Mr James Wood AO QC
Commissioner, Special Commission of Inquiry into Child Protection Services in NSW
PO Box K1026
SYDNEY NSW 2001
Email: cps_inquiry@agd.nsw.gov.au

CC: Carl Hook, The Secretary/Executive Officer

10 March 2008

Dear Mr Woods AO QC

Submission to the Special Inquiry into Child Protection Services in NSW

Thank you for the opportunity to make a submission to the Special Inquiry into Child Protection Services in NSW.

Combined Community Legal Centres Group (NSW) Inc. **(CCLCG)** has 38 member Community Legal Centres (**CLCs**) that work for the public interest. In particular, CLCs assist people who, for a range of reasons, have difficulty in accessing the legal system. This includes people with disabilities, women, young people, Indigenous people and people from culturally and linguistically diverse backgrounds. CLCs provide legal services including information, referral and advice, strategic casework, community legal education and law reform campaigns. CCLCG is a not-for-profit organisation.

Care and protection is a significant area of work for CLCs. A significant proportion of CLCs assist clients with a range of matters relevant to the support of families and protection of children in NSW.

The matters with which CLCs provide referral, advice, case work and community legal education provide a valuable cross-section of the problems people in the community face when engaging with the NSW care and protection system. CLC staff therefore, have significant insight into the delivery of services for supporting families and protecting children and what measures might be undertaken to make improvements. To best reflect this information, where possible, CLC case studies have been used to illustrate the issues raised by this submission.

In addition to the recommendations made by this submission, we also endorse the recommendations made in submissions already provided to the Commission by:

- Public Interest Advocacy Centre Ltd
- Women's Legal Services (NSW)
- Youth Justice Coalition
- Intellectual Disability Rights Service

Combined
Community
Legal Centres'
Group (NSW) Inc

Suite 3B Briad House
491-493 Elizabeth St
Surry Hills NSW 2010
Ph: 02 9318 2355
Fax: 02 9318 2863

In response to the terms of reference for this inquiry, this submission will focus on the following issues:

i. Legislative coherence;

ii. Administrative and judicial review and accountability of the Department of Child Safety (**DoCS**);

iii. Enforcement;

iv. Service provision to Indigenous children in need of care;

v. Accommodation for youth;

vi. Mandatory reporting;

vii. DoCS staffing and resources.

(I) LEGISLATIVE COHERENCE

Care and protection issues potentially encompass several different pieces of legislation from both Federal and the NSW State jurisdictions. These include the *Family Law Act 1975* (Cth) (**the Family Law Act**), the *Children and Young Person's (Care and Protection) Act 1998* (NSW) (**the Act**) and the *Crimes Act 1900* (NSW) as it relates to Apprehended Violence Orders (**AVOs**).

Currently, there is a lack of coherence between these three areas of laws and their application to the care and protection of children in NSW. As Case Study 1 below shows, actions performed in one jurisdiction can impact on actions performed in the other.

CASE SUDY 1

Louise's baby son was removed from her care due to neglect and placed in the care of a family member. The child has remained in the care of the family member with the mother's agreement. However, upon the expiry of previous orders for the child's care, the DoCS officer assigned to the case considered the child should be restored to the mother's care. The following week, another caseworker involved in the case stated there was no such proposal and refused to consider it. It was not until Louise's lawyer pointed out a restoration plan had been suggested and directed the caseworker to the fact that a meeting had occurred one-week prior that the caseworker acknowledged this had been suggested. DoCS then failed to follow up on arranging new orders for the child and the child's current care order expired, meaning the parental responsibility had reverted back to the mother under the Family Law Act. Louise's lawyer then advised the DoCS that she was considering Family Court action in relation to the child given the expiration of the orders and the "legal limbo" the child was in. DoCS' response to this was to threaten to apply for a care order in relation to the child.

The Family Law Council was quoted in the 2003 Federal Government report 'Every picture tells a story[1] as follows:

[1] House of Representatives Standing Committee on Family and Community Affairs, (2004) *Every picture tells a story: Report on the Enquiry into Child Custody Arrangements in the Event of Family Separation*, Canberra.

> We regard the split in jurisdiction (between family law and allegations of child abuse or family violence) as one of the most pressing matters affecting children in Australia. There is evidence suggesting that it can lead to terrible outcomes for children.

