts.³⁷⁴

Leaving care planning

Despite the lack of ‘nationally representative Australian studies assessing the trajectories of young people leaving care’, there is little doubt that many care-leavers face acute challenges – not just those who have been sexually abused. While many ‘go on to have successful lives’:³⁷⁵

a considerable body of research from small-scale qualitative studies and international research indicate that young people who exit care experience significant social and economic marginalisation ... including a range of poor educational and health outcomes.³⁷⁶

A 2009 survey of 471 young people aged 15 to 25 years who were in care or who had left care showed that, at the time of the survey, 35 per cent were homeless in the first year of leaving care, 28 per cent were already parents and 46 per cent of boys were involved in the juvenile justice system.³⁷⁷ Also, 64 per cent of those surveyed did not have a leaving care plan.

Despite a greater emphasis on improving the discharge planning processes in most jurisdictions since the 2009 study,³⁷⁸ we were told that leaving care plans are often not done, or not done well. The National Standards for Out-of-Home Care require all states and territories to initiate planning for leaving care long before statutory care ends so that care-leavers have safe housing to go to, and know how to access health assistance, education, employment and other supports. However, when the Northern Territory’s Office of the Children’s Commissioner checked records relating to a group of young Territorians in care in 2013, it found that just 17 per cent of those aged 15 to 17 years ‘had a leaving care plan or any evidence to suggest that a plan had been considered’.³⁷⁹ After additional scrutiny and targeted strategies, a similar audit a year later found that 42 per cent had a leaving care plan, but the most recent survey showed that only 27 per cent of care-leavers had an endorsed leaving care plan.³⁸⁰

We heard that prospective care-leavers are often not adequately consulted by the out-of-home care agencies supporting their placement, or not consulted at all, and plans can be rushed and incomplete. Legal Aid NSW told us that only 22 per cent of young New South Wales care-leavers have an endorsed leaving care plan when statutory care ends,³⁸¹ despite there being a statutory requirement that:

The designated agency having supervisory responsibility for a child or young person must prepare a plan, in consultation with the child or young person, before the child or young person leaves out-of-home care.³⁸²

Although most care-leavers had a plan in place within five months of leaving, the ‘vast majority’ of the plans that Legal Aid’s Children’s Civil Law Service had reviewed ‘were template plans developed with limited or no participation from the young person and bore little relevance or resemblance to their needs or circumstances’.³⁸³ We heard that one young Aboriginal man was placed in a residential care service eight months before he turned 18, but that the development of his leaving care plan began with a 30-minute meeting with him just two days before his 18th birthday in June 2015.³⁸⁴ The subsequent plan identified no ongoing supports, and made no provision for where he might live. He avoided exiting into homelessness after the residential care service was funded for a further four weeks to enable leaving care planning to take place.³⁸⁵

Other recent small-scale studies have highlighted concerns about care-leavers’ limited access to training and employment opportunities; the impact of mental health concerns, substance abuse, and involvement in the youth detention system while transitioning from out-of-home care; and the needs of Aboriginal and Torres Strait Islander care-leavers, care-leavers with disability, and care-leavers living in rural and remote areas.³⁸⁶

Unfortunately, the underlying theme emerging from all these studies is one of young people struggling against the odds with ‘no clear evidence to demonstrate significant improvements in their life chances’.³⁸⁷

Aboriginal and Torres Strait Islander care-leavers often leave care at a younger age than other care-leavers, which renders ‘many ineligible for post-care assistance because they were no longer under statutory care at age 16’.³⁸⁸ Aboriginal and Torres Strait Islander care-leavers are also less likely to have finished school or go on to further education and training, and are more likely to be involved in the criminal justice system.³⁸⁹

Research suggests that most young care-leavers with disability are unable to access appropriate, stable and safe accommodation and those who move into adult disability services experience ‘greatly reduced levels of support’.³⁹⁰ They are also ‘less likely to be in employment or post-school training, are less likely to have had input into post-care arrangements, and lack awareness of the post-care services and funding that they are entitled to’.³⁹¹ While there are few care-leaver support services in rural and remote areas, services for care-leavers with disability are even rarer.³⁹²

The National Framework for Protecting Australia's Children 2009–2020 commits all Australian governments to strengthening supports for young people leaving care, including actions to reduce the incidence of homelessness.³⁹³ In practice, better planning and preparation for leaving care is seen as crucial to achieving stronger supports and improved outcomes.³⁹⁴

The failure of out-of-home care service providers to develop tailored leaving care plans for children who have been sexually abused in care can greatly increase the risks of homelessness and reduce the likelihood of these children accessing therapeutic treatment after leaving care. When out-of-home care service providers fail to work with care-leavers to prepare them for their future, it can also undermine their ability to access further education, pre-employment schemes and other universal supports that reduce their vulnerability to sexual exploitation as they transition from care to independence. While inadequate discharge planning particularly affects vulnerable care-leavers, including those who have been directly or indirectly affected by sexual abuse in care, deficiencies in post-care supports may increase the vulnerability of all care-leavers.

We heard that safe, stable accommodation with links to the community at the time of leaving care was an important factor for young people. In commissioned research into the safety of young people in residential care, we heard from a young man who said he was in a residential unit towards the end of his time in care where he had developed strong ties to his local community, had a girlfriend, a part-time job, was attending a local church and had supportive relationships with a network of trusted adults. He said he had a plan for the future.³⁹⁵

The young man said he was overwhelmed when he was told that he was to be moved to another unit so his room could be given to a younger, more vulnerable client. He was told the unit he was moving to was unsuitable for younger clients because it was less safe. He recognised he was better able to protect himself than the younger child, but felt his need for links to the community at that time were being ignored:

Yeah. Like I said, 'I don't want to move from here' and they said, they'll escort the – they'll get the police to escort me out and I won't have a place to live anymore.
(Young man, aged 17-20)³⁹⁶

Supports for care-leavers to disclose sexual abuse

Beyond the lack of support for care-leavers to transition to independent living, we also know that care-leavers are not well supported to disclose any experience of sexual abuse from their time in care. Over the course of our inquiry, we have learned that disclosure of sexual abuse is extremely difficult unless people are supported. As one young care-leaver told us during our *Out-of-home care* case study:

I personally think they are just not comfortable, because you're still coming out of that system where nobody has listened to you ... So we're still not going to be comfortable with sharing who we are and, you know, I wasn't comfortable with sharing who I was until I joined up with the CREATE Foundation. That's when they have given me that courage actually to speak up with my story.³⁹⁷

Another emphasised that care-leavers will not share sensitive information about their experiences in out-of-home care unless there is a high level of trust in the person they disclose to:

for me, I was afraid to say anything. I didn't want, I didn't have, anybody to talk to where it wasn't going to go to somebody that I didn't want to know. I had my youth worker, who was a part of my leaving care service. She was the first person I spoke to. I trusted her because she wasn't a part of the government, like [the child protection department], she was an individual and she didn't – she wasn't biased. She took my side – well, as best as she could.³⁹⁸

One care-leaver, who told us in a private session that she had been sexually abused by her biological brother while in kinship care, described her experience of leaving the out-of-home care system:

I received a letter saying, 'Congratulations 'Kylie', you've turned 18, you're now on your own' ... [I] cut all ties with my mother and just stayed in touch with my cousins and my aunty ... kept busy by working and studying.³⁹⁹

Several submissions to our *Out-of-home care* consultation paper stressed the need for much more cohesive supports for children leaving statutory care. Measures to strengthen supports for survivors of child sexual abuse as they leave care and transition to independence are discussed in Chapter 5.

Endnotes

- 1 Australian Children's Commissioners and Guardians, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Issues paper No 3: Child safe institutions*, 2013.
- 2 See for example, Senate Community Affairs References Committee, *Out of home care*, Commonwealth of Australia, Canberra, 2015; Child Protection Systems Royal Commission, *The life they deserve: Child Protection Systems Royal Commission Report*, South Australian Government, Adelaide; Protecting Victoria's Vulnerable Children Inquiry, *Report of the protecting Victoria's vulnerable children inquiry*, Victorian Government, Melbourne, 2012; Commission of Inquiry into Abuse of Children in Queensland Institutions, *Report of the commission of inquiry into abuse of children in Queensland institutions*, Queensland Government, Brisbane, 1999.
- 3 See for example, studies of abuse in out-of-home care cited in T Blakemore, JL Herbert, F Arney & S Parkinson, *Impacts of institutional child sexual abuse on victims/survivors: A rapid review of research findings*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017.
- 4 A Jay, *Independent Inquiry into child sexual exploitation in Rotherham*, Rotherham Metropolitan Borough Council, Rotherham, 2014.
- 5 Commission for Children and Young People, "...as a good parent would..." *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, Commission for Children and Young People, Melbourne, 2015.
- 6 New South Wales Children's Guardian, *Statutory out-of-home care*, 2017, www.kidsguardian.nsw.gov.au/statutory-out-of-home-care-and-adoption/statutory-out-of-home-care (viewed 25 March 2017).
- 7 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 1: The response of institutions to the conduct of Steven Larkins*, Sydney, 2014, pp 31–32.
- 8 At that time the department was responsible for administering Working with Children Checks. See Finding 15, Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 1: The response of institutions to the conduct of Steven Larkins*, Sydney, 2014, p 27.
- 9 Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 1: The response of institutions to the conduct of Steven Larkins*, Sydney, 2014, p 11.
- 10 See Finding 26, Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 1: The response of institutions to the conduct of Steven Larkins*, Sydney, 2014, p 36.
- 11 For example, the failure of Hunter Aboriginal Children's Service employees to advise the Hunter Aboriginal Children's Service Management Committee in late 2010 of their concerns about the content of text messages from Steve Larkins to a child he was caring for, 'was another missed opportunity for Steven Larkins' conduct to be scrutinised by those with authority to do so'. See Finding 24, Royal Commission into Institutional Responses to Child Sexual Abuse, *Report of Case Study No 1: The response of institutions to the conduct of Steven Larkins*, Sydney, 2014, p 34. See also discussion of management committee members' inexperience in organisational management and lack of knowledge of the regulatory regime governing out-of-home care, pp 8–10.
- 12 *Human Services Standards Policy*, Victorian Department of Health and Human Services, Melbourne, 2016, pp 11–13.
- 13 State of Victoria, Department of Health and Human Services, 'Foster care spot audits', *Fact sheet for community service organisations*, Department of Health and Human Services, Melbourne, March 2017.
- 14 See Office of the Children's Guardian, *About designated agencies*, www.kidsguardian.nsw.gov.au/statutory-out-of-home-care-and-adoption/designated-agencies/about-designated-agencies (viewed 21 June 2017).
- 15 Wesley Mission Vic, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, p 10.
- 16 See for example the following submissions to the Royal Commission into Institutional Responses to Child Sexual Abuse on *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016: Care Leavers Australasia Network, p 5; The Salvation Army Southern Territory, p 5.
- 17 Anglicare NT, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, p 2.
- 18 Uniting Church in Australia, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, p 15.
- 19 Children and Young People with Disability Australia, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, p 9.
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- 21 M Benton, R Pigott, M Price, P Shepherdson, & G Winkworth, *A national comparison of carer screening, assessment, selection and training and support in foster care, kinship and residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 25.
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- 23 M Benton, R Pigott, M Price, P Shepherdson, & G Winkworth, *A national comparison of carer screening, assessment, selection and training and support in foster care, kinship and residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 57.
- 24 M Benton, R Pigott, M Price, P Shepherdson, & G Winkworth, *A national comparison of carer screening, assessment, selection and training and support in foster care, kinship and residential care*, report prepared for the Royal Commission

into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 58.

M Benton, R Pigott, M Price, P Shepherdson, & G Winkworth, *A national comparison of carer screening, assessment, selection and training and support in foster care, kinship and residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, p 58.

See for example, Centre for Excellence in Child and Family Welfare Inc., Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, pp 18–19.

Transcript of M Couch, Royal Commission into the Protection and Detention of Children in the Northern Territory, 31 May 2017, at P-4176:12–47.

See *Working with Children Act 2005* (Vic) s 28. Following amendments introduced by the *Working with Children Amendment Act 2016* (Vic) that came into effect on 1 August 2017, kinship carers are no longer exempt from Working With Children Check requirements in Victoria. Section 28 continues to exempt ‘closely related’ family members from having to obtain Working With Children Checks for other child-related work (for example, tutoring), but not for ‘child-related work’ involving a placement in kinship care. See also Transcript of C Haire, Case Study 24, 10 March at 12870:16–22.

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5 Creating child safe out-of-home care

5.1 Overview

Improving safety in out-of-home care

The role of contemporary out-of-home care is to ensure the safety and wellbeing of children who, for whatever reason, are unable to live safely with their families or in informal care arrangements. It is therefore imperative that robust systems are in place to care for and protect these children.

In earlier chapters we described the contemporary out-of-home care system in Australia and detailed what we learned about the nature and extent of child sexual abuse in this setting. We considered the risks to children associated with different forms of care, and some of the barriers for children in identifying and disclosing sexual abuse. We also considered some institutional responses to disclosures of sexual abuse, institutional responses to risks in particular settings and additional risks for particular cohorts of children.

We acknowledge the contemporary out-of-home care system is an important component of ensuring children are kept safe and well. There have been many reviews of the system across jurisdictions and many reforms have been made to improve the system. The recommendations we make in this volume are not aimed at extensive system-wide reform, but are intended to strengthen and enhance existing mechanisms and to assist governments and out-of-home care service providers to better ensure the safety of some of the most vulnerable children in our community.

Our recommendations for protecting children in out-of-home care from sexual abuse and improving institutional responses when abuse occurs have been informed by our public hearings, consultations with stakeholders, research and what we heard in private sessions from survivors of sexual abuse in contemporary (post-1990s) out-of-home care. These recommendations seek to address the risks we discussed in Chapter 3 and the failures of institutional responses identified in Chapter 4.

Drawing on what we have learned about child safe institutions and the importance of institutions implementing child safe frameworks, we have made recommendations aimed at improving governance and strengthening systems to protect children from sexual abuse. We recognise the critical importance of supporting children to make disclosures and have made recommendations that address current gaps in the provision of this support. We know that the response children receive to a disclosure is crucial to reducing the harm resulting from sexual abuse and we focus on the role played by out-of-home care service providers and oversight agencies in ensuring appropriate responses to the individual needs of children and appropriate systemic responses.

While this volume necessarily highlights the significant risks to children's safety in contemporary out-of-home care, and has as its focus those children who have been sexually abused in care, it is important to acknowledge the many carers and workers who are committed to protecting and supporting the children in their care. We recognise that many children's lives are improved, and in some cases saved, by contemporary out-of-home care services.

Children's views on safety in contemporary out-of-home care

Throughout this volume we have highlighted the risks inherent in out-of-home care and discussed the abuse experienced by some children in this institutional setting. As part of our inquiry, we commissioned a number of research projects to develop an understanding of how children perceive safety and consider it within institutional contexts.¹ Among the key messages from the children and young people who took part in this research was that most adults were doing reasonably well in keeping them safe. 'Tell them that adults are doing a pretty good job and that most of the time we're safe'.²

Children and young people consulted in this research recognised that many children were unsafe, but felt that adults should be aware of the real risks to their safety, and not make it harder, or more restrictive for children as a result. As one participant said, 'When adults freak out, kids stop wanting to talk about things that are worrying them. [Adults] have to get the risk but do things that will make things better'.³ When children in residential care were asked what made them feel safe, there was an overwhelming view that:

a safe residential care unit was home-like – where children would be loved and cared for, where there was a sense of stability and security, and where they could enjoy their childhoods.⁴

When the CREATE Foundation, in 2013, surveyed 1,069 children aged eight to 17 years living in out-of-home care, it found that 83 per cent of respondents were 'quite happy' or 'very happy' with their current placement.⁵ However, many were dissatisfied with their placement history, nominating placement instability as a particular cause for concern.⁶ Those living in 'Residential' or 'Other' types of accommodation said they had experienced more disruption during their time in care than other respondents described, as did Aboriginal and Torres Strait Islander children.⁷ This survey also found that 'the best predictor of happiness in placement was how comfortable the child or young person felt in his/her care environment', how home-like it felt, whether relationships with others in the household were positive, and whether the child felt loved and cared for.⁸

A national pilot data collection undertaken by the Australian Institute of Health and Welfare (AIHW) on the views of children in out-of-home care suggests that the majority of respondents had a sense of security, attachment to a significant person, sense of community and family connection.⁹

This survey has limitations that make it difficult to generalise about the wellbeing of the overall contemporary out-of-home care population. Data was collected from 2,083 children aged eight to 17 years on care and protection orders during a five month period in 2015. This number represents 5.1 per cent of the 40,263 children in out-of-home care on care and protection orders as at 30 June 2015.¹⁰ No information was made available to the AIHW about the size of the in-scope population for the survey or the number of those who refused to participate. Additionally, this survey by definition does not include the views of younger children under the age of eight. Perhaps significantly, in many locations ‘the agency with case management responsibility’ administered and collated the survey responses and, in some locations, caseworkers directly helped children to fill out the survey form.¹¹

Most of the respondents to this survey were living in foster care (44 per cent) or with relatives/kin (40 per cent) on the night before completing the survey.¹² Noting the above limitations, of respondents to the pilot survey: 91 per cent said they felt safe and settled in their current placement; 97 per cent said they had a significant adult who cared about what happens to them; 94 per cent said they felt close to at least one family group – the people they were living with at the time, family members they did not live with, or both.¹³

Of the 130 children aged 15 to 17 who responded to questions about the adequacy of assistance they were receiving to transition to independence, 58 per cent said they were getting as much help as they needed to plan for their future and 30 per cent said they would like additional help.¹⁴

Within the acknowledged limitations of the survey, the results suggest that out-of-home care has the potential to meet the needs of many children in care, provided there is an appropriate investment of time and resources in policies and practices that have been shown to be effective in making children feel safe and well in out-of-home care.

Throughout this volume we describe numerous instances of contemporary out-of-home care institutions failing to adequately protect children in their care or respond appropriately when disclosures were made. However, it is important to acknowledge that many survivors of child sexual abuse in out-of-home care settings also told us about positive experiences with carers and workers. ‘Dee Ann’, a survivor who spoke to us in a private session, told us her foster father treated her, ‘really, really well’, and she remembers him with great fondness.¹⁵

If I hadn’t lived with that man for the time that I did, I don’t think that I’d be alive ...
He was a gentleman. Nothing but ... I know I’ve called hundreds of women ‘Mum’,
but that’s my dad, you know.¹⁶

‘Vince Tom’, who was born with intellectual disability, told us he was removed from his parents and placed in foster care when he was eight years old.¹⁷ He said the foster family were ‘wonderful’ to him and he was very happy to live with them in this short-term placement.

Other survivors described foster carers who provided sanctuary and healing at critical points in their young lives. 'Larissa' told us that when she was 13 years old and had been through a succession of placements, including placements where she had been sexually abused, she was placed into the care of an older woman for whom she had a lot of respect.¹⁸ 'Larissa' said, 'No matter how much crap I gave her or I threw at her, she still stuck around'. 'Larissa' often slept on the woman's bedroom floor because she was petrified of someone coming and hurting her. 'I was bashing myself up. I was pretty traumatised by the time I even got there. She got me medicated for wetting the bed, I was still wetting the bed.'¹⁹

For others, like 'Mikel', who told us he had been physically and sexually abused prior to his placement with a foster family when he was 11 years old, 'No money in the world would compare to it. That's how perfect it was. I went to school. I went to church. First time I went to school properly'.²⁰

Residential care was also positive for some survivors. 'Angela Kate' told us about a physically abusive home life at the hands of her stepfather, followed by some sexually abusive placements in foster care.²¹ 'Angela Kate' told us that after that she went to a government home for girls. She described this as a positive experience where the girls were properly prepared for independent living.

For some survivors there was not only an appreciation for individual carers and child protection workers, but an acknowledgement of their circumstances prior to being taken into care and the benefits offered by contemporary out-of-home care. Survivor 'Kylie Lynne' told us she is grateful to the people who did try to help her as a child.²² She said:

There's some good things about it, being a ward of the state or foster care, it's like a second chance at life, because I know where I would have been ... if it hadn't have been for everyone [helping]. I know there's been quite a few people who've stuck up for me.²³

5.2 Initiatives for improving safety in out-of-home care

We have heard cases where children were not adequately protected from sexual abuse in contemporary out-of-home care or responded to appropriately when disclosures were made. We have also identified the need for improvements to institutions in certain areas that would reduce the risks to children in care.

In this section we consider some initiatives we have identified for improving the safety of children in out-of-home care, which are informed by our public hearings, research and what we were told by survivors in private sessions. These initiatives include improvements to data collection and the quality of information captured, the consistent application of child safe standards, better accountability for the safety of children in care and improved oversight of complaint investigations.

5.2.1 Strengthening data collection and reporting

Our inquiry identified limitations to the information reported on out-of-home care across Australia, and the need to make much better use of crucial records relating to the safety and wellbeing of children in out-of-home care.

As discussed in Chapter 3, Australia lacks critical information about child sexual abuse in contemporary out-of-home care. By using statutory powers to remove children in order to prevent abuse from continuing, the state takes on responsibility for protecting some of Australia's most vulnerable children from further harm. Without records systems that enable accurate monitoring of abuse in out-of-home care, there is no way to be sure which children may still be at risk and whether these risks are being properly addressed. Systems that tell us who is abused, by whom and in what context are required to enable effective monitoring of systemic issues and to inform prevention strategies.

The need for a nationally consistent approach

The lack of nationally consistent, accurate data on child sexual abuse in out-of-home care is a significant gap in our understanding of such abuse. We know that three-quarters of the substantiated reports of all child abuse in Australia in 2015–16²⁴ involved children in out-of-home care.²⁵ Yet no one knows how many of the 5,559 substantiated reports of child sexual abuse that year involved children who were in care at the time of the abuse and what proportion of abuse occurred before those children entered care. Further, there is no accurate and accessible way to profile who perpetrated the abuse of children in out-of-home care and there are significant gaps in what conclusions may reliably be drawn about when and where abuse occurs. Without this information, it is impossible to measure the effectiveness of programs aimed at preventing and responding to child sexual abuse in out-of-home care.

In response to measures proposed in our *Consultation paper: Institutional responses to child sexual abuse in out-of-home care (Out-of-home care)* to improve the collection and reporting of data about child sexual abuse in out-of-home care,²⁶ state and territory governments were broadly supportive of proposals to strengthen the evidence base.²⁷ However, some also voiced concerns about the 'burden' of 'introducing new data outputs' and warned against implementing requirements that could impede frontline casework.²⁸

Clearly, there is a need to avoid imposing additional unnecessary administrative requirements on caseworkers whose primary job is to work with children and families. However, properly implemented reporting is essential for external accountability (measurement) and for facilitating shared learning (feedback).²⁹

Data about the experience of children and young people are essential for managers to know whether they are providing a good service and whether that service is contributing to better outcomes. The central issue is, therefore, not about whether data collection is a burden. Rather it is about whether it provides the information necessary to evidence the impact and effectiveness of work undertaken to help and protect children and young people.³⁰

The gaps in Australia's current evidence base were noted in the public hearing for *Case Study 24: Preventing and responding to allegations of child sexual abuse occurring in out-of-home care (Out-of-home care)* by Ms Megan Mitchell, the National Children's Commissioner:

There is some data at the national level that indicates the numbers of children in out-of-home care who were abused while they were in care. However, it's not comprehensive across all states and territories, and there are different definitional issues and data collection methods. So I would say that there is absolutely a gap in our knowledge.³¹

Our *Out-of-home care* consultation paper identified significant deficiencies in the reporting on child sexual abuse, including that:

- Sexual abuse is often recorded together with other forms of abuse, such as physical abuse and neglect, rather than as a separate category. Even if a prevention strategy is effective in reducing sexual abuse, a decrease in sexual abuse reports may not be evident if it coincides with increases in other forms of abuse. This makes it difficult to assess the effectiveness of prevention strategies and establish a strong evidence base for such strategies.
- Jurisdictions use different definitions and thresholds within their data collection systems which can lead to what we consider to be an unacceptable level of inconsistency and unreliability in the way some terms are defined and interpreted. For example, there is no consistency in the way the states and territories classify alleged perpetrators in care settings, making it difficult to ascertain the differing levels of risk that may be posed by caregivers, other household members, family friends, other children, or adults outside of the care setting.
- An absence of 'date of alleged incident' data makes it impossible to know whether incidents of abuse are occurring in current care placements or whether admission to out-of-home care has provided children with the support they need to disclose prior abuse.
- There is a lack of reliable data on specific types of sexual abuse of children in out-of-home care, including incidents involving children with harmful sexual behaviours. Much of what we know about these issues is based on local small-scale studies and limited international research.

- Although the case notes created by caseworkers routinely include details about Aboriginal and Torres Strait Islander children and children with disability in care (including in voluntary out-of-home care), there are significant gaps in the data used for measuring the effectiveness of strategies targeting these groups, despite the fact that both groups are significantly over-represented in contemporary out-of-home care.
- Data about children from culturally and linguistically diverse backgrounds is not available. Despite all jurisdictions requiring caseworkers to record information such as a child's country of birth, preferred language and other such variables, the information is often recorded in a way that cannot be easily extracted.

The lack of reliable data about child sexual abuse in out-of-home care and gaps in the evidence base for prevention strategies mean that effective strategies might be scrapped for want of evidence. Conversely, scarce resources may be wasted on ineffective programs.

Building on recent improvements

Despite these gaps, recent enhancements to the systems for collecting and reporting on information relating to child sexual abuse in out-of-home care provide a sound foundation for further improvements. The AIHW has collected child protection data from the states and territories annually since 1993.³² However, as noted in our *Out-of-home care* consultation paper and summarised in Chapter 3, the AIHW has faced numerous challenges, such as the disparity between definitions and categories of out-of-home care across states and territories, which make it difficult to draw comparisons or see the national context.

In 2009, the Council of Australian Governments (COAG) endorsed the National Framework for Protecting Australia's Children 2009–2020 and recommended consistency in the collection of national child protection data, namely collection on a 'unit record basis'. Replacing 'once a year' aggregate or snapshot reports with unit record level data (that is, data that relates to individual children and by which information about individual children can be uniquely identified and tracked) enables a more accurate count of the total number of children receiving child protection services in each jurisdiction, how many receive multiple services, and the pathways of children moving between different services. For example, data collection of this kind would capture information about individual children receiving multiple child protection responses, then moving in and out of care.³³

In working with the states and territories to establish a Child Protection National Minimum Data Set (CP NMDS), the AIHW has broadened the available information about children in out-of-home care, including child protection notifications, the number of substantiated reports of abuse per child, and movements in and out of care each year.³⁴ However, there are still significant gaps in our understanding of:

- how many children in out-of-home care are the victims of sexual abuse and the demographic characteristics of those children that could be used to help identify more effective responses
- who sexually abused the child
- when and where the sexual abuse occurred
- the response to the sexual abuse.

Through our work, we heard that the lack of reliable data on child sexual abuse in contemporary out-of-home care continues to undermine Australia's attempts to identify or predict emerging trends or accurately measure and monitor the effectiveness of programs aimed at preventing and responding to child sexual abuse in out-of-home care.

A case in point is the poor quality of information about children with disability in national reporting on out-of-home care. All jurisdictions collect and record a range of valuable information about the disabilities affecting children who are in their care, often in the form of medical records or records about supports provided to assist children to access education and therapeutic services. All jurisdictions have long recognised the pressing need for nationally consistent data on disability. Yet we were told the lack of nationally consistent data remains a significant deficiency:

The implementation of the Child Protection National Minimum Data Set is a welcome beginning. Unit record data reliably recorded in each jurisdiction is needed, however, to ensure a useful, robust and reliable data set. The in-principle agreement for jurisdictions to include the disability identifier must be implemented as soon as possible. Otherwise Australia will have to continue to rely on international evidence. This is a second best approach, especially when we understand that settings can be very different in the countries that produce the research data. In our view, it is critically important that Australia has its own data from which we can derive evidence-informed approaches to preventing sexual abuse of children with disability.³⁵

The National Framework for Protecting Australia's Children 2009–2020 acknowledges that 'measuring a reduction in child abuse and neglect is difficult, as Australia currently does not have robust data on incidence/prevalence'.³⁶

Targeting gaps in current reporting

To establish an evidence base that can inform best practice and enable the monitoring of responses to sexual abuse of children in out-of-home care, it is necessary to develop a solid data system to enable informed analysis. In our *Out-of-home care* consultation paper, we sought views on a six-point data model of measures intended to improve the quality of data on child sexual abuse in out-of-home care, enable informed analysis of the safety of children in out-of-home care and improve the performance of the system in responding to instances of child sexual abuse.

The data model that we proposed included the following:³⁷

1. That all allegations of sexual abuse concerning children in all forms of out-of-home care should be extractable as a unit record data file with a unique identifier for each child.
2. For each allegation of sexual abuse, data should be recorded in fixed-response fields that describe:
 - the date of the incident
 - the date of the report
 - the location where the incident took place
 - the relationship of the perpetrator to the victim.
3. Each allegation should include demographic descriptors for the child and the perpetrator, including:
 - disability (including the type of impairment)
 - mental health
 - Aboriginal or Torres Strait Islander background
 - culturally and linguistically diverse background.
4. Data should be disaggregated by placement type.
5. Data should be used to monitor treatment and support provided, and life outcomes.
6. Data should include police reports, and outcomes of criminal and civil justice responses.

Most of the 57 submissions we received in response to the consultation paper – including detailed submissions from the Australian Government and all state and territory governments, non-government out-of-home care service providers, various regulatory and oversight bodies, and peak/representative bodies – provided views on this data model.

There was broad in-principle support in these submissions for a nationally consistent approach to data collection on child sexual abuse in out-of-home care and for our proposed data model to form the focus of this work. The non-government out-of-home care service providers we heard from were among the strongest advocates for immediate action to improve national data collection and reporting. Many of the submissions from this group were unequivocal in calling for state and territory governments to play a much more active role in making more effective use of existing records to identify threats to the safety of children in care, to improve standards of care and to use this information to drive improvements. For example, CareSouth told us that:

improved data collection is vital if the incidence of institutional sexual abuse is to be monitored, and the outcomes of strategies to reduce this incidence are to be assessed. Data should be collected in a way that enables comparisons across jurisdictions and incorporates all forms of sexual abuse, including as sexual exploitation and grooming.³⁸

Families Australia, which represents more than 800 not-for-profit out-of-home care agencies and child welfare organisations, said an improved national evidence base could, if properly reported, help all service providers to strengthen their support for vulnerable children and families:

Nationally consistent identification and terminology and improvements in data collection are essential. Our member organisations have long argued for improved data capture and usage in this area. Improved coordination, collection and analysis of NGO [non-government organisation]-held data has also been of great interest to our members.³⁹

Some of the large non-government organisations that provide out-of-home care services in multiple jurisdictions – including Anglicare, Life Without Barriers and Barnardos Australia – noted the waste and inefficiencies associated with having to provide standardised reports to different states and territories with inconsistent definitions and reporting thresholds. In response, they have begun to develop their own ‘national standards’ to enable them to collect and report on nationally consistent data across their various state and territory divisions.⁴⁰

All the government submissions were broadly supportive of our proposed data model. The Australian Government and the New South Wales, Australian Capital Territory and Northern Territory governments expressed support for developing a stronger evidence base and made recommendations to strengthen the model.

Some government submissions – such as those from Queensland, Victoria and Western Australia – expressed concern about the challenges associated with implementing nationally consistent data collection and reporting.⁴¹ However, all agreed that the current evidence base is seriously deficient and there would be benefits from implementing improvements.

The need for a sustained commitment

The Australian Government told us of the AIHW's success in working with the state and territory governments to establish the current Child Protection National Minimum Data Set and outlined the process for making further improvements.⁴² Its submission emphasised that the AIHW's ability to enhance data collection and reporting depended on the cooperation and support of all state and territory governments. This is because any changes to the national minimum data set (and any arrangements to extract data from the administrative systems in each jurisdiction) require the agreement of all state and territory governments. The complexity associated with changing and aligning the disparate information systems will require a sustained commitment over several years.

In evidence to the Royal Commission as part of *Case Study 51: Institutional review of Commonwealth, state and territory governments*, the heads of the departments responsible for out-of-home care in each of the states and territories agreed that:

- There are significant gaps in the out-of-home care data in each state and territory – both the information relating to child sexual abuse in the out-of-home care systems in each state and territory, and how the incidence of child sexual abuse in each jurisdiction compares with jurisdictions elsewhere.⁴³
- Our proposed data model is sound. All jurisdictions provided in-principle support for elements of the model. Most of them noted that all the elements in the data model are already being recorded, but not necessarily in a form that can easily be extracted for use in nationally consistent reports on incidents of sexual abuse of children in out-of-home care.⁴⁴

The state and territory representatives all acknowledged the need for immediate investment in new or upgraded administrative records systems to facilitate better recordkeeping.⁴⁵ All agreed that upgrades were necessary 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.⁴⁶ We heard that the New South Wales, Victorian and Australian Capital Territory governments were already in the process of replacing their child protection administrative information systems.⁴⁷ 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.⁴⁸

When asked whether our proposed data model was an appropriate in-principle starting point for a scheme to improve the quality of national reporting on child sexual abuse in out-of-home care, Mr Michael Coutts-Trotter, Secretary of the New South Wales Department of Family and Community Services, responded:

Yes, it is, and we share the [Royal] Commission's view that it is a significant gap in our ability, both within New South Wales and nationally, to determine whether children for whom the state has accepted the deepest responsibility, children taken into care, whether they are safe from abuse and whether that situation is improving or worsening. We wholly agree with it.⁴⁹

Ms Kym Peake, Secretary of the Victorian Department of Health and Human Services, said:

Similarly, Victoria is very supportive of the proposed data set and [the model] has been quite influential in how we've been thinking about improving our own data collections, analysis, reporting systems and public reporting.⁵⁰

Ms Peake said Victoria is investing in a new information technology system, while revising its critical incident reporting procedures so that it can better identify and prioritise more serious reports.⁵¹ She added:

at the moment we get 33,000 critical incidents reported a year. It's a bit like the previous conversation about reports to child protection, you can lose the wood for the trees when you have that volume of reporting ... We are moving to a system where the focus is on impact and harm and, of course, sexual abuse and sexual exploitation would be first and foremost in that, separately identifiable, a focus on both where a child was at the time of the incident and the report.⁵²

In response to questions about whether there was information in our proposed data model that was not already being collected (or that did not need to be included in a national minimum data set), Mr Michael Hogan, Director-General of Queensland's Department of Communities, Child Safety and Disability Services, said:

We do collect much of the data identified by the Royal Commission as the appropriate data set. Some of the data at the moment is reportable data, so we can extract and report on it, and some of the fields that you have identified at the moment are in case note files, which at the moment we don't have the capability that Victoria is obviously developing around being able to extract and report on some of the elements ...⁵³

Mr Hogan acknowledged the need for his department to replace its current administrative records system. He said, 'it ought to be a priority for the work that is done nationally with the Productivity Commission in relation to ROGS [*Report on government services*] reporting and with the [Australian] Institute of Health and Welfare'⁵⁴ that any Queensland government investment in a new state system is aligned with the AIHW's national reporting requirements.

