

Our Ref: WGS

8 November 2013

The Hon. P McClellan AM
Chair
Royal Commission into Institutional Responses to Child Sexual Abuse
GPO Box 5283
Sydney NSW 2001

By email: solicitor@childabuseroyalcommission.gov.au

Dear Judge,

**RE: Royal Commission into Institutional Responses to Child Sexual Abuse –
Submission about Issues Paper 4: Preventing Sexual Abuse of Children in Out of Home Care**

This submission is provided on behalf of **knowmore** legal service.

As you know, **knowmore** is a free legal service set up to help people navigate the Royal Commission. Advice is provided through a national telephone service and at face to face meetings, including at outreach locations. **knowmore** has been established by the National Association of Community Legal Centres Inc, with funding from the Australian Government represented by the Attorney-General's Department.

PRELIMINARY COMMENTS

Our service was launched in July this year and since that time we have spoken to hundreds of clients who have experienced out of home care (OOHC). The majority of these clients experienced sexual abuse in an OOHC context. Many have already engaged with the Royal Commission by providing statements or attending private sessions, or have indicated to us their intention to so engage. Accordingly, the Commission will hear directly of their experiences.

The majority of these clients were placed in OOHC as children by the state, usually in response to a perceived risk, or the actual occurrence, of abuse and/or neglect. This often included sexual abuse. It is unacceptable that such placements by the state in turn exposed these children to abuse, at the hands of those entrusted by the state with their welfare.

Obviously, many of the survivors of sexual abuse in an OOHC context who are now coming forward to **knowmore** and the Commission were placed in OOHC at times when the regulation and oversight mechanisms for the various forms of OOHC (to the extent that any oversight occurred at all, in some OOHC contexts), differed considerably to those now in place. However, their experiences remain, in our view, highly relevant to current considerations of how to better protect children now from suffering sexual abuse while in OOHC arrangements. Indeed, in coming forward to **knowmore** and the Royal Commission, many of our clients have indicated that their primary motivation in recounting their own experience is to help to ensure that what happened to them does not happen to other children in the future.

As noted in the Commission's Factsheet accompanying the Issues Paper, all Australian states and territories have had at least one major review of their child protection systems generally, or of OOHC systems specifically, in the last decade. As the Factsheet notes, many of these recommendations are relevant to the provision and regulation of OOHC, although obviously not all recommendations were concerned with the prevention of sexual abuse in OOHC.

Given that existing body of work and **knowmore's** limited resources and priority on direct service delivery to clients in need, our submission does not focus on a comparative analysis of alternative regulation and oversight models and strategies.

Instead, our submission addresses those points identified in the Issues Paper where common themes have emerged from our work with clients, particularly where the experiences of our clients has highlighted gaps (that remain topical) between regulatory procedures and supposed safeguards, and the actual practice within institutions.¹ This, in our view, is the key issue to be addressed in the Commission's recommendations and subsequent reforms. While there is obviously room for views to differ about some aspects of regulation and oversight, there is perhaps now a generally shared understanding of the essential features of an OOHC system and the types of regulation and safeguards required to deliver 'best practice'. For example, we understand that the Coalition of Australian Government's (COAG) national framework for protecting Australia's children: "Protecting Children is Everyone's Business" (2009 – 2020), outlines a number of strategies for keeping children in OOHC safe from sexual abuse. These strategies include: enhancing access to appropriate support services for recovery where abuse or neglect has occurred; supporting grandparent, foster and kinship carers to provide safe and stable care (including financial and non-financial support); improving support for young people who are leaving care and supporting enhanced national consistency and continuous improvement in child protection services.

However, it is in the implementation of such systems in practice in specific institutional contexts that challenges continue to exist, as graphically illustrated in recent weeks by the evidence emerging from the Commission's second case study/public hearing, involving the YMCA. It is an unfortunate but unavoidable reality that the experience of our clients provides opportunities to understand how policy and practice can diverge. These insights remain highly relevant to preventing sexual abuse in OOHC in the future.

For the above reasons, we make this submission in response to the Royal Commission's Issues Paper 4. We have no objection to our submission being made public.

¹ As such, our submission will not address in detail every point raised in the Issues Paper.

SUBMISSION

1. An essential element of OOHC is for a child to be safe and secure. Are there core strategies to keeping children in OOHC safe from sexual abuse and what is the evidence that supports them?