In 2001 the Family Court developed a case management model known as the Magellan Program to respond to the need to properly investigate and resolve cases involving allegations of serious physical and sexual child abuse. The Magellan Program requires both intensive management of cases by the court and cooperation from state child protection authorities. The Magellan Program was considered an important initiative for the protection of children whose parents were in the Family Court system when it was trialled in Melbourne and then introduced more broadly in 2003. While NSW was slow to adopt the initiative (which we understand was due the reluctance of the NSW DoCS), the program is now operating in all Family Court registries.

The Australian Institute of Family Studies published an evaluation of the Magellan Program in late 2007. [2] We consider that it would be useful for the Commission to investigate the extent to which the Magellan Program has been implemented in NSW, and whether the evaluation report provides a point of reference for assessing the role of DoCS in the program in NSW.

Recommendation 1:

To ensure greater consistency between the legislative frameworks we recommend the Commission consider:

- The need for a national care and protection strategy to be developed in conjunction with other States and the Federal Government; and

- An evaluation of the Magellan Program in NSW.

(II) ADMINISTRATIVE AND JUDICIAL REVIEW AND ACCOUNTABILITY OF DoCS

One of the features of the Act is that it allocates a wide discretion to DoCS officers when making decisions necessary for the implementation of the Act. The advantage of such discretion is that it allows a wide range of factors pertinent on a case-by-case basis to be taken into consideration.

While this is important to ensure that DoCS officers are able to respond flexibly to the array of situations they are required to deal with, CLC cases demonstrate that where this discretion is left unfettered it can lead to inappropriate decisions being made, with limited avenues of review.

For the efficient and effective functioning of the Act, we consider it necessary for discretion in decision-making to have checks and balances that also ensure accountability for the decisions made.

Limitations of current review mechanisms

To ensure a transparent and accountable care and protection system it is essential to have a range of avenues for review for administrative decisions made by DoCS. The current available review mechanisms for administrative decisions, and their limitations include:

[2] Higgins, Dr Daryl J *Cooperation and Coordination: an Evaluation of the Family Court of Australia's Magellan Case Management Model - October 2007* Australia Institute of Family Studies.

- Administrative law challenges can currently be raised through the Supreme Court of NSW. However, due to financial and other resources required, this avenue remains unachievable for many people. Further, many decisions made by caseworkers within the discretion currently provided them, would not be of the nature appropriate for an administrative review. The jurisdiction of the Administrative Decisions Tribunal in care and protection matters is very limited - confined essentially to review of specific decisions about authorization and accreditation of out of home care agencies and carers (s 245 of the Act).

- The NSW Office of Children's Guardian was established under the Act as a mechanism for review of children's placements. However, as the full scope of powers and authority required for it to undertake this were never fully enacted, it has been unable largely to fulfill this role. In the absence of this there are insufficient avenues for monitoring and reviewing placements of children.

  Periodic review is a right pursuant to the Convention on the Rights of the Child and its implementation through an independent body such as the Children's Guardian, properly resourced, is a single measure which has the potential to improve outcomes for children in the care system significantly.

- There are ancillary avenues for review such as the NSW Ombudsman, which bears the responsibility for ensuring government departments act reasonably and responsibly, within their jurisdiction. The Ombudsman is able to respond to individual complaints or to investigate issues, including scrutinising the complaints systems employed by government departments. The Ombudsman also has a specific function to "review the care and circumstances of children, young people and people with a disability who are in the full-time care of government and non-government services and people who live in licensed boarding houses." However the focus of investigations has been on deaths of children, and there have not been substantial investigations carried out by the NSW Ombudsman on issues of accountability, participation or resources.[3]

Strengthening Implementation of the 'Least Intrusive' Principle

As Case Study 2 below shows, there are occasions where DoCS officers are making decisions about the removal of children without adequately exploring alternative placement options, as required by the Act's 'least intrusive' principle.

The critical issue is that, in practice, the removal of a child by an emergency care and protection order is rarely formally opposed by the parents in Children's Court proceedings. Instead, our experience is that consequent issues such as an allocation of parental responsibility, duration of care orders, and contact that are the focus of contested care applications.

In practice this means that the Act's least intrusive principle is implemented at the discretion of the DoCS officer with limited checks and balances on the extent to which the Act's least intrusive principle has been conformed with and rarely are there any consequences for DoCS where the principle has not been applied.