We are also looking at a major project to replace our information system and to give us a much better reporting and recording capability and analytic capability, along the lines that Victoria have described, so we are supportive of the model that is proposed by the [Royal] Commission.⁵⁵

Ms Cathy Taylor, Chief Executive of South Australia's Department for Child Protection, also acknowledged the critical need for substantial new investment to enhance her department's information collection and reporting capabilities.

One of the challenges that every jurisdiction has is that they were originally designed as client management systems rather than performance management systems, and so we've all spent a lot of time trying to leverage as much as we can out of our old systems, and it's clear, and following the New South Wales advice, that we actually need different capability going forward.⁵⁶

Like the representatives from Victoria and South Australia, the Secretary of Tasmania's Department of Health and Human Services, Mr Michael Pervan, agreed that Tasmania's ageing administrative information system was not designed to support contemporary reporting and case-management requirements and that his agency was preparing 'to go out to the market for a replacement system' to substantially enhance its capacity to work with the Tasmania Police and the Department of Education Tasmania to identify and protect the children who are at greatest risk of harm.⁵⁷

What the evidence base should look like

Agreement across jurisdictions on definitions in relation to child sexual abuse will allow more consistent identification and reporting of child sexual abuse in out-of-home care.

Recommendation 12.1

The Australian Government and state and territory governments should develop nationally agreed key terms and definitions in relation to child sexual abuse for the purpose of data collection and reporting by the Australian Institute of Health and Welfare and the Productivity Commission.

Improving the data collected by governments about children in out-of-home care will enable better monitoring to increase the safety of children from sexual abuse, as well as enabling better identification of risks that are particular to certain settings and certain cohorts of children. Ensuring data collection that distinguishes between categories of all abuse and neglect – including sexual abuse – will provide important information about the extent and types of abuse experienced by children in out-of-home care.

Recommendation 12.2

The Australian Government and state and territory governments should prioritise enhancements to the Child Protection National Minimum Data Set to include:

- a. data identifying children with disability, children from culturally and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander children
- b. the number of children who were the subject of a substantiated report of sexual abuse while in out-of-home care
- c. the demographics of those children
- d. the type of out-of-home care placement in which the abuse occurred
- e. information about when the abuse occurred
- f. information about who perpetrated the abuse, including their age and their relationship to the victim, if known.

Our *Out-of-home care* consultation paper also noted the need to develop, over time, more meaningful data about the quality and outcomes of institutional response to disclosures of child sexual abuse, including information about the outcomes of criminal justice proceedings and 'life outcomes'.⁵⁸ While there was in-principle support for this proposal, and some jurisdictions advised that they were already taking steps to broaden their evidence base,⁵⁹ there is a need for a sustained commitment to develop and implement measures – such as measures of life outcomes – and then to incorporate those measures in the Child Protection National Minimum Data Set.

Improved data will not, in itself, improve the evidence base if the data cannot be accessed for policy purposes. During our inquiry, we learned that research into child sexual abuse has historically been characterised by small and selected samples, limiting the ability of policymakers to draw generalisations from research findings. We have identified administrative data holdings as having significant potential for policy development, monitoring and evaluation of services. Despite the limitations associated with some data holdings, a significant barrier to their use is access. For example, *Child protection Australia* annual reports produced by AIHW are now based on unit record data. This data could be made available more broadly, with appropriate safeguards as occurs with Australian Bureau of Statistics holdings, including Census information.

Out-of-home care service providers need to know whether the services and support they are providing to vulnerable children who may have been removed from their families of birth are giving those children the best possible life opportunities. The lack of reliable indicators, even at an individual level, currently make this assessment difficult.

The framework of performance indicators for child protection services across Australia in the annual *Report on government services* includes indicator results for outputs, equity, effectiveness, efficiency and outcomes. Effectiveness indicators are intended to measure how well the outputs of a service meet its delivery objectives. The effectiveness indicators in the report's chapter on 'Child protection services' include 'safety in out-of-home care' and 'stability of placement'. Both are said to be:

an indicator of governments' objective to provide quality care for children and young people aged 0–17 years who cannot live with their parents for reasons of safety or family crisis, with an emphasis on safety, stability and permanency in children's living arrangements.⁶⁰

As discussed in Chapter 3, the principal measure of 'safety in out-of-home care' is substantiated reports of abuse of children while in out-of-home care.⁶¹

In addition, the *Report on government services* also identifies 'outcome indicators' that are intended to 'provide information on the overall impact of a service on the status of individuals and the community'.⁶² The outcome indicators for out-of-home care are:

- improved safety, which uses data on substantiated reports of abuse of children (although not just children in out-of-home care), and
- improved education, which relies on NAPLAN data.

The remaining indicators for assessing the impact of out-of-home care outcomes – 'improved health and wellbeing of the child', 'safe return home' and 'permanent care' – are 'yet to be defined'.⁶³ Although all three were identified as 'key area[s] for further development of outcome indicators for future reports' as long ago as 2005,⁶⁴ the 2017 *Report on government services* simply notes that all have been 'identified for development and future reporting'.⁶⁵

The failure of governments to achieve discernible progress on developing these outcome measures for out-of-home care despite more than a decade of working parties⁶⁶ means the main indicator for measuring the quality of out-of-home care is whether or not children in care have been the subject of substantiated abuse reports. This is insufficient. It is essential that government reporting on out-of-home care services tries to determine whether there has been any positive impact on a child's welfare and wellbeing during their time in out-of-home care.

By fulfilling existing commitments to agree on such measures, as set out in the *Report on government services*, state and territory governments would be more readily held to account as to whether they are investing in education, health and therapeutic interventions to improve the wellbeing of children in out-of-home care, including those who have experienced sexual abuse during their time in care.

Recommendation 12.3

State and territory governments should agree on reporting definitions and data requirements to enable reporting in the *Report on government services* on outcome indicators for ‘improved health and wellbeing of the child’, ‘safe return home’ and ‘permanent care’.

5.2.2 Child Safe Standards

As part of its Terms of Reference the Royal Commission was required to inquire into what institutions and governments should do to better protect children against child sexual abuse and related matters in institutions in the future. A key aspect of this task has been to examine what makes institutions ‘child safe’.

While our inquiry has focused on sexual abuse of children in institutions, most child safe frameworks have a broader application and aim to help institutions prevent, identify and improve responses to physical, sexual, emotional and/or psychological abuse and neglect of children. Stakeholders told us that a broader approach, which seeks to prevent all forms of harm to children in institutions, would better address the often co-existing nature of different types of abuse.

Our inquiry into and recommendations regarding child safe institutions is underpinned by the United Nations Convention on the Rights of the Child. Consistent with Article 3, all institutions concerned with children should act with the best interests of the child as a primary consideration.⁶⁷

We have identified 10 Child Safe Standards that articulate the essential elements of a child safe institution. The standards set out best practice and can guide institutions towards becoming child safe (see Figure 12.1).



Figure 12.1 – Child Safe Standards

We discuss the 10 Child Safe Standards we have identified in Volume 6, *Making institutions child safe*. We recommend that all institutions concerned with children implement the Child Safe Standards and be guided by the core components for each standard, as outlined in Recommendations 6.4, 6.5 and 6.6 in that volume. These recommendations, including the complete Child Safe Standards, are set out in Appendix A of this volume. Appendix B provides practical guidance for implementing the Child Safe Standards.

Applying the Child Safe Standards in the out-of-home care system

The Child Safe Standards are a benchmark against which institutions can assess their child safe capacity and set performance targets. The standards all work together to articulate what makes a child safe institution. All of the Child Safe Standards are equally important and interrelated. For example, the standard regarding institutional leadership, governance and culture is an important element in supporting other standards, such as children's participation and empowerment. Similarly, the standard regarding equity and responding to diverse needs cuts across, and is a relevant consideration for, all standards.

The standards are principles-based and focused on outcomes, as opposed to setting detailed and prescriptive rules that must be followed or specific initiatives that should be implemented. This means the standards could be implemented by any institution concerned with children in a flexible way, informed by each institution's nature and characteristics. The standards are intended to be dynamic and responsive, rather than static and definitive, and would be subject to review.

We are of the view that compliance with the Child Safe Standards should be incorporated into a mandatory accreditation scheme for out-of-home care service providers.

We have been told that a mandatory accreditation scheme for all out-of-home care service providers – both government and non-government – is a regulatory mechanism that would help protect children in out-of-home care from sexual abuse. Mandatory accreditation would promote high standards, transparency and public confidence in out-of-home care services. As Anglicare Australia submitted to us:

Approaches adopted across all jurisdictions should minimise the likelihood of sexual abuse through the implementation of safeguards along the entire chain of service: agency accreditation and procedures, recruitment of carers and staff, education, training, supervision, monitoring, regular home visiting and checks.⁶⁸

In public hearings and submissions, there was broad support for the adoption of consistent regulation and oversight of both government and non-government out-of-home care service providers. Our understanding of the need for this requirement was informed by what we heard in private sessions from survivors of child sexual abuse in contemporary out-of-home care. Many survivors did not give us information that allowed us to ascertain the provider of the out-of-home care service in which they were abused. However, about a quarter of survivors in private sessions (25.3 per cent) told us that the sexual abuse occurred while they were in the care of government providers. A further 13.2 per cent said they were in the care of religious organisations providing out-of-home care and 3.5 per cent said they were placed with private secular providers at the time of the sexual abuse.

Some submissions noted that any nationally consistent standards for accreditation should not lead to lower standards. Non-government out-of-home care service providers were particularly insistent that, where their standards were more focused or rigorous than the existing National Standards for Out-of-Home Care, they not be diluted.⁶⁹

As noted in Chapter 2, the 13 National Standards for Out-of-Home Care aim to ensure that children in contemporary out-of-home care receive consistent and best-practice care:

The National Standards seek to drive improvements in the quality of care so that children and young people in out-of-home care have the same opportunities as other children and young people to reach their potential in life wherever they live in Australia.⁷⁰

In general, the Child Safe Standards and National Standards for Out-of-Home Care are compatible with each other. However, as their purposes are distinct – the Child Safe Standards being explicitly focused on child safety – there is no simple correspondence between them and they do not always overlap.

The National Standards for Out-of-Home Care are not mandatory and there are no mechanisms to monitor their implementation. Submissions to our *Out-of-home care* consultation paper stated that the National Standards for Out-of-Home Care have not had a significant impact on practice and are ‘not designed to be used at the service level’.⁷¹ The Child Safe Standards are designed to drive cultural change to create a focus on child safety.

The submission from the Care Leavers Australasia Network (CLAN) was explicit about the need to ensure that there would be no repeat of the abuses of the past:

No organisation should be allowed to care for children if they are not accredited, whether they are government or non-government. CLAN believes that the mistakes of the past are being repeated all over again with organisations and agencies failing to be properly authorised and regulated, namely the main government department responsible for caring for children. CLAN therefore agrees with your mandatory accreditation scheme for ALL child welfare providers. **Governments need to be reminded that they are the legal guardians of children in the child welfare system**, [emphasis in original] therefore they need to be accredited and reminded of the child’s best interests.⁷²

As noted in Chapter 4, because accreditation requires demonstration of management competence and compliance with legislative and regulatory frameworks, it is an important mechanism for ensuring that out-of-home care service providers are performing to a high standard in all aspects of their operations.

Including the Child Safe Standards as the foundation of a mandatory accreditation scheme would ensure nationally consistent standards that promote a best-practice approach to child safety in out-of-home care. The benefits would include:

- protecting children equally, regardless of their location or the institutions they engage with or receive services from
- reducing opportunities for potential perpetrators to seek out jurisdictions or institutions with less rigorous child safety requirements
- sending clear messages about what it means for an institution to be child safe
- facilitating national collaboration on capacity building and support, and continuous improvement to make institutions child safe
- helping institutions working across borders to comply with child safe standards
- promoting effective responses to the needs of all children regardless of their diverse experiences, circumstances and needs.

Recommendation 12.4

Each state and territory government should revise existing mandatory accreditation schemes to:

- a. incorporate compliance with the Child Safe Standards identified by the Royal Commission
- b. extend accreditation requirements to both government and non-government out-of-home care service providers.

Monitoring and enforcing the Child Safe Standards

We are of the view that all Australian out-of-home care service providers should have the same Child Safe Standards in place to protect all children. In Chapter 2 we discussed the inconsistent regulation between states and territories regarding the responsibilities of institutions and individuals to keep children safe in out-of-home care. This inconsistency means that children may have more or less protection depending on where they live.

In Volume 6, *Making institutions child safe* we recommended that the Child Safe Standards should be mandatory for all institutions that engage in child-related work – including out-of-home care service providers – and that a new or existing state or territory oversight body should be appointed as a central regulator of the mandatory child safe standards (Recommendations 6.8, 6.10 and 6.11). We recommend that the proposed oversight body be able to delegate this responsibility to another state or territory body, such as a sector regulator.

In submissions and from consultations with government and non-government agencies, we heard that the best way to reduce duplication and regulatory burden in highly regulated sectors such as out-of-home care would be to integrate the Child Safe Standards into existing regulatory frameworks – with responsibility for enforcement falling to existing regulators. Such an approach would capitalise on existing relationships between sectors and regulators and make use of information about risk that regulators are already collecting. We consider this would be the most efficient and effective way of overseeing the standards in sectors where an appropriate regulator already exists. For more information on improving regulatory oversight and practice for all institutions concerned with children, see Volume 6, *Making institutions child safe*.

If the Child Safe Standards are incorporated into the mandatory accreditation of out-of-home care service providers, we believe that an existing oversight or independent oversight body, such as a children’s guardian, would be in the best position to monitor and enforce the Child Safe Standards by way of accreditation and audit processes.

As discussed in Chapter 4, the child protection department in each state and territory is responsible for the accreditation of out-of-home care service agencies, except in New South Wales. Submissions to our *Out-of-home care* consultation paper expressed considerable support for the accreditation of out-of-home care service providers being undertaken by an agency independent of the child protection department, in line with the New South Wales model.⁷³

Several submissions raised the potential for conflicts of interest where the funding agency (usually the child protection department) was also responsible for accreditation of non-government providers. The submissions noted that differentiating between the responsibilities of the contract engager/funder and the contract overseer would be a valuable step in improving the out-of-home care system.⁷⁴

The implementation of Recommendation 12.4 would lead to an obvious conflict should a government provider of out-of-home care services be required to assess and accredit itself.

Recommendation 12.5

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:

- a. receiving, assessing and processing applications for accreditation of out-of-home care service providers
- b. conducting audits of accredited out-of-home care service providers to ensure ongoing compliance with accreditation standards and conditions.

Recommendations 12.4 and 12.5 are consistent with the Child Safe Standards, in particular Standard 5: People working with children are suitable and supported, and Standard 9: Implementation of Child Safe Standards is continuously reviewed and improved. They also align with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, and Standard 12: Carers are assessed and receive relevant ongoing training, development and support, in order to provide quality care.⁷⁵

In Volume 6, *Making institutions child safe* we recommend that state and territory independent oversight bodies promote, report on and exchange information about the Child Safe Standards (Recommendations 6.10 to 6.11). We also recommend that the Australian Government establish a National Office for Child Safety to coordinate the implementation of the standards across states and territories, including through national evaluation, consultation with children, collaboration on capacity building, and awareness raising (Recommendations 6.14 and 6.17). Collaboration between independent oversight bodies and the proposed National Office for Child Safety would be essential to performing these functions.

Agencies responsible for the accreditation of out-of-home care service providers should work together, with oversight agencies as appropriate, and with the National Office for Child Safety. These bodies should collaborate to tailor guidance on the Child Safe Standards to out-of-home care service providers and disseminate best practice among the sector and its regulators. Other relevant institutions in the sector, including peak bodies, should support out-of-home care service providers to meet the Child Safe Standards.

As noted in Section 5.2.1, improving the quality of out-of-home care data – including the data gathered and used for auditing the quality of out-of-home care services – will not, in itself, improve the evidence base unless that data is also made accessible for policy and research purposes. Consideration should be given to using such data to assess the quality and safety of out-of-home care services available to researchers and policymakers.

5.2.3 Accountability for safety of children in out-of-home care

The Child Safe Standards are essential to achieving the cultural change that needs to occur in institutions for children to be protected. Governments can play a key role in facilitating this cultural change. Stakeholders in our consultations and commissioned research on the elements of a child safe institution told us that governments should focus on building institutions' capacity, changing their culture and clarifying what the Child Safe Standards mean in practice. Commissioned research found that government regulation and oversight should prioritise supporting institutions to continuously improve the way they measure outcomes and identify inferior performance.⁷⁶

As described in Chapter 4, the different out-of-home care systems in each state and territory are complex and need strengthening in some areas to reduce the risk of child sexual abuse. This section sets out our recommendations to achieve this.

We have learned that genuine cultural change, rather than mere ‘tick-the-box’ compliance, is needed to make institutions child safe, and to improve the way institutions value children and respect their rights. Commissioned research suggests combining a monitoring and enforcement regime with measures to support institutions and build their capacity. Developing a model with a central regulator that is focused on gaining sector-wide commitment to policies regarding child safety will increase the likelihood of improving institutional culture and facilitating desirable behaviour and attitudes towards children in institutions.⁷⁷

Authorisation of carers

Carers are the bedrock of the contemporary out-of-home care system. Ensuring that the carers authorised to care for Australia’s children are the right people is essential. Chapters 3 and 4 detailed the harm to our children that has resulted from sexual abuse by carers or the failure of carers to support children in their care who had been sexually abused by someone else. The advice and recommendations in this section are aimed at increasing the strength and consistency of carer authorisation processes.

In strengthening the processes for screening and authorising carers, it must be emphasised that the skills and experience of assessors are crucial to these processes and adequate resourcing of this work is essential. As one submission to our consultation paper stated: ‘good assessment will see children being placed more safely’.⁷⁸

Consistent standards of carer authorisation

As discussed in Chapter 4, requirements for carer authorisation differ somewhat between states and territories, depending on the jurisdiction’s legislative and departmental requirements. This issue was also raised in the report of the 2015 Senate Community Affairs References Committee inquiry into out-of-home care.⁷⁹

There was significant support in submissions from non-government agencies to our *Out-of-home care* consultation paper for a nationally consistent carer authorisation scheme, provided that national consistency does not limit the capacity of agencies to employ higher standards or additional processes.⁸⁰

The basic probity checks (that is, an identity check, a Working With Children Check, National Police Check and referee checks) conducted in all jurisdictions for all types of carers generally have a statutory basis. Out-of-home care service providers must conduct these checks for all individuals they authorise as carers.⁸¹

Strengthening Working With Children Checks

In our *Working With Children Checks* report we concluded that there is a need for a nationally consistent approach to Working With Children Checks.⁸² Detailed in the report are recommendations we made to:

- align each of the Working With Children Check schemes operating in each jurisdiction through introducing consistent standards to key aspects of the schemes
- create a national system by establishing a centralised database, improving information sharing and expanding the continuous monitoring of the criminal records of Working With Children Check cardholders in all jurisdictions.

The implementation of recommendations to strengthen Working With Children Checks will, in turn, strengthen the screening of carers in the out-of-home care sector.

Authorisation of kinship/relative carers

We have heard concerns about the risks to children if lower standards of assessment are applied to kinship/relative carers (see Chapter 4, Section 4.2.1). Recommendation 12.6 for nationally consistent authorisation of all carers addresses these concerns.

Unlike foster carers, kinship/relative carers typically take on the care of a child in emergency situations. In such situations, carers are sometimes approached about agreeing to take on the care of a child on the same day the placement starts. Commissioned research comparing the approaches used in each state and territory showed that the same screening and assessment processes are applied to kinship/relative carers as are applied to foster carers, but that:

in practice, jurisdictions typically had some form of provisional assessment to enable short-term emergency placements with relatives ... Kinship carers are often granted care of a child after the minimum probity and safety checks are done.⁸³

The same research reported that follow-up work to complete further checks and a comprehensive assessment, in line with foster carer assessments, was not being completed in a timely way, if at all.⁸⁴ This issue was also raised by some witnesses in our *Out-of-home care* public hearing and by participants in our roundtable on preventing child sexual abuse in out-of-home care.⁸⁵

While we acknowledge that in emergency circumstances a child might be placed with a carer who has not been fully screened or authorised, it is clearly essential that these checks and processes are completed – and completed without delay. The timely completion of these essential processes could be monitored by developing an additional indicator in the annual *Report on government services*.

Some submissions advised that the assessment of carers, particularly kinship/relative carers, needs to consider only the carers' relevant criminal convictions, not, for example, driving offences committed in the carer's adolescence, many years before.⁸⁶ We have heard that otherwise suitable carers are excluding themselves from consideration as kinship/relative carers for reason of criminal history. This point was made during our public roundtable discussion about protecting children from child sexual abuse in out-of-home care. As a senior child protection official from Victoria observed:

I have been in the position of needing to review and assess whether someone that has had an adverse police record – it might be a grandfather who has been in stable employment for 40 years; there has been no other antisocial behaviour; and there is a bond of love between he and this grandchild. I would be worried about a rigid standard that said any adverse police finding, for example, wiped out that possibility to support that family, because that child will grow up and know that they're loved, they're claimed, they belong.⁸⁷

Assessments of suitability

Beyond statutory requirements for probity screening, it is essential that carer assessments include thorough inquiries about the suitability of carers. Research commissioned by us suggested:

In some jurisdictions, the screening process is significantly strengthened through mandatory reference to a carers register and data held by child protection agencies and other OOHC [out-of-home care] providers.⁸⁸

From what we have heard, it is apparent that assessments of the suitability of all carers would be strengthened by the mandatory inclusion of three processes which are currently utilised to greater or lesser degrees across a number of jurisdictions to assess prospective carers: values-based interviews, structured reference checking and 'community services checks'.

Values-based interviewing offers the assessor an opportunity to explore a prospective carer's:

- motivation to care
- knowledge and use of appropriate child-rearing practices
- understanding of how to keep children in out-of-home care safe (including demonstrating empathy for past life experiences, the stigma of being in out-of-home care, frequently poor health and education outcomes)
- attitudes to diversity (including attitudes to cultural and linguistic diversity and lesbian, gay, bisexual or transgender children)
- willingness to facilitate and encourage birth family contact
- willingness to work cooperatively with the out-of-home care service provider, including accepting regular caseworker visits and supervision.

While referee checks are a typical part of screening processes for prospective carers, we have heard that it is important that the relationship between the referee and the prospective carer needs to be clarified,⁸⁹ as does the referee's understanding of the values and aptitude of the prospective carer. One non-government out-of-home care service provider who participated in commissioned research advised that they spoke to all children of a prospective carer (whether living with them or not) as referees and that this had been a useful source of information. This service provider recounted, 'We've had women who report having been victims and not endorsing their parents' application'.⁹⁰ A written record of all the information provided by a referee should be reviewed as part of the assessment process.

All jurisdictions review child protection records in relation to kinship placements.⁹¹ For prospective foster carers, however, such reviews are not applied in all jurisdictions. In New South Wales, Victoria, Western Australia and South Australia, the baseline checks conducted as part of the screening and authorising of foster carers are augmented by 'community services checks'. This check is 'the interrogation of information held by government agencies in relation to, for example, allegations or reports of child abuse and neglect, or domestic violence'.⁹² Information obtained through this check may provide assessors with essential information about the suitability of a prospective carer that may not be available by other probity checks. As such, community services checks should be conducted for all carers. As with other probity checks, it is our view that community services checks should also be completed on all members of a prospective carer's household over the age of 16 years, in line with the existing New South Wales practice.⁹³

Information obtained by way of community services checks that indicate risks that could be posed by the carer or other household members over the age of 16 should be carefully assessed with a view to deciding whether those risks can be managed and how, and whether, based on this, the authorisation should be refused. If risks are identified and it is decided that authorisation will proceed, a risk management plan should be developed. Any risk management plan should be detailed in the carer authorisation documentation, with signed agreement from the carer indicating their willingness to comply with any special instructions or restrictions. Regular review of the risk management plan will enable out-of-home care service providers to ensure all necessary protections are identified and implemented by the carer. Ensuring the safety of children in their care is a fundamental responsibility for carers and compliance with agreed risk management plans should form part of ongoing regular carer reviews.

Screening and authorisation of residential care staff

The heightened risks associated with placing groups of very vulnerable children in residential care settings were discussed in Chapter 4. That discussion also considered the risks associated with the high turnover of residential care staff and the heavy reliance on casual workers in many residential care facilities. In light of these risks, consistent and effective systems for screening and authorising residential care staff are crucial to ensuring the safety of children in residential care.

Residential care staff are often employed via recruitment agencies or labour hire firms as well as directly by the out-of-home care service provider. According to a national comparison of carer screening, all states and territories:

stipulate the probity checks that must be undertaken before an individual can be employed to provide direct care [in a residential care facility], either by a government agency or by an approved or contracted NGO.⁹⁴

These checks include an identity check, Working With Children Check, National Police Check and referee check.

We have learned that carers registers may provide an important transparency mechanism for ensuring the exchange of relevant information about carers. Given the transience of some residential care workers and the high levels of vulnerability of the children living in residential care settings, it is our view that residential care staff should be formally authorised and included in carers registers. This issue is considered further in the discussion on carer registers, later in this section.

As discussed in Chapter 4 at Section 4.3.2, out-of-home care service providers need to provide training, mentoring and professional supervision for all residential care staff, but as with all prospective carers, the suitability of prospective residential care staff is a fundamental consideration. As part of screening and authorisation processes, residential care staff, whether permanent, casual or contracted, need to demonstrate their communication skills, their understanding of adolescent behaviour and their empathy for the impact of trauma on the children in their care.

In Section 5.4.3 we discuss the training and supervisory needs of residential care staff in the context of broader initiatives aimed at extending models of therapeutic residential care.

Recommendation 12.6

In addition to a National Police Check, Working With Children Check and referee checks, authorisation of all foster and kinship/relative carers and all residential care staff should include:

- a. community services checks of the prospective carer and any adult household members of home-based carers
- b. documented risk management plans to address any risks identified through community services checks
- c. at least annual review of risk management plans as part of carer reviews and more frequently as required.

Recommendation 12.6 is consistent with the Child Safe Standards, in particular Standard 5: People working with children are suitable and supported, Standard 8: Physical and online environments minimise the opportunity for abuse to occur, and Standard 9: Implementation of Child Safe Standards is continuously reviewed and improved. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, and Standard 12: Carers are assessed and receive relevant ongoing training, development and support, in order to provide quality care.⁹⁵

Regular review

Foster and kinship/relative carers are reviewed annually in most jurisdictions, with the exceptions being in Queensland and the ACT.⁹⁶ These reviews are extensive, including discussion and documentation of any changes to the household, the physical environment of the house, any allegations against the carer and the willingness of the carer to continue in the role. Additional needs or support requirements of carers can also be identified during this formal process.

Having regular reviews of authorised carers is an important accountability mechanism for ensuring out-of-home care service providers can maintain confidence in the quality and competence of their authorised carers. Regular performance reviews of all staff is good practice and we believe that annual reviews should also be conducted of all residential care staff as well as home-based carers to ensure the appropriateness of their ongoing authorisation as carers.

Submissions to our consultation paper on preventing child sexual abuse in out-of-home care indicate that a number of agencies, particularly non-government out-of-home care service providers, already seek children's views as part of their carer review processes.⁹⁷

It is our view that interviews with all the children in a placement, including those in residential care settings, should, as a matter of course, form part of the annual review of carers. Clearly the interviews need to be conducted taking into account the age and capacity of the child, by someone the child trusts from the out-of-home care service provider (most likely the caseworker), and should not be conducted in the presence of the carer. Children should be told that they will be given this opportunity as it will provide them with a relatively formal and regular opportunity to provide feedback on the placement and the carer or carers. Should concerns be raised about the child's safety or the safety of other children in the placement, appropriate action in line with organisational procedures will need to be taken.

Children's views, in their entirety, should be documented and included in the review documents on the carer's file – including action taken on concerns raised. A copy should also be held on the child's file and made available if the child requests their file at any time, including when they leave care.

Recommendation 12.7 identifies the need for all children in a placement to be included in the annual review of all authorised carers, including residential care staff. This annual review will ensure carers continue to meet probity and suitability criteria for authorisation.

Recommendation 12.7

All out-of-home care service providers should conduct annual reviews of authorised carers that include interviews with all children in the placement with the carer under review, in the absence of the carer.

Recommendation 12.7 is consistent with the Child Safe Standards, in particular Standard 2: Children participate in decisions affecting them and are taken seriously, Standard 5: People working with children are suitable and supported, Standard 8: Physical and online environments minimise the opportunity for abuse to occur, and Standard 9: Implementation of Child Safe Standards is continuously reviewed and improved. It aligns with the National Standards for Out-of-Home Care, namely Standard 2: Children and young people participate in decisions that have an impact on their lives, and Standard 12: Carers are assessed and receive relevant ongoing training, development and support, in order to provide quality care.⁹⁸

Codes of conduct

We have heard that once carers have been assessed and approved, they generally sign a carer authorisation agreement with the out-of-home care service provider. Ensuring that the service provider's code of conduct is part of this authorisation agreement, or is signed as a separate part of the agreement, would strengthen the authorisation process and the framework within which the carers' ongoing performance is assessed and managed.

Assessment of kinship/relative carers

In recent years there has been a rapid increase in the proportion of children in kinship care placements across all Australian states and territories.⁹⁹ While generally research on outcomes for children who reside in kinship care is inconclusive, some research suggests that children in this type of care:¹⁰⁰

- may have significantly fewer placements than children in other types of out-of-home care
- that outcomes, where measured, may be as good as or better for children in kinship/relative care than for those in foster care.

We were told, for example, that high self-esteem and strong social networks are recognised as significant protective factors against child maltreatment. Children who are part of a broader community with an interest in their wellbeing are more likely to be noticed when they are in danger and have networks of support to draw upon when they feel unsafe.¹⁰¹

Some research also suggests that ‘kinship placements do not afford children the same level of safety as non-kin placements’ and that because of the common demographic characteristics of kinship/relative carers (for example, kinship/relative carers are on average older, poorer, experiencing health issues and perhaps less well educated than foster carers) children in kinship care may experience ‘greater environmental hardship’.¹⁰² It is clearly essential that kinship/relative carers are properly assessed and authorised and that adequate support is provided to the placement. A targeted approach to supporting kinship/relative care such as the initiatives discussed in Chapter 4 at Section 4.4.2 may offer useful models (see also Section 5.4.2, ‘Supporting kinship/relative care placements’).

The 2015 Senate Community Affairs References Committee inquiry into out-of-home care also considered the comparative disadvantage of kinship/relative carers,¹⁰³ while the Special Commission of Inquiry into Child Protection Services in NSW (also known as the Wood Inquiry) recommended that ‘priority should be given to strengthening the capacity for Aboriginal families to undertake foster and kinship caring roles’.¹⁰⁴

While the standards applied to assessment and authorisation of kinship/relative carers need to be equivalent to those applied to other carers, we understand that there are essential differences that need to be acknowledged and incorporated into the assessment of kinship/relative carers. A summary of Australian research about kinship care for children in 2007 noted that, ‘kinship foster carers are recruited differently from non-relative foster carers, but assessment procedures have not been modified to account for the different circumstances’.¹⁰⁵

Research suggests that a specific model of assessment, appropriately tailored for kinship/relative care, would not necessarily result in more carers being rejected. Rather, a model of assessment that meets initial safety checks and then shifts the emphasis from ‘approving’ to ‘enabling’ the placement, would underpin stronger kinship/relative care. This type of assessment is designed to better identify the support and training needs of kinship/relative carers, and to ensure that an appropriately resourced support plan is put in place, where caseworkers work with the family to provide an environment that is conducive to ongoing safety and quality care.¹⁰⁶

We learned that there was considerable support for the development of specific models of screening, assessment and authorisation for kinship/relative carers, and note that pilots of such models are being run and evaluated in some jurisdictions, for example, New South Wales, Queensland and Victoria. Some of the tools being developed are strengths-based, enabling assessors to recognise the strengths of families while still establishing what supports the family needs to keep the child safe, including building and maintaining supportive relationships and community connections.

One example of a tailored model of screening that we have heard about is the Winangay Aboriginal Kinship Care Assessment Tool – a model that is culturally safe and appropriate for Aboriginal and Torres Strait Islander kinship/relative carers. We have been told that the Winangay Aboriginal Kinship Care Assessment Tool can be tailored for all kinship assessments.¹⁰⁷

The 2015 Senate Community Affairs References Committee inquiry into out-of-home care recommended that:

COAG include in the third action plan (2015-2018) of the National Framework [for Protecting Australia's Children 2009–2020] a project to better support Aboriginal and Torres Strait Islander children in relative/kinship care, including:

- streamlining accreditation and assessment processes for Aboriginal and Torres Strait Islander kinship carers; and
- implementing the Winangay kinship resources to improve relationship between carers and child protection authorities.¹⁰⁸

We note that this project would need to be included in the fourth action plan of the National Framework for Protecting Australia's Children 2009–2020.