We submit that five of the core strategies that must be employed are:

- i. appropriate vetting and accreditation of OOHC providers;
- ii. a strong internal culture of supervision and accountability, supported by a robust element of effective and independent supervision;
- iii. effective co-ordination and exchange of information between service providers and other relevant authorities;
- iv. appropriate and on-going training (reflective of a culture of continuous improvement) of care providers and others involved less directly in child protection work; and
- v. adequate resourcing; particularly in relation to staffing numbers, supervision practices and record-keeping and reporting procedures.

All five strategies are key elements in preventing sexual abuse and in providing enhanced opportunities to identify, as early as possible, incidents that may involve abuse and/or situations where children are at risk of abuse in an OOHC context.

Regrettably, many of our clients have recounted experiences of abuse within OOHC contexts, including foster care, that establish that abusive practices within those institutions and institutional settings were widespread, and either ignored, condoned or even perpetrated by senior officials and the supposed 'care' providers involved in the institution. The collective experience of our clients who suffered sexual abuse indicates that there was very little supervision provided when they were in OOHC in institutions, including foster care. In the absence of regular supervision, and particularly any external supervision, it was possible for abuse to start and continue without any questions being asked.

'Care' was often provided by officials, workers and even foster parents who, beyond in some contexts claiming a particular religious affiliation, were entirely untrained and completely ill-equipped and ill-suited to deliver support and services to children, particularly those children who had disabilities or were especially vulnerable as a consequence of earlier trauma leading to their OOHC placements.

The needs for appropriate accreditation and monitoring of OOHC providers, including strong and independent supervisory mechanisms, are obvious and are addressed at length in the abovementioned reviews.

The experiences of our clients also reflect many 'missed' opportunities to detect sexual abuse and to intervene, arising from no or ineffective co-ordination and information exchange between agencies and relevant officials. Clients have recounted instances where it seems clear that greater collaboration might have facilitated the reporting of incidents of child sexual abuse within OOHC contexts, and some effective response, including the taking of future preventative action. This is particularly relevant in the contexts of information exchange between different child protection agencies (given our state based structures); and between child protection agencies and police, education and health care providers.

Many of our clients suffered abuse in OOHC settings where any attempt by them to report such abuse led to either no action, punishment, or not uncommonly, further sexual abuse at the hands of those receiving such a complaint. Faced with such responses, some children understandably took matters into their own hands and ran away, usually to be apprehended eventually by police and/or child welfare officers. Many subsequently appeared in court. Rarely was such a child ever questioned by anyone in authority about the reasons for their action, in circumstances where such an approach would readily have elicited information from the child about the abuse sustained by them and the practices in the institution.

Clients have also recounted instances where information about abuse was provided to an agency (such as within a school), but not in turn passed on to child welfare authorities. Again, potential opportunities within the school system to identify children who had suffered abuse or were at risk – such as attendance records, changes in demeanour, presentation and achievements – were reportedly often overlooked. There remains a current heightened risk of a failure to connect changed behaviours and the occurrence or risk of abuse where children in OOHC are on lengthy suspensions, or have been expelled, from the school system.

In other cases, children in foster care were moved across state boundaries by their foster parents and effectively became ‘lost’ for the purposes of future official monitoring or intervention. One client has advised our service of how their life in OOHC unfolded in such a manner. The family of this client had become dysfunctional. This resulted in the client being put into a state-run home. No formal court orders were made. From this home the child was given to foster parents who then moved to a different state. The client then remembers as a child being woken at night and taken by a priest or minister to an orphanage. From the orphanage the client was put out to work on a local farm. The client was sexually abused while they were at this orphanage. At no stage were questions ever asked about where this child was. No records can now be found. The client has sought our assistance to try and piece together what had happened in their childhood – why had this been allowed to happen to them? Did no-one care where they were?

We also suggest that there is real value in exploring enhanced collaboration between health care systems and OOHC institutions, as a way of mitigating the risk of undetected child abuse. Many of our callers who were abused in OOHC situations reported receiving inadequate health care during their placements. As a result they have endured ongoing negative health consequences into their adult lives. Others suffered sexual abuse of such severity that medical treatment was required, both immediate and ongoing. Many of these clients have expressed their frustration, and their inability to understand, how medical professionals could treat such injuries but not either realise that sexual abuse must have caused the injury (notwithstanding that it was common for children to be instructed and threatened by perpetrators about disclosing the true cause), or to take any positive action that may have helped to protect the child and others.

While mandatory reporting obligations are now imposed in these contexts, we suggest that further specific training of relevant officials would assist, as addressed in section 6 below. Ensuring enhanced collaboration and providing regular trauma-informed health care services for children in OOHC contexts would not only mitigate the risk of undetected child abuse, but also ensure that children’s health needs are appropriately addressed while in OOHC.