Case Study 2 illustrates how the least intrusive principle may be inadequately implemented, or not at all.

[3] In 2003 the NSW Ombudsman produced a special report to Parliament: *Improving outcomes for children at risk of harm – a case study (A report arising from an investigation into the Department of Community Services and NSW Police following the death of a child)*

CASE STUDY 2

An Indigenous mother with language barriers and depression moved from rural NSW to Sydney with her children. The mother misinterpreted a DoCS television advertisement as an offer of temporary assistance. She contacted DoCS for help, which was in turn interpreted by the DoCS as a situation of 'abandonment'. This resulted in the permanent removal of her two school aged children when she was of the understanding that they would be temporarily cared for while she was treated for depression. It also saw the unannounced removal of her infant at 2am in the morning by DoCS workers and police who handcuffed her to a bedpost and responded to her emotional outburst with an AVO. A psychologist's report of the mother and children on DoCS' files stated that the children were not at risk and had a good relationship with their mother. This information was not made available to the court. The subsequent trauma caused by DoCS' actions to both the mother and her children was avoidable and unnecessary.

The impact of failing to apply the least intrusive principle on the child and family members can be severe. Case Study 3 below illustrates the consequences of the failure to explore options prior to birth. Waiting periods for assessing other potential carers as well as parenting courses makes the timing of case plans prior to birth crucial.

In particular, failure to undertake early investigation is leading to Aboriginal children being placed with non-Aboriginal families, even where members of the child's family have displayed a willingness to be assessed as a carer. We consider that early exploration of options is required if placements are to be in the best interests of the child and to ensure trauma to the family is minimised.

CASE STUDY 3

Young Aboriginal parents, the mother 16 years and the father 17 years had their baby removed at birth by DoCS, because the mother was at the time living with her father and he had been subject to DoCS reports in the past and DoCS was concerned about her residential arrangements. However DoCS did not seek to make alternative residential arrangements for the mother prior to the birth.

The paternal grandmother offered to DoCS for the mother and child to live with her and her husband. DoCS said this was not possible until they assessed the grandmother and this could take weeks. DoCS wanted the mother to do a residential parenting course but could not get her in for a few days, which meant the child was to be placed with a foster family. DoCS officers turned up at the hospital and pressured the father into signing a paper without his parents being present.

The social worker at the hospital was very concerned about the impact of the fostering of the child on bonding between mother and child and wanted to arrange for the mother's stay at the hospital to be extended until space became available in the program. DoCS refused to allow this as they considered the mother to be a flight risk. Fourteen days later the baby was still with the foster parents and the mother was only having 2 hours of contact each day.

Given the significance of the decision to remove a child from it's family, in terms of the impact on the child and the family, it would be useful to consider the possibility for amending the Act to include additional categories of reviewable decisions pertaining to DoCS' discretion or decision-making in exercise of parental responsibility.

In relation to section 9 of the Act, we would suggest consideration of an expansion to include a reference to the Court considering the psychological and/or harmful consequences of removal as opposed to the child remaining in the current circumstances. This relates particularly to DoCS removing a child or seeking to place a child in continuous and permanent out of home care (foster care). In our experience, there tends to be an assumption that any other care will be better than what the child currently receives, however, this is not always the case. There is evidence that children in foster care may be more damaged by foster care, particularly if they are subjected to numerous placements or are placed in group-home situations.

Further, in light of the limited options for external review, we consider that it is important for DoCS to further strengthen its internal review mechanisms. This could include formalising the internal merit review process as other government departments have, and allowing for written requests of decisions made by DoCS to be reviewed internally by an authorised review officer. If the person requesting the review is still not satisfied, we consider that the Act should allow for matters reviewed by the authorised review officer, to be deemed 'reviewable decisions' under the Act, and therefore subject to further review at the Administrative Appeals Tribunal.

We consider the need for more independent review mechanisms for administrative decisions to be critical, particularly in light of a widespread reluctance among clients to raise concerns over decisions made by caseworkers or to make complaints about caseworkers for fear of prejudicing their case. Case Study 4 below illustrates the impact the fear of prejudicing one's case places on being able to effectively raise complaints through DoCS internal processes.