Kinship care has been recognised as the preferred placement option for Aboriginal and Torres Strait Islander children through the Aboriginal and Torres Strait Islander Child Placement Principle that has been legislated in each state and territory. Given what we have heard about the insufficient availability of appropriate placement options for Aboriginal and Torres Strait Islander children, the adoption of assessment tools that encourage and support Aboriginal and Torres Strait Islander people to apply to be carers is clearly important.

In public hearings for *Case Study 57: Nature, cause and impact of child sexual abuse in institutional contexts*, Mr Andrew Jackomos, Commissioner for Aboriginal Children and Young People in Victoria, spoke about a child protection system that:

has significant institutional racism that is limiting opportunities for our children to be placed with Aboriginal carers. Nobody can tell me that 91 per cent of Aboriginal children in Victoria placed outside of our community is purely because we can't find responsible Aboriginal people.¹⁰⁹

What we have learned, in fact, is that 'kinship is a form of social capital that provides a strong foundation for the healthy functioning of family and community'¹¹⁰ and that additional effort and resources need to be directed to supporting Aboriginal and Torres Strait Islander communities to care for Aboriginal and Torres Strait Islander children.

Recommendation 12.8

Each state and territory government should adopt a model of assessment appropriately tailored for kinship/relative care. This type of assessment should be designed to:

- a. better identify the strengths as well as the support and training needs of kinship/relative carers
- b. ensure holistic approaches to supporting placements that are culturally safe
- c. include appropriately resourced support plans.

Recommendation 12.8 is consistent with our Child Safe Standards, in particular Standard 3: Families and communities are informed and involved, Standard 4: Equity is upheld and diverse needs are taken into account, and Standard 5: People working with children are suitable and supported. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, Standard 3: Aboriginal and Torres Strait Islander communities participate in decisions concerning the care and placement of their children and young people and Standard 10: Children and young people in care are supported to develop their identity, safely and appropriately, through contact with their families, friends, culture, spiritual sources and communities and have their life history recorded as they grow up.¹¹¹

No matter what model of assessment is used, the skills, experience and cultural expertise of the practitioner doing the assessment are fundamental components of the process. Professional supervision of those conducting assessments would be critical to ensure a high standard of assessment and reflective practice.

Our recommendation for the full implementation of the Aboriginal and Torres Strait Islander Child Placement Principle is set out in Section 5.5.1.

Carers register

Some jurisdictions maintain a carers register as a standalone central index of information about people who have applied for or are authorised to care for children in out-of-home care in that jurisdiction. Information on these registers can be accessed by approved organisations.¹¹² Other jurisdictions record this information on a government database available to employees of the relevant statutory child protection agency only.¹¹³

Existing carers registers (and databases) vary in the range of information captured.¹¹⁴ There are also differences between jurisdictions as to whether the registers are legislatively or administratively established and governed, whether they are maintained by an independent out-of-home care regulator or by the relevant child protection department,¹¹⁵ and in the bodies that have access to the register.¹¹⁶ With variable and often limited arrangements for capturing relevant information about carers, opportunities to promote children's safety in out-of-home care may be missed.

Submissions to our *Out-of-home care* consultation paper were broadly supportive of carers registers that would apply to all carers and staff in out-of-home care.¹¹⁷ The main caveat to this support, and which was expressed by Anglicare NT, was that:

Any register would need to be developed in collaboration with the sector to ensure that the administration burden is acceptable, and that issues of privacy and fairness are adequately explored.¹¹⁸

In Volume 8, *Recordkeeping and information sharing* we make recommendations for carers register reforms to improve information sharing about prospective and current carers and their household members in order to reduce risks to children's safety arising from the inappropriate authorisation of carers.

Existing carers registers (and child protection agency databases), which enable out-of-home care agencies to ascertain or confirm carer status, play an important role in protecting children in out-of-home care. Information such as the relevant history of an applicant and authorised carers, and others residing on the same property, can contribute to better decision-making about carer suitability and placement safety.

While we acknowledge that some children in care may themselves present risks to other children, we do not believe that they should be included in carers registers. Any concerns about such risks should be documented in the case management records held by the child protection department and the out-of-home care service provider.

Our recommendations for legislated carers registers in all states and territories (see Recommendations 8.17 to 8.23 set out in Appendix A) complement and will support the implementation of our recommendations for minimum carer authorisation requirements across Australia (Recommendations 12.6, 12.7 and 12.8).

Some concern has been expressed that the prospect of inclusion on carers registers, together with the imposition of standardised and more stringent carer authorisation requirements, may deter some prospective kinship/relative carers.¹¹⁹ However, it is our view that given the potential risk to children arising from inappropriate authorisation of kinship/relative carers in statutory out-of-home care, they should be included on carers registers, together with other carers.

We also recommend the inclusion of residential care workers on carers registers, because unsuitable carers in residential care can pose significant risks to children's safety. In its 2015 report, '*...as a good parent would...*': *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, the Victorian Commission for Children and Young People examined the adequacy of residential care services for Victorian children who have been subjected to sexual abuse or sexual exploitation while in residential care.

It found that the current system ‘creates opportunities for the sexual abuse of children and young people’ and that ‘Children living in residential care in Victoria are reporting an alarming level of sexual abuse and sexual exploitation’.¹²⁰ The report noted the risks arising from the ability of potential perpetrators to move between sectors that provide services to different vulnerable groups – for example, between aged care, disability and children’s sectors – without detection.¹²¹

The NSW Carers Register does not currently include residential care workers. We understand that the feasibility of developing a register of workers engaged in statutory residential care settings is under consideration.¹²² In Victoria, the carers register includes residential care workers, as well as foster carers. However, we have been told that the information contained in the register is limited in scope and focuses primarily on whether a carer is disqualified from providing care in the future.¹²³

In our view, there is sufficient indication of risk to some of the most vulnerable children in out-of-home care to justify the inclusion of residential care workers on carers registers in each jurisdiction.

We discuss the inclusion of all carers on carers registers in more detail in Chapter 4 of Volume 8, *Recordkeeping and information sharing*.

Mandatory reporting to child protection authorities

The principle that individuals who work closely with children in out-of-home care should be obliged to report child sexual abuse to an external government authority is persuasive. Staff and caseworkers involved in the provision of out-of-home care services to tens of thousands of Australian children each year are uniquely placed to detect and receive disclosures of both familial and institutional child sexual abuse.

As noted in Chapter 2, mandatory reporting laws create an additional duty requiring certain professionals and community members to report any known or suspected child abuse or neglect to child protection authorities. Currently, departmental staff (that is, paid public servants, such as caseworkers) are mandatory reporters in six Australian jurisdictions.¹²⁴ Residential care staff are mandatory reporters in five jurisdictions.¹²⁵ Caseworkers employed by non-government out-of-home service providers are mandatory reporters in New South Wales, South Australia and the Northern Territory.¹²⁶ They are also mandatory reporters in Tasmania if they work for a government-funded service.¹²⁷

In Volume 7, *Improving institutional responding and reporting* we recommend that out-of-home care workers should be mandatory reporters in every jurisdiction (see Recommendation 7.3, which is also set out in Appendix A of this volume).

The main benefits of extending mandatory reporting to out-of-home care workers in every jurisdiction are that:

- More individuals who work closely with children in out-of-home care settings – and who therefore have a moral and professional imperative to report known or suspected child abuse and neglect to an external government authority – would be obliged to report such abuse and neglect to child protection and also be protected in making a report. This should result in increased reporting of both institutional and familial child abuse and neglect, including child sexual abuse, thereby allowing child protection authorities to prevent or stop children from being abused.
- Many mandated reporter groups receive training and education on their reporting obligations. Expanding the number of out-of-home care workers who receive such training and education should increase awareness and understanding of child abuse and neglect, including child sexual abuse, in the sector.

Designating out-of-home care workers as mandatory reporters to child protection authorities in the few jurisdictions in which they are not already mandatory reporters would be unlikely to overburden governments and would promote greater national consistency in reporter groups.

We have not proposed that foster carers and kinship/relative carers be included as mandatory reporters where they are not presently covered by state and territory mandatory reporting laws. In our view, given the range of measures recommended by the Royal Commission, mandatory reporting by home-based carers in a family setting (exposing those carers to potential criminal penalties for failing to report) is unlikely to increase protection of children from sexual abuse in institutional settings. Our concern is that any such inclusion might introduce a range of unintended consequences without necessarily achieving identifiable benefits.

Civil liability

In our *Redress and civil litigation* report we have made a number of recommendations to reform aspects of civil litigation.¹²⁸ These reforms are intended to make civil litigation a far more effective means of providing justice for survivors, particularly for victims of institutional child sexual abuse in the future.

Most states and territories have already implemented the recommended reforms to remove limitation periods for personal injury claims resulting from institutional child sexual abuse (see Volume 17, *Beyond the Royal Commission* for more information).

Removing limitation periods will facilitate damages claims by victims of institutional child sexual abuse, regardless of the time it takes for victims to be able to disclose the abuse and seek compensation.

In relation to the liability of institutions for institutional child sexual abuse, we recommend reforms in two areas. The difficulty in imposing liability on institutions has arisen because, while institutions are liable for the negligence of their members or employees, Australian courts have struggled to accept that they should be liable for deliberate criminal acts – such as sexual abuse – committed by their members or employees.

First, we recommend that states and territories introduce legislation to impose a non-delegable duty on some types of institutions for child sexual abuse committed by members or employees of the institution, broadly defined.¹²⁹ A non-delegable duty would impose liability on the institution without requiring proof that it was negligent. Thus, these types of institutions would be liable for damage occasioned by child sexual abuse committed by their members or employees against children who are in the care, supervision or control of the institution, without requiring proof that the institution failed to exercise reasonable care.

We recommend that this non-delegable duty be placed only on certain types of institutions, including providers of residential out-of-home care services, but not providers of foster or kinship/relative care.

Second, we recommend that the onus of proof be reversed for claims of negligence against any institution relating to child sexual abuse committed by the institution's members or employees so that the institution bears the onus to prove that it exercised reasonable care to prevent abuse. This means that if a survivor could prove that they were abused in an institution, it would be for the institution to prove that it took reasonable steps to prevent the abuse. We recommend that the reverse onus of proof apply to all institutions, including those that we recommend be excluded from the non-delegable duty.¹³⁰

We recommend that these changes to the duty of institutions apply only prospectively. That is, they should apply only to damages claims in relation to institutional child sexual abuse committed after the reforms are made.¹³¹

These recommendations are intended to provide those who suffer child sexual abuse in institutions in the future with a more effective avenue to obtain compensation for the abuse through civil litigation.

However, the recommendations are also intended to prevent child sexual abuse in an institutional context by encouraging leaders of institutions to facilitate a child safe environment, given the risk of the institution being liable for the abuse if they do not. An aspect of facilitating a child safe environment would be through implementation of our proposed national Child Safe Standards in institutions. Institutions that take steps to prevent child sexual abuse will potentially reduce their liability. The more effective those steps are at preventing abuse, the more an institution's potential liability will be reduced.

Some states have taken steps to implement or further develop the recommended reforms we made in our *Redress and civil litigation* report (see Volume 17, *Beyond the Royal Commission* for more information).

We also have made recommendations designed to assist survivors and their legal advisers to identify the proper institutional defendant to sue; and we make recommendations for government and non-government institutions to adopt guidelines for responding to claims for compensation concerning allegations of child sexual abuse.¹³²

The reforms already made in response to our recommendations in relation to civil litigation, and any further reforms to implement our recommendations, are likely to make civil litigation a far more effective means of providing justice for survivors, particularly for future victims of institutional child sexual abuse. This means that civil liability is likely to become an increasingly important means of holding institutions to account for institutional child sexual abuse, unless institutions take all reasonable steps to prevent abuse.

See our *Redress and civil litigation* report for more information.¹³³

Criminal law

In our *Criminal justice* report we recommend two new criminal offences that are targeted at the reporting and prevention of institutional child sexual abuse.¹³⁴ The offences are ‘third-party’ offences, in that they apply to persons other than the perpetrator of the abuse. In each case, the offence can be committed by an adult in the institution, rather than the institution itself.

The ‘failure to report’ offence would require adults in the institution to report to police in circumstances where they know, suspect, or should have suspected that another adult associated with the institution was sexually abusing or had sexually abused a child. We discuss this offence in detail in Chapter 16 of the *Criminal justice* report.¹³⁵

The ‘failure to protect’ offence would require an adult in an institution who knows there is a substantial risk that another adult associated with the institution will commit a child sexual offence, to reduce or remove this risk, where they have the power or responsibility to do so. If that person negligently fails to do so, they would commit the offence. The failure to protect offence that we recommend is based on an offence introduced in Victoria in 2015. We discuss this offence in detail in Chapter 17 of the *Criminal justice* report.¹³⁶

For each of these two offences, we recommend that relevant institutions be defined to include institutions that operate facilities or provide services to children in circumstances where the children are in the care, supervision or control of the institution, including out-of-home care service providers, but not individual foster and kinship/relative carers.

We believe that these offences will reinforce rather than compete with regulatory and other measures designed to require institutions to be safe for children. These offences are designed to require adults within institutions to take responsibility for reporting and preventing child sexual abuse in institutional contexts.

See our *Criminal justice* report for more information.¹³⁷

5.2.4 Oversight of institutional complaint handling

Complaint handling in out-of-home care should be subject to independent oversight. This oversight is important in addressing problems that arise in the way institutions handle complaints about child sexual abuse and encourages improvements in institutional complaint handling through training, education and guidance. Further, independent oversight can assure the public that the institutions entrusted to care for children cannot minimise or ignore complaints, and that the leaders and employees of these institutions cannot operate with impunity.

In Volume 7, *Improving institutional responding and reporting* we recommend that such oversight operate through reportable conduct schemes legislated by every state and territory (see Recommendations 7.9 and 7.12, included in Appendix A). Governments have a unique opportunity to achieve national consistency in reportable conduct schemes by using the New South Wales scheme as a model – as Victoria and the Australian Capital Territory have already done.

The handling of child sexual abuse complaints should be subject to the oversight of a reportable conduct scheme only where institutions:

- exercise a high degree of responsibility for children
- engage in activities that involve a heightened risk of child sexual abuse due to institutional characteristics, the nature of their activities involving children, or the additional vulnerability of the children the institution engages with.

Out-of-home care service providers meet these criteria. As discussed in Chapter 3, research identifies a number of risk factors for child sexual abuse in out-of-home care, including ‘institutional culture, gender issues and gender ideology’ and violence involving other children.¹³⁸ We also observed that failure to supervise placements and carers can leave children at immense risk, and that residential care is associated with greater risk than other forms of out-of-home care.

Out-of-home care service providers were broadly supportive of the implementation of reportable conduct schemes, noting that benefits were likely to include:

- improved investigative practices¹³⁹
- increasing transparency and natural justice in the investigation of allegations, as well as increased support to all parties¹⁴⁰
- facilitating the coordination and efficiency of inquiries conducted by different authorities¹⁴¹
- resultant education and capacity building that would assist in improving the child safety culture in organisations.¹⁴²

The New South Wales, Victorian and Australian Capital Territory reportable conduct schemes currently cover out-of-home care service providers.¹⁴³

As discussed in Chapter 2, some states supplement their complaint handling and oversight mechanisms with official or community visitor schemes. Official visitors who are generally independent of the child protection department and out-of-home care service providers give children in out-of-home care an alternative channel for raising concerns about their carers or about the out-of-home care service provider. The visitors are empowered to visit children in out-of-home care and seek to resolve any concerns raised by children – either locally or with the support of statutory bodies such as an independent Children’s Commissioner.¹⁴⁴ Queensland has the most expansive official visitor scheme, and includes home-based care placements. The schemes in states such as New South Wales and Western Australia are more limited in scope.

Early in our inquiry we invited submissions on ‘the strengths and weaknesses’ of various audit and oversight schemes used in the out-of-home care sector, including the use of independent community visitor schemes.¹⁴⁵ Among those favouring visitor schemes were CREATE, which cited a survey of children in foster care in Queensland showing that 95 per cent of respondents supported community visitor schemes,¹⁴⁶ and Uniting Care Australia, which argued that any moves to reduce the advocacy role of visitors would weaken an effective independent voice for vulnerable children.¹⁴⁷

However, a number of other submissions either opposed community visitor schemes or were equivocal about these schemes. One submission argued that a community visitor scheme for foster children would be ineffective, unnecessarily disruptive to the lives of children and their carers, and might divert funds from the delivery of frontline services.¹⁴⁸ Another warned that unless community visitors were adequately screened and checked, they may themselves present a risk to the children that they visited.¹⁴⁹ Several submissions cited the findings of the Carmody Report, which recommended a less resource-intensive approach to the Community Visitors Program in Queensland as it was then configured.¹⁵⁰

In section 5.3.3 we discuss ways to improve support for children to disclose abuse and to make complaint handling mechanisms more responsive to the needs of children, and make recommendations to address these issues.

5.3 Improving institutional responses to child sexual abuse in out-of-home care

In Chapter 4 we considered some factors which may contribute to or enable child sexual abuse in out-of-home care settings, ways in which children were not adequately protected from sexual abuse, and the need for institutions to better address the identified risks for children and to increase support for their carers.

In this section we outline recommendations for supporting children to make disclosures when they are sexually abused and ensuring there are trusted and skilled adults in an institution to whom a child can disclose. We recommend strategies for responding to children with harmful sexual behaviours, disrupting the sexual exploitation of children in out-of-home care and better sharing of information to increase the safety of children.

5.3.1 Training and support of caseworkers

Community and academic groups that made submissions in response to our *Issues paper 4: Preventing sexual abuse of children in out-of-home care* said that training in preventing child sexual abuse and responding appropriately to indications of sexual abuse should be mandatory for all staff and volunteers who care for children or work in support roles in care arrangements.¹⁵¹ We heard that training and support for out-of-home care caseworkers, as well as carers, is very important and often under-resourced. We have learned that training should include:

- 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
- understanding key features of the institution's child protection and complaint handling policies, including pathways for reporting and how the institution should respond to the disclosure/complaint
- recognising the high prevalence of child sexual abuse in some out-of-home care population groups

- recognising disability and improving the competence of caseworkers and carers in responding to particular needs
- strategies to maintain the cultural identity of children in care and strengthen their connections with community, with an emphasis on safety
- working in a culturally safe way, that is the ‘integration of attitudes, values, knowledge, understanding and skills that enable effective interventions with people from a culture different to their own’.¹⁵²

It is beyond the scope of this inquiry to examine the reasons for high staff turnover in contemporary out-of-home care services, but we have learned that it is essential for children to have stable and trusting relationships to enable them to disclose sexual abuse. As discussed in Chapter 4, the high turnover of caseworkers is extremely disruptive for children in out-of-home care and limits the opportunities for caseworkers and children to build an understanding and a rapport that may be very protective for children.

Training and support of caseworkers is an essential element to preventing and responding to the sexual abuse of children in out-of-home care. We have also been told that effective and regular supervision of caseworkers may increase the effectiveness of the work they do with children in out-of-home care and lessen the stress and pressure they feel. Volume 9, *Advocacy, support and therapeutic treatment services* details the need for frontline staff working with victims and survivors of child sexual abuse to have access to professional supervision with more experienced practitioners to provide opportunities for counselling, debriefing, mentoring and clinical development.

This professional supervision is distinct from managerial supervision in that, where managerial supervision aims to ensure that the practitioner’s activities are in line with the priorities of the agency, professional supervision aims to foster the practitioner’s clinical capacity and skill and provide opportunities for self-care. Professional supervision is important for ethical practice¹⁵³ and the quality, safety and wellbeing of staff.¹⁵⁴ It assists agencies to retain staff, as well as maintain and further develop skills and knowledge. Commissioned research that surveyed practitioners from support services for victims and survivors noted that ongoing support and debriefing of staff can also help reduce impacts of vicarious trauma on practitioners.¹⁵⁵

5.3.2 Investing in prevention through education

For institutions to be safe for children, the communities in which the institutions are located need to be safe for children. A well-informed and proactive community could help to create an environment that is hostile to child sexual abuse. In Volume 6, *Making institutions child safe* we recommend the development and implementation of a national strategy to prevent child sexual abuse that includes prevention education for all children and parents. These recommendations are based on the ‘population health’ approach, an approach that is used when a preventable problem is widespread, serious and associated with severe long-term effects on individuals

and communities. This approach was originally designed for disease prevention, but has been modified to address other complex problems relating to social behaviour. The model is well established and has been applied to child sexual abuse, both in Australia and overseas.

Recognising the particular vulnerability of children in out-of-home care, we believe a tailored education strategy is necessary for these children, their carers and caseworkers.

Across Australia, 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. Through our inquiry, we also heard that children in out-of-home care:¹⁵⁶

- are more likely to miss out on school-based education programs because of frequent disruptions to schooling as a result of factors such as family crises and care placement instability
- often have ‘limited knowledge or education about sex, sexuality and healthy relationships to draw on’.

Although some children in care, especially residential care, may appear ‘worldly’ and knowledgeable about sexual matters, they may lack basic knowledge of human development, sexual functioning and what constitutes sexual abuse.¹⁵⁷ They may not know about safe sex practices, including the risk of pregnancy and sexually transmitted infections.

Like many children, children in out-of-home care frequently have ready access to the internet and social media, via which they may be exposed to pornography. This may result in distorted and violent views about sexual relationships. At particular risk are children in residential care, who may accept the online advances of adults from outside in the hope of receiving attention and developing relationships.¹⁵⁸ The internet and social media provide unique access to these vulnerable children. We heard in submissions that maintaining safe online environments for children is a significant challenge for providers of out-of-home care and ‘strategies to manage this risk are not well developed at this time’.¹⁵⁹

Without protective adults taking the initiative to discuss these matters with children in out-of-home care – to empower them with information and protective strategies – these children may be more vulnerable to being exploited. We also heard ‘an effective response requires an organisation to possess the resources to protect children when they are engaging online, supported by a workforce with the knowledge and skills, to moderate the risks presented by the internet, while not limiting access to the benefits’.¹⁶⁰

In evidence during our *Out-of-home care* public hearing, we heard from young people who had lived in out-of-home care about sensible supports for children using the internet or social media:

it's not about taking the internet or media away from them; it's helping them understand the dangers that can come from that. So you're not saying, 'No, you can't do this,' you're saying, 'Okay, we can let you do this, but here's an understanding of what can happen'. I don't think that just goes for kids in the out-of-home care sector; it goes for every child.¹⁶¹

I had a carer who went to ... an internet safety class [at school] for teenagers about social media and how to have those conversations and use it effectively. That worked really well. Then she had enough background to be able to explain the dangers to me, and explain to me why there should be safety protocols, like don't use your last name, don't talk to people you don't know in person, those kind of things. She was able to explain to me more fully why, and she had an understanding then about why she couldn't just put a black ban on it.¹⁶²

We discuss preventing and responding to online child sexual abuse in more detail in Chapter 5 of Volume 6, *Making institutions child safe*.

In addition to disruptions to schooling and a shortage of protective adults and good role models who can pass on knowledge about healthy relationships, we heard of other factors that can impede attempts to educate children, carers and caseworkers about sexuality, sexual health, perpetrator behaviours and child sexual abuse. We have learned that the out-of-home care environment is often characterised by:

- inadequate attention to proactive or preventive measures, such as sexuality education and personal safety programs for children and young people
- inadequate knowledge of what constitutes sexual abuse and appropriate responses for children and their carers
- inexperienced carers, case-managers or caseworkers failing to identify indicators of sexual abuse or minimising or excusing sexual exploitation as 'adolescent sexual experimentation'
- a failure to ensure adequate staff training and support to facilitate disclosures of child sexual abuse
- the absence of 'trusted adult relationships' for children and young people in out-of-home care.

We heard that there is a need for evidence-informed strategies to address these issues.

Survivors told us that new information can sometimes be a catalyst to prompt disclosure. This information may be in the form of school-based education on sex and sexuality, personal safety or body safety, respectful relationships, or conversations with carers, parents and peers. Such information can challenge the belief in some children – created by perpetrators – that they are the only person in the world to whom this has happened or is happening, or, conversely, that sexual abuse is normal and happens to all children, and that there is therefore no use in resisting.

A national education strategy

We know that many children in contemporary out-of-home care are likely to have experienced sexual abuse or sexual exploitation, or are at least likely to be aware of these experiences among their peers. Given these experiences of abuse, either prior to entering care or in care, combined with the heightened risk of sexual abuse in out-of-home care, any preventative education targeting these children will differ from standard school-based strategies.

Our *Out-of-home care* consultation paper sought comments on the main elements we identified for a potential national education strategy aimed at preventing the sexual abuse of children in contemporary out-of-home care. In submissions responding to this proposal, there was broad agreement that such a strategy was needed to create and guide greater national consistency in policy and practice expectations, to prevent child sexual abuse in contemporary out-of-home care in Australia and to encourage and support the disclosure of child sexual abuse at the earliest opportunity. There was also agreement that this strategy requires the development and evaluation of resources and program implementation.

The consultation paper also proposed that the strategy be embedded in the National Framework for Protecting Australia's Children 2009–2020.¹⁶³

Aims and objectives

To educate children, carers and caseworkers about sexuality, sexual health, perpetrator behaviours and sexual abuse, we proposed in the consultation paper that a nationally consistent education strategy should:

- raise awareness among carers, children in contemporary out-of-home care, practitioners and service providers about the vulnerability of children in out-of-home care to sexual victimisation and re-victimisation
- develop a prevention program targeting children, carers and practitioners in out-of-home care, which
 - identifies the necessary elements of prevention education, drawing on those covered in school-based programs identified below
 - covers all forms of child sexual abuse by adult perpetrators and children with harmful sexual behaviours
 - is flexible and tailored to meet the individual needs of a child and their history
 - is delivered in a variety of formats, such as supportive group formats or on an individual basis
 - covers how children can make a disclosure
 - covers how children will be supported when a friend or peer discloses sexual abuse to them.

- develop and distribute resources that are culturally safe and appropriately tailored for children with learning delays or disability, and meet the needs of lesbian, gay, bisexual or transgender children
- develop an education and training framework for all foster, kinship/relative and residential carers and practitioners, based on
 - role clarity, processes and recording practices as set out in out-of-home care policies and procedures
 - understanding the importance of enabling a culture of openness and creating an environment where a child feels safe to disclose abuse
 - developing skills and knowledge about how to talk to children about healthy relationships and sexuality education
 - understanding social media policies, with specific reference to pornography and the transmission of sexualised images (sexting)
 - awareness about the added risk of bullying, exploitation, depression and risk-taking for same-sex attracted and gender-questioning young people
 - ongoing coaching and supervision of staff and carers, building on their initial education and training to develop their knowledge of and skills in using the resources.
- feature mechanisms for implementing, reviewing, evaluating and improving prevention strategies and their components.

Improving the reach and effectiveness of school-based programs

There was strong agreement expressed in submissions to our consultation paper that the best way to ‘normalise’ sexual abuse prevention education for children in contemporary out-of-home care is through schools delivering well-rounded, age-appropriate and accessible education programs about interpersonal relationships, sex and sexual relationships. For example, Anglicare Victoria said that relying on schools to deliver prevention education was preferable because:¹⁶⁴

- sex education should be part of a complete educational program for all children and young people, whether they are in out-of-home care or not
- providing a sex education program aimed only at children and young people in out-of-home care would duplicate any program aimed at children and young people generally, would run the risk of marginalising children and young people in out-of-home care and would be contrary to service providers’ efforts to ‘normalise’ the out-of-home care experience for children and young people.

On the other hand, we heard that school-based protective behaviours programs often do not reach children in out-of-home care or adequately address gaps in their understanding of healthy and respectful relationships:

Children in care are less likely to access school sexuality education programs and are less likely to have the same sexuality knowledge of their peers, therefore have a high need for specialised sexuality education.¹⁶⁵

Factors such as family crises, care placement instability and moving to new schools can disrupt school attendance and limit the scope for school-based strategies to reach children in out-of-home care. As these children are among those who would benefit the most from such programs, 'any national education strategy would need to incorporate strategies that address' these issues.¹⁶⁶ As Anglicare Australia told us:

the lived reality of disrupted schooling means that education programs need to address the possibility that the audience has mixed prior knowledge, and not assume that school is the location for the delivery of sexual abuse prevention education for children and young people. This is especially important as in many cases of child sexual abuse in care the 'perpetrator' is another child.¹⁶⁷

We also heard that any school-based programs should be supplemented with strategies that address the specific needs and vulnerabilities of children in out-of-home care, especially those who live in residential care. For example, the Centre for Excellence in Child and Family Welfare told us that:

evidence shows that many children in out-of-home care miss out on education, with very poor attendance rates. The Centre reiterates its recommendation that specific sex education and respectful relationships education needs to be developed for children and young people in residential care settings, who often have limited access to positive role models and information about sex and respectful relationships.¹⁶⁸

The specific needs of children in residential care are examined further in Section 5.4.3, where we discuss improving the safety of children in residential care, and in Section 5.3.6, where we discuss strategies to disrupt and prevent child sexual exploitation.

Other considerations

Other issues regarding the development of a national education strategy aimed at preventing sexual abuse for children in contemporary out-of-home care that were raised in submissions included that:

- awareness training and education targeting out-of-home carers, practitioners and service providers should not be limited to introductory seminars for new personnel, but strengthened by regular reviews and engagement¹⁶⁹
- education strategies must emphasise the primacy of children's safety, while taking care to avoid introducing 'distance' between children and their caregivers¹⁷⁰
- the voice of the child should be heard¹⁷¹
- as far as possible, the concepts underpinning any national education strategy to prevent abuse in out-of-home care should complement and build on other violence prevention education in Australia.¹⁷²

Essential elements of prevention education

In their submissions to our *Out-of-home care* consultation paper, some out-of-home care service providers said there would be value in distilling the essential elements we identified as part of a potential national education strategy. For example, CareSouth supported the development of targeted educational strategies to help prevent sexual abuse by informing children about:¹⁷³

- their rights
- complaints/disclosure avenues
- protective behaviours
- predatory and grooming tactics.

Other service providers emphasised principles that should inform the development of a national education strategy for this sector. According to Life Without Barriers:¹⁷⁴

- educational strategies involving children should be framed by the concept of healthy relationships, including exploration of issues of respect and consent, as children in out-of-home care are particularly vulnerable in this area
- education strategies should include children, young people, practitioners and carers, and should
 - complement measures aimed at supporting carers and others to provide age-appropriate information and to initiate and respond to discussions with children about sexuality and relationships
 - include legislative and other requirements on reporting and responding to disclosures.

Commissioned research suggests that education about preventing abuse ‘should be informed by young people themselves, to ensure their needs and promotes strategies they believe they would use in situations when they were unsafe’.¹⁷⁵ This research stated that education strategies needed to take into account ‘the different needs and gaps in knowledge of children and young people of different ages and genders’.¹⁷⁶

This may involve practical advice to children and young people as to how to respond in abusive situations. For example, in consultations with young people as part of commissioned research on the safety of children in residential care, one young man identified information he thought would be valuable for young people in care to have: ‘I guess awareness of how things would play out, what to be careful of, what to do if you find yourself in these situations’.¹⁷⁷

Some young women participating in this research argued that it was important for young people in care ‘to understand their vulnerability and to know what a healthy relationship looked and felt like so that they could assess the intentions of adults’.¹⁷⁸

There was consensus among service providers responding to our consultation paper that a consistent, national education strategy should be part of and complement broader strategies to prevent child sexual abuse in out-of-home care. For example, Anglicare Victoria ‘believes that there are three key processes that work together towards prevention of sexual abuse in out-of-home care’.¹⁷⁹ These processes are to ensure:

- the best possible outcome of the placement matching process
- that children and young people in out-of-home care have received appropriate education about sex, relationships and sexual relationships
- that staff and volunteer carers understand how to assess for risk and the presence of sexually abusive behaviours and tendencies, and intervene and respond in a ‘trauma-informed’ or ‘therapeutic’ manner.

Recommendation 12.9

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:

- a. input from children in out-of-home care and care-leavers
- 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
- c. resources tailored for children in care, for foster and kinship/relative carers and residential care staff, and for caseworkers
- d. resources that can be adapted to the individual needs of children with disability and their carers.

The development of this targeted strategy could be undertaken by the National Office for Child Safety we have proposed as part of its broader work on child safety that includes child sexual abuse prevention education for children and parents (see Recommendations 6.16 and 6.17 in Volume 6, *Making institutions child safe* and set out in Appendix A).

Recommendation 12.9 is consistent with our Child Safe Standards, particularly Standard 2: Children participate in decisions affecting them and are taken seriously, Standard 4: Equity is upheld and diverse needs are taken into account, Standard 7: Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training and Standard 8: Physical and online environments minimise the opportunity for abuse to occur. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, Standard 2: Children and young people participate in decisions that have an impact on their lives, Standard 5: Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way, and Standard 12: Carers are assessed and receive relevant ongoing training, development and support, in order to provide quality care.¹⁸⁰

5.3.3 Creating a culture that supports disclosure and identification of child sexual abuse

In Chapter 4 we heard about barriers to disclosure and identification of child sexual abuse in contemporary out-of-home care. These include barriers faced by victims, barriers created by perpetrators to serve their own purposes, and those created by institutions. For victims, those barriers may include not knowing that sexual abuse is actually abuse, and not being listened to or taken seriously. We heard that certain cohorts of children, including Aboriginal and Torres Strait Islander children, children with disability, and children from culturally and linguistically diverse backgrounds, may face additional barriers.