2. Is there evidence for having different strategies to keep children in OOHC safe from sexual abuse depending upon whether a child is in relative or kinship care, foster care or one of the forms of residential care?

We would simply note that obviously the abovementioned core strategies need to be implemented in different ways, depending on the particular OOHC context.

Additionally, arrangements applying to kinship care in particular need to operate in effective and culturally relevant and appropriate ways, for the specific Indigenous communities involved. Some of these communities will be remote, and appropriate resources must be made available to support the effective implementation of strategies in those communities, so that 'remoteness' does not itself become a risk factor for children.

3. What are the strengths and weaknesses of models that check OOHC practices by an audit approach, a regular supervisory visit, or an irregular visit by someone like a community visitor?

All such oversight and accountability mechanisms have their individual strengths and weaknesses and resourcing implications. For those reasons, we submit that effective oversight and monitoring of OOHC cannot be dependent on any one model alone, and that a combination of robust internal measures, supported by an appropriate culture according primacy to the child's interests, and a strong and independent element of external oversight, is the ideal.

The community visitor model is one common in the corrective services environment. Its effectiveness depends in large part on the experience and capacity of the official visitor and the degree of co-operation provided by the relevant institution. As such, the potential weaknesses of such a mechanism include the possibility of 'capture' of the visitor by the institution and its staff (or at the least perceived capture, militating against the making of complaints by children and/or staff); and an inability to access information that may be of relevance to detecting incidents of abuse. Obviously, children in care who have been sexually abused by a person in authority have suffered a profound breach of trust, which will understandably impact upon their ability and willingness to make a disclosure to another person perceived to be an authority figure, or in any way associated with the institution.

Our clients' experiences demonstrate that there needs to be in place easy ways for children to report abuse that has happened to them, or situations presenting risks. Children do not have financial independence when they are in OOHC. Ringing for help or escaping a risk situation is difficult, if not impossible, in some OOHC contexts. Mechanisms for reporting and complaint-making by children must be established and operate in a way that promote up-take by the children, and protect confidentiality to the extent that is possible.

Additionally, we would favour an approach to any 'supervisory' visits that does not concentrate solely on 'regular' visits; that is, those scheduled and publicised within an institution. It is not difficult in an institutional environment to structure staff attendances, availability of children and so on, in a way that potential disclosers have their access to this complaint mechanism fettered. A potential implication of such a model, but one that should be tolerated, is increased stress upon staff and resources arising from unannounced inspections.

A strong external accountability element is essential to promote disclosures by OOHC staff members about potential wrongdoing involving sexual abuse or risks to children. Staff will understandably be concerned about reprisals and other employment consequences, and need to be able to report to an effective external mechanism as an alternative to internal reporting. OOHC providers must have in place internal mechanisms to support a staff member who makes such a disclosure.

4. What are the strengths and weaknesses of having OOHC providers regulated by the child protection department, or regulated by a body separate from the child protection department?

There is a risk that where child protection issues are dealt with by different bodies, information may become lost or not have the proper significance or urgency attached to it. This may allow for incidents of sexual abuse to remain undetected.

Nevertheless, as noted above, a strong regulatory mechanism that is external to the actual OOHC provider is essential. There are obvious benefits in the regulator having a span of coverage, rather than different mechanisms being implemented across different forms of OOHC. It is our submission that OOHC providers should be regulated by one authority and that this oversight mechanism should be independent of the OOHC care-providers. It is essential that there is adequate resourcing for the regulatory body and that there be a community of approaches and standards across state agencies.

5. What are the core components of the training needs of those working with children who might be sexually abused including carers, caseworkers and staff of regulatory bodies? What priority should be given to training in relation to sexual abuse compared to other training needs?

From the experiences related by many of our clients, we believe that training in complex trauma is an essential requirement for all service providers working with children who might have experienced sexual abuse. An understanding of complex trauma and the ways in which this manifests for children who have experienced abuse and neglect can lend itself to more compassionate, timely, informed and effective responses to disclosures or indicators of sexual abuse, and consequently mitigate the risks of children becoming further traumatised through uninformed care and response practices.

Additionally, training should address the practical aspects of how to respond to disclosures of sexual abuse in a manner that protects the interests of the child and also the integrity of any consequential investigative process. As an example, some of our clients have disclosed situations where they (as children) reported being sexually abused to a worker, only to be asked to then provide details of the sexual abuse to that worker in the presence of the nominated perpetrator.