CASE STUDY 4

Fleur is an Indonesian mother with a 4-year-old daughter. She married Scott and assumed care of his children from a previous relationship -10 year old twins with alcohol foetal syndrome. The relationship was abusive and Fleur spent time with the children in refuges. She was having trouble coping with the behaviour of the stepchildren and contacted DoCS for assistance. The stepchildren were removed and Fleur is no longer living with her husband and resides with her 4 year old in a Department of Housing flat. She has weekly contact with the stepchildren and tries to speak to them on the phone as often as she can.

Fleur has experienced difficulties with her cases workers throughout her case. Her English is poor; interpreters have not been arranged for important meetings; and poor cross-cultural communications skills of case workers have made it difficult to get feedback about the status of her case. Neutrality of caseworkers has also been an issue with leading suggestions about violence made to her children during contact visits. The client felt that this bias was reflected in affidavits, which contained exaggerated and inaccurate statements, but which were not challenged in court. Fleur complained to DoCS about her case workers but the caseworker's supervisor informed her that they had been acting appropriately.

The wide unreviewable discretion of workers and the tendency of complaints to make the situation worse left Fleur feeling powerless. The centre is prevented from lodging an Ombudsman complaint while the case is in progress for fear of prejudicing client. This means authorities cannot document systemic issues until years after they have occurred limiting the responsiveness of administrative review.

Recommendation 2:

We recommend the Commission consider means of increasing the accountability of DoCS decisions by:

- Amending the Act to expand the categories of reviewable decisions particularly relating to DoCS' discretion or decision-making in exercise of parental responsibility and in relation to the removal of children; and

- Expanding section 9 of the Act to include a reference to the Court considering the psychological/harmful consequences of removal as opposed to the child remaining in the current situation.

In relation to implementing the least intrusive principle we encourage the commission to consider the need for DoCS to:

- Develop clear guidelines for caseworkers on assessing what levels of support are required for parents to be able to keep their children, prior to removal options being considered;

- Ensure alternative least intrusive options are explored in a timely manner before the birth, where there is a risk of removal at birth;

- Communicate information and assistance available accurately to the community in any advertisements as well as to those contacting DoCS for assistance. This information should include reference to the fact that a request for assistance might in certain circumstances give rise to an inference by DoCS that a child is at risk of harm, and thus potentially subject to an emergency removal;

- Caseworkers to appropriately accommodate domestic violence, mental health and cultural issues in discussions and case conferences for assessing alternative placement options;

- Increase DoCS' capacity to undertake preventative measures such as independent mediation, particularly in rural and regional areas;

- Formalise internal review procedures in DoCS, to allow for written requests for review of DoCS decisions and the appointment of an authorised review officer;

- Develop a systematic procedure to ensure section 82 reports are provided to the Court; and

- Develop mechanisms to ensure that all children placed in care have a periodic review of their treatment and all other circumstances relevant to their placement.

(III) ENFORCEMENT

Enforcement of Contact Orders

The Act makes limited provisions for the Court's enforcement powers, which seem to be limited to contempt, and only when it is contempt "in the face of the Court" (see section 21 *Children's Court Act*

1987). This appears not to extend to apply to wilful breach of the Court's orders.

For example, where parental responsibility has been allocated to the other parent or to someone other than the contact parent (i.e. DoCS) the court can make an order for contact under section 86 in favour of the contact parent. However, if the person with parental responsibility does not comply with the contact order, there is no mechanism by which the matter can be addressed and the contact parent therefore has no remedy to enforce the contact arrangement.

In comparison, the *Family Law Act (Cth) 1975* has strong and clear provisions for the enforcement of parenting orders, including a series of procedures ranging from courses, alterations to orders including "make up" contact, and penalties including fines and even imprisonment in severe cases.

Case Study 5 below illustrates the kind of problems that can occur as a result of non-enforcement and the need for the Children's Court to have the power to enforce orders.

CASE STUDY 5

After Children's Court proceedings parental responsibility was allocated to the father of the child until the child attained the age of 18 years. The mother was given contact pursuant to a section 86 contact order. The father has since refused to provide the mother with contact. The mother has no remedies available to her to enforce the contact with her child, as they do not exist in the Act.

In addition, there are some cases where the party refusing to comply with orders is DoCS. Likewise with the situation above, there is no action that can be taken to enforce orders or to even encourage compliance with orders by DoCS.