Institutional barriers to disclosure, whether intentional or unintentional, may include power imbalances between children in the institution and those in authority, the institution's disclosure and post-disclosure processes (that children do not trust), children not knowing or having faith in the complaint handling process, and children being seen by institutions and staff as 'problems' to be managed, rather than supported. Such institutional cultures have led to institutions making poor and inadequate responses to disclosures of child sexual abuse.

In Chapter 3, we discussed that perpetrators in out-of-home care, as in other institutional contexts, have used a wide range of tactics and strategies, including grooming, to facilitate the sexual abuse of children. Grooming may be less common in out-of-home care, where carers and other trusted adults routinely have unsupervised access to children, and often have a high degree of authority over the children in their care. In such circumstances, there may be opportunities for sexual offending to occur without the need for grooming.

What is clear is that in contemporary out-of-home care there are obvious limits to the effectiveness of screening mechanisms and situational prevention strategies. Only strong child safe organisational cultures, coupled with regular oversight of placements that includes genuine interactions with children in care, are likely to reduce the opportunities for sexual abuse.

This section discusses how institutional cultures should be changed to help remove barriers to disclosure and identification of child sexual abuse in out-of-home care.

Ensuring the voices of children are heard

A lack of participation by children is one of the contributors to an environment that enables sexual abuse to occur. Where children do not feel listened to, they are less likely to report abuse and to have their reports taken seriously. Children need easy access to an adult they can talk to, and a complaints system that is accessible and in which they can have confidence.

We heard much about the difficulties that children in out-of-home care experience in being heard and having their concerns taken seriously, not least because of the significant power imbalances between a child and their carer. Commissioned research supports this proposition.¹⁸¹ In addition, 56.4 per cent of survivors who attended private sessions spoke about barriers to disclosure. Of these survivors, 31.7 per cent said they did not report the sexual abuse they experienced in contemporary out-of-home care because they had no one to tell, 24.1 per cent said they felt shame or embarrassment as a barrier to disclosure, 22.1 per cent said they did not feel safe to disclose or feared retribution if they spoke out, and 18.6 per cent said they feared they would not be believed.

We know that processes for making a complaint of sexual abuse are not always child friendly and that the idea of making a formal complaint may be foreign to a child. An understanding of these issues should be at the centre of every agency's policies and procedures, ensuring that children are able and supported to make disclosures. This requires service providers to: 'Put your kid's hat on and take your big-person's hat off'.¹⁸²

Additional barriers to disclosure for a child may include concerns about breaches of confidentiality, which may occur, for example, in small or remote communities or in kinship/relative care placements, where the complaint may be about a family member.

In public hearings and the roundtable forum for our *Out-of-home care* case study we heard that children are much more likely to disclose abuse – and any other concerns – when they have a trusting relationship with an adult who is close to them.¹⁸³ Some witnesses gave evidence that the scope to improve child safety and strengthen confidence in departmental complaints processes was contingent on 'each child or young person [having] a trusted adult in whom they have confidence'¹⁸⁴ and on supporting caseworkers to earn the trust of the children they work with so they can take on that role.¹⁸⁵ We were told that, as a result in part of high levels of caseworker and carer turnover, 'we place these vulnerable children in a situation where they have a passing parade of strangers'.¹⁸⁶

In explaining who children are most likely to trust, one participant told our roundtable forum:

if we look at patterns of disclosure and what the research says and what our practice experience says, it is generally somebody who is putting them to bed at night. It is generally someone they are seeing most days. It is a peer or it is a family member.¹⁸⁷

Research suggests that children mostly disclose to family and friends, with mothers being the family member children most frequently disclose to.¹⁸⁸ It is clearly difficult for parents to maintain close relationships with their child once the child has been removed into out-of-home care.¹⁸⁹ Acknowledging the need for the safety of children to be paramount and contact with families to be appropriately managed and supported by out-of-home care service providers, parents can still play an important role in their child's wellbeing while their child is in out-of-home care. As discussed in Chapter 4, where it is possible and safe for a child in care to maintain relationships with their birth families, there are identifiable benefits for the child in staying connected – not least because of a child's need for an adult to whom they may disclose abuse, but also to have relationships that extend beyond their leaving care.

The importance of a child maintaining family relationships was stressed by Ms Connie Salamone, Director of Strategy and Services at the Victorian Aboriginal Child Care Agency, who said in our *Out-of-home care* public hearing:

I think the most important relationships are those that are going to endure post care, so I think we also need to think about where children can safely have contact with their families, that we invest significantly in that and in their sibling relationships. The care system cannot give children continuity of relationships post-care. We know most children in care go home. We want that experience to be really solid. We don't want children to go home to experiences where they don't actually know the family, they have had very minimal contact, and it sets them up to fail. It sets them up to have no social networks, no contacts.¹⁹⁰

The particular challenges for Aboriginal and Torres Strait Islander children and the need to ensure there are culturally safe ways for them to disclose are discussed in Chapter 4 and in Section 5.5.1.

A participant in our roundtable discussion on preventing sexual abuse of children in out-of-home care observed that, in addition to ensuring there are trusted adults children can confide in, children must be empowered to speak up. This participant explained that if children don't feel empowered or don't feel they have a right to participate, 'it probably means that they won't'.¹⁹¹

Volume 7, *Improving institutional responding and reporting* discusses the development of complaint mechanisms that are appropriate for disclosures of child sexual abuse in an institutional context. It is essential that children in out-of-home care have clear information about where they can safely disclose or report sexual abuse or any other abuse they are experiencing. Children in out-of-home care should be given age-appropriate information about their right to contact an ombudsman or other external agency responsible for investigating out-of-home care, as well as information about the means by which they can contact these agencies should they decide to do so.

We also know that children with disability may experience barriers to making a complaint due to impairments that may make communicating complex information difficult or because of their reliance on others to support their communication. Stereotypes that deny agency to children with disability should be addressed. Complaint handling mechanisms should be transparent and accessible for all children, including children with disability.¹⁹² It is also important to note that children, particularly children with disability, may sometimes make non-verbal disclosures of sexual abuse through behaviours and/or physical signals.¹⁹³ Staff should understand the vulnerability of children with disability to sexual abuse and the signs of possible sexual abuse for children with disability, and should be able to support the diverse communication needs of children with disability.¹⁹⁴

We were told in submissions about the use of ‘an interactive computer program designed to engage children in an age appropriate way’ that enabled out-of-home care agencies to obtain feedback directly from children in care.¹⁹⁵ There is also some evidence from the area of health services that children can accept and use mobile technologies to communicate sensitive information, even when they do not have an existing relationship with a health service provider.¹⁹⁶ There is potential for mobile and online technologies, which provide mechanisms for children in contemporary out-of-home care to give feedback, to be used more widely, including for making complaints. Such technologies have the potential to reduce or overcome the power imbalance between victim and perpetrator that often underpins the abuse and creates a barrier to disclosure.

Communication between a child in out-of-home care and their carer and/or caseworker should, of course, not be restricted to disclosures or complaints of abuse. Participants in the CREATE Foundation conference in Brisbane in 2015 were clear that being part of a community can keep a child safe, and that improved communication generally between children, their carers and caseworkers is an essential element of a child safe organisation.

Recommendation 12.10

State and territory governments, in collaboration with out-of-home care service providers and peak bodies, should develop resources to assist service providers to:

- 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
- 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
- c. regularly consult with the children in their care as part of continuous improvement processes.

Recommendation 12.10 is consistent with our Child Safe Standards, in particular Standard 2: Children participate in decisions affecting them and are taken seriously, Standard 4: Equity is upheld and diverse needs are taken into account, Standard 6: Processes to respond to complaints of child sexual abuse are child focused, and Standard 7: Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, Standard 2: Children and young people participate in decisions that have an impact on their lives, and Standard 12: Carers are assessed and receive relevant ongoing training, development and support, in order to provide quality care.¹⁹⁷

Implementing child-focused complaint handling

All of the 10 Child Safe Standards we have identified should inform an institution's complaint handling process, policy and procedures to create an environment where children, families and staff feel empowered to raise complaints and complaints are taken seriously.

Child Safe Standard 6, that processes to respond to complaints of child sexual abuse are child focused, aims to ensure that institutions have a complaint handling system in place that is understood by children, staff, volunteers and families. Effective complaint handling policies and procedures should clearly outline staff and carers' roles and responsibilities, the approaches they should take to deal with various types of complaints, and their obligations to act and report on those complaints.

Complaint handling policies should be accessible to all children and adults connected to the institution. If children and adults have particular communication needs – for example, in language or culture, or to account for disability – institutions should consider how best to

communicate the policies with them. In Volume 7, *Improving institutional responding and reporting* we recommend that institutions have a child-focused complaint handling policy and code of conduct, and outline the key components of these policies (see Recommendations 7.7 and 7.8 set out in Appendix A).

It is however important to note in relation to out-of-home care, children – especially younger children – may not complain by following a formal complaint handling process. Children may instead make a verbal or non-verbal disclosure of sexual abuse. Children with disability may make non-verbal disclosures of sexual abuse through behaviours and/or physical signals.¹⁹⁸

Strengthening the capacity of carers, staff and caseworkers to support children

This section examines measures aimed at strengthening the capacity of those working in the out-of-home care system – principally foster and kinship/relative carers, residential care staff, and child protection caseworkers – to support and meet the needs of children in care, including those who have been sexually abused and children with harmful sexual behaviours.

Research suggests that children often present to child or family welfare services:

with a complex range of symptoms and behaviours related to prior and/or past trauma, which neither they nor those working with them have linked to this previous trauma exposure.¹⁹⁹

Dislocation from family and community as a result of being placed in out-of-home care may, in itself, lead to further harm unless the care provided recognises and addresses the needs of individual children arising from prior trauma.²⁰⁰

The concept of ‘trauma-informed’ care was developed ‘in an effort to “short-circuit” the re-traumatising potential in many human and community services’.²⁰¹

human service systems such as the mental health and alcohol and drug sectors often served survivors of trauma without treating them for the consequences of that trauma, and, more significantly, without even being aware of the trauma that occurred.²⁰²

We heard that unless services are alert to this trauma there was an increased risk that the service’s usual practices and procedures could inadvertently re-traumatise the people they are trying to help. Because of this, trauma-informed approaches explicitly envisage that:

all staff of an organisation, from the receptionist to the direct care worker to the board of directors, must understand how violence impacts on the lives of the people being served so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatisation.²⁰³

A trauma-informed approach is distinct from trauma-specific interventions, therapeutic treatments²⁰⁴ and therapeutic care. These interventions are part of, but not the same as, a system-wide trauma-informed approach. A trauma-informed approach does not require a service to provide therapeutic treatment, but rather to provide a safe and positive environment in which children can be stabilised, supported and managed ‘in a way that improves their outcomes’.²⁰⁵

Research indicates that ‘much of the healing from trauma can take place in non-clinical settings’ and that ‘parents, counsellors, teachers, coaches, direct care workers, case managers, and others are all in a position to help a child heal’.²⁰⁶

We heard that initiatives are being trialled in all Australian states and territories to provide better, more consistent and individualised care that aims to help children and young people in out-of-home care recover from trauma and prevent further victimisation.²⁰⁷

Implementing trauma-informed care as an element of good practice

As described in Volume 9, *Advocacy, support and therapeutic treatment services*, trauma-informed care is increasingly recognised as a promising approach for human and mental health services in Australia.²⁰⁸ The key principles of a trauma-informed system of care include:

- ‘having a sound understanding of the prevalence and nature of trauma arising from interpersonal violence and its impacts on other areas of life and people’s functioning
- ensuring that organisational, operational and direct service-provision practices and procedures promote, not undermine, the physical, psychological and emotional safety of consumers and survivors
- adopting service cultures and practices that empower consumers in their recovery by emphasising autonomy, collaboration and strength-based approaches
- recognising and being responsive to the lived, social and cultural contexts of consumers (for example, recognising gender, race, culture and ethnicity), which shape their needs as well as recovery and healing pathways
- recognising the relational nature of both trauma and healing’.²⁰⁹

Although the principles of trauma-informed care appear sound, we learned of the following issues that are relevant to its application to out-of-home care in Australia.

There are benefits in trauma-informed care, but the research is limited: In our *Out-of-home care* consultation paper,²¹⁰ we considered evaluations of programs that applied trauma-informed care principles to foster care and therapeutic residential care pilot programs in Victoria. The evaluation of the Victorian therapeutic residential care pilot program was particularly noteworthy because it demonstrated benefits in outcomes for young people in comparison with standard residential care.²¹¹ While these programs do not directly prove

that trauma-informed care reduces occurrences of child sexual abuse, they do demonstrate improved outcomes in relation to factors such as placement stability and school attendance that are thought to mediate risk of sexual abuse.

All jurisdictions embrace the principles of trauma-informed care, but have limited experience in how to apply them: As yet, there are few agreed frameworks to guide the introduction of trauma-informed care in a systemic way.²¹² Research we commissioned suggests that there is significant interest across a range of sectors in becoming trauma-informed, but that ‘practice wisdom and evaluation knowledge have not yet coalesced sufficiently to guide how the principles are put into practice in different settings’.²¹³ The research also indicated that there is a lack of publicly available, coordinated material on the trauma-informed care programs and models being developed and the development of trauma-informed care models is being driven by individual services, rather than as part of a coordinated strategy.²¹⁴

The need for agreed terminology and a common understanding: Without an agreed terminology and a common understanding of ‘trauma-informed care’, there are risks that the potential benefits of this approach (such as improved placement stability and stronger connections with family and community) could be undermined by:

- programs that are ‘trauma-informed’ in name only, wasting scarce resources and opportunities on initiatives of limited value
- expectations that exceed what trauma-informed care can deliver.

Applying trauma-informed principles to out-of-home care

For state and territory governments to strengthen trauma-informed practice and improve the evidence base for trauma-informed care, we are of the view that they should consider:

- adopting an overarching policy that mandates trauma-informed care and an agreed framework to guide evidence-based practice
- improving the collection of research data on trauma-informed care programs and adopting standardised outcome measures for evaluation that would support a more systemic approach to evaluating the implementation of trauma-informed care.²¹⁵

Research indicates that in out-of-home care settings, a trauma-informed approach is likely to reduce the risk of re-traumatising children. It has been suggested that there are three pillars of trauma-informed care: creating a safe place for children, creating ‘comfortable connections between traumatised children and their care providers and mentors’ and teaching traumatised children self-management and coping skills.²¹⁶ ‘One does not have to be a therapist to help address these three crucial elements of healing’²¹⁷ but appropriate training and support will ensure those working with children in out-of-home care are sensitive to their needs. As we were told during the *Out-of-home care* case study, it is important for carers to understand a child’s traumatic family background and why they might be behaving the way they do: ‘looking at instead of asking that child, “What is wrong with you?”, rather, “What has happened to you?”’.²¹⁸

Recommendation 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.

Recommendation 12.11 is consistent with our Child Safe Standards, in particular Standard 1: Child safety is embedded in institutional leadership, governance and culture, Standard 2: Children participate in decisions affecting them and are taken seriously, and Standard 7: Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training. They align with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, and Standard 5: Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way.²¹⁹

Developing best practice models

To make best use of any lessons learned from applying trauma-informed care in a range of practice settings, research suggests there would be value in undertaking a systematic and rigorous gathering and synthesis of information from practitioners working with traumatised clients in a variety of fields. Additionally, there may be value in gathering this information from practitioners in service delivery systems that are not yet trauma-informed, in order to examine the barriers and enablers of systemic change:²²⁰

there is a need to articulate findings from the emerging field of trauma-informed practice into concrete policy statements or frameworks that can be applied to different client groups within and across a range of service systems and settings.²²¹

While there would be benefits in each of the state and territory governments making available information and insights on what they have learned from investing in trauma-informed care, the benefits are likely to be limited without an organisation to take on the responsibility of leading and coordinating this work. Volume 9, *Advocacy, support and therapeutic treatment services* considers the benefits of, and barriers to, implementing trauma-informed approaches across human services in Australia and proposes establishing a national centre with responsibility for improving the quality of service responses to victims and survivors of child sexual abuse (see Recommendation 9.9, set out in Appendix A). The national centre's proposed functions include increasing practitioners' knowledge and competence in responding to the impacts of child sexual abuse, and leading the development of better service models and interventions. State and territory governments and out-of-home care service providers may be able to draw on training materials and best practice clinical resources disseminated by this national centre to develop trauma-informed training modules for carers and child protection caseworkers.

5.3.4 Sharing information for the safety and wellbeing of children

Improved information sharing is a core component of the Child Safe Standard concerning institutional leadership, governance and culture (Standard 1). Institutions that do not share information with relevant authorities put children at risk of sexual abuse.

Information sharing in the out-of-home care sector

Information sharing between institutions (and professionals) with responsibilities related to children's safety and wellbeing is necessary to identify, prevent and respond to incidents and risks of child sexual abuse.²²² The timely provision of background information about children and carers is a critical factor in assessment of carer suitability, placement safety and placement matching by out-of-home care service providers, and the effective support of children with harmful sexual behaviour.²²³

Across Australia, information-sharing arrangements have been established to enable and sometimes require the sharing of information related to the safety and wellbeing of children for specified purposes. We consider legislative and administrative arrangements for sharing this information, and their limitations, in Volume 8, *Recordkeeping and information sharing*.²²⁴

In Volume 8 we recommend that governments build upon these existing arrangements to establish a legislative scheme for the exchange of information related to children's safety and wellbeing, including information relevant to child sexual abuse in institutional contexts. We recommend that this scheme provide for prescribed bodies to exchange this information both within and across Australian jurisdictions (see Recommendations 8.6, 8.7 and 8.8 set out in Appendix A).

In Volume 8 we also consider the circumstances in which prescribed bodies should be permitted, and the circumstances in which they should be required, to share information under the scheme. This information exchange scheme should facilitate timely and appropriate information exchange between those who need that information to prevent, identify and respond to child sexual abuse in institutional contexts.

In our view, this information exchange should operate within and across a range of sectors that provide services to or for children. We have not specified which institutions (or professionals operating as individual service providers) should be included as prescribed bodies under this scheme. Instead, we have recommended that Australian governments consider the need to include a range of service providers, government and non-government agencies, law enforcement agencies and regulator and oversight bodies that have responsibilities related to children's safety and wellbeing. Our discussion in Volume 8 sets out what are, in our view, relevant considerations for Australian governments to take into account in identifying those prescribed bodies. Amongst other institution types, we consider the need for including child

protection departments and other (government and non-government) out-of-home care service providers as prescribed bodies under the scheme.

Our recommendations for an intra-jurisdictional and inter-jurisdictional information exchange scheme would enable non-government out-of-home care service providers to seek and obtain relevant information from child protection departments. However, we note that service providers gave evidence in our public hearings and information in submissions and roundtable forums indicating that, even when information could have been shared under existing laws, non-government out-of-home care service providers have sometimes had difficulties obtaining relevant information from the child protection department.²²⁵ Reflecting on her organisation's difficulties obtaining information, Ms Louise Voight, the then CEO of Barnardos Australia, told us in our *Out-of-home care* case study that:

most government departments, certainly in all their stated policies, say that good information should be shared. I think each [government department] worker then makes up their own mind what it is that they share, and the net result is insufficient information on many, many occasions.²²⁶

She noted barriers to information sharing include the high workload of child protection departments, some departmental workers' lack of familiarity with 'working in collaboration with the non-government sector', and the need for better training on information sharing.²²⁷ In Volume 8 we discuss the importance of non-legislative measures to improve information sharing and make recommendations for education, training and guidelines to complement and support the implementation and operation of legislative reforms.

As discussed in Section 5.2.3, we make recommendations in Volume 8, *Recordkeeping and information sharing* for carers register reforms to improve information sharing about prospective and current carers and reduce risks to children's safety arising from the inappropriate authorisation of carers (see Recommendations 8.17 to 8.23 set out in Appendix A).

In Section 5.4.1 we consider how sharing of relevant information by out-of-home care agencies with carers should be improved. We also make recommendations for better information sharing with carers as part of a range of strategies to increase placement safety and stability.

Records and recordkeeping

Accurate and complete records provide an essential foundation for sharing important information between institutions, carers and care-leavers.

We heard about poor records and recordkeeping practices by contemporary out-of-home care institutions, and about the adverse effects this has had in terms of responding to child sexual abuse and alleviating the trauma of survivors. It is clear that institutional practices as regards records and recordkeeping must be improved.

In Volume 8, *Recordkeeping and information sharing* we recommend that institutions that engage in child-related work should implement five high-level principles for records and recordkeeping (see Recommendation 8.4 set out in Appendix A).

In relation to records disposal specifically, we recommend that, in order to allow for delayed disclosure of child sexual abuse by victims and take account of limitation periods for civil actions for child sexual abuse, institutions that engage in child-related work (including child protection departments and out-of-home care service providers) should retain records relating to child sexual abuse that has occurred or is alleged to have occurred for at least 45 years (see Recommendation 8.1 set out in Appendix A).

5.3.5 Identifying, assessing and supporting children with harmful sexual behaviours

We have learned that children in out-of-home care have been sexually abused not only by adults, but also by other children. We have heard from experts, practitioners and survivors that institutions did not protect children from sexual abuse by other children; that institutions often did not respond effectively to the complaints of children and their families who said another child had been sexually abusing them; and that institutions did not provide appropriate support and intervention to either victims or the children who exhibited harmful sexual behaviours.

In Chapter 4 we discussed the limited availability of specialised placements for children with harmful sexual behaviours and outlined the risks posed by inappropriate matching of children with harmful sexual behaviours with other vulnerable children in out-of-home care, particularly in residential care settings. Child protection departments and out-of-home care service providers need to develop strategies to more explicitly manage and assist children with harmful sexual behaviours in out-of-home care settings.

We recognise that harmful sexual behaviours occur across a broad spectrum and therefore a range of responses may be required. Depending on the age of the child and the nature of the harmful sexual behaviour, children may require different types of intervention. Expert assessment is essential to determine the most appropriate interventions for a child, based on their particular situation, history and the behaviours they have exhibited.²²⁸

When a child first enters care, we have been told that there is a need for statutory child protection systems to make thorough assessments and placement-matching decisions. We understand that children with harmful sexual behaviours, and their carers and families, may need timely access to specialised trauma-informed services and support programs.

Issues raised in submissions to us included:

- the shortage of home-based care for children with harmful sexual behaviours and the inappropriate matching of these children with other vulnerable children in residential and home-based care²²⁹
- the insufficient treatment responses for children across Australia who display harmful sexual behaviours, including the lack of culturally informed therapeutic approaches for Aboriginal and Torres Strait Islander children²³⁰
- the need for mainstream out-of-home care services to respond more effectively when dealing with the harmful sexual behaviours of children with disability²³¹
- the lack of policies, procedures and/or best practice guidelines for preventing and responding to children with harmful sexual behaviours in out-of-home care²³²
- the lack of nationally consistent accreditation and professional development training for counsellors working with children with harmful sexual behaviours²³³
- the shortage of expert advice and assistance for foster and kinship/relative carers regarding harmful sexual behaviours displayed by children, including for carers of children with disability who exhibit harmful sexual behaviours²³⁴
- the insufficient information provided to carers about a child's background prior to placement, including information about any harmful sexual behaviours²³⁵
- the lack of nationally consistent identification and terminology in relation to children with harmful sexual behaviours, broadly and in out-of-home care, and the resulting impacts on data collection and knowledge.²³⁶

Volume 10, *Children with harmful sexual behaviours* describes the need for an overarching framework and strategy for preventing and responding to children with harmful sexual behaviours, both within institutions and in the broader community, and recommends that expertise and funding be directed towards prevention and early intervention to address children's harmful sexual behaviours (See Recommendation 10.1 set out in Appendix A). We also recommend that governments take steps to ensure children exhibiting problematic and harmful sexual behaviours have access to specialist assessment and a range of therapeutic interventions that can address the varying levels of need and risk that these behaviours present (See Recommendations 10.2 and 10.3 set out in Appendix A).

Recommendation 12.12

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:

- a. undertake professional assessments of the child with harmful sexual behaviours, including identifying their needs and appropriate supports and interventions to ensure their safety
- b. establish case management and a package of support services
- c. undertake careful placement matching that includes
 - 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
 - ii. rigorously assessing potential threats to the safety of other children, including the child's siblings, in the placement.

Recommendation 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.

Recommendations 12.12 and 12.13 are consistent with our Child Safe Standards, in particular Standard 1: Child safety is embedded in institutional leadership, governance and culture, Standard 2: Children participate in decisions affecting them and are taken seriously, Standard 5: People working with children are suitable and supported, and Standard 7: Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training. They align with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, Standard 4: Each child and young person has an individualised plan that details their health, education and other needs, Standard 5: Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way, and Standard 12: Carers are assessed and receive relevant ongoing training, development and support, in order to provide quality care.²³⁷

5.3.6 Preventing and responding to child sexual exploitation

We have heard that children in out-of-home care may be at increased risk of sexual exploitation compared to children not in care – that is, being manipulated or coerced to participate in sexual activity by an adult outside the placement in exchange for, or for the promise of, an incentive.²³⁸ The Salvation Army Southern Territory submitted that: ‘The vast majority of young people in residential care have a range of concerning and high risk-taking behaviours that increase their exposure to sexual exploitation’.²³⁹

Children who have been sexually exploited and sexually abused may not appear to act like other victims of child sexual abuse. Children who have experienced sexual exploitation may be hostile, aggressive, involved in low-level criminality, be under the influence of drugs or drunk and disorderly. Research suggests that:

These children require significant input in terms of time and resources but they need such a response because they are either suffering or likely to suffer significant harm... [their] failure to engage [with professionals] is an additional risk factor and should be recognised as such.²⁴⁰

We were told that online grooming places children in out-of-home care at increased risk from adults who may initially engage with the child through online contact, then provide the child with a mobile phone so that they are contactable without their carer’s knowledge. One out-of-home care service provider submitted to us that:

All children are vulnerable to this type of abuse but children placed in out-of-home care are particularly vulnerable due to their trauma background and a strong desire to connect with others during puberty and adolescence. The increased placement changes that children in out-of-home care experience leave them without long-term relationships with trusted adults and peers which then leaves them vulnerable.²⁴¹

We heard in evidence that incidents of sexual exploitation by adult men are increasing and represent a very real risk for children in out-of-home care. As we heard from one participant in our roundtable on preventing sexual abuse of children in out-of-home care:

We know sexual exploitation is not just an issue in Victoria. It is an issue in every state and internationally it is a problem. We have social media and access to kids through Facebook, through phones and offenders who will target particularly vulnerable kids.²⁴²

Strategies to disrupt child sexual exploitation

We have heard that strategies to identify and disrupt opportunities for the sexual exploitation of children, including children in out-of-home care, are more successful if the relevant agencies share appropriate information and coordinate their approaches.

The 2014 report resulting from England's Independent Inquiry into Child Sexual Exploitation in Rotherham (also known as the Jay report) describes a number of multi-agency initiatives aimed at tackling child exploitation, where the emphasis was on 'safeguarding the young person and on the proactive disruption and prosecution of their abusers'.²⁴³ Failures that were identified by the inquiry regarding these initiatives included lack of leadership as a result of not understanding the seriousness of child sexual exploitation and lack of clarity about whether it should be treated primarily as a child protection issue or a criminal matter: 'If they won't help themselves, what are we expected to do about it?'²⁴⁴ A coordinated multi-agency response and a strategic approach were identified as necessary to ensure timely responses that effectively engaged with children, adequate allocation of resources and assessment of the success of strategies.²⁴⁵

We have heard that children are at a heightened risk of sexual exploitation when the location of residential units becomes known to perpetrators. It is essential that coordinated action is taken in all jurisdictions to ensure that potential perpetrators are not given reason to see children in residential care as easy targets for sexual exploitation. We heard that the response to child sexual exploitation in a location in Melbourne, outlined as follows, demonstrates the potential benefits of a coordinated response to apparent sexual exploitation risks in Australia.

Victoria's coordinated response to sexual exploitation

A recent initiative in Victoria illustrated the way a coordinated response to child sexual exploitation can be effective. Victoria Police led an operation to respond to reports of child sexual exploitation in Melbourne's south-east region. Residential care staff provided information to police about people who were seen waiting near residential homes, including car registration numbers and descriptions of individuals. If a young person asked a residential care staff member to collect them from a private address, the address was recorded by that staff member and provided to police.

Police used this information to implement a range of tactics to disrupt the activities of the suspects, including conducting vehicle inspections and other policing operations that had the effect of deterring suspects from contacting children in adjacent residential care facilities. With the support of uniformed police, staff from Victoria's Department of Health and Human Services' Child Protection Service also issued harbouring notices on suspects to emphasise the criminal nature of their activities. Specialist detectives from Victoria Police's Sexual Offences and Child Abuse Investigation Teams (SOCIT) were also involved to conduct investigations.

While these activities were taking place, there were regular meetings between senior Child Protection Service representatives, SOCIT investigators, the DHHS Office of the Principal Practitioner and representatives of the Commission for Children and Young People. Communications between these agencies were supported by robust information-sharing protocols, including measures to protect the security and integrity of information.²⁴⁶

As we heard in evidence during our *Out-of-home care* case study about the Victorian response to child sexual exploitation:

there was a very concerted effort around mapping children, understanding the relationships between children and organised groups of paedophile rings that were accessing kids and that we have been able to keep some kids safe, and that's right, in order to do that there have been a range of strategies. The disruptive policing approach that has been built on very strong and respectful relationships between the bodies and sharing of information has been critical to keeping some kids much safer.²⁴⁷

A range of strategies can be employed by professionals when they become suspicious that a child is being sexually exploited or a residential care centre is being targeted by people whose intention is the sexual exploitation of residents. Interventions aimed at protecting children from sexual abuse and deterring sexually exploitative people from targeting children in out-of-home care require cooperation between professionals with shared understanding of the risks of sexual exploitation and coordinated strategies between these professionals.

Recommendation 12.14

All state and territory governments should develop and implement coordinated and multi-disciplinary strategies to protect children in residential care by:

- a. identifying and disrupting activities that indicate risk of sexual exploitation
- b. supporting agencies to engage with children in ways that encourage them to assist in the investigation and prosecution of sexual exploitation offences.

Recommendation 12.14 is consistent with our Child Safe Standards, in particular Standard 1: Child safety is embedded in institutional leadership, governance and culture, Standard 2: Children and young people participate in decisions that have an impact on their lives, and Standard 8: Physical and online environments minimise the opportunity for abuse to occur. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care.²⁴⁸

Adopting a common understanding of the issues and language

We heard that an important step towards preventing and responding to child sexual exploitation is for agencies from different sectors (for example, police, child protection services and out-of-home care service providers) to participate in cross-disciplinary training to develop a common understanding of the issues and the language used to describe child sexual exploitation. In particular, there can be a need to deal with problematic residual attitudes that automatically blame victims, as were discussed in Chapter 4. As one non-government agency submitted to us:

A key factor in the increased understanding of the issue of child sexual exploitation was the adoption of shared language and definitions and a commitment to a multi-agency approach involving police, child protection services and community service organisations ... In Victoria, stakeholders moved away from characterising child sexual exploitation as ‘prostitution’. This outdated description carries the implication that a vulnerable and traumatised child is capable of consenting to sex with an adult who is likely to hold a great deal of power and resources compared with the child.²⁴⁹

Subsequently, there was a shift to criminalising the activities of the perpetrator rather than the activities of the child. We were told that there would be value in all jurisdictions encouraging agencies to review their understanding of the issues and use of language to ensure that culpability for sexually exploitative activities rests with the perpetrator.²⁵⁰

Recommendation 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.

The collection of this data will enable governments to evaluate the success of strategies to reduce the sexual exploitation of children in out-of-home care.

Recommendation 12.15 is consistent with our Child Safe Standards, in particular Standard 1: Child safety is embedded in institutional leadership, governance and culture, and Standard 9: Implementation of the Child Safe Standards is continuously reviewed and improved. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care.²⁵¹

5.4 Improving the safety of children in particular settings

In Chapter 4 we outlined what we have learned about the risks of child sexual abuse in different out-of-home care settings. In this section, we outline our recommendations for reducing the risks to children from placement instability and different out-of-home care settings. This includes improvements to the support of carers, as well as the need to review the role of residential care and to refocus its purpose on providing short-term therapeutic interventions for certain children.

5.4.1 Increasing the stability of placements

Witnesses who gave evidence in our public hearings and many of the submissions to our *Out-of-home care* consultation paper emphasised the importance of stable placements and consistent care for children in out-of-home care, both for the overall wellbeing of children and as a way of improving the safety of children in care. This point was strongly made in the 2015 report of the Senate Community Affairs References Committee inquiry into out-of-home care, which referred to submissions critical of the ‘churn’ through multiple placements experienced by many children. One submission described this churn as ‘systems abuse’.²⁵²

Some placement instability is built into the out-of-home care system. Carers are approved for different types of home-based care in order to provide states and territories with emergency placements, short-term and long-term placements and respite carers. Emergency carers can be called upon at very short notice to take a child who needs an urgent placement because of concerns for their immediate safety. These placements are generally overnight or up to a week or so. Short-term care is generally used when there is a high likelihood of the child returning to the birth parents, where those parents may just need time to manage an issue, or while court orders are being determined. Only when a child is not expected to return to their family is a long-term placement contemplated.²⁵³ This means that it is very likely that a child removed from their family will experience at least two placements in their first year in out-of-home care, as indicated by the Productivity Commission’s data (see Chapter 3, Section 3.5.2)

In addition, we have learned that poorly matched placements, insufficient information being provided to the carers about the child being placed and insufficient ongoing support for carers to deal with the individual needs of the children in their care are factors that are very likely to lead to the breakdown of placements.

Matching placements

We know that children who have been sexually abused require supported and safe environments where they can heal and grow. We have heard from many people that service providers often face difficulties in appropriately matching children within placements, given the growing demand for and scarcity of placement options.