We also submit that enhanced understanding about grooming behaviours by offenders² is another fundamental training need for all involved in OOHC provision and regulation. Additionally, it is our submission that all children need to be taught protective behaviours, which should also address grooming behaviour. From the accounts we have heard, it would appear that perpetrators of child sexual abuse often target the most vulnerable children, often being those with disabilities, and any training about grooming needs to address such factors.

² In this context, we refer to the explanation of child grooming provided by Senior Counsel Assisting the Commission on the opening day (3 April 2013 transcript p.13)

It is critical that such training be ongoing and afforded priority by OOHC providers. The devastating impact of sexual abuse upon a child mandates that such training be given high priority. It is not enough that training is delivered on a one-off basis as part of induction (although all induction training should include a component of this type) and then not repeated or refreshed during a worker's career. It should be conducted in person (not on-line or simply through the provision of reading material), and be interactive and involve scenarios so that staff can relate the training and learnings to their individual roles, and the needs of the children in their care. All managers must participate, to show leadership and to help bridge gaps between procedure and actual practice, and organisations must allocate appropriate resources to support such training activities.

Training programs should include a strong cross-cultural awareness component and information about the delivery of specific and culturally safe services and support to relevant children. This is particularly important in light of how cultural norms and customs may impact upon children's understanding and disclosure of sexual abuse.

Training activities and staff participation must be recorded and reported against, for accreditation and monitoring purposes. Each form of OOHC should have a mandatory annual training program.

6. Is there adequate and effective training and information available to carers who are caring for children who have sexually abused other children?

We reiterate here the importance of trauma informed practice and training for those involved in all forms of OOHC. Obviously different care and risk factors arise in the support of children who have exhibited a history of sexual abuse of other children. Again, co-ordination and sharing of information is critical. We are aware of instances, particularly in foster care contexts, where information about prior offending and/or risks was not provided to foster carers who were also responsible for the care of other children, leading to those children being placed in a position of unacceptable risk and in some instances, being the victims of sexual offending.

7. How should the rate of sexual abuse of children in OOHC be determined, noting that the *National Standards for Out-of-Home Care* require reporting of substantiated claims of all types of abuse? Would a form of exit interview assist in capturing information? What should be introduced to ascertain whether information on child sexual abuse in OOHC is resulting in changed OOHC practices?

Over and over our clients have recounted that no-one cared about them, or the abuse they suffered, often over periods of years. No-one followed up on their welfare or when they left one form of institutional care for another (e.g. foster care, or were moved to another foster care family). This facilitated both the commission of sexual abuse and the offenders remaining undetected – no-one knew or cared to ask the child.

While an exit interview is certainly a good idea, in terms of gathering both general and specific information from children about their experiences, which may in turn lead to service delivery improvements, children who experience child sexual abuse in OOHC will often be offended against well before they leave the institutional setting. Regular interviews and independent, accessible disclosure

mechanisms during the time the children are in OOHC, as noted above, are better means of obtaining timely information about behaviours that may be concerning and indicative of sexual abuse.

8. What is the usefulness and validity of different ways to address allegations of sexual abuse brought against carers? In particular, which approaches enhance participation by the child, particularly approaches best suited to seeking possible disclosures of abuse (including disclosures that might be inferred from behavioural changes) from children? Are the current processes fair? What appeal processes should be available for carers?

Much of what we have said above in relation to the need for independent and accessible complaint mechanisms is relevant here. Many of our clients have referred to their reluctance to tell people what was happening because of the fear (often entirely well-founded) of repercussion. It is crucial that children in OOHC be able to freely speak about actual sexual abuse, or potential risks to them, to someone who is independent of their care provider. The presence of carers will inevitably have a suppressing effect on children.

Obviously all allegations or concerning information must be taken seriously and fully investigated. Failures by an OOHC to appropriately report and take action on information suggestive of a risk or the occurrence of sexual abuse of children in care is a betrayal of those children, and must invariably have severe consequences in terms of the OOHC provider's accreditation and monitoring.

While obviously any investigative process should comply with any applicable legal obligations to provide procedural fairness to carers (or others) who are subject officers, the guiding principle in handling an allegation or other information suggesting that sexual abuse may have occurred must be a focus on the interests of the child or children involved, and others at risk, and their protection.³

9. What measures could be used to assess whether the safety of children from sexual abuse in OOHC is enhanced by independent oversight of the handling of allegations of sexual abuse?