Recommendation 3:

We recommend the Commissioner consider the need for:

- Contact orders to be reviewed by the Children's Guardian;
- The Children's Guardian be given powers and resources to review contact orders;
- The NSW Legal Aid Commission to be resourced to represent recipients of contact orders that are not met;
- DoCS to allocate distinct fund to support costs associated with contact visit, as a means of supporting the enforcement of contact orders.

Limited capacity of the Court to bind the parties to recommendations and orders.

Similarly, the Court has no power to order the provision of particular services be carried out or provided by DoCS where they have been allocated parental responsibility. This limitation has resulted from Supreme Court decisions arising from challenges by DoCS to specific orders made by the Court. For example, in *Minister for Community Services & Anor v The Children's Court & Ors* [2003] NSWSC863, the Court ordered that DoCS pay the costs of the parent's reasonable accommodation and travel expenses to facilitate contact. This decision was overturned on appeal. The Supreme Court, when reviewing the decision, noted that section 15 of the *Children's Court Act* provides some support for the power to bind

parties with ancillary orders, as does section 74 of the Act. However, the Court found that there was no implied or express power to make an order requiring DoCS to provide financial support for contact.

In other cases the Courts have decided that where parental responsibility is allocated to DoCS, it must occur in an unfettered way. That is, any order that tells DoCS how to exercise parental responsibility is *ultra vires*. In *Re Josie* [2004] NSWSC 642, the Children's Court ordered that there was to be no change in residential arrangements for an interim period in respect of a child for whom DoCS had parental responsibility. This order was deemed as *ultra vires*.

This issue arises because once DoCS has been allocated parental responsibility under the Act, there is limited capacity, if any at all, for the Court to go into the specifics of that parental responsibility. The Court therefore has no power over any of the following issues:

- The child's health care;
- The child's education;
- The child's contact with the parents and extended family in the event that a section 86 contact order has not been made (at times Magistrates do not make orders, only recommendations);
- Specifics as to the child's contact arrangements such as pick up and drop off, supervision and payment of expenses;

The resulting situation is that everyone is reliant upon DoCS to make decisions in the best interests of the child, but without the presence of any checks on the discretionary power attributed to DoCS. In practice, despite DoCS' best intentions, the best interests of the child are not always met. This is particularly problematic in situations where there is animosity between DoCS workers and the parents.

While the parents should be able to call on the Court to sort out such matters, in practice, individual parents are unable to challenge decisions made by DoCS for their child, because DoCS possesses the parental responsibility. This can lead to highly unjust results as Case Study 6 below demonstrates.

CASE STUDY 6

DoCS removed a young child and placed him in foster care, approximately three hours distance from the mother. The mother was unable to access public transport to visit her child because of the limited public transport available to the particular area, and her responsibilities in raising her three other children. DoCS began to pay for a person to drive the child from his foster home to his mother's home and back again, and this situation has been ongoing for approximately four years.

However, if DoCS were to change their minds and alter this arrangement because the cost is too high, the parent would have no way of challenging the decision. The parent may be able to come to the Court and request that the arrangements are made into an order, but this would only cover the contact itself, and not the intricacies of the contact or how it was to occur - such detailed orders would be considered *ultra vires*.

We consider it to be a highly unsatisfactory situation that the Court cannot make orders incidental to the

primary orders for the purpose of rendering the primary orders capable of being complied with. We consider that the ability to make ancillary orders is a useful and necessary tool.

Recommendation 4:

We recommend the Commission consider calling for the Act to be amended to:

- Allow the Court to draw on a range of procedures to enforce contact orders made by the Court (e.g. courses, alterations to orders including "make up" contact, and penalties including fines)

- Allow for the Courts to make ancillary orders that go towards achieving the primary contact order.

(IV) SERVICE PROVISION TO INDIGENOUS CHILDREN IN NEED OF CARE

We do not need to repeat the statistics that demonstrate that Indigenous children are grossly over-represented in the child protection system. We submit that the current child protection system in NSW is failing Indigenous children.

We submit that the NSW government needs to completely re-think how child protection and out-of-home care for Indigenous children is managed. We urge the Commissioner to take guidance from peak Indigenous organisations that have the expertise in how best to work with Indigenous families, such as the Secretariat of National Aboriginal and Islander Child Centre Inc (**SNAICC**). SNAICC states: "For effective services to be provided, and the best interests of children protected, it is essential that self-determination and self-management by Aboriginal and Torres Strait Islander people extend to total management of the welfare of ATSI children and families, including needing child protection services and out of home care"[4]).