We have heard that inadequate assessments prior to placement and inappropriate matching may increase the risk of child sexual abuse, for example, due to:

- gender imbalances in a placement
- age differences of the children and young people in a placement
- inappropriate placement of children from culturally and linguistically diverse backgrounds
- the risk from children who have exhibited harmful sexual behaviours to other children in a placement.

Many submissions to our *Out-of-home care* consultation paper discussed the issues surrounding placement matching. For instance, Legal Aid NSW made the following observations in its submission:

Legal Aid NSW has also observed an inappropriate client mix in the allocation of placements. There is very little client matching applied to placements to take into account the particular needs and vulnerabilities of the young person. Legal Aid NSW's experience has been that a client is not so much matched to a placement, but allocated to the only placement that might be available because of limited resources available in the sector. This often results in young people being placed in houses with other young people who might be an entirely inappropriate mix for them (including, for example, a twelve year old child being placed in a house with seventeen year old youths with criminal histories). This increases the risk of further trauma being caused by conflict with, or victimisation by, other young people living at the service.²⁵⁴

We were told that poor placement matching and a lack of planning to address the shared needs of everyone in a residential care unit can significantly increase the likelihood of children with harmful sexual behaviours being placed with those who have been sexually abused.²⁵⁵ Despite these risks, we heard that it was still common for placements to occur at short notice and with little planning to minimise the disruption and risks to children already in that unit. Mr Howard Bath, the then Children's Commissioner, Northern Territory, told us of the pressures on agencies to fill scarce places at short notice, often without a proper assessment of the shared needs of the child being placed and those already living in the unit. He said:

residential care has become increasingly used for kids with behavioural challenges, and increasingly behavioural challenges have to do with sexualised problems ... placements are expensive, there are few of them and there are enormous pressures from the statutory departments to oblige agencies to take kids in, to place kids. I remember, as an agency director, on numerous occasions being obliged to take a child who had serious sexual behaviour problems to be with other vulnerable children in a care unit.²⁵⁶

Ms Sue-Anne Hunter, Deputy Chair of Child Protection for the Secretariat of National Aboriginal and Islander Child Care (SNAICC), said that for various reasons the placement-matching process is often not done well and that care placements frequently break down because of the mismatching that occurs.

So you're sort of rung up and you have to take a placement and you have to use that bed, because the State is paying for it and they are funding you ... So are we putting children at risk there? Yes ... half the time, we probably are, especially around sexual abuse. So are we placing a child with sexualised behaviours that is older than [the other] children, that are younger, that can't defend themselves? It happens ... Mismatching is a huge issue for us, especially around residential units.²⁵⁷

All out-of-home care service providers need to develop strategies to increase the likelihood of safe and stable placements, with the safety and wellbeing of children being the paramount consideration in all decision-making about placements.

Sharing information with carers

We were told in our *Out-of-home care* case study, in submissions and in private sessions about the importance of sharing information with carers about the trauma history, particular needs and any known harmful sexual behaviours of children placed in their care. As discussed in Chapter 4, we were told that carers are not always given timely and adequate information to enable them to meet their care responsibilities and to manage risks. We learned that, especially where a child has displayed sexualised behaviours or behaviour that is difficult to manage, inadequate sharing of information with carers may undermine placement stability and risk the safety of the child and other children in the household.

The Salvation Army Southern Territory, for example, submitted:

To deliver the most effective care and support for children and young people in OOHC [out-of-home care], carers require information about the child or young person's needs, and how to effectively respond to and support them. This is especially critical when a child or young person has a history of sexual abuse or presents with sexually harmful behaviours. Given this presents a potential risk to others, appropriate information sharing with carers helps ensure the safety and wellbeing of all children in OOHC.²⁵⁸

We understand the complexity of sharing information with carers, including safeguarding against the inappropriate use of sensitive information about vulnerable children. The following factors have been highlighted as essential components of appropriate information sharing with carers:

- clear legislative provisions that give child protection departments and out-of-home care service providers the confidence to share information with carers
- organisational culture, policies and procedures that support compliance with legislation
- safeguards that protect the privacy of children in out-of-home care, without compromising the safety and wellbeing of all children in a placement
- training and guidance for carers and caseworkers.

Clear legislative provisions

Clear legislative provisions are needed to address any legal restrictions (including under privacy laws) on sharing relevant information with carers. Child protection legislation in most jurisdictions²⁵⁹ has provisions addressing information sharing with carers prior to and during placement. There is some variation in these provisions, including as to whether the child protection department or non-government out-of-home care provider may or must share information.²⁶⁰ Such legislative differences may be of significance in the context of concerns about privacy and confidentiality and confusion about the application of legal restrictions on disclosure.

In jurisdictions where non-government service providers arrange and supervise placements, their capacity to share information with carers may be affected by their own limited access to relevant information held by the child protection department. Non-government out-of-home care service providers have told us, in evidence to public hearings and in submissions, about their difficulties in obtaining information from a child protection department which needs to be shared with carers.²⁶¹

In Volume 8, *Recordkeeping and information sharing*, we discuss how concerns about privacy and confidentiality, and confusion about the application of complex laws, can limit the sharing of information which is needed to keep children safe in a range of institutional contexts. Our recommendations for an information exchange scheme would enable non-government out-of-home care service providers to seek and obtain information from the relevant child protection department (see Recommendations 8.6, 8.7 and 8.8 set out in Appendix A).

Organisational culture, policy and procedures

Organisational culture may also be a factor limiting information sharing with carers. In our *Out-of-home care* case study, Ms Voight, the then Chief Executive Officer of Barnardos Australia, told us:

There is a general philosophy in out-of-home care that good information is shared with carers. The reasons why this information is not shared, I think, is because [for] bureaucracies and people in organisations – the organisation comes first.²⁶²

In Chapter 4 we discussed instances where inadequate sharing of information compromised carers' capacity to keep children safe from sexual abuse.

One of the 10 Child Safe Standards we identified is that child safety is embedded in institutional leadership, governance and culture. An important part of meeting this standard would be that staff understand information sharing and recordkeeping obligations.²⁶³ The role of organisational culture in discouraging information sharing between institutions is discussed in Volume 8, *Recordkeeping and information sharing*.²⁶⁴

Policies and procedures that support compliance with legislation are required to promote timely, lawful and adequate information sharing with carers. Submissions to our *Out-of-home care* consultation paper provided some examples of measures that are intended to ensure information is accessible and appropriately shared with carers.²⁶⁵

Policies and procedures for sharing information with carers need to clearly articulate the purpose of information sharing in order to reduce breaches of the privacy of children in out-of-home care. For example, depending on the particular purpose and context, it may not be necessary to share specific details of sexual abuse experienced by a child. We note the view expressed by the CREATE Foundation, which represents children and young people in out-of-home care and young care-leavers who are transitioning from care, that 'Information provision [to carers] should focus on equipping carers to deal with the child's behavioural needs and how to handle this, rather than necessarily the details of abuse'.²⁶⁶

Safeguards that protect the privacy of children in out-of-home care

We acknowledge the importance of concerns about confidentiality and children's privacy when sharing information with carers. However, excessively strict maintenance of children's privacy and confidentiality may compromise their safety and must be balanced with the need to ensure, as far as possible, the safety and wellbeing of all children in a placement.

Some submissions addressed the need to balance a child's right to privacy with the need to ensure their safety. For example, the Victorian Aboriginal Child Care Agency (VACCA) said:

VACCA supports the notion that children's safety and wellbeing should be prioritised over confidentiality and privacy both as this is, in our view, in the best interests of the safety issues for both children at risk of being sexually abused and for a child who has engaged or is at risk of engaging in harmful sexual behaviours.²⁶⁷

The issue most consistently raised in submissions to our *Out-of-home care* consultation paper was that carers need more information than is usually provided, particularly in relation to children with specialised needs and children with harmful sexual behaviours. The aim of sharing information with carers is to ensure the safety of all children, to give the carer the best chance of supporting the child and to ensure the most suitable placement. Nonetheless, child protection departments and out-of-home care service providers that need to share information with carers relevant to child sexual abuse in out-of-home care settings should implement measures to prevent inappropriate sharing and use of that information.

In their submission to our *Out-of-home care* consultation paper, CLAN stated:

if something is disclosed to a carer in the best interests of a child, that carer must not breach the child's privacy, and once again must not disclose any personal information of a child's unless it is for their benefit. Foster carers should sign a contract stating this fact and suffer some sort of penalties if they are in breach of this contract.²⁶⁸

In some jurisdictions, child protection legislation prohibits a carer from disclosing information about a child provided to them under that legislation, except in specified circumstances.²⁶⁹ Those circumstances may include disclosure, by a carer, to a health professional for the purposes of a health service. Such provisions, where they exist, may serve as effective safeguards. We agree that consideration should be given to prohibiting carers from disclosing sensitive information except in certain circumstances.

We note that legislation in Queensland requires the child protection department, when sharing information with a carer, to tell the child what information is being given and why it is being given.²⁷⁰ This reflects the importance of trust in the relationship between a carer and the child in their care. We also acknowledge the importance of taking the views of children in care into account in making decisions about their lives²⁷¹ – including decisions about sharing their personal information. However, it is also important to recognise that children may not be in a position to determine appropriate use of their information for their own and other children's safety. Seeking children's consent to disclosure of personal information may not always be possible, reasonable or appropriate. In some cases, seeking consent may unduly delay or compromise decision-making and risk management. In addition, children may lack the capacity to consent.²⁷²

Policies and training for out-of-home care workers should include guidance on informing a child of an intention to share their information with carers and considering their views before doing so, as best practice. At the same, policies and training should also reflect that, in some cases, doing this may be problematic. In our view, guidance on this issue should be largely consistent with the principles we have outlined in Volume 8, *Recordkeeping and information sharing* in relation to institutions informing a child and considering their views before they share that child's personal information with other institutions.

Training and guidance

Another common theme in submissions to our *Out-of-home care* consultation paper was the importance of education and training, as well as clear guidelines, being provided for all out-of-home care service provider staff responsible for sharing information with carers.²⁷³ Training would promote understanding of and confidence in legislative provisions, policies and procedures for sharing information with carers, and may drive cultural change to overcome individual and organisational resistance to information sharing.

Children's need for confidentiality and privacy should be addressed through training and guidance for staff of out-of-home care service providers. This training and guidance should also address how service provider staff should support carers to appropriately use information about the child that is shared with them. Training and guidance for carers should include how to protect and properly use personal and sensitive information that has been shared with them.

Some out-of-home care contexts, such as kinship/relative care placements, may raise additional familial and cultural complexities for sharing information with carers.²⁷⁴ As the Victorian Aboriginal Child Care Agency (VACCA) told us in relation to institutions sharing information to ensure the safety and wellbeing of Aboriginal children in out-of-home care:

VACCA believes carers need accurate information to be able to make informed decisions about their capacity to care for any child they are being asked to consider. It is in how the issues pertaining to a particular child are discussed and the respect that is afforded the child and family in these discussions that is important.²⁷⁵

Training for staff of out-of-home care service providers and carers should address these complexities and sensitivities in all out-of-home care settings.

Supporting carers

As well as sharing information with carers, we have heard that more support for carers could lead to greater placement stability for children in out-of-home care. We have learned that carers are often dissatisfied, as they do not feel adequately supported to care for the needs of children for whom they are responsible. Areas of concern for carers included the need for:

- adequate support from experienced caseworkers who understand the needs of carers
- better training and supervision
- information about legal entitlements and eligibility for benefits and services.

Submissions to our *Out-of-home care* consultation paper broadly agreed that increased support for carers would increase their ability to create safe, stable and supportive environments for children in out-of-home care. The high turnover of caseworker staff in the out-of-home care system is a further concern for carers, just as it is for children. We received submissions noting this systemic issue with the out-of-home care system:

Parents and families encounter caseworkers, managers, carers and other staff with a wide variety of skills and qualifications. The variability in these skills and qualifications is of concern to the quality of care being provided. Families and parents also confront rapidly changing staff and struggle to understand what is expected of them as parents and what they should expect from staff members and carers.²⁷⁶

Submissions to our consultation paper commented on professional models of foster care, but did not universally support the concept. CareSouth, a not-for-profit community-based organisation in southern New South Wales that provides a range of services including foster care, said:

While CareSouth supports the professional development of carers through training and upskilling and supervision, it does not support the introduction of a professional foster care model. There are concerns about the impact of professionalisation on rostering, placement stability, longevity, engagement after the child turns 18 and recruitment.²⁷⁷

Recommendation 12.16 aims to ensure that out-of-home care service providers develop practical strategies to help secure the longer-term stability of all out-of-home care placements.

Recommendation 12.16

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:

- a. improved processes for ‘matching’ children with carers and other children in a placement, including in residential care
- 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
- c. support and training for carers to deal with the different developmental needs of children as well as manage difficult situations and challenging behaviour.

Recommendation 12.16 is consistent with our Child Safe Standards, in particular Standard 2: Children participate in decisions affecting them and are taken seriously, Standard 5: People working with children are suitable and supported, and Standard 7: Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, Standard 2:

Children and young people participate in decisions that have an impact on their lives, and Standard 12: Carers are assessed and receive relevant ongoing training, development and support, in order to provide quality care.²⁷⁸

5.4.2 Supporting kinship/relative care placements

We know that increasing numbers of children are being placed in kinship/relative care placements. Research indicates that the benefits for children of being placed in kinship/relative care include:

- feeling loved, cared for and valued
- maintaining a sense of identity and belonging and feeling settled because they were with family
- more stable placements than for children placed with foster carers
- maintenance of contact with family and friends.²⁷⁹

Despite the value of kinship/relative care and its increasing use, during our *Out-of-home care* public hearing we heard about a lack of support currently being provided to kinship carers across jurisdictions. In particular we heard that greater support is needed for kinship carers in terms of training and financial support, in particular for Aboriginal and Torres Strait Islander carers and for grandparents who are the most common kinship carers.

The President of the Australian Foster Care Association, Ms Bev Orr, told us in the *Out-of-home care* public hearing that ‘kinship carers right across this country don’t get access to the same sort of training, or the same sort of support as a consequence of that training’, and as such, ‘kinship carers really struggle to meet the needs of the children’.²⁸⁰

Research suggests that kinship carers are less likely to be supervised or supported regularly than non-related carers, and they are less likely to have a caseworker.²⁸¹ Although many kinship carers receive financial support, it is often less than that received by non-related foster carers.²⁸²

Commissioned research suggests that, across jurisdictions, there are less stringent requirements for kinship/relative carers to participate in training, either pre- or post-placement, and even where pre-placement training is made a requirement in policy, compliance is reportedly variable in practice.²⁸³ This research also suggests that fewer kinship/relative carers have access to and participate in training than foster carers. Unlike foster carers, kinship carers are often asked to take on a child by a child protection department without being given time to prepare for the role and undertake pre-assessment training.²⁸⁴

In addition to gaps in access to training for kinship/relative carers, we have been told that kinship/relative carers – such as grandparents – who are caring for children who have experienced sexual abuse are not consistently having their needs met and are not adequately supported, and that this issue requires the attention of all state and territory governments. Chapter 4 of Volume 9, *Advocacy, support and therapeutic treatment services* considers the difficulties that secondary victims of child sexual abuse – for example, carers of children who have been sexually abused – often experience trying to get their support needs met. Impediments include a lack of services and a lack of knowledge about the needs of secondary victims. As discussed in Volume 9, responding to the advocacy, support and therapeutic treatment services needs of secondary victims should be an integral part of a holistic service system response.

There are challenges in providing support and training to a dispersed carer population, including many who live in rural and remote areas.²⁸⁵ There is a lack of available training specific to kinship carers, particularly culturally specific training to support carers of Aboriginal and Torres Strait Islander children, although some positive training programs are referred to below. There are also fewer training resources for carers with low literacy, and a lack of knowledge about available training.²⁸⁶

A lack of access to trauma training for kinship carers of Aboriginal and Torres Strait Islander children was of particular concern to Mr Jackomos, the Victorian Commissioner for Aboriginal Children and Young People. Mr Jackomos told us during the *Out-of-home care* public hearing:

our [kinship] carers don't get the full suite of training that foster carers do, and there are difficulties around accessing training on trauma. Our kids coming into care have trauma, and a lot of our carers are older people.²⁸⁷

Recommendation 12.11 addresses the need for kinship/relative carers to receive training in trauma-informed care.

Mr Jackomos also raised concerns about the costs to kinship carers of transporting children to early years schooling and to health services.²⁸⁸ In the same public hearing, the Director of Grandparents Australia, Ms Anne McLeish, told us:

Very often, the costs of these children [in kinship care] don't present themselves until quite some years down the track where they start to have serious dental problems or even mental health problems, and no money is made available.²⁸⁹

While care allowances are generally considered to be the same for foster and kinship carers, evidence suggests that in some jurisdictions kinship carers receive lower rates of financial reimbursement than foster carers.²⁹⁰ Mr Jackomos told us:

The department will say that both kin and foster carers are eligible to receive the three levels of payment. Well, it's the exception where our kin will receive the higher level ... there is a lot we ask of kinship carers, and Koori kin are, as a group, financially less well off, more disadvantaged, than others, and to not be able to access the full levels based on the children's needs rather than just being based on whether they are kin or not.²⁹¹

The Victorian Commission for Children and Young People (Victorian CCYP) expressed a similar position in its submission to the 2015 Senate Community Affairs References Committee inquiry into out-of-home care. The Senate Committee reported that the Victorian CCYP stated it was only in 'exceptional circumstances' that kinship carers were reimbursed more than the 'general base rate'. The Victorian CCYP submitted that 'the financial burden kinship carers are under is not reasonable, viable or sustainable. At present kinship carers receive less than the base rate for foster carers'.²⁹²

The Senate Committee reported that Baptcare, a non-government out-of-home care service provider, had found that the complexity of kinship placements is often not acknowledged in Victoria. As such, 'the current funding model, based on the presumption that most placements only require a low level of support, is inadequate to meet the needs of these kinship care families'.²⁹³

We are aware of some encouraging policies and programs that aim to bridge the gaps in kinship carers' training and support. In particular, we heard about culturally specific education packages in Victoria designed to inform Aboriginal carers about child sexual abuse,²⁹⁴ provide trauma training that acknowledges Aboriginal history and culture and the effects of intergenerational, family and community trauma,²⁹⁵ as well as provide training targeted to Aboriginal kinship carers.²⁹⁶ We heard kinship carer support and training packages were also being developed or had been established in New South Wales, the ACT and Western Australia.²⁹⁷

In the light of the increasing placement of children in kinship/relative care and the known benefits of these placements, it is essential that kinship/relative carers are provided with additional support in order to sustain this essential type of out-of-home care.

Recommendation 12.17

Each state and territory government should ensure that:

- a. the financial support and training provided to kinship/relative carers is equivalent to that provided to foster carers
- b. the need for any additional supports are identified during kinship/relative carer assessments and are funded
- c. additional casework support is provided to maintain birth family relationships.

Recommendation 12.17 is consistent with our Child Safe Standards, in particular Standard 3: Families and communities are informed and involved, Standard 4: Equity is upheld and diverse needs are taken into account, and Standard 5: People working with children are suitable and supported. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care and Standard 9: Children and young people are supported to safely and appropriately maintain connection with family, be they birth parents, siblings or other family members.²⁹⁸

5.4.3 Residential care

Our examination of contemporary out-of-home care systems in Australia has shown that the factors that disproportionately affect children in out-of-home care – such as disability, previous experiences of abuse and/or neglect, social or economic deprivation, family trauma and dislocation from family – can also increase the risk of child sexual abuse.²⁹⁹ As discussed in Chapter 4, we heard that these risks are much higher when out-of-home care is provided in residential care settings. According to national child protection data, about 5 per cent of all children in out-of-home care were in residential care at 30 June 2016.³⁰⁰ However, our analysis of government and non-government agency data indicates that 33 per cent of child sexual abuse reports where the care type was known were about children in residential care.³⁰¹

Despite the risks commonly associated with residential care, research suggests there is an ongoing need for ‘appropriately designed residential and group care’ as part of the ‘continuum of care options’ provided by out-of-home care services.³⁰² Home-based care remains the preferred form of placement for most children in out-of-home care. However, as home-based care does not suit, or is not feasible for, all children,³⁰³ some research supports the selective use of time-limited residential care for small numbers of children with ‘high support needs, sibling groups, young people moving on to independent living, and children and young people following a foster placement breakdown’.³⁰⁴

The risks associated with residential care appear to be higher for children with disability. In submissions we were told that the ‘tendency to segregate and/or institutionalise people with disability’ has resulted in these children being ‘over-represented in residential settings rather than in home-like settings’.³⁰⁵ More broadly, children with disability are estimated to make up ‘at least 24 per cent and maybe up to around 30 per cent’ of children currently in out-of-home care.³⁰⁶ Attempts to protect children in contemporary residential care should incorporate strategies that specifically address the needs of children with disability.

Following the recommendations made earlier in this volume that aim to improve the safety of all children in contemporary out-of-home care, we consider in this section whether additional measures might be needed to mitigate certain risks that are specific to residential care.

Constraints on implementing systemic change

System-wide change requires a sustained commitment to reform, as illustrated by initiatives currently underway in Victoria as a result of the Commission for Children and Young People inquiry in 2015, which examined the adequacy of services provided to 166 children and young people (25 of whom were Aboriginal) who were alleged to have been sexually abused or sexually exploited while in residential care. While acknowledging that its residential care sector has ‘many committed and dedicated staff who want to make a difference to the lives of children’ in their care,³⁰⁷ the Victorian inquiry ‘found that the current system inhibits [residential care workers’] ability to realise these outcomes, which often leads to fatigue, discontent and desensitisation’.³⁰⁸

The inquiry found that the best ways to reduce the risks associated with residential care were to divert children from that form of care and to better support those who remain in it. It recommended immediate measures aimed at:³⁰⁹

- reducing the number of children in residential care in Victoria from 500 to 300 within two years
- restricting the uses and duration of residential care placements, reserving this form of care to ‘a small number of children’ who may require ‘specialist group care ... for short periods to allow for intensive treatment before transitioning to an appropriate home-based care option with the services following them’.

While the Victorian Government endorsed this advice, its 2016 *Roadmap for reform: Strong families, safe children* strategy also recognised the need to invest in transitional measures to improve the safety of children who already live in residential care units, while expanding the capacity of and supports for home-based care.³¹⁰

The 2016 Child Protection Systems Royal Commission in South Australia made a number of recommendations aimed at reducing the risks faced by children in the state’s residential care system. At present, 15 per cent of South Australia’s out-of-home care population live in residential care – triple the national rate.³¹¹ The South Australian Government expects demand for residential care places to increase as it takes steps to dismantle its ‘emergency care’ system, and cease placing vulnerable children in the care of agency contractors in short-term rentals.³¹² Although the South Australian Government is committed to reducing the number of children in residential care and applying ‘a therapeutic framework ... across all care environments’,³¹³ it acknowledges that it must first build capacity in other parts of its out-of-home care system at the same time as strengthening supports for families to reduce the number of children entering the system.³¹⁴

Creating ‘home-like’ care

Through commissioned research that sought the views of children about what was needed for them ‘to be safe and feel safe in residential care’, we were told ‘Residential care felt most safe when it was home-like: where young people felt welcome, where things felt “normal” and where adults looked out for them’.³¹⁵

Safe residential units were also those where children and young people had multiple trusted relationships within and outside the unit, and got along with their peers, who were not aggressive or abusive; that had a sense of stability and predictability, with rules in place for residents, and minimal physical risks; where residents felt that they had a say in how things operated; and where life was better than it was when they lived with their biological families or in foster care.³¹⁶

In private sessions, written submissions, public hearings and research, we heard that several interrelated factors must be addressed to create a sense of ‘normality’ in residential care. Among the most commonly reported factors were:

- placement assessment and matching – placements of children who have complex needs and histories of abuse and trauma should consider the best interests of both the child being placed and the children who are already living in the residential care unit.³¹⁷ At a minimum, very young children and children with disability should not be placed with children with harmful sexual behaviours (noting that children with disability may themselves exhibit harmful sexual behaviours, some of which may be driven by a lack of emotional, physical or cognitive control and some of which may be the result of not understanding that the behaviour is unacceptable)³¹⁸
- staffing ratios, skills and stability – ensuring that staff are properly supported; have a stable, consistent presence; and have the necessary training, skills and experience to meet the highly complex care needs of children in residential care³¹⁹
- responsive systems – ensuring that residential care is focused on helping children and young people; that the systems and processes for preventing, monitoring, reporting and responding to allegations of sexual abuse are consistent and effective; and that targeted and specialised care options are available to meet the individual needs of vulnerable children³²⁰
- a safe and welcoming physical environment – ensuring that the environment is home-like, secure and encourages residents to stay at home. Ideally, facilities should be designed to minimise intrusions on residents’ privacy, yet enable appropriate supervision of interactions and activities within the residential unit³²¹
- family, community and cultural connectedness – this is important for all children, but especially important for Aboriginal and Torres Strait Islander children, whose separation from family and community may add to the stress on families and communities already dealing with the legacy of ongoing collective and intergenerational trauma, cultural dispossession, and family disintegration.³²²

Applying therapeutic models to residential care

For vulnerable children with complex behavioural problems, who may have experienced high levels of placement instability, conventional home-based care may be ill-suited to their needs.³²³ In residential care facilities staffed by skilled workers who understand and are trained to apply trauma-informed approaches when interacting with the children in their care, children who have experienced sexual abuse are more likely to feel safe and supported – and thus more likely to have the confidence to access the help they may need.

In Australia, therapeutic residential care is an emerging model that may ‘represent optimal therapeutic care for children in the Australian out-of-home care environment’.³²⁴ As with all trauma-informed systems of care, therapeutic residential care aims to equip frontline staff with the skills needed to create a healing, therapeutic environment as part of their broader care responsibilities.³²⁵ As defined by the National Therapeutic Residential Care Alliance at a forum in Melbourne in September 2010, therapeutic residential care is:

intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs.³²⁶

Volume 9, *Advocacy, support and therapeutic treatment services* examines the therapeutic treatment needs of victims and survivors of child sexual abuse in institutional contexts, and how these services could assist survivors towards recovery. The recommendations in that volume largely focus on what is needed to achieve responsive service systems that are underpinned by the principles of trauma-informed practice and an understanding of institutional child sexual abuse.

The 2015 Senate Community Affairs References Committee inquiry into out-of-home care reported on the ‘potential of therapeutic models of care that address trauma and abuse to improve outcomes for children and young people in out-of-home care’,³²⁷ and that many jurisdictions were committed to extending therapeutic care options in out-of-home care.³²⁸ We were advised that the Victorian Government is taking steps:

to transform the current model of residential care from a placement of last resort to an intensive, short-term intervention to provide treatment and stabilisation for young people with complex behaviours.³²⁹

Following the reforms, Victoria expects residential care facilities to deliver:

sub-acute and intensive trauma-informed treatment programs for young people who have highly complex or extreme symptoms and challenging behaviours, caused by recent or past histories of sexual, physical, and/or emotional abuse and/or placement disruptions.³³⁰

After a short stay in therapeutic residential care, it is expected that most residents will then ‘transition to sustainable home-based care’.³³¹ Other jurisdictions also advised that they were looking for ways to use residential care as the conduit for delivering therapeutic care to children and young people in out-of-home care.³³²

Submissions to our *Out-of-home care* consultation paper commented on the potential for therapeutic models of care to improve the quality of residential care. Life Without Barriers noted the need for further research to improve the available evidence on promising models such as the Sanctuary and Children and Residential Experiences (CARE) models, but the organisation ‘strongly endorsed’ proposals to broaden the use of these models in out-of-home care.³³³ Life Without Barriers said its attempts to apply the CARE model in its New South Wales residential care facilities was helping to strengthen leadership skills within the organisation, while enhancing the consistency and responsiveness of the care that its teams now provide.³³⁴ Mackillop Family Services, another residential care service provider, emphasised the importance of tailoring therapeutic treatment to the individual needs of children for as long as is needed.³³⁵ In many cases this involves establishing links with mainstream agencies that provide mental health, drug and alcohol treatment and other specialist outreach services, and ensuring the staff of those agencies ‘understand out-of-home care and the experiences – particularly experiences of trauma – of children and young people’.³³⁶

As the children and young people who have been sexually abused sometimes include those who have also exhibited harmful sexual behaviours themselves, it is essential that programs providing therapeutic support for victims of sexual abuse also address the needs of children with harmful sexual behaviours. Mr Dale Tolliday, the clinical adviser for the New Street Adolescent Service program in New South Wales (a therapeutic program for treating children aged 10 to 17 who have sexually harmed others), told us that children in out-of-home care currently make up about half of the program’s clients. He said:

we had a quarter of the children in our service in out-of-home care. The proportion is now about a half. So we have a growing proportion of participation in our program by children who are in some form of out-of-home care.³³⁷

Mr Tolliday said some children had entered out-of-home care ‘because of sexually harming behaviour’, and some ‘for other reasons’; some had ‘sexually harmed others before they have come into care, and after’.³³⁸ He added:

In terms of the experience, or our experience, of children who have harmed others whilst in out-of-home care, it’s clearly a more significant issue for children at the residential care [residential care] end of the spectrum.³³⁹

We support the view that the key focus of residential care should be to provide time-limited intensive interventions for children who require specialist care and that this model of care should be based on a therapeutic framework. Although many of the therapeutic models of care are yet to be fully implemented or evaluated, we accept the arguments put forward by commissioned research and submissions that initiatives founded on the principles articulated by the National Therapeutic Residential Care Alliance represent sound practice.

Recommendation 12.18

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.

However, residential care may still be the most suitable placement for some children who may not need intensive interventions or specialist care. Residential care may be appropriately used to accommodate children who do not want to be placed in home-based care, or for whom home-based care is not appropriate for other reasons and to keep family groups together when a home-based placement is not available to accommodate all the siblings.³⁴⁰

We understand that transition plans will be necessary to establish new models of residential care and that the adoption of Recommendation 12.18 will require careful planning, resourcing and implementation. As a minimum, immediate action needs to be taken to ensure the suitability, skills and appropriate supervision of residential care staff. As discussed, we heard that ensuring residential care staff know and understand how to apply principles of trauma-informed care when caring for vulnerable children – especially children whose behaviours may indicate prior experiences of abuse or neglect-related trauma – has the potential to significantly improve the life trajectories of these children.³⁴¹

Recommendation 12.11 references the need for residential care staff to be trained in trauma-informed practice and Recommendation 12.13 addresses the need for residential care staff to be provided with guidelines and ongoing professional development to improve responses to the harmful sexual behaviours of some children in out-of-home care. One of the most effective ways of ensuring these approaches are reflected in day-to-day practice and that staff are properly supported to provide the necessary level of care is to involve experienced clinicians in the training, mentoring and professional supervision of caregivers.³⁴²

Recommendation 12.19

All residential care staff should be provided with regular training and professional supervision by appropriately qualified clinicians.

Recommendations 12.18 and 12.19 are consistent with the Child Safe Standards, in particular Standard 5: People working with children are suitable and supported and Standard 7: Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, Standard 5: Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way, and Standard 12: Carers are assessed and receive relevant ongoing training, development and support, in order to provide quality care.³⁴³

5.5 Supporting and improving responses to certain cohorts of children

The risks we identified for certain cohorts of children in out-of-home care are detailed in Chapter 4. In this section we recommend strategies to address the particular risks faced by Aboriginal and Torres Strait Islander children and children with disability in out-of-home care. We also outline the need for improved support for care-leavers.

5.5.1 Aboriginal and Torres Strait Islander children

We know that Aboriginal and Torres Strait Islander children are increasingly over-represented in out-of-home care. Given what we have learned about the risks inherent in care, recommendations to improve the protection of Aboriginal and Torres Strait Islander children in care from child sexual abuse are warranted.

The focus of this volume is on child sexual abuse in out-of-home care rather than the whole system. However, in considering how to ensure the safety of Aboriginal and Torres Strait Islander children from sexual abuse in care it is necessary to consider the findings of other inquiries and reports into why these children are so over-represented in a system that of itself appears to constitute a risk to their safety.

The importance of culture

In the course of our inquiry we were told that, in settings such as contemporary out-of-home care, strong cultural identity and connection to community may be a protective factor for Aboriginal and Torres Strait Islander children, helping them to be confident and to know how and where to disclose abuse.³⁴⁴

Aboriginal and Torres Strait Islander child safety literature shows that ‘provided the necessary social conditions’ are in place, Aboriginal and Torres Strait Islander cultures ‘act as a protective force for children and families’.³⁴⁵ While Aboriginal and Torres Strait Islander cultures are diverse, children are central to the life of all communities.³⁴⁶ In Aboriginal and Torres Strait Islander communities, ‘parenting roles, nurturing and socialising responsibilities are widely shared’.³⁴⁷ This collective approach to raising children may provide additional protection against abuse because there are ‘many eyes’ watching out for children and many adults who can provide support or help when children ‘need someone to turn to’.³⁴⁸ In terms of protective factors, commissioned research shows that Aboriginal and Torres Strait Islander child-rearing practices increase the number of secure attachment relationships children have in their extended kin network.³⁴⁹

Empirical data now supports the idea that connection to culture is associated with improved emotional, social and physical health for Aboriginal and Torres Strait Islander peoples.³⁵⁰ Positive cultural connection can increase the protective factors available to Aboriginal and Torres Strait Islander children by helping them to develop their identities, fostering high self-esteem, emotional strength and resilience.³⁵¹ Our commissioned research also highlights that positive cultural connection indirectly increases protective factors by supporting the social conditions necessary for all adults in a kinship placement to be available, responsive and protective of children in the community.³⁵²

Despite research and the attention brought to the issue by government inquiries, *The Family Matters report: Measuring trends to turn the tide on Aboriginal and Torres Strait Islander child safety and removal (Family Matters)*, published in 2016, states that:³⁵³

- 17 per cent (\$700 million) of overall child protection funding was invested in support services for all children and their families, compared to 83 per cent (\$3.5 billion) being spent on statutory child protection and out-of-home care services
- only 1.4 per cent of Aboriginal and Torres Strait Islander children started with an intensive family support service in 2014–15.