Any model of OOHC and monitoring and regulation of those models should be subject to robust evaluation and a process of continuous improvement. Such evaluation cannot effectively focus only on how reported allegations have been handled (e.g. substantiated or not substantiated). An OOHC may be able to accurately report that no allegations of sexual abuse were reported during a period, or that none of those reported was substantiated. Some of the more notorious homes with which the Commission will now be familiar could well have made such claims in times past, as internal practices and attitudes were such that no allegation of any type of abuse, if made, was ever acted upon in a way that had even a remote prospect of official substantiation resulting. For these reasons, oversight and evaluation needs also to address whether relevant information was brought forward as an allegation in the first place. The general phenomenon of sexual offending being grossly under-reported will be well understood by the Commission, and it is a particularly relevant factor in the context of OOHC and the relative powerlessness of children in such care.

³ In this respect, we note the provisions in the *Family Law Act 1975* as to the considerations that must be taken into account in applications for parenting orders where an allegation of child abuse by one of the parties is raised (s 67ZBB); and also the procedures under that Court's Magellan case management program

Accordingly, evaluation and monitoring must focus also on the examination of sources of information that may reveal that relevant information indicative of sexual abuse was not reported, when it should have been. Such sources obviously include the children in care and staff, and records, including the children's school and health care records.

The understanding of the staff of an OOHC provider around risk factors and reporting obligations should be tested during any evaluation. This could be done in ways that protected the confidentiality of staff, through surveys etc, that provide insight into the providers' approaches and culture in practice, compared to the standards espoused in policy and on paper.

10. What are the strengths and weaknesses of different oversight mechanisms in keeping children safe from sexual abuse in OOHC?

We have above set out our views regarding the general principle of strong and accessible oversight, independent of the care provider. We have no further specific submission as to preferred models.

11. What implications exist for record keeping and access to records, from delayed reporting of child sexual abuse?

Record-keeping is a complex issue and perhaps one meriting specific research and a separate future Issues Paper, as to establishing best practice in terms of both the perspective of facilitating the effective detection and investigation of child sexual abuse and more generally, in addressing the record-keeping needs of specific institutional contexts.

It is clear from our clients' experiences that the lack of available (or accessible⁴) records relating to their time in OOHC continues to cause many great pain and distress, and to increase feelings of abandonment and isolation. Poor and non-existent record keeping about time spent in OOHC obviously also has adverse impacts upon clients' prospects of successfully obtaining compensation for abuse suffered while in 'care', or in now holding offenders to account. It is not uncommon for there now to be no records whatsoever relating to time spent by a client in particular homes and other forms of OOHC.

It has to be accepted that some who suffer abuse as children, for a variety of reasons, will be unable to make timely complaints. The trauma suffered will inevitably cause some children to suppress memories of the abuse, or inhibit their capacity to take action, for many years. Even with the most supportive OOHC environments and accessible complaint mechanisms, historical complaints about child sexual offending will continue to be made. Therefore record-keeping systems must be established and maintained in a way that recognises and responds to that reality, as well as the other and multiple needs of the children in OOHC, the provider, and monitoring and evaluation agencies.

Other Issues

At the beginning of this submission we drew attention to the unacceptable reality that children in OOHC who have suffered sexual abuse were often placed in care to supposedly protect them against that very risk. We recognise the difficulty any child protection system faces in balancing risk factors and intervention strategies against providing primary, preventative support to families in an endeavour to

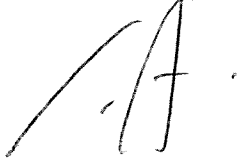
⁴ Our clients have frequently recounted receiving records which in large part are redacted

address issues of concern. Any consideration of OOHC practice and preventing child sexual abuse should recognise that effective and culturally relevant early intervention and prevention programs are a foundational strategy in minimising child abuse and neglect.⁵ Empowering families within their own community-based support systems reduces the likelihood of children requiring placement and consequently being at risk of sexual abuse in OOHC situations. Adequate, long-term funding for culturally appropriate, accessible family support and case management services is essential – particularly in addressing the needs of families and individuals who are seeking to address the impacts of transgenerational abuse.

Many of our clients are survivors of transgenerational child sexual abuse. The Coalition of Australian Governments (COAG) National Framework for Protecting Children 2009 – 2020 emphasises the validity of such a public health approach to child protection, whereby universal supports are available for all families to prevent child abuse and neglect from occurring in the first place. More intensive prevention interventions are then provided to those families in need of additional assistance and child protection services are implemented as a last resort. This COAG Framework positions the safety and well-being of children as every community member's responsibility.

Thank you for the opportunity to respond to Issues Paper 4.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'A. Strange', with a large, stylized 'A' and a smaller 'S'.

WARREN STRANGE
Principal Solicitor

⁵ Australian Association of Social Workers "Child Wellbeing and Protection Position Paper", 2010