The report also noted that there is no publicly available data in any Australian jurisdiction on the rate at which Aboriginal and Torres Strait Islander children are reunited with their families, or on the length of time they spend in out-of-home care before reunification.³⁵⁴

The 2015 Senate Community Affairs References Committee inquiry into out-of-home care reported on evidence it heard about a lack of understanding of ‘the communal nature of Aboriginal families’³⁵⁵ leading to assumptions, particularly about children being neglected, that do not account for community practices. For example, the Senate Committee set out the evidence of Ms Janette Kennedy from the Commission for Children and Young People in Victoria about this lack of understanding:

a community was very distressed that children were taken away after a child protection visit around neglect. The worker visited and had a look in the cupboards and there was no food, and there was no food in the fridge, and, of course, the children were neglected! ... The worker was without the thought, understanding and knowing that everyone eats [at] Auntie Elsie’s place and that no one else needs to have the food in the house because they live as a communal family.³⁵⁶

The injustices to families and the dangers to children of child protection workers who lack cultural competence were discussed in earlier chapters. The Senate Committee reported that ‘all jurisdictions employ Aboriginal and Torres Strait Islander liaison officers or cultural workers’ but noted that the proportion of staff who were Aboriginal and Torres Strait Islander was very low and that there were insufficient workers to meet demand, especially in out-of-home care.³⁵⁷ We also heard that Aboriginal and Torres Strait Islander staff working in mainstream agencies are not always supported to be ‘Aboriginal in their work practice ... They can’t operate from the same foundation that they work through when they work in an Aboriginal agency’.³⁵⁸

The need for all out-of-home care managers and caseworkers to be trained and informed about culturally competent and safe work practices is self-evident – child protection departments and out-of-home care service providers also need to ensure ongoing culturally competent practice.

We heard evidence from Mr Jackomos, Commissioner for Aboriginal Children and Young People in Victoria, of the need not just for more Aboriginal caseworkers, but for:

Koori executives, Aboriginal executives. We need managers ... We need it to be where culture for Aboriginal children isn’t just one hour a week or two hours a week in Parkville College, but it needs to be part of the whole institution. It’s not just an Aboriginal flag flying outside of the institution or the manager having an Aboriginal painting behind his head in his office – it needs to be right throughout the institution.³⁵⁹

Cultural planning for Aboriginal and Torres Strait Islander children in out-of-home care is intended to ensure they maintain strong connections with their ‘cultural identity, language, spirituality and religion, connection and sense of belonging to family’.³⁶⁰ It is an essential component of case planning for children in care.

It is clear from the very limited cultural support plans developed for Aboriginal and Torres Strait Islander children that understanding of the importance of culture by mainstream out-of-home care service providers can be immature. A sample review of cultural plans conducted by the Commission for Children and Young People, Victoria, found that the quality of plans was ‘overwhelmingly poor’, and there was a ‘strong need for improved cultural competence within the sector’.³⁶¹

Many plans were rudimentary and could be considered tokenistic. They had not been updated or reviewed and had minimal input from the child’s parents, extended family or Aboriginal community, nor did they consider the child’s views. Involvement and engagement with ACCOs [Aboriginal community controlled organisations] in completing the plans did not occur consistently.³⁶²

The Senate Community Affairs References Committee inquiry into out-of-home care reported that the Taskforce 1000 project in Victoria (a collaborative project between the Victorian Department of Health and Human Services and the Victorian Commission for Children and Young People)³⁶³ found there was low compliance with legislative obligations to ensure Aboriginal and Torres Strait Islander children had cultural support plans and that most plans that had been written ‘lacked integrity’.³⁶⁴

What we found was that the plans focused on things like cultural events, cultural days and genealogy and had very little focus on relationships, which is really what mattered in the plan for the child. They also were very much the same, a little bit cut-and-paste style across, so a plan for a three-month-old child and a plan for a 13-year-old child looked the same. You would ask, developmentally how was that okay, let alone culturally.³⁶⁵

Despite legislative and policy in all states and territories requiring the involvement of Aboriginal and Torres Strait Islander communities in out-of-home care placement decisions, it appears that there is insufficient recognition in the child protection system in all jurisdictions of the essential importance of Aboriginal and Torres Strait Islander culture in keeping children safe.

The Aboriginal and Torres Strait Islander Child Placement Principle

The Aboriginal and Torres Strait Islander Child Placement Principle has been enacted in legislation in every state and territory.

The fundamental goal of the principle is to enhance and preserve Aboriginal and Torres Strait Islander children’s connection to family and community and their sense of identity and culture. ‘The importance of the principle and its place in child protection legislation and policy has been recognised in major reviews and inquiries into child protection systems across Australian jurisdictions.’³⁶⁶ Limitations on the implementation of the principle were also highlighted in these inquiries.

In legislation, policy and practice, the principle is often reduced to a ‘placement hierarchy’ for children placed in out-of-home care. In order of priority, the preferred placement options for Aboriginal and Torres Strait Islander children are with:

- family and kinship networks
- non-related carers in the child’s community
- carers in another Aboriginal and/or Torres Strait Islander community.

If no other suitable placement with Aboriginal or Torres Strait Islander carers can be found, child protection departments can place children with non-Indigenous carers as a last resort, provided they are willing and able to maintain the child’s connections to their family, community and cultural identity.

Conceived of only as a placement hierarchy, the implementation of the principle is severely curtailed:

the [Aboriginal and Torres Strait Islander Child Placement Principle], is not simply about where or with whom an Aboriginal or Torres Strait Islander child is placed. Placement in out-of-home care is one of a range of interventions to protect an Aboriginal or Torres Strait Islander child at risk of harm.³⁶⁷

Even as a placement hierarchy, we heard that out-of-home care agencies often only paid lip-service to the principle when assessing the suitability of potential placements. In evidence during our *Out-of-home care* case study, Ms Dana Clarke, Chair of the Aboriginal Child, Family and Community Care State Secretariat (AbSec) told us:

It is up for interpretation as to how the placement principles are utilised, and quite often there is a tick and flick kind of attitude to the principles ... They aren’t something that is used in the best interests of the child; they are used in the best interests of a placement.³⁶⁸

As discussed in Chapter 4, while recognising the importance of a child’s connection to their family and community, Aboriginal and Torres Strait Islander agencies are clear that the child’s safety is always the paramount consideration.³⁶⁹ We heard evidence in public hearings that these agencies are best placed to identify suitable and safe placements for Aboriginal and Torres Strait Islander children:

I think the uniqueness of Aboriginal agencies and the uniqueness of us being able to do those assessments is that we have the connectedness to the community. We know what is suitable and who - and to be informed. You know, kids need to be on their community and need to be raised there, but they need to be raised by people who can raise them and give them every life chance. I think having workers and people who come from that community inform that.³⁷⁰

Submissions to us also highlighted that attempts made by child protection departments to identify Aboriginal and Torres Strait Islander kin and family can often be limited:

There is a need for more rigorous family search during placement planning, to ensure every effort is made to place children and young people with extended family networks where possible, particularly for Aboriginal children. The Commission [for Children and Young People] noted through the work of the Taskforce 1000, that there was often a lack of understanding and acknowledgement of the impact on Aboriginal families of past government policies. This led to insufficient effort being made to search within the extended family for suitable Aboriginal carers or family that could provide additional support. Through the work of Taskforce 1000, some progress has been made in the development of genograms³⁷¹ for Aboriginal children in care, but greater attention and effort is required to ensure Aboriginal children are placed according to the Aboriginal Child Placement Principle as legislated.³⁷²

Mr Jackomos, in commenting on the Taskforce 1000 recommendations, stated:

I have been heartbroken by the record numbers of our children placed with non-Koori carers whilst responsible and loving Koori kin, grandparents and siblings have waited in vain to be contacted and connected, falsely believing the legislated Aboriginal Child Placement Principle will bring their loved ones home. And the Commission [for Children and Young People in Victoria] hears this story repeated almost daily as family members contact seeking our support to bring the children home or at least some contact.³⁷³

According to the Secretariat of National Aboriginal and Islander Child Care (SNAICC), the full aims of the Aboriginal and Torres Strait Islander Child Placement Principle are to:³⁷⁴

- a. recognise and protect the rights of Aboriginal and Torres Strait Islander children, family members and communities
- b. increase the level of self-determination for Aboriginal and Torres Strait Islander people in child welfare matters
- c. reduce the disproportionate representation of Aboriginal and Torres Strait Islander children in the child protection system.

There are five constituent elements of the principle: prevention, partnership, placement, participation and connections. As can be seen, the placement hierarchy is only one of these elements. The full implementation of the principle would acknowledge, in practice, that 'Aboriginal and Torres Strait Islander people have the knowledge and experience to make the best decisions concerning their children'.³⁷⁵ The principle:

recognises the importance of each child staying connected to their family, community, culture and country. It promotes a partnership between government and Aboriginal and Torres Strait Islander communities in decision making about children's welfare.³⁷⁶

Measuring implementation of the Aboriginal and Torres Strait Islander Child Placement Principle

There is currently ‘no Australia-wide systematic protocol in place to [effectively] monitor and assess implementation of the Principle’.³⁷⁷ Data compiled by the Australian Institute of Health and Welfare refers to the placement hierarchy. This data includes children placed with non-Indigenous kin and those placed in Indigenous-run residential care rather than in the community.³⁷⁸ Even using this limited proxy measure for compliance, in 2015 only 66 per cent of Aboriginal and Torres Strait Islander children in out-of-home care were placed with ‘family, kin or other Aboriginal and Torres Strait Islander carers’, representing a decline nationally.³⁷⁹

Where there have been detailed audits of compliance, actual compliance with the principle is even lower. For example, in Queensland in 2010–11, only 15 per cent of children’s placements fully complied with legislative requirements relating to the principle; in Victoria in 2013–14, no matters were fully compliant.³⁸⁰

The Aboriginal and Torres Strait Islander Working Group, formed under the Third Three-Year Action Plan 2015–2018 of the National Framework for Protecting Australia’s Children 2009–2020, is taking steps to address these issues, including publishing a series of resources that will include:³⁸¹

- a baseline analysis of the progress of states and territories to implement the Aboriginal and Torres Strait Islander Child Placement Principle
- a resource for child and family services practitioners on applying the five elements of the Aboriginal and Torres Strait Islander Child Placement Principle.

Community-based Aboriginal and Torres Strait Islander child welfare agencies

We were told in evidence during our *Out-of-home care* case study and in submissions that full implementation of the Aboriginal and Torres Strait Islander Child Placement Principle, and increased safety of Aboriginal and Torres Strait Islander children in contemporary out-of-home care, would be possible only through child protection departments and out-of-home care service providers actively engaging with community-based Aboriginal and Torres Strait Islander child welfare agencies and communities.

Element 2 of the Aboriginal and Torres Strait Islander Child Placement Principle is partnership:

The participation of Aboriginal and Torres Strait Islander community representatives, external to the statutory agency, is required in all child protection decision-making, including intake, assessment, intervention, placement and care, and judicial decision-making processes.³⁸²

The involvement of Aboriginal and Torres Strait Islander families and communities in decisions about their children is in practice very limited. In Victoria, the Lakidjeka Aboriginal Child Specialist Advice and Support Service, run by the Victorian Aboriginal Child Care Agency,

is one example of a model that could be developed and built on elsewhere.³⁸³ In 2008, the Special Commission of Inquiry into Child Protection Services in New South Wales (the Wood Inquiry) recommended that this model be adopted:

The NSW Government should develop a strategy to build capacity in Aboriginal organisations to enable one or more to take on a role similar to that of Lakidjeka Aboriginal Child Specialist Advice and Support Service, that is, to act as advisors to DoCS [Department of Community Services, now Department of Family and Community Services] in all facets of child protection work including assessment, case planning, case meetings, home visits, attending court, placing Aboriginal children and young persons in [out-of-home care] and making restoration decisions.³⁸⁴

In New South Wales, the Department of Family and Community Services and AbSec developed Protecting Aboriginal Children Together (PACT), based on Victoria's Lakidjeka program. There are four pilot programs that have commenced, but there is no guarantee of continued funding or support. We were told that the Aboriginal child placement panels in New South Wales work well if implemented properly, but are not always made up of community representatives. They sometimes use Aboriginal workers from the child protection department, in which case 'they are consulting with themselves and, therefore, it's not always in the best interests of the child'.³⁸⁵

A key recommendation of the 2016 *Family Matters* report is for:

Broad-based legislative and policy reform to strengthen representation of Aboriginal and Torres Strait Islander organisations, communities, families and children in decisions about child safety and removal, from before and throughout their engagement with child protection systems. This would include compliance with the five elements of the Aboriginal and Torres Strait Islander Child Placement Principle and strong models of Aboriginal family-led decision-making.³⁸⁶

We have learned that increased funding and support of community Aboriginal and Torres Strait Islander child welfare agencies, including out-of-home care service providers, could address several of the risks for Aboriginal and Torres Strait Islander children in contemporary out-of-home care by:

- embedding cultural safety³⁸⁷ in child protection decisions
- ensuring children placed through Aboriginal and Torres Strait Islander agencies remain connected to their culture and community, and therefore family³⁸⁸
- achieving more effective recruitment, training and support of Aboriginal and Torres Strait Islander foster carers and kinship carers because they are connected to and have knowledge of community.³⁸⁹

We were told that there are only a small number of Aboriginal and Torres Strait Islander child welfare agencies in Australia.³⁹⁰ The *Family Matters* report calls for:

Investment in service delivery by community-controlled organisations in line with self-determination and quality of service provision. There is strong capacity in many communities to take up further service provision and partnership models to support capacity development for sustainable community-controlled service sectors.³⁹¹

Acknowledging the need to support and build the capacity and numbers of community-based Aboriginal and Torres Strait Islander child welfare agencies, we note that mainstream out-of-home care service providers could play a role by working in capacity-building partnerships with community-based agencies, including providing the management and governance experience that is essential to ensure the highest standards of out-of-home care.³⁹²

Recommendation 12.20

Each state and territory government, in consultation with appropriate Aboriginal and Torres Strait Islander organisations and community representatives, should develop and implement plans to:

- a. fully implement the Aboriginal and Torres Strait Islander Child Placement Principle
- b. improve community and child protection sector understanding of the intent and scope of the principle
- c. develop outcome measures that allow quantification and reporting on the extent of the full application of the principle, and evaluation of its impact on child safety and the reunification of Aboriginal and Torres Strait Islander children with their families
- d. invest in community capacity building as a recognised part of kinship care, in addition to supporting individual carers, in recognition of the role of Aboriginal and Torres Strait Islander communities in bringing up children.

The work done by the Commission for Children and Young People in conjunction with the Department of Health and Human Services in Victoria has provided valuable insight into the implementation of the Aboriginal and Torres Strait Islander Child Placement Principle in Victoria. The project's detailed reviews, recommendations and consequent action plans are a useful model for all jurisdictions to utilise in reviewing their implementation of the Aboriginal and Torres Strait Islander Child Placement Principle with a view to improving outcomes for Aboriginal and Torres Strait Islander children and 'addressing issues associated with their over representation in out-of-home care'.³⁹³

Recommendation 12.20 is consistent with our Child Safe Standards, in particular Standard 1: Child safety is embedded in institutional leadership, governance and culture, Standard 3: Families and communities are informed and involved, and Standard 4: Equity is upheld and diverse needs are taken into account. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, and Standard 3: Aboriginal and Torres Strait Islander communities participate in decisions concerning the care and placement of their children and young people.³⁹⁴

5.5.2 Children with disability

Improving the safety of children requires mainstream out-of-home care services to develop competence in working with children with disability. Research into the needs of children with disability notes that interventions that target their needs are required, otherwise there is a risk that they will be ignored.³⁹⁵ In the case of therapeutic residential care, therapeutic models involve cognitive-behavioural strategies that may not be suitable for, or may require adaptation for, children with intellectual disabilities.³⁹⁶ Where children are prioritised for therapeutic care on the basis of their ability to ‘benefit from the trauma-informed therapeutic approach’,³⁹⁷ there is a risk that children with disability will be excluded from such care. There is therefore a need for mainstream trauma services to understand and accommodate the needs of children with disability in their programs.³⁹⁸

The main conclusions of commissioned research on the safety in institutional settings of children with disability and high support needs were:³⁹⁹

- there is a need to address systemic issues that impact on the lives of children and young people, including the effects of segregation, lack of choice and discrimination
- work is needed to assist children and their supporters to recognise and assess the relative risk of harm
- the nature and quality of support relationships need to be monitored in a strategic and concerted way
- evidence-based educational resources and strategies are needed to improve children’s capacity to identify and respond to potential harm
- the active participation of children with disability in institutions needs to be developed and supported.

All children entering out-of-home care should have individualised care plans. The individualised care plans for children with disability in out-of-home care need to include institution-level and individual-level strategies to manage risk for these children.

Recommendation 12.21

Each state and territory government should ensure:

- a. the adequate assessment of all children with disability entering out-of-home care
- b. the availability and provision of therapeutic support
- c. support for disability-related needs
- 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.

Recommendation 12.21 is consistent with our Child Safe Standards, in particular Standard 1: Child safety is embedded in institutional leadership, governance and culture, and Standard 4: Equity is upheld and diverse needs are taken into account. It aligns with the National Standards for Out-of-Home Care, namely Standard 1: Children and young people will be provided with stability and security during their time in care, and Standard 4: Each child and young person has an individualised plan that details their health, education and other needs.⁴⁰⁰

5.5.3 Care-leavers

As discussed in Chapter 4, many of the children who leave contemporary out-of-home care each year transition to independent living at a younger age, in a more abrupt manner and with far fewer emotional, social and financial supports than other young Australians.⁴⁰¹

There were 5,559 substantiated reports of child sexual abuse across Australia in 2015–16. Even though children in contemporary out-of-home care are likely to be at heightened risk,⁴⁰² the reporting gaps noted at Section 5.2.1 mean there is no way to know how many substantiated sexual abuse reports involve children in care or what proportion of the abuse occurred while in, or prior to entering, care.⁴⁰³ What is known is that among the 3,100 or more Australian children who transition from out-of-home care each year,⁴⁰⁴ it is highly likely that there will be some who were sexually abused as children in out-of-home care, and who have already disclosed the abuse; some who were sexually abused in care, and who are yet to disclose the abuse; and some who were not sexually abused directly, but who may have witnessed or been affected by the sexual abuse of other children. For many children who experienced or were affected by sexual abuse in care and who are yet to disclose that abuse, information we have gathered through private sessions, submissions and research suggests that it may sometimes be many years before such disclosures are made.⁴⁰⁵

As 'very few young people transitioning from care are developmentally ready to live independently at 18 years of age',⁴⁰⁶ post-care supports provide a way of ensuring all care-leavers are able to access safe accommodation, further education, advice and other essentials as they transition

to adulthood.⁴⁰⁷ For the many care-leavers who themselves become parents within their first year of leaving care, and who often lack crucial family and social supports, there is a need for the universal services made available to all care-leavers to include parenting programs.⁴⁰⁸

Post-care supports are especially important for those experiencing a volatile transition from care. This may include children who have experienced physical or sexual abuse before or while in out-of-home care, may still be recovering from prior maltreatment, have had multiple placements or poor experiences in statutory care, and who may have little, if any, direct family support or other social networks to ease their transition to independent living.⁴⁰⁹ Existing universal supports for all care-leavers can, if properly implemented, provide child sexual abuse survivors with valuable tools to help them safely transition to adulthood, regardless of whether they have disclosed the abuse. In addition, comprehensive leaving-care planning and other universal supports have the potential to provide a platform for the ramping up of specialist post-care supports targeting the specific needs of child sexual abuse survivors, such as referrals to therapeutic treatment services.⁴¹⁰

Government commitments to strengthen care-leaver supports

The National Framework for Protecting Australia's Children 2009–2020 (the National Framework) warns that 'young people leaving care are at great risk of experiencing negative life outcomes',⁴¹¹ and advises that care-leavers are better supported when:⁴¹²

- they are equipped with improved employment and independent living skills, and more social and emotional skills while in care, and
- the state continue to act as a 'good' parent in the first few years after they leave care.

The National Framework does not specify how many years the state should continue to provide parenting support to care-leavers after statutory care ceases. However, the Australian Government's policy is to support care-leavers until the age of 25⁴¹³ and most states and territories offer schemes to support care-leavers until the age of 21 years, and in some cases to 25 years.⁴¹⁴ The framework recommends all Australian governments adopt strategies to improve supports for young people leaving care, including actions to reduce the incidence of homelessness among care-leavers.⁴¹⁵

The framework's Second Action Plan 2012–2015 sets out measures intended to reduce the fragmentation of various federal and state/territory post-care supports for vulnerable care-leavers.⁴¹⁶ In a section on 'Transitioning to Independence', the plan calls for action to:

Integrate support for young people leaving care that is tailored to their individual needs and builds on a lifespan approach, including the Transition to Independent Living Allowance and State and Territory leaving care packages for care leavers.⁴¹⁷

The main indicator for whether governments were taking steps to implement this and several related actions under the plan was the ‘proportion of young people aged 15 years and over who have a leaving care plan’.⁴¹⁸

The framework’s Third Action Plan 2015–2018 identified the need for all Australian governments to ‘Develop and strengthen support for young people in care transitioning to adulthood and improve priority access to support services’.⁴¹⁹

The ‘signature actions’ supporting this strategy include:⁴²⁰

- commitments to improve care-leavers’ access to Commonwealth employment schemes
- a Towards Independent Adulthood Trial of methods to improve the delivery of holistic ‘wrap around services’ to young care-leavers⁴²¹
- review of the ‘efficiency’ of the Transition to Independent Living Allowance
- evaluation of the ‘impact of jurisdictions’ policy changes to extend statutory responsibility and access to services to young people who exit out-of-home care over the age of 18 years.

While there are no specific measures linked to these actions, there is a commitment ‘to develop targets and progress markers ... to measure progress’ and to fully implement and ‘give best effect to, the *National Standards for Out-of-Home Care*’.⁴²² Significantly, Standard 13 of the National Standards for Out-of-Home Care requires that ‘Children and young people have a transition from care plan commencing at 15 years old, which details support to be provided after leaving care’.⁴²³

The number of 15- to 17-year-olds in out-of-home care with a transition to independence plan has become an indicator of whether individuals who are preparing to leave care are being offered information about potential post-care supports. However, this measure is not included in either Australian Institute of Health and Welfare or Productivity Commission reports.⁴²⁴ As discussed in Chapter 4, despite the increased emphasis on discharge planning processes in all jurisdictions, we were told that leaving care plans are often not done, or not done well.

Although the scope and content of leaving care plans differ widely across jurisdictions and care providers, the National Framework commits governments in all jurisdictions to address inadequacies in current transition planning processes.⁴²⁵ In broad terms, leaving care plans are expected to provide care-leavers with information about health, housing, education, training, employment, self-care skills, financial management, relationships and accessing personal records.⁴²⁶ In tailoring this information to the needs of individual care-leavers, there is also an expectation that plans provide young care-leavers with advice about their entitlements and how to access them, ensure that both general and individualised supports are in place, and address any health needs.⁴²⁷

For care-leavers who have been sexually abused while in out-of-home care, who are at greater risk of a volatile transition from care, the provision of individualised leaving care plans would be a valuable step in reducing their vulnerability.⁴²⁸ If properly implemented, government commitments to implement individualised transition-from-care planning would be consistent with our Child Safe Standards, in particular Standard 2: Children participate in decisions affecting them and are taken seriously, and Standard 4: Equity is upheld and diverse needs are taken into account.

In its submission to our *Out-of-home care* consultation paper, MacKillop Family Services praised Victorian regulators for introducing spot audits of residential homes in Victoria, noting the success of this independent oversight strategy in helping ‘to ensure that agencies are consistently compliant and accountable’ in adhering to agreed out-of-home care standards.⁴²⁹ MacKillop Family Services recommended that spot audits be incorporated into the monitoring of residential care in all jurisdictions.⁴³⁰ Similarly, there would be value in applying the independent oversight of Child Safe Standards (proposed in Recommendation 12.5) to checking government and non-government agencies’ compliance with requirements to provide effective discharge plans for all 15 to 17-year-olds in out-of-home care.⁴³¹ As noted in Chapter 4, the Northern Territory Children’s Commissioner monitors and reports annually on how many children in out-of-home aged 15 to 17 years have ‘a leaving care plan or any evidence to suggest that a plan had been considered’.⁴³² Children’s commissioners and guardians (or their equivalent) in all states and territories should consider adopting this approach.

Supports for care-leavers who have survived sexual abuse

As discussed in Volume 4, *Identifying and disclosing child sexual abuse*, although children often disclose or try to disclose sexual abuse around the time it occurs, we have learned that a proportion of disclosures are not made until long after the occurrence of the abuse. In some cases, it can take victims years to disclose sexual abuse. We have been told that young people who have been sexually abused while in out-of-home care and who have not disclosed the abuse are unlikely to disclose until they leave the environment in which the abuse occurred and they feel safe.⁴³³

The implementation of government commitments to provide adequate post-care supports to all care-leavers, and for individualised planning to begin well before children leave the out-of-home care system, would go a long way to helping survivors of child sexual abuse in care to feel safer and better supported as they transition to adulthood. Strengthening supports immediately before and throughout the transition from care may also encourage disclosures of abuse. ‘Ella’, a care-leaver who told us in a private session that she had been sexually abused in foster care, said she was ill-prepared to live on her own when she turned 18 in 2011.⁴³⁴ She said the abrupt removal of supports as state guardianship ended heightened her sense of vulnerability: ‘I just got a house and I cried at my first bill because they’re trying to tell me I have to pay \$40 a fortnight from my \$100 payment. [I thought] this can’t be right’.⁴³⁵

‘Ella’ told us that police were supportive when she reported the sexual abuse three years after leaving care and she was hopeful there might be a successful prosecution.

From evidence in our *Out-of-home care* case study, as well as through research, submissions and advice provided to our *Out-of-home care* case study and roundtable, we have learned that a number of factors can significantly improve the safety and resilience of young care-leavers as they exit statutory care.⁴³⁶ The prospects of a safe transition to independence increases when there has been placement stability while in care, good and safe care experiences before leaving care, a gradual and well-planned transition, preparation for leaving care that addresses the specific needs of each individual (especially those with additional needs), suitable housing upon discharge, and an ability to return to care if the accommodation placement breaks down.⁴³⁷

We heard that the care-leavers who are at greatest risk are those who lack safe accommodation after leaving out-of-home care. As the Centre for Excellence in Child and Family Welfare observed, ‘the greatest protection for these young people is to have ongoing supportive relationships and a supportive pathway into adulthood’.⁴³⁸ A supportive pathway typically involves post-secondary education or pre-employment training, and secure accommodation with adults who can provide advice and support.⁴³⁹ The centre, which represents almost 100 child and family services in Victoria, said care-leavers in ‘safe and supportive’ kinship care placements are more likely to be able to access such transitional support, whereas those in foster or residential care are usually ‘required to move out at 18 and subsequently receive generally low levels of leaving care support’.⁴⁴⁰

The centre’s submission also expressed strong concerns about ‘the particular vulnerability of care-leavers to sexual exploitation’ as they transition to adulthood.⁴⁴¹

While legal childhood ends at the age of 18, the risk of sexual exploitation does not. The risks are heightened for young people who have experienced trauma in earlier years when they no longer have caregivers.⁴⁴²

The centre recommended that strategies to prevent the sexual exploitation of care-leavers be addressed by prioritising care-leavers’ access to supported accommodation services.

Through submissions, we were told of other potential strategies that could improve the wellbeing of children who have survived child sexual abuse in out-of-home care and lead them to feel better supported as they transition to independent living. These include proposals to provide care-leavers with ongoing caseworker support until they turn 21, or preferably 25, so that even after leaving care, there would be someone who has responsibility for helping sexual abuse survivors to find and more easily access professionals who have the skills and experience to support them should they choose to disclose the abuse they experienced in care.

Such a caseworker could also connect care-leavers with various other post-care supports, including help to access safe housing, and further education and pre-employment training schemes. For the many care-leavers who become parents, homeless or involved in the justice

system soon after leaving care, specialist supports may be required. And because of the high proportion of children with disability in out-of-home care, especially residential care, it is crucial that caseworkers include those with specialist expertise in the available supports, services and training and employment opportunities to assist care-leavers with disability to successfully transition to independent living.

In considering any other strategies to strengthen the provision of leaving care supports for children who have experienced sexual abuse in out-of-home care, the focus should be on:

- improving the quality of out-of-home care, as positive experiences preceding discharge from care pave the way for smoother, better-planned transition from care
- ensuring a more gradual and flexible transition from care to independent living, preferably via strategies mandating that universal post-care supports offered to all care-leavers be much more easily accessible until at least the age of 21, and to 25 where possible
- ensuring that any targeted supports to address the specific needs of sexual abuse survivors, such as help in accessing therapeutic treatment to deal with impacts of abuse, be more easily accessible until at least the age of 25, and beyond that age where necessary
- requiring the child's active involvement in the planning for leaving care, and that leaving care plans address the particular needs of individual care-leavers.

Recommendation 12.22

State and territory governments should ensure that the supports provided to assist all care-leavers to safely and successfully transition to independent living include:

- 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
- 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.

Recommendation 12.22 is consistent with our Child Safe Standards, in particular Standard 2: Children participate in decisions affecting them and are taken seriously, and Standard 4: Equity is upheld and diverse needs are taken into account. It aligns with the National Standards for Out-of-Home Care, namely Standard 11: Children and young people in care are supported to safely and appropriately identify and stay in touch with at least one other person who cares about their future, who they can turn to for support and advice, and Standard 13: Children and young people have a transition from care plan commencing at 15 years old which details support to be provided after leaving care.⁴⁴³

Endnotes

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- 5 JJ McDowall, *Experiencing out-of-home care in Australia: The views of children and young people (CREATE report card 2013)*, CREATE Foundation, Sydney, 2013, p xvi.
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- 9 Australian Institute of Health and Welfare, *The views of children and young people in out-of-home care*, Australian Government, Canberra, 2016, pp 6, 9, 12, 13.
- 10 Australian Institute of Health and Welfare, *Child Protection Australia: 2014–15*, cat no CWS 57, Australian Institute of Health and Welfare, Canberra, 2016, p 53. The report itself estimates 10 per cent of all children in care but does not explain the calculation. See Australian Institute of Health and Welfare, *The views of children and young people in out-of-home care*, Australian Government, Canberra, 2016, p 4.
- 11 See 'Technical notes', Australian Institute of Health and Welfare, *The views of children and young people in out-of-home care*, Australian Government, Canberra, 2016, pp 16–22.
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- 14 Australian Institute of Health and Welfare, *The views of children and young people in out-of-home care*, Australian Government, Canberra, 2016, p 14.
- 15 Name changed, private session, 'Dee Ann'.
- 16 Name changed, private session, 'Dee Ann'.
- 17 Name changed, private session, 'Dee Ann'.
- 18 Name changed, private session, 'Larissa'.
- 19 Name changed, private session, 'Larissa'.
- 20 Name changed, private session, 'Mikel'.
- 21 Name changed, private session, 'Angela Kate'.
- 22 Name changed, private session, 'Kylie Lynne'.
- 23 Name changed, private session, 'Kylie Lynne'.
- 24 In this volume a date range, for example, 2015–16 refers to a period of 12 months from 1 July – 30 June, unless otherwise specified.
- 25 There were 60,989 substantiated reports of all types of abuse in Australia in 2015–16, and 45,714 involving children in out-of-home care. As abuse can lead to children being placed in care, it is likely that many of these substantiations related to incidents prior to entering care. Australian Institute of Family Studies, *Child abuse and neglect statistics*, Australian Government, Melbourne, 2017.
- 26 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, Sydney, 2016, pp 43–46.
- 27 Most government submissions endorsed the proposed data model set out in Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, Sydney, 2016, as an appropriate blueprint for future reforms. The submissions from the Australian, NSW, ACT and Northern Territory governments indicated that there was a need for a stronger evidence base and made specific recommendations to strengthen the model. See the following submissions to the Royal Commission into Institutional Responses to Child Sexual Abuse on *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016: Commonwealth Government; NSW Government; ACT Community Services Directorate; Northern Territory Department of Children and Families.

- 28 Although broadly supportive of the changes needed to strengthen reporting on child sexual abuse in out-of-home care, some submissions – including those from Victoria, Western Australia and Queensland – also expressed reservations about the feasibility of national data consistency and/or whether the effort needed to align the disparate records systems was justified. See the following submissions to the Royal Commission into Institutional Responses to Child Sexual Abuse on *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016: State Government of Victoria; Government of Western Australia; Queensland Family and Child Commission. See also, Exhibit 51-004, ‘Queensland Government Response to the Royal Commission into Institutional Response to Child Sexual Abuse’, Case Study 51, STAT.1183.001.0001 at 0011–0012.
- 29 E Munro, *Munro review of child protection: Final report*, UK Parliament, London, 2011, p 50.
- 30 E Munro, *Munro review of child protection: Final report*, UK Parliament, London, 2011, p 129.
- 31 Transcript of M Mitchell, Case Study 24, 2 July 2015 at 14946:5–19.
- 32 Australian Institute of Health and Welfare, *A new approach to national child protection data: Implementation of the child protection national minimum data set*, Australian Government, Canberra, 2014, p 4.
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- 34 Australian Institute of Family Studies, *Child abuse and neglect statistics*, Australian Government, Melbourne, 2017, p 4; Australian Institute of Health and Welfare, *Child protection Australia: 2015–16*, cat no CWS 60, Australian Institute of Health and Welfare, Canberra, 2017, pp 5–6.
- 35 G Llewellyn, S Wayland & G Hindmarsh, *Disability and child sexual abuse in institutional contexts*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2016, p 36.
- 36 Council of Australian Governments, *Protecting children is everyone’s business: National framework for protecting Australia’s children 2009–2020*, Commonwealth of Australia, Canberra, 2009, p 11.
- 37 Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, Sydney, 2016, p 46.
- 38 CareSouth, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, p 3.
- 39 Families Australia, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, p 3.
- 40 See the following submissions to the Royal Commission into Institutional Responses to Child Sexual Abuse on *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016: Anglicare Australia, p 4; Life Without Barriers, p 3; Barnardos Australia, p 3.
- 41 For example, see the following submissions to the Royal Commission into Institutional Responses to Child Sexual Abuse on *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016: State Government of Victoria, p 7; Government of Western Australia, p 5.
- 42 Commonwealth Government, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Consultation paper: Institutional responses to child sexual abuse in out-of-home care*, 2016, pp 6–7.
- 43 For example, the representatives of Australia’s three most populous states – New South Wales, Victoria and Queensland – agreed that there is insufficient data and there needs to be more data and reporting in relation to children in out-of-home care and sexual abuse, see Transcripts of M Coutts-Trotter, K Peake & M Hogan, Case Study 51, 8 March 2017 at 26444:45–26445:8. Although all jurisdictions already collect much or all of the information needed for nationally consistent reporting on child sexual abuse in out-of-home care, inconsistent definitions, technical limitations and other constraints make it difficult to compare data across jurisdictions. For example, see Transcripts of K Peake & M Hogan, Case Study 51, 8 March 2017 at 26448:21–43.
- 44 See Transcripts of State and Territory representatives: Transcript of M Coutts-Trotter, Case Study 51, 8 March 2017 at 26445:10–26446:12; Transcript of K Peake, Case Study 51, 8 March 2017 at 26446:16–26448:30; Transcript of M Hogan, Case Study 51, 8 March 2017 at 26448:35–26451:46; Transcript of C Taylor, Case Study 51, 8 March 2017 at 26452:1–26454:9; Transcript of E White, Case Study 51, 8 March 2017 at 26454:13–26455:35; Transcript of M Pervan, Case Study 51, 8 March 2017 at 26456:3–28; Transcript of M De’Ath, Case Study 51, 8 March 2017 at 26456:42–26457:16; Transcript of J Kerr, Case Study 51, 8 March 2017 at 26457:20–46.
- 45 See Transcripts of State and Territory representatives, Transcript of M Coutts-Trotter, Case Study 51, 8 March 2017 at 26445:41–47; Transcript of K Peake, Case Study 51, 8 March 2017 at 26447:36–46, 26448:21–30; Transcript of M Hogan, Case Study 51, 8 March 2017 at 26448:45–47, 26450:25–27; Transcript of C Taylor, Case Study 51, 8 March 2017 at 26452: 4–26, 26453:11–40; Transcript of E White, Case Study 51, 8 March 2017 at 26454:20–28, 26455:21–35; Transcript of M Pervan, Case Study 51, 8 March 2017 at 26456:3–28; Transcript of M De’Ath, Case Study 51, 8 March 2017 at 26457:1–16; Transcript of J Kerr, Case Study 51, 8 March 2017 at 26457:20–27.

46 For example, in explaining why Victoria had invested in new ‘data analytics’ software to enable the extraction and interrogation of existing records, the Secretary of the Department of Health and Human Services explained, ‘We see that not only as being important for public accountability ... but fundamentally important to ensure that we follow up where there is harm that has been alleged or caused, so that we can support young people in our care effectively.’ Transcript of K Peake, Case Study 51, 8 March 2017 at 26446:43–26447:1. The Secretary of Tasmania’s Department of Health and Human Services said his agency was preparing to ‘go out to the market for a replacement system’ that, in addition to enhancing its reporting capacity and ‘giving us that capacity to better assess risk internally so that we can red-flag particular children’ who exhibit signs of having been abused, the new system should include linkages with ‘the data systems in police and education’ to enhance the capacity of Tasmanian authorities to ‘focus our efforts on the children that are most at risk’. Transcript of M Pervan, Case Study 51, 8 March 2017 at 26456:16–28.

47 See Transcripts of Panel 2.5: Transcript of M Coutts-Trotter, Case Study 51, 8 March 2017 at 26445:41–47; Transcript of K Peake, Case Study 51, 8 March 2017 at 26446:22–30; Transcript of M De’Ath, Case Study 51, 8 March 2017 at 26457:1–16.

48 See Transcripts of Panel 2.5: Transcript of M Hogan, Case Study 51, 8 March 2017 at 26448:45–26449:2; Transcript of E White, Case Study 51, 8 March 2017 at 26454:20–28, 26455:17–35; Transcript of C Taylor, Case Study 51, 8 March 2017 at 26453:8–13; Transcript of M Pervan, Case Study 51, 8 March 2017 at 26456:3–28; Transcript of J Kerr, Case Study 51, 8 March 2017 at 26457:20–27.

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50 Transcript of K Peake, Case Study 51, 8 March 2017 at 26446:16–36.

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113 This includes Queensland and South Australia. See Queensland Family and Child Commission, Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse, *Discussion paper: Strengthening information sharing arrangements*, 2017, p 8. Child Protection Systems Royal Commission, *The life they deserve: Child protection systems Royal Commission report*, South Australian Government, Adelaide, 2016, Chapter 20. The government's plans to address the issues identified by that inquiry are set out in Government of South Australia, *Child protection – A fresh start. Government of South Australia's response to the child protection systems Royal Commission report: The life they deserve*, Attorney General's Department, Adelaide, 2016, pp 140–141. In the Northern Territory there is no standalone register; authorised carers are added to Territory Families' core computer database, the Community Care Information System by staff who assess carers. Territory Families staff access information on the CCIS for placement matching. A review of the CCIS is considering enhancing and increasing its ability to record, access and share information relevant to registered carers: Advice from Territory Families, 21 March 2017. In the ACT, details of approved out-of-home care carers are kept on the Child and Young Person System, an electronic record system. This system is managed within Child and Youth Protection Services in the ACT Government Community Services Directorate. All staff have access to the system, but only staff involved in the approval and funding process for carers have access to data showing who is approved: Advice from ACT Community Services Directorate, 25 May 2017.

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 s 14(1)(k) does include in its definition of 'information sharing entities' any employees or volunteers in Government
 agencies or organisations that receive Crown funding for the provision of 'health, welfare, education, child care or
 residential services wholly or partly for children'.

- 260 Child protection legislation that requires agencies to provide carers with adequate information include: *Children and Young People (Care and Protection) Act 1998* (NSW) ss 143, 144; *Care and Protection of Children Act* (NT) s 80; *Child Protection Act 1999* (Qld) s 83A; *Children Youth and Families Act 2005* (Vic) s 179. In the Northern Territory, carers are also included in the safety and wellbeing information exchange scheme under Part 5.1A of the *Care and Protection of Children Act* (NT). This permits and requires a range of bodies to share information with carers (and vice versa) in certain circumstances – see *Care and Protection of Children Act* (NT) s 293C(1)(c). Legislation in the ACT permits the department to provide safety and wellbeing information to an out-of-home carer. See *Children and Young People Act 2008* (ACT) s 859(1)(c). Information can also be shared among members of a ‘care team’. See *Children and Young People Act 2008* (ACT) s 863. See also the arrangements in WA that permit the disclosure of ‘relevant information’ to an ‘interested person’: *Children and Community Services Act 2004* (WA) s 23. The Nyland Royal Commission recommended that the South Australian *Family and Community Services Act 1972* be amended to include provisions in similar terms to the New South Wales legislation, to provide carers with a right to information for the purposes of caring for children (see Child Protection Systems Royal Commission, *The life they deserve: Child protection systems Royal Commission report*, South Australian Government, Adelaide, 2016, p 298; and *Children and Young People (Safety) Act 2017* (SA), div 4. In New South Wales, agencies can also share information with carers about the progress and outcomes of reportable allegations investigations under the *Ombudsman Act 1974* (NSW). See *Ombudsman Act 1974* (NSW) s 25GA.
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- 269 See *Children, Youth and Families Act 2005* (Vic) s 180; *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 144(2); *Care and Protection of Children Act* (NT) s 80(3); *Children and Young People (Safety) Bill 2017* (SA) s 72(2).
- 270 See *Child Protection Act 1999* (Qld) s 83A(5).
- 271 See *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990), arts 9, 12.
- 272 Determining children’s capacity to consent to disclosure of their personal information may be complex. Generally, privacy laws do not prescribe the age at which individuals may be considered capable of consent to disclosure. The general law on capacity, which is relevant in this context, recognises that children may have capacity to consent, depending on their maturity, understanding and ability to communicate, assessed on a case-by-case basis (see *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112 and *Secretary of the Department of Health and Community Services v JWB and SMB (Re Marion)* (1992) 175 CLR 218 on children’s capacity to consent to medical treatment; see also *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990), art 12. This understanding of capacity to consent is reflected in some privacy legislation, which also expressly enables authorised representatives (such as persons with parental responsibility) to consent where a child does not have capacity (see, for example: *Health Records and Information Privacy Act 2002* (NSW) s 7; *Health Records Act 2001* (Vic) s 85; *Privacy and Data Protection Act 2014* (Vic) ss 28(1), 28(3)). However, in some cases, privacy legislation may exclude children from consenting, and restrict the power to consent to those with parental responsibility (see *Health Records (Privacy and Access) Act 1997* (ACT) ss 7(4), (25).
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286 M Benton, R Pigott, M Price, P Shepherdson & G Winkworth, *A national comparison of carer screening, assessment, selection and training and support in foster care, kinship and residential care*, report prepared for the Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney, 2017, pp 71–72.

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290 Senate Community Affairs References Committee, *Out of home care*, Commonwealth of Australia, Canberra, 2015, p 169.

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309 Commission for Children and Young People, “...as a good parent would...” *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*, Commission for Children and Young People, Melbourne, 2015, p 13 and p 18.

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324 S McLean, R Price-Robertson & E Robinson, *Therapeutic residential care in Australia: Taking stock and looking forward*, Australian Institute of Family Studies, Melbourne, 2011.

325 S McLean, R Price-Robertson & E Robinson, *Therapeutic residential care in Australia: Taking stock and looking forward*,
Australian Institute of Family Studies, Melbourne, 2011, p 1.

326 S McLean, R Price-Robertson & E Robinson, *Therapeutic residential care in Australia: Taking stock and looking forward*,
Australian Institute of Family Studies, Melbourne, 2011, p 2.

327 Senate Community Affairs References Committee, *Out of home care*, Commonwealth of Australia, Canberra,
2015, p 125.

328 Senate Community Affairs References Committee, *Out of home care*, Commonwealth of Australia, Canberra,
2015, p 279; Queensland Government, *Evolve Therapeutic Services and Evolve Behaviour Support Services*, 2015,
www.health.qld.gov.au/townsville/IMHS/imhs_evolve.asp (viewed 8 October 2015); Victorian Government Department
of Human Services, *The Circle Program – A therapeutic approach to foster care: Program guidelines*, Melbourne, 2009.

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Exhibit 51-004, 'Queensland Government Response to the Royal Commission into Institutional Responses to Child Sexual
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APPENDICES

Appendix A Relevant recommendations from other volumes and reports

Volume 6, Making institutions child safe

Creating child safe communities through prevention (Chapter 2)

Recommendation 6.1

The Australian Government should establish a mechanism to oversee the development and implementation of a national strategy to prevent child sexual abuse. This work should be undertaken by the proposed National Office for Child Safety (see Recommendation 6.16 and 6.17 in Volume 6, Chapter 3 ‘What makes institutions safer for children’), and be included in the National Framework for Child Safety (see Recommendation 6.15 in Volume 6, Chapter 3 ‘What makes institutions safer for children’).

What makes institutions safer for children (Chapter 3)

Recommendation 6.4

All institutions should uphold the rights of the child. Consistent with Article 3 of the United Nations Convention on the Rights of the Child, all institutions should act with the best interests of the child as a primary consideration. In order to achieve this, institutions should implement the Child Safe Standards identified by the Royal Commission.

Recommendation 6.5

The Child Safe Standards are:

1. Child safety is embedded in institutional leadership, governance and culture
2. Children participate in decisions affecting them and are taken seriously
3. Families and communities are informed and involved
4. Equity is upheld and diverse needs are taken into account
5. People working with children are suitable and supported
6. Processes to respond to complaints of child sexual abuse are child focused
7. Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training
8. Physical and online environments minimise the opportunity for abuse to occur
9. Implementation of the Child Safe Standards is continuously reviewed and improved
10. Policies and procedures document how the institution is child safe.

Recommendation 6.6

Institutions should be guided by the following core components when implementing the Child Safe Standards:

Standard 1: Child safety is embedded in institutional leadership, governance and culture

- a. The institution publicly commits to child safety and leaders champion a child safe culture.
- b. Child safety is a shared responsibility at all levels of the institution.
- c. Risk management strategies focus on preventing, identifying and mitigating risks to children.
- d. Staff and volunteers comply with a code of conduct that sets clear behavioural standards towards children.
- e. Staff and volunteers understand their obligations on information sharing and recordkeeping.

Standard 2: Children participate in decisions affecting them and are taken seriously

- a. Children are able to express their views and are provided opportunities to participate in decisions that affect their lives.
- b. The importance of friendships is recognised and support from peers is encouraged, helping children feel safe and be less isolated.
- c. Children can access sexual abuse prevention programs and information.
- d. Staff and volunteers are attuned to signs of harm and facilitate child-friendly ways for children to communicate and raise their concerns.

Standard 3: Families and communities are informed and involved

- a. Families have the primary responsibility for the upbringing and development of their child and participate in decisions affecting their child.
- b. The institution engages in open, two-way communication with families and communities about its child safety approach and relevant information is accessible.
- c. Families and communities have a say in the institution's policies and practices.
- d. Families and communities are informed about the institution's operations and governance.

Standard 4: Equity is upheld and diverse needs are taken into account

- a. The institution actively anticipates children's diverse circumstances and responds effectively to those with additional vulnerabilities.
- b. All children have access to information, support and complaints processes.
- c. The institution pays particular attention to the needs of Aboriginal and Torres Strait Islander children, children with disability, and children from culturally and linguistically diverse backgrounds.

Standard 5: People working with children are suitable and supported

- a. Recruitment, including advertising and screening, emphasises child safety.
- b. Relevant staff and volunteers have Working With Children Checks.
- c. All staff and volunteers receive an appropriate induction and are aware of their child safety responsibilities, including reporting obligations.
- d. Supervision and people management have a child safety focus.

Standard 6: Processes to respond to complaints of child sexual abuse are child focused

- a. The institution has a child-focused complaint handling system that is understood by children, staff, volunteers and families.
- b. The institution has an effective complaint handling policy and procedure which clearly outline roles and responsibilities, approaches to dealing with different types of complaints and obligations to act and report.
- c. Complaints are taken seriously, responded to promptly and thoroughly, and reporting, privacy and employment law obligations are met.

Standard 7: Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training

- a. Relevant staff and volunteers receive training on the nature and indicators of child maltreatment, particularly institutional child sexual abuse.
- b. Staff and volunteers receive training on the institution's child safe practices and child protection.
- c. Relevant staff and volunteers are supported to develop practical skills in protecting children and responding to disclosures.

Standard 8: Physical and online environments minimise the opportunity for abuse to occur

- a. Risks in the online and physical environments are identified and mitigated without compromising a child's right to privacy and healthy development.
- b. The online environment is used in accordance with the institution's code of conduct and relevant policies.

Standard 9: Implementation of the Child Safe Standards is continuously reviewed and improved

- a. The institution regularly reviews and improves child safe practices.
- b. The institution analyses complaints to identify causes and systemic failures to inform continuous improvement.

Standard 10: Policies and procedures document how the institution is child safe

- a. Policies and procedures address all Child Safe Standards.
- b. Policies and procedures are accessible and easy to understand.
- c. Best practice models and stakeholder consultation inform the development of policies and procedures.
- d. Leaders champion and model compliance with policies and procedures.
- e. Staff understand and implement the policies and procedures.

Improving child safe approaches (Chapter 4)

State and territory governments

Recommendation 6.8

State and territory governments should require all institutions in their jurisdictions that engage in child-related work to meet the Child Safe Standards identified by the Royal Commission at Recommendation 6.5.

Recommendation 6.9

Legislative requirements to comply with the Child Safe Standards should cover institutions that provide:

- a. accommodation and residential services for children, including overnight excursions or stays
- b. activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children
- c. childcare or childminding services
- d. child protection services, including out-of-home care
- e. activities or services where clubs and associations have a significant membership of, or involvement by, children
- f. coaching or tuition services for children
- g. commercial services for children, including entertainment or party services, gym or play facilities, photography services, and talent or beauty competitions
- h. services for children with disability

- i. education services for children
- j. health services for children
- k. justice and detention services for children, including immigration detention facilities
- l. transport services for children, including school crossing services.

Recommendation 6.10

State and territory governments should ensure that

- a. 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
- b. the independent oversight body is able to delegate responsibility for monitoring and enforcing the Child Safe Standards to another state or territory government body, such as a sector regulator
- c. regulators take a responsive and risk-based approach when monitoring compliance with the Child Safe Standards and, where possible, utilise existing regulatory frameworks to monitor and enforce the Child Safe Standards.

Recommendation 6.11

Each independent state and territory oversight body should have the following additional functions:

- a. provide advice and information on the Child Safe Standards to institutions and the community
- b. collect, analyse and publish data on the child safe approach in that jurisdiction and provide that data to the National Office for Child Safety
- c. partner with peak bodies, professional standards bodies and/or sector leaders to work with institutions to enhance the safety of children
- d. provide, promote or support education and training on the Child Safe Standards to build the capacity of institutions to be child safe
- e. coordinate ongoing information exchange between oversight bodies relating to institutions' compliance with the Child Safe Standards.

Local government

Recommendation 6.12

With support from governments at the national, state and territory levels, local governments should designate child safety officer positions from existing staff profiles to carry out the following functions:

- a. developing child safe messages in local government venues, grounds and facilities
- b. assisting local institutions to access online child safe resources
- c. providing child safety information and support to local institutions on a needs basis
- d. supporting local institutions to work collaboratively with key services to ensure child safe approaches are culturally safe, disability aware and appropriate for children from diverse backgrounds.

Australian Government

Recommendation 6.13

The Australian Government should require all institutions that engage in child-related work for the Australian Government, including Commonwealth agencies, to meet the Child Safe Standards identified by the Royal Commission at Recommendation 6.5.

Recommendation 6.14

The Australian Government should be responsible for the following functions:

- a. evaluate, publicly report on, and drive the continuous improvement of the implementation of the Child Safe Standards and their outcomes
- b. coordinate the direct input of children and young people into the evaluation and continuous improvement of the Child Safe Standards
- c. coordinate national capacity building and support initiatives and opportunities for collaboration between jurisdictions and institutions
- d. develop and promote national strategies to raise awareness and drive cultural change in institutions and the community to support child safety.

National Framework for Child Safety

Recommendation 6.15

The Australian Government should develop a new National Framework for Child Safety in collaboration with state and territory governments. The Framework should:

- a. commit governments to improving the safety of all children by implementing long term child safety initiatives, with appropriate resources, and holding them to account
- b. be endorsed by COAG and overseen by a joint ministerial body
- c. commence after the expiration of the current National Framework for Protecting Australia's Children, no later than 2020
- d. cover broader child safety issues, as well as specific initiatives to better prevent and respond to institutional child sexual abuse including initiatives recommended by the Royal Commission
- e. include links to other related policy frameworks.

National Office for Child Safety

Recommendation 6.16

The Australian Government should establish a National Office for Child Safety in the Department of the Prime Minister and Cabinet, to provide a response to the implementation of the Child Safe Standards nationally, and to develop and lead the proposed National Framework for Child Safety. The Australian Government should transition the National Office for Child Safety into an Australian Government statutory body within 18 months of this Royal Commission's Final Report being tabled in the Australian Parliament.

Recommendation 6.17

The National Office for Child Safety should report to Parliament and have the following functions:

- a. develop and lead the coordination of the proposed National Framework for Child Safety, including national coordination of the Child Safe Standards
- b. collaborate with state and territory governments to lead capacity building and continuous improvement of child safe initiatives through resource development, best practice material and evaluation
- c. promote the participation and empowerment of children and young people in the National Framework and child safe initiatives
- d. perform the Australian Government's Child Safe Standards functions set out at Recommendation 6.14
- e. lead the community prevention initiatives as set out in Recommendation 6.2.

Recommendation 6.18

The Australian Government should create a ministerial portfolio with responsibility for children's policy issues, including the National Framework for Child Safety.

Volume 7, Improving institutional responding and reporting

Reporting institutional child sexual abuse (Chapter 2)

Recommendation 7.2

Institutions and state and territory governments should provide mandatory reporters with access to experts who can provide timely advice on child sexual abuse reporting obligations.

Recommendation 7.3

State and territory governments should amend laws concerning mandatory reporting to child protection authorities to achieve national consistency in reporter groups. At a minimum, state and territory governments should also include the following groups of individuals as mandatory reporters in every jurisdiction:

- a. out-of-home care workers (excluding foster and kinship/relative carers)
- b. youth justice workers
- c. early childhood workers
- d. registered psychologists and school counsellors
- e. people in religious ministry.

Improving institutional responses to complaints (Chapter 3)

Recommendation 7.7

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 set out how the institution should respond to complaints of child sexual abuse. The complaint handling policy and procedure should cover:

- a. making a complaint
- b. responding to a complaint
- c. investigating a complaint
- d. providing support and assistance
- e. achieving systemic improvements following a complaint.

Recommendation 7.8

Consistent with Child Safe Standard 1: Child safety is embedded in institutional leadership, governance and culture, institutions should have a clear code of conduct that:

- a. outlines behaviours towards children that the institution considers unacceptable, including concerning conduct, misconduct or criminal conduct
- b. includes a specific requirement to report any concerns, breaches or suspected breaches of the code to a person responsible for handling complaints in the institution or to an external authority when required by law and/or the institution's complaint handling policy
- c. outlines the protections available to individuals who make complaints or reports in good faith to any institution engaging in child-related work (see Recommendation 7.6 on reporter protections).

Oversight of institutional complaint handling (Chapter 4)

Recommendation 7.9

State and territory governments should establish nationally consistent legislative schemes (reportable conduct schemes), based on the approach adopted in New South Wales, which oblige heads of institutions to notify an oversight body of any reportable allegation, conduct or conviction involving any of the institution's employees.

Recommendation 7.12

Reportable conduct schemes should cover institutions that:

- exercise a high degree of responsibility for children
- engage in activities that involve a heightened risk of child sexual abuse, due to institutional characteristics, the nature of the activities involving children, or the additional vulnerability of the children the institution engages with.

At a minimum, these should include institutions that provide:

- a. accommodation and residential services for children, including
 - i. housing or homelessness services that provide overnight beds for children and young people
 - ii. providers of overnight camps
- b. activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children.

- c. childcare services, including
 - i. approved education and care services under the Education and Care Services National Law
 - ii. approved occasional care services
- d. child protection services and out-of-home care, including
 - i. child protection authorities and agencies
 - ii. providers of foster care, kinship care or relative care
 - iii. providers of family group homes
 - iv. providers of residential care
- e. disability services and supports for children with disability, including
 - i. disability service providers under state and territory legislation
 - ii. registered providers of supports under the National Disability Insurance Scheme
- f. education services for children, including
 - i. government and non-government schools
 - ii. TAFEs and other institutions registered to provide senior secondary education or training, courses for overseas students or student exchange programs
- g. health services for children, including
 - i. government health departments and agencies, and statutory corporations
 - ii. public and private hospitals
 - iii. providers of mental health and drug or alcohol treatment services that have inpatient beds for children and young people
- h. justice and detention services for children, including
 - i. youth detention centres
 - ii. immigration detention facilities.

Volume 8, Recordkeeping and information sharing

Records and recordkeeping (Chapter 2)

Minimum retention periods

Recommendation 8.1

To allow for delayed disclosure of abuse by victims and take account of limitation periods for civil actions for child sexual abuse, institutions that engage in child-related work should retain, for at least 45 years, records relating to child sexual abuse that has occurred or is alleged to have occurred.

Records and recordkeeping principles

Recommendation 8.4

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.

Principle 1: 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.

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.

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 that 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.

Strengthening information-sharing arrangements (Chapter 3)

Elements of a national information exchange scheme

Recommendation 8.6

The Australian Government and state and territory governments should make nationally consistent legislative and administrative arrangements, in each jurisdiction, for a specified range of bodies (prescribed bodies) to share information related to the safety and wellbeing of children, including information relevant to child sexual abuse in institutional contexts (relevant information). These arrangements should be made to establish an information exchange scheme to operate in and across Australian jurisdictions.

Recommendation 8.7

In establishing the information exchange scheme, the Australian Government and state and territory governments should develop a minimum of nationally consistent provisions to:

- a. enable direct exchange of relevant information between a range of prescribed bodies, including service providers, government and non-government agencies, law enforcement agencies, and regulatory and oversight bodies, which have responsibilities related to children's safety and wellbeing
- b. permit prescribed bodies to provide relevant information to other prescribed bodies without a request, for purposes related to preventing, identifying and responding to child sexual abuse in institutional contexts
- c. require prescribed bodies to share relevant information on request from other prescribed bodies, for purposes related to preventing, identifying and responding to child sexual abuse in institutional contexts, subject to limited exceptions
- d. explicitly prioritise children's safety and wellbeing and override laws that might otherwise prohibit or restrict disclosure of information to prevent, identify and respond to child sexual abuse in institutional contexts
- e. provide safeguards and other measures for oversight and accountability to prevent unauthorised sharing and improper use of information obtained under the information exchange scheme
- f. require prescribed bodies to provide adversely affected persons with an opportunity to respond to untested or unsubstantiated allegations, where such information is received under the information exchange scheme, prior to taking adverse action against such persons, except where to do so could place another person at risk of harm.

Supporting implementation and operation

Recommendation 8.8

The Australian Government, state and territory governments, and prescribed bodies should work together to ensure that the implementation of our recommended information exchange scheme is supported with education, training and guidelines. Education, training and guidelines should promote understanding of, and confidence in, appropriate information sharing to better prevent, identify and respond to child sexual abuse in institutional contexts, including by addressing:

- a. impediments to information sharing due to limited understanding of applicable laws
- b. unauthorised sharing and improper use of information.

Carers registers (Chapter 4)

Recommendation 8.17

State and territory governments should introduce legislation to establish carers registers in their respective jurisdictions, with national consistency in relation to:

- a. the inclusion of the following carer types on the carers register:
 - i. foster carers
 - ii. relative/kinship carers
 - iii. residential care staff
- b. the types of information which, at a minimum, should be recorded on the register
- c. the types of information which, at a minimum, must be made available to agencies or bodies with responsibility for assessing, authorising or supervising carers, or other responsibilities related to carer suitability and safety of children in out-of-home care.

Recommendation 8.18

Carers registers should be maintained by state and territory child protection agencies or bodies with regulatory or oversight responsibility for out-of-home care in that jurisdiction.

Recommendation 8.19

State and territory governments should consider the need for carers registers to include, at a minimum, the following information (register information) about, or related to, applicant or authorised carers, and persons residing on the same property as applicant/authorised home-based carers (household members):

- a. lodgement or grant of applications for authorisation
- b. status of the minimum checks set out in Recommendation 12.6 as requirements for authorisation, indicating their outcomes as either satisfactory or unsatisfactory
- c. withdrawal or refusal of applications for authorisation in circumstances of concern (including in relation to child sexual abuse)
- d. cancellation or surrender of authorisation in circumstances of concern (including in relation to child sexual abuse)
- e. previous or current association, with an out-of-home care agency, whether by application for authorisation, assessment, grant of authorisation, or supervision
- f. the date of reportable conduct allegations, and their status as either current, finalised with ongoing risk-related concerns, and/or requiring contact with the reportable conduct oversight body.

Recommendation 8.20

State and territory governments should consider the need for legislative and administrative arrangements to require responsible agencies to:

- a. record register information in minimal detail
- b. record register information as a mandatory part of carer authorisation
- c. update register information about authorised carers.

Recommendation 8.21

State and territory governments should consider the need for legislative and administrative arrangements to require responsible agencies:

- a. before they authorise or recommend authorisation of carers, to:
 - i. undertake a check for relevant register information, and
 - ii. seek further relevant information from another out-of-home care agency where register information indicates applicant carers, or their household members (in the case of prospective home-based carers) have a prior or current association with that other agency
- b. in the course of their assessment, authorisation, or supervision of carers, to:
 - i. seek further relevant information from other agencies or bodies, where register information indicates they hold, or may hold, additional information relevant to carer suitability, including reportable conduct information.

State and territory governments should give consideration to enabling agencies to seek further information for these purposes under our recommended information exchange scheme (Recommendations 8.6–8.8).

Recommendation 8.22

State and territory governments should consider the need for effective mechanisms to enable agencies and bodies to obtain relevant information from registers in any state or territory holding such information. Consideration should be given to legislative and administrative arrangements, and digital platforms, which will enable:

- a. agencies responsible for assessing, authorising or supervising carers
- b. other agencies, including jurisdictional child protection agencies and regulatory and oversight bodies, with responsibilities related to the suitability of persons to be carers and the safety of children in out-of-home care

to obtain relevant information from their own and other jurisdictions' registers for the purpose of exercising their responsibilities and functions.

Recommendation 8.23

In considering the legislative and administrative arrangements required for carers registers in their jurisdiction, state and territory governments should consider the need for guidelines and training to promote the proper use of carers registers for the protection of children in out-of-home care. Consideration should also be given to the need for specific safeguards to prevent inappropriate use of register information.

Volume 9, Advocacy, support and therapeutic treatment services

National leadership to reduce stigma, promote help-seeking and support good practice

Recommendation 9.9

The Australian Government, in conjunction with state and territory governments, should establish and fund a national centre to raise awareness and understanding of the impacts of child sexual abuse, support help-seeking and guide best practice advocacy and support and therapeutic treatment. The national centre's functions should be to:

- a. raise community awareness and promote destigmatising messages about the impacts of child sexual abuse
- b. increase practitioners' knowledge and competence in responding to child and adult victims and survivors by translating knowledge about the impacts of child sexual abuse and the evidence on effective responses into practice and policy. This should include activities to:
 - i. identify, translate and promote research in easily available and accessible formats for advocacy and support and therapeutic treatment practitioners
 - ii. produce national training materials and best practice clinical resources
 - iii. partner with training organisations to conduct training and workforce development programs
 - iv. influence national tertiary curricula to incorporate child sexual abuse and trauma-informed care
 - v. inform government policy making
- c. lead the development of better service models and interventions through coordinating a national research agenda and conducting high quality program evaluation.

The national centre should partner with survivors in all its work, valuing their knowledge and experience.

Volume 10, Children with harmful sexual behaviours

A framework for improving responses

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).

Harmful sexual behaviours by children should be addressed through each of the following:

- a. primary prevention strategies to educate family, community members, carers and professionals (including mandatory reporters) about preventing harmful sexual behaviours
- b. secondary prevention strategies to ensure early intervention when harmful sexual behaviours are developing
- c. tertiary intervention strategies to address harmful sexual behaviours.

Improving assessment and therapeutic intervention

Recommendation 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.

Recommendation 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.

Redress and civil litigation report

Duty of institutions

Recommendation 89

State and territory governments should introduce legislation to impose a non-delegable duty on certain institutions for institutional child sexual abuse despite it being the deliberate criminal act of a person associated with the institution.

Recommendation 90

The non-delegable duty should apply to institutions that operate the following facilities or provide the following services and be owed to children who are in the care, supervision or control of the institution in relation to the relevant facility or service:

- a. residential facilities for children, including residential out-of-home care facilities and juvenile detention centres but not including foster care or kinship care
- b. day and boarding schools and early childhood education and care services, including long day care, family day care, outside school hours services and preschool programs
- c. disability services for children
- d. health services for children
- e. any other facility operated for profit which provides services for children that involve the facility having the care, supervision or control of children for a period of time but not including foster care or kinship care
- f. any facilities or services operated or provided by religious organisations, including activities or services provided by religious leaders, officers or personnel of religious organisations but not including foster care or kinship care.

Recommendation 91

Irrespective of whether state and territory parliaments legislate to impose a non-delegable duty upon institutions, state and territory governments should introduce legislation to make institutions liable for institutional child sexual abuse by persons associated with the institution unless the institution proves it took reasonable steps to prevent the abuse. The 'reverse onus' should be imposed on all institutions, including those institutions in respect of which we do not recommend a non-delegable duty be imposed.

Recommendation 92

For the purposes of both the non-delegable duty and the imposition of liability with a reverse onus of proof, the persons associated with the institution should include the institution's officers, office holders, employees, agents, volunteers and contractors. For religious organisations, persons associated with the institution also include religious leaders, officers and personnel of the religious organisation.

Recommendation 93

State and territory governments should ensure that the non-delegable duty and the imposition of liability with a reverse onus of proof apply prospectively and not retrospectively.

Criminal justice report

Moral or ethical duty to report to police

Recommendation 32

Any person associated with an institution who knows or suspects that a child is being or has been sexually abused in an institutional context should report the abuse to police (and, if relevant, in accordance with any guidelines the institution adopts in relation to blind reporting under Recommendation 16).

Failure to report

Recommendation 33

Each state and territory government should introduce legislation to create a criminal offence of failure to report targeted at child sexual abuse in an institutional context as follows:

- a. The failure to report offence should apply to any adult person who
 - i. is an owner, manager, staff member or volunteer of a relevant institution – this includes persons in religious ministry and other officers or personnel of religious institutions
 - ii. otherwise requires a Working With Children Check clearance for the purposes of their role in the institution

but it should not apply to individual foster carers or kinship carers.

- b. The failure to report offence should apply if the person fails to report to police in circumstances where they know, suspect, or should have suspected (on the basis that a reasonable person in their circumstances would have suspected and it was criminally negligent for the person not to suspect), that an adult associated with the institution was sexually abusing or had sexually abused a child.
- c. Relevant institutions should be defined to include institutions that operate facilities or provide services to children in circumstances where the children are in the care, supervision or control of the institution. Foster and kinship care services should be included (but not individual foster carers or kinship carers). Facilities and services provided by religious institutions, and any services or functions performed by persons in religious ministry, should be included.
- d. If the knowledge is gained or the suspicion is or should have been formed after the failure to report offence commences, the failure to report offence should apply if any of the following circumstances apply
 - i. A child to whom the knowledge relates or in relation to whom the suspicion is or should have been formed is still a child (that is, under the age of 18 years).
 - ii. The person who is known to have abused a child or is or should have been suspected of abusing a child is either
 - still associated with the institution
 - known or believed to be associated with another relevant institution.
 - iii. The knowledge gained or the suspicion that is or should have been formed relates to abuse that may have occurred within the previous 10 years.
- e. If the knowledge is gained or the suspicion is or should have been formed before the failure to report offence commences, the failure to report offence should apply if any of the following circumstances apply
 - i. A child to whom the knowledge relates or in relation to whom the suspicion is or should have been formed is still a child (that is, under the age of 18 years) and is still associated with the institution (that is, they are still in the care, supervision or control of the institution).
 - ii. The person who is known to have abused a child or is or should have been suspected of abusing a child is either
 - still associated with the institution
 - known or believed to be associated with another relevant institution.

Failure to protect

Recommendation 36

State and territory governments should introduce legislation to create a criminal offence of failure to protect a child within a relevant institution from a substantial risk of sexual abuse by an adult associated with the institution as follows:

- a. The offence should apply where
 - i. an adult person knows that there is a substantial risk that another adult person associated with the institution will commit a sexual offence against
 - a child under 16
 - a child of 16 or 17 years of age if the person associated with the institution is in a position of authority in relation to the child
 - ii. the person has the power or responsibility to reduce or remove the risk
 - iii. the person negligently fails to reduce or remove the risk.
- b. The offence should not be able to be committed by individual foster carers or kinship carers.
- c. Relevant institutions should be defined to include institutions that operate facilities or provide services to children in circumstances where the children are in the care, supervision or control of the institution. Foster care and kinship care services should be included, but individual foster carers and kinship carers should not be included. Facilities and services provided by religious institutions, and any service or functions performed by persons in religious ministry, should be included.
- d. State and territory governments should consider the Victorian offence in section 49C of the *Crimes Act 1958* (Vic) as a useful precedent, with an extension to include children of 16 or 17 years of age if the person associated with the institution is in a position of authority in relation to the child.

Appendix B Practical guidance for implementing the Child Safe Standards

This appendix describes initiatives, actions and practices to implement the Child Safe Standards. While it is a general guide for institutions, the information is not exhaustive and institutions should make their own decisions about implementing the standards. We acknowledge some actions listed below may not be practicable or necessary for some institutions.

Standard 1: Child safety is embedded in institutional leadership, governance and culture

A child safe institution is committed to child safety. This commitment should be supported at all levels of the institution and be embedded in an institution's leadership, governance and culture, and all aspects of the institution's business and practice.

Institutional culture consists of the collective values and practices that guide the attitudes and behaviour of staff and volunteers. It guides the way things are done and the way issues are managed, dealt with and responded to. A positive, child-focused culture could help to protect children from sexual abuse and facilitate the identification of and proper response to child sexual abuse.

The standard's core components

We consider the core components of leadership, governance and culture in a child safe institution to be the following:

- a. The institution publicly commits to child safety and leaders champion a child safe culture.
- b. Child safety is a shared responsibility at all levels of the institution.
- c. Risk management strategies focus on preventing, identifying and mitigating risks to children.
- d. Staff and volunteers comply with a code of conduct that sets clear behavioural standards towards children.
- e. Staff and volunteers understand their obligations on information sharing and recordkeeping.

Implementing the core components

The institution publicly commits to child safety and leaders champion a child safe culture

The institution:

- explains in publicly available information how the institution is meeting its commitment to child safety and welcomes feedback
- addresses child safety in duty statements and performance agreements for all staff, including senior leaders and board members
- raises staff awareness about obligations to protect the safety and wellbeing of children within a broader context of supporting children's rights
- establishes and maintains a workplace culture of respect for children, regardless of their individual characteristics, cultural backgrounds and abilities
- lists child safety as a standing meeting agenda item.

Child safety is a shared responsibility at all levels of the institution

To embed this responsibility in the institution's culture:

- children's cultural safety is addressed in the institution's policies and procedures
- information about child safety is accessible, regularly promoted, and staff, volunteers, children and families are encouraged to raise safety issues without fear of retribution
- staff, volunteers, children and families report that they know that child safety is everyone's responsibility and they feel empowered to have a say in and influence decisions about child safety.

Leaders of the institution:

- inform themselves about all aspects of child safety
- model and foster a commitment to child safe practices
- set accountabilities for child safe principles at all levels of the institution's governance structure
- understand the problem of child sexual abuse
- foster a culture that supports anyone to disclose safely their concerns about harm to children
- appoint to the institution's board a Child Safe Trustee or Children's Champion who is willing and able to advocate on behalf of children, and a Child Protection Coordinator who reports to the executive about the institution's child safe performance.

Staff are made aware of their responsibilities through:

- duty statements that identify roles and responsibilities (including child safety) for all positions
- an organisational chart that shows lines of authority, reporting and accountability for each position.

Risk management strategies focus on preventing, identifying and mitigating risks to children

Risk management strategies support a structured approach to identifying and assessing the characteristics of an institution that may heighten the risk of child sexual abuse. They are an important tool to help keep children safe.

The institution's risk management strategy:

- is developed from a clear, evidence-informed concept of potential intentional and unintentional risks to children in an institution's specific setting. For sexual abuse, it requires knowing the characteristics of abusers and victims, and how, when and where abuse tends to occur
- has a prevention focus that addresses child safety
- has appropriate controls to identify, assess and address risks
- considers increased risk with specific roles and activities, and children with heightened vulnerability, but does not discourage positive relationships between adults and children, and healthy child development
- attends more closely to risk in situations where staff have roles that involve working alone with children or without supervision; in private settings; in intimate care routines or situations with children (for example, bathing, dressing, or counselling and guidance); and in leading or supervising others in child safety roles.

For more information, see Standard 6 below and Chapter 3 of Volume 7, *Improving institutional responding and reporting*.

Staff and volunteers comply with a code of conduct that sets clear behavioural standards towards children

A code of conduct sets out clear behavioural standards, practices or rules that are expected of individuals in an institution. This includes standards of behaviour that are expected between adults and children.

The institution's code of conduct:

- applies to all staff and volunteers, including senior leaders and board members
- clearly describes acceptable and unacceptable behaviour of employees and volunteers towards children (for example, by illustrating behaviours with relevant examples)
- is communicated effectively to all staff
- requires signed acknowledgement by all staff and volunteers
- is published, accessible to everyone within the institution (including children and families) and communicated throughout the institution using a range of modes and mechanisms
- if breached, requires a prompt response and includes clearly documented response mechanisms, on a continuum from remedial education and counselling through to suspension, termination and official reports.

For more information, see Standard 6 below and Chapter 3 of Volume 7, *Improving institutional responding and reporting*.

Staff and volunteers understand their obligations on information sharing and recordkeeping

Within the institution:

- staff and volunteers are aware of and understand their obligations in relation to data collection, information sharing and recordkeeping
- records are stored in accordance with best practice principles for access and use.

Standard 2: Children participate in decisions affecting them and are taken seriously

Children are safer when institutions acknowledge and teach them about their rights to be heard, listened to and taken seriously. Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) details the rights of a child to express their views and participate in decisions that affect their lives. Enabling children and young people to understand, identify and raise their safety concerns with a trusted adult and to feel safe within the institution is important.

A child safe institution is one that seeks the views of children and considers their age, development, maturity, understanding, abilities and the different formats and means of communication they may use. It provides children with formal and informal opportunities to share their views on institutional issues. Children can access sexual abuse prevention programs and information, and feel confident to complain, for example, by using helplines. Staff are aware of signs of harm, including unexplained changes in behaviour, and routinely check children's wellbeing.

The standard's core components

We consider the core components of children's participation and empowerment within an institution to be the following:

- a. Children are able to express their views and are provided opportunities to participate in decisions that affect their lives.
- b. The importance of friendships is recognised and support from peers is encouraged, helping children feel safe and be less isolated.
- c. Children can access sexual abuse prevention programs and information.
- d. Staff and volunteers are attuned to signs of harm and facilitate child-friendly ways for children to communicate and raise their concerns.

Implementing the core components

Children are able to express their views and are provided opportunities to participate in decisions that affect their lives

The institution:

- asks children to participate and talk about the things that affect their lives, including their safety
- embeds children's participation into institutional practices, for example, by providing opportunities for children to participate in decisions that affect their lives
- matches participation methods to the age, capabilities and cultural background of the children, and the type of institution
- creates opportunities for children to be involved in institutional governance, while also being honest with children about the extent of their involvement and giving children feedback on how their views have been actioned by the institution
- plans formal and informal times and activities for information sharing and discussion with children about broad institutional issues and/or decisions
- provides opportunities for children to give feedback to the institution, including anonymous surveys and/or suggestion boxes.

The importance of friendships is recognised and support from peers is encouraged, helping children feel safe and be less isolated

The institution:

- recognises the importance of children's friendships and peer support in helping children feel safe and be less isolated
- actively supports children to develop and sustain friendships (for example, a 'buddy system')
- provides children with education about safe and respectful peer relationships, including through social media.

Children can access sexual abuse prevention programs and information

The institution:

- provides children with access and referral to educational programs on child protection appropriate to their age, ability and level of understanding
- openly displays contact details for independent child advocacy services and child helpline telephone numbers, and explains their use to children
- arranges appropriate referrals or support for children.

Staff and volunteers are attuned to signs of harm and facilitate child-friendly ways for children to communicate and raise their concerns

The institution:

- establishes mechanisms that enable children to raise any complaints safely
- provides staff with resources and/or training opportunities to support children's participation
- requires staff to be vigilant to signs of harm and routinely check to see if children are okay
- provides child-focused and inclusive complaint handling processes
- allows sufficient time, opportunity and appropriate support for children with disability to raise concerns
- draws on a culturally diverse workforce to nurture and support children's diverse needs and cultural safety
- ensures sufficient time to build healthy relationships between staff, volunteers and children.

Standard 3: Families and communities are informed and involved

A child safe institution observes Article 18 of the UNCRC, which states that parents, carers or significant others with caring responsibilities have the primary responsibility for the upbringing and development of their child. Families and caregivers are engaged with the child safe institution's practices and are involved in decisions affecting their children. Families and caregivers are recognised as playing an important role in monitoring children's wellbeing and helping children to disclose any complaints.

A child safe institution engages with the broader community to better protect the children in its care. Institutions are more likely to foster a child safe culture if the surrounding community values children, respects their rights, and ensures that their rights are fulfilled.

The standard's core components

We consider the core components of family and community involvement in a child safe institution to be the following:

- a. Families have the primary responsibility for the upbringing and development of their child and participate in decisions affecting their child.
- b. The institution engages in open, two-way communication with families and communities about its child safety approach and relevant information is accessible.
- c. Families and communities have a say in the institution's policies and practices.
- d. Families and communities are informed about the institution's operations and governance.

Implementing the core components

Families have the primary responsibility for the upbringing and development of their child and participate in decisions affecting their child

The institution:

- supports families to take an active role in monitoring children's safety across institutions
- clearly describes the roles and responsibilities of parents and carers to ensure the safe participation of children
- keeps families informed of progress and actions relating to any complaint, and discusses matters with families and carers in accordance with the law
- if it has specific expertise, may take a leadership role in raising community awareness of child sexual abuse in institutional contexts.

The institution engages in open, two-way communication with families and communities about its child safety approach and relevant information is accessible

The institution:

- ensures families have seen/read information stating the institution's commitment to child safety and detailing actions it will take to meet this commitment
- ensures families know where to find the institution's code of conduct and child safe policies and procedures (these may be transmitted in fact sheets, information sessions or apps)
- ensures families know how, when and to whom complaints should be made
- uses multiple strategies and modes for communicating institutional policies and activities with families
- ensures institutional communications are publicly available, current, clear, timely, and delivered in multiple modes and formats as appropriate to a diverse stakeholder audience, taking into account cultural relevance and different levels of English language skills
- allows sufficient time to establish a rapport with families and communities, particularly for children with heightened vulnerability
- identifies barriers to communication and enacts specific strategies to overcome them.

Families and communities have a say in the institution's policies and practices

The institution:

- consults families and communities on the development of institutional policies and practices
- consults families and communities on institutional decisions, where feasible and appropriate.

Families and communities are informed about the institution's operations and governance

The institution:

- ensures families are aware of the institution's leadership team and their roles
- ensures families are aware of the roles and responsibilities of the staff delivering services directly to their children.

Standard 4: Equity is upheld and diverse needs are taken into account

Equity and non-discrimination are central tenets of the UNCRC. Article 2 emphasises non-discrimination and a commitment to fulfil children's rights 'irrespective of ... [their] race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status'. Just as the safety of children should not depend on where they live, their right to safety should not depend on their social or economic position, their cultural context or their abilities and impairments.

A child safe institution pays attention to equity by taking into account children's diverse circumstances. It recognises that some children are more vulnerable to sexual abuse than others, or find it harder to speak up and be heard, and makes the necessary adjustments to equally protect all children. A child safe institution would tailor standard procedures to ensure these children have fair access to the relationships, skills, knowledge and resources they need to be safe, in equal measure with their peers.

The standard's core components

We consider the core components of upholding equity and meeting diverse needs of children in an institution to be the following:

- a. The institution actively anticipates children's diverse circumstances and backgrounds and responds effectively to those with additional vulnerabilities.
- b. All children have access to information, support and complaints processes.
- c. The institution pays particular attention to the needs of Aboriginal and Torres Strait Islander children, children with disability, and children from culturally and linguistically diverse backgrounds.

Implementing the core components

The institution actively anticipates children's diverse circumstances and backgrounds and responds effectively to those with additional vulnerabilities

The institution:

- learns about circumstances and experiences that increase a child's vulnerability to harm or abuse in institutional contexts
- understands barriers that prevent children from disclosing abuse or adults from recognising children's disclosures, with particular attention to children's cultural contexts, languages, cognitive capabilities and communication needs
- takes action to minimise barriers to disclosure
- focuses particular attention on safety in closed or segregated environments, such as out-of-home care, boarding schools, youth detention, some religious institutions, specialist education facilities and disability support settings
- consults with a range of stakeholders from diverse backgrounds and with the necessary expertise (including children, families and communities) in developing institutional strategies for addressing all of the Child Safe Standards.

All children have access to information, support and complaints processes

The institution:

- recognises and respects diverse backgrounds, identities, needs and preferences
- provides culturally safe and culturally responsive child-friendly services
- uses translation services and bicultural workers with knowledge of child abuse issues, particularly to facilitate disclosure, reporting and complaint handling
- provides accessible information in multiple formats for individuals with different levels of English literacy and proficiency, modes of communication, languages and cognitive abilities
- accesses external expert advice when required, such as cultural advice or disability support.

The institution pays particular attention to the needs of Aboriginal and Torres Strait Islander children, children with disability, and children from culturally and linguistically diverse backgrounds

The institution:

- strives for a workforce that reflects diversity of cultures, abilities and identities
- implements awareness training as part of induction and ongoing staff education, with specific content related to Aboriginal and Torres Strait Islander children, children with disability, children from culturally and linguistically diverse backgrounds, and others with particular experiences and needs

- makes clear reference in its policies and procedures to additional considerations related to Aboriginal and Torres Strait Islander cultures, disability, culturally and linguistically diverse backgrounds, and other experiences and needs
- implements and monitors the outcomes of specific strategies tailored to the needs of Aboriginal and Torres Strait Islander children, children with disability, and children from culturally and linguistically diverse backgrounds, to ensure their safety and participation in the organisation.

Standard 5: People working with children are suitable and supported

Human resource management, through screening, recruitment and ongoing performance review, can play an important role in protecting children from harm.

Child-focused human resource practices help screen out people unsuitable for working with children or discourage their application. Such practices make sure child safety is prioritised in advertising, recruiting, employment screening, and selecting and managing staff and volunteers. During induction processes, all staff and volunteers should be given clear conduct and behavioural guidelines, such as a code of conduct. Child safe institutions recognise that Working With Children Checks can detect only a subset of people who are unsuitable to work with children, and that these checks should be part of a suite of screening practices.

The standard's core components

We consider the core components of human resource management in a child safe institution to be the following:

- a. Recruitment, including advertising and screening, emphasises child safety.
- b. Relevant staff and volunteers have Working With Children Checks.
- c. All staff and volunteers receive an appropriate induction and are aware of their child safety responsibilities, including reporting obligations.
- d. Supervision and people management have a child safety focus.

Implementing the core components

Recruitment, including advertising and screening, emphasises child safety

Employment advertising packages include:

- the organisation's statement of commitment to being a child safe institution
- the institution's code of conduct, and child safe policy and procedures
- specific selection criteria concerning attitudes to and application of child safety measures to which applicants must respond
- job descriptions and duty statements that set clear expectations about child safety, including induction and training.

Recruitment, selection and screening procedures:

- show clearly documented recruitment procedures and processes
- verify applicants' identity, qualifications and professional registration
- involve children and/or families where feasible and appropriate
- include thorough, structured interviews
 - providing clear information to applicants about the institutional commitment to child safety
 - assessing the values, motives and attitudes of job applicants who will work directly with children
 - establishing why the applicant is leaving their current job
 - thoroughly assessing the applicant's professional experience, qualifications and competence to work with children
- include stringent and careful reference checks
 - involving direct conversations with at least two professional referees
 - including the applicant's current or most recent employer
 - ascertaining, where possible, the applicant's attitudes and behaviours in previous child-related roles
 - ascertaining whether the applicant has ever been involved in any complaint processes
- check that staff have formal qualifications commensurate with their role and responsibilities, or are informed they will be expected to engage with and qualify in relevant study

- encourage a culturally diverse workforce to nurture and support children's cultural safety
- ensure human resources staff and interview panels have the appropriate education and training to dispense their obligations appropriately and effectively
- are followed by recruitment agencies, labour suppliers, contractors and volunteers.

Relevant staff and volunteers have Working With Children Checks

The institution:

- requires staff and volunteers to undertake screening procedures including criminal history checks to assess a person's fitness to work with children as specified in law (for example, Working With Children Checks)
- builds in allowance for revalidation.

All staff and volunteers receive an appropriate induction and are aware of their child safety responsibilities, including reporting obligations

The institution's induction for new staff and volunteers:

- is a documented process and tracked through a register for new staff and volunteers
- occurs immediately after appointment and, ideally, before work with children begins
- provides instruction on
 - children's rights
 - respect for children, regardless of their individual characteristics, cultural backgrounds, and abilities
 - the code of conduct and child safe policies and procedures
 - strategies that identify, assess and minimise risk to children
 - how to respond to a disclosure from a child
 - complaints processes, including how to respond to a complaint about behaviour towards children
 - reporting obligations (including mandatory reporting) and procedures including format, content and destinations for reports
 - protections for whistleblowers
- is more detailed for staff working in roles and situations with higher risk, for example, with children who may be more vulnerable to maltreatment
- is reviewed regularly.

Supervision and people management have a child safety focus

The institution's people management includes:

- a probationary employment period for new staff and volunteers, to allow time to assess suitability to the position
- regular reviews of staff and volunteer performance, including adherence to the code of conduct and child safe policies and procedures
- opportunities to formally or informally raise concerns about harm or risk of harm to children
- appropriate responses to concerns about performance in the institution's code of conduct
- feedback on staff performance from children and/or families, where feasible and appropriate
- a structure and process for professional supervision and support.

Standard 6: Processes to respond to complaints of child sexual abuse are child focused

A child-focused complaints process is an important strategy for helping children and others in institutions to make complaints. Child safe institutions respond to complaints by immediately protecting children at risk and addressing complaints promptly, thoroughly and fairly.

A child safe institution has clear and detailed policies and procedures about how to respond to complaints. Staff and volunteers understand their responsibility for making a complaint promptly if they become aware of concerning behaviours, as well as their reporting obligations to external authorities. Complaint processes specify steps that need to be taken to comply with requirements of procedural fairness for affected parties, have review mechanisms, and ensure any disciplinary action that is taken withstands external scrutiny in accordance with relevant employment law and other employer responsibilities.

The standard's core components

We consider the core components of complaint handling in a child safe institution to be the following:

- a. The institution has a child-focused complaint handling system that is understood by children, staff, volunteers and families.
- b. The institution has an effective complaint handling policy and procedure which clearly outline roles and responsibilities, approaches to dealing with different types of complaints and obligations to act and report.
- c. Complaints are taken seriously, responded to promptly and thoroughly, and reporting, privacy and employment law obligations are met.

Implementing the core components

The institution has a child-focused complaint handling system that is understood by children, staff, volunteers and families

The institution:

- ensures children, staff, volunteers and families know who to talk to if they are worried or are feeling unsafe
- takes all complaints seriously and responds promptly and appropriately, as detailed in clear procedures
- has an open culture that supports safe disclosure of risks of harm to children
- provides information in accessible, age-appropriate and meaningful formats to children and families who use the service, mindful of their diverse characteristics, cultural backgrounds and abilities
- offers a variety of avenues for children to make complaints
- provides information about its complaint handling process, including how to make a complaint and what to expect.

The institution has an effective complaint handling policy and procedure which clearly outline roles and responsibilities, approaches to dealing with different types of complaints and obligations to act and report

The institution's complaint handling policy includes:

- approaches to dealing with different types of complaints, including concerns, suspicions, disclosures, allegations and breaches
- links to the code of conduct and definitions of various forms of abuse, including sexual abuse and sexual misconduct
- actions to be taken where the subject of a complaint is a staff member, volunteer, parent, another child or person otherwise associated with the institution. In the case of a staff member, for example, this may include supervision, removal of contact with children or being stood down
- detailed guidance on how institutional members (including senior management, supervisors, staff and volunteers) should respond to allegations, including steps for reporting externally as required by law and/or the complaint handling policy
- communication, referral and support mechanisms for staff, volunteers, children and their families

- approaches to dealing with situations in which a child may cause abuse-related harm to another child
- a clear commitment that no one will be penalised or suffer adverse consequences for making a complaint.

Complaints are taken seriously, responded to promptly and thoroughly, and reporting, privacy and employment law obligations are met

When a complaint is made, the institution can show that:

- children are consulted and have input into the design of a complaint process and access to a support person at all times
- responses are quick and thorough and relevant people are kept informed of the progress, outcomes and resolution of the complaint
- cooperation occurs with investigating authorities, including police
- personal information arising from complaints is treated in accordance with the law
- effective recordkeeping practices are used in accordance with the law
- all complaints are documented regardless of whether the complaint meets statutory reporting thresholds.

Given the significant issues that we have heard regarding complaint handling, further guidance is available in Chapter 3 of Volume 7, *Improving institutional responding and reporting*.

Standard 7: Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training

A child safe institution promotes and provides regular ongoing development opportunities for its staff and volunteers through education and training, beginning with induction. Child safe institutions are ‘learning institutions’, where staff and volunteers at all levels are continually building their ability and capacity to protect children from harm.

This standard is premised on all staff and volunteers receiving comprehensive and regular training, including induction on the institution’s child safe strategies and practices, as well as broader training on child protection.

The standard's core components

We consider the core components of staff education and training in a child safe institution to be the following:

- a. Relevant staff and volunteers receive training on the nature and indicators of child maltreatment, particularly institutional child sexual abuse.
- b. Staff and volunteers receive training on the institution's child safe practices and child protection.
- c. Relevant staff and volunteers are supported to develop practical skills in protecting children and responding to disclosures.

Implementing the core components

Relevant staff and volunteers receive training on the nature and indicators of child maltreatment, particularly institutional child sexual abuse

Training has the following features:

- Training is culturally responsive to the needs of Aboriginal and Torres Strait Islander, migrant, refugee and multi-faith communities and to the needs of people with disability; for example, by being delivered jointly by bilingual and/or bicultural workers and interpreters.
- Training is evidence based and provided by expert trainers relevant to the institutional context.
- Training resources and tools are consistent, simple, accessible and easy to use. Materials are tailored to meet the needs of the particular institution with respect to individual characteristics, cultural backgrounds and abilities, and the roles of workers and volunteers.
- Training covers specific topics including
 - children's rights and children's perceptions of what makes an institution safe
 - respect for children, regardless of their individual characteristics, cultural backgrounds and abilities
 - the indicators of child sexual abuse
 - how to respond to indicators and disclosures of child sexual abuse
 - definitions and examples of child sexual abuse and grooming/manipulation
 - the characteristics of victims, offenders, and risky environments and situations
 - combating stereotypes of both victims and offenders
 - understanding and responding to harmful behaviours by a child towards another child.

- Methods used in training include presentation of information, interactive discussion, values clarification, worked examples, role play and feedback.
- Training programs are regularly and externally reviewed including in response to the emerging evidence base.

Staff and volunteers receive training on the institution's child safe practices and child protection

Training on the institution's policies and practices:

- is provided to all staff on induction and through frequent refresher training (for example, annually)
- includes records of participation to ensure all personnel attend training sessions
- covers institutional risk management, code of conduct, child safe policies and procedures, including specific information on reporting obligations, complaints mechanisms and protections
- includes examples of where, when, how, to whom and by whom child sexual abuse can occur in institutional settings.

Relevant staff and volunteers are supported to develop practical skills in protecting children and responding to disclosures

The institution:

- provides more detailed training for staff working in roles and situations with higher risk, such as closed or segregated settings or with children who may be more vulnerable to maltreatment
- provides training that empowers staff with the knowledge and competencies to identify risks, prevent sexual abuse, report complaints and respond appropriately
- trains senior leaders, supervisors and staff engaged in recruitment processes to be alert to signs of unusual attitudes towards children (for example, if applicants profess to have 'special relationships' with children, disagree with the need for rules about child protection, or have a desire to work with children that seems focused on meeting their own psychological or emotional needs)
- provides advanced training for senior leaders and supervisors and children's champions
- briefs all staff and volunteers on how to respond to children who disclose through a variety of mechanisms
- provides training that prepares staff to respond to critical incidents, such as complaints of child sexual abuse.

Standard 8: Physical and online environments minimise the opportunity for abuse to occur

Certain physical and online environments can pose a risk to children. Institutions seeking to be child safe could improve safety by analysing and addressing these risks, reducing opportunities for harm and increasing the likelihood that perpetrators would be caught.

A child safe institution designs and adapts its physical environment to minimise opportunities for abuse to occur. The institution finds a balance between visibility and children's privacy and their capacity to engage in creative play and other activities. It consults children about physical environments and what makes them feel safe.

Child safe institutions address the potential risks posed in an online environment, educating children and adults about how to avoid harm and how to detect signs of online grooming. The institution articulates clear boundaries for online conduct, and monitors and responds to any breaches of these policies.

The standard's core components

We consider the core components of a child safe physical and online environment to be the following:

- a. Risks in the online and physical environment are identified and mitigated without compromising a child's right to privacy and healthy development.
- b. The online environment is used in accordance with the institution's code of conduct and relevant policies.

Implementing the core components

Risks in the online and physical environment are identified and mitigated without compromising a child's right to privacy and healthy development

To minimise risks, the institution would have the following features:

- effective natural surveillance with few out-of-the-way places, taking into account children's right to privacy
- routine movements of responsible adults to provide formal and informal line-of-sight supervision

- rooms with large, unobstructed windows or observation panels (including for sensitive places such as principals', chaplains' or counsellors' rooms).
- surveillance equipment (for example, CCTV) installed in high-risk environments where natural surveillance is not feasible, taking into account children's right to privacy and complying with sector standards
- consultation with children about physical and online environments and what makes them feel safe
- consideration of the age, gender mix and vulnerabilities of children in the setting
- random checks of obstructed and out-of-the-way locations (for example, dressing rooms, first-aid rooms or sporting grounds away from main buildings)
- open discussions of children's safety, the nature of organisational activities, the quality of equipment and the physical environment
- a strong prevention and awareness focus, by educating children, parents, staff, volunteers and the institution's stakeholder community about online safety and security.

The online environment is used in accordance with the institution's code of conduct and relevant policies

The institution:

- routinely monitors the online environment, reporting breaches of its code of conduct or child safe policies in accordance with the institution's complaint handling processes
- reports serious online offences to police in accordance with mandatory reporting obligations
- provides education and training about the online environment that is consistent with its code of conduct and child protection and other relevant policies, and addresses the use of mobile phones and social media.

Standard 9: Implementation of the Child Safe Standards is continuously reviewed and improved

Child safe institutions know it is a significant challenge to maintain a safe environment for children in a dynamic organisation. The institution's leadership maintains vigilance by putting in place systems to frequently monitor and improve performance against the Child Safe Standards. An open culture encourages people to discuss difficult issues and identify and learn from mistakes. Complaints are an opportunity to identify the root cause of a problem and improve policies and practices to reduce the risk of harm to children. Where appropriate, the institution seeks advice from independent specialist agencies to investigate failures and recommend improvements.

The standard's core components

We consider the core components of continuous review and improvement of child safe practices to be the following:

- a. The institution regularly reviews and improves child safe practices.
- b. The institution analyses complaints to identify causes and systemic failures to inform continuous improvement.

Implementing the core components

The institution regularly reviews and improves child safe practices

The institution:

- regularly reviews and records its implementation of the Child Safe Standards, including improvement mechanisms
- is regularly audited for all of the Child Safe Standards, either internally or externally by an independent, specialist agency
- maintains a culture of awareness to ensure that policies and practices are implemented and routinely reviewed, even though staffing may change.

The institution analyses complaints to identify causes and systemic failures to inform continuous improvement

The institution:

- undertakes a careful and thorough review to identify the root cause of the problem, any systemic issues (including failures), remaining institutional risks and improvements to institutional policies and practices. This is undertaken as soon as a complaint is made, and again when it is finalised
- may consider employing an external expert or agency to offer an independent case review, which should be underpinned by the following key features
 - a preventive, proactive and participatory approach to ensure everyone understands, and has confidence in, the institution's child safety approach
 - accountability for maintaining child safe policies and practices that are communicated, understood and accepted at all levels of the institution
- can show the ways in which policies and practices have changed, when the need for improvement is identified

- if serving children who are at risk, more vulnerable or hard to reach, gives attention to the evolving evidence base in relation to the safety of all children, being mindful of their individual characteristics, cultural backgrounds and abilities
- if employing staff in roles that involve working either alone or without supervision with children, or in intimate care situations with them, gives attention in the institution's review and continuous improvement process to the evolving evidence base in relation to effective risk management in these contexts.

Standard 10: Policies and procedures document how the institution is child safe

A child safe institution has localised policies and procedures that set out how it maintains a safe environment for children. Policies and procedures should address all aspects of the Child Safe Standards. The implementation of child safe policies and procedures is a crucial aspect of facilitating an institution's commitment to them.

The standard's core components

We consider the core components of policies and procedures in a child safe institution to be the following:

- a. Policies and procedures address all Child Safe Standards.
- b. Policies and procedures are accessible and easy to understand.
- c. Best practice models and stakeholder consultation inform the development of policies and procedures.
- d. Leaders champion and model compliance with policies and procedures.
- e. Staff understand and implement the policies and procedures.

Implementing the core components

Policies and procedures address all Child Safe Standards

The institution's policies and procedures incorporate the intent of all Child Safe Standards to ensure the best interests of children are placed at the heart of their operation and central to their purpose.

Policies and procedures are accessible and easy to understand

The institution's child safe policies and procedures are:

- readily and publicly accessible (for example, there is a link to them from the institution's website home page that is no more than three clicks from the home page, or available on public noticeboards)
- downloadable or available as a single Word or PDF document
- provided to staff and volunteers at induction, and communicated further via education and training
- ideally available in multiple modes for individuals with different levels of English literacy and proficiency, modes of communication and access to digital technologies (for example, multiple languages/dialects, visual aids/posters, audio and audio visual resources)
- ideally available in child-friendly and developmentally appropriate formats that pay attention to children's diverse characteristics, cultural backgrounds and abilities
- provided to staff and volunteers at induction, and communicated further via education and training.

Best practice models and stakeholder consultation inform the development of policies and procedures

In institutions working primarily or exclusively with children, policies and procedures are subject to regular external review.

Specific administrative details appear on the policies and procedures document, including:

- the effective date, review date, author(s), and executive approval details
- a list of related documents or policies that must be read in conjunction with the child safe policies and procedures (including relevant legislation, regulations).

The policies and procedures document:

- states the underlying institutional child safety values or principles
- defines terms used in the policy
- specifies to whom the policy applies and the responsibilities of staff and volunteers
- defines the different types of child maltreatment covered by the policy
- lists indicators of possible abuse and how to respond
- specifies legal reporting obligations for staff and volunteers
- includes a diagram that shows reporting chains (for example, a decision tree)
- describes what actions to take if a child is at imminent risk of harm
- clearly identifies when reports are to be made and the relevant authority to whom they should be directed (including reporting child sexual abuse to the police)
- sets out child safe education and training requirements (including frequency) for staff and volunteers.

Leaders champion and model compliance with policies and procedures

Leaders in the institution:

- can access appropriate experts/mentors when dealing with complaints
- develop collaborative relationships with other relevant organisations and stakeholders to share knowledge about implementing practical child safety measures.

Staff understand and implement the policies and procedures

Staff and volunteers in the institution:

- are aware of, have read, understand and intend to follow the child safe/child protection policies and procedures and can provide examples in which they have done this
- receive adequate training and education regarding the policies and procedures and how to implement them
- know that they are required to comply with reporting obligations concerning suspected or known child sexual abuse
- know who to approach with concerns or questions.



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to Child Sexual Abuse

Commonwealth of Australia

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