We refer the Commissioner to alternative models such as Lakidjeka Aboriginal Child Specialist Advice and Support Service as run by the Victorian Aboriginal Child Care Agency (**VACCA**). We also refer the Commissioner to the project "Indigenous Responses to child protection issues", in particular the collaboration of SNAICC and the Australian Institute of Family Studies, which profiled a number of promising Indigenous programs and services across Australia in providing out of home care.[5]

Aboriginal Placement Principles

Despite the existence of the Aboriginal placement principles, contained within the Act, CLCs regularly deal with cases when Indigenous children are not being placed with Indigenous families, despite the existence of suitable Indigenous family members being willing to be carers. This means that Indigenous family members are being made to apply for leave to appear in the Children's Court for them to be considered as a carer of the child.

[4] SNAICC, Policy Paper "Achieving Stable and Culturally Out of Home Care for Aboriginal and Torres Strait Islander Children" (2005) at page 11.
[5] Higgins, J.R. and Butler, N. (2007) Indigenous responses to child protection issues. 'Promising Practices in Out-of-Home care for Aboriginal and Torres Strait Islander Carers, Children and Young People' (booklet 4). Melbourne: Australian Institute of Family Studies.

In many instances DoCS workers are not sufficiently investigating the cultural and family background of these children, nor making contact with extended members of the child's family to establish if there are family or kinship members able to care for the child. In some instances the Court is dealing with Indigenous children without the Court even knowing that the child is Indigenous. The following case studies are illustrations of when the Aboriginal Placement Principles have not been applied. They are also illustrations of the frequent failure of the Children's Court to make contact orders (see below for more discussion on this issue).

CASE STUDY 7

An Aboriginal grandmother approached a CLC for assistance in obtaining residency or at least contact with her 18-month old grandchild. The child had been removed from its mother (our client's 18 year old daughter-in-law) a week previously and had been placed with the mother's non-Aboriginal Aunt, who had very little previously to do with the child and whose own partner had a sordid reputation.

The Aboriginal grandmother had, until the child's removal, played a principal role in both caring for the child and supporting the mother to parent the child. The grandmother usually saw the child several times a week for several hours at a time and had looked after the child overnight and unsupervised numerous times. The grandmother is a well-known elder in the community and was trusted by her various neighbours (both Aboriginal and non-Aboriginal) with the care of many of the neighbourhood children, who she often entertained and played with unsupervised.

DoCS did not consult the grandmother as to her concerns for the child or potential placements for the child, prior to the child being removed. This was despite the fact that DoCS had a short meeting with the grandmother only days prior to the child's removal.

The first time the matter was listed for mention in the local Children's Court, being a week after the child's removal, the grandmother had not been listed as a party and the Magistrate refused to acknowledge her standing to be heard by the court. No orders for contact were made, despite there being little evidence of harm on the Court file and no appearance by any DoCS officer to present information to the Court. The second court mention was held a week after this and the CLC had at this stage been contacted and had arranged representation for the grandmother as well as a lengthy affidavit supporting orders for residency or at least contact. The Court indicated that there was nothing on the Court file to suggest that the child was Aboriginal or that any other family members should be a party to proceedings because of their relationship with the child.

CASE STUDY 8

A CLC provided legal advice to an Aboriginal woman regarding her niece aged 4 years. The father of the 4-year-old child is Aboriginal and the mother is non-Aboriginal. Due to mother's alcohol and mental health issues the father had informal custody of child since birth but recently was gaoled for criminal offences. The child remained with father's non-Aboriginal girlfriend for a while and the Aboriginal side of the family started private family law action to have child reside with an Aboriginal family member. Family law action was close to having a decision (within days) made when DoCS removed the child and placed the child with the biological mother. The child was with the mother for two months but then was removed again by DoCS and placed with an unknown person who resides more than a hundred kilometres away from the Aboriginal side of the family. No arrangements have been made for any Aboriginal family members to have contact

with the child.

The Aboriginal family members continue to ask DoCS to have the child placed with them, but instead DoCS are considering placing the child back with its biological mother (who still has alcohol and mental health issues) but now has support of her mother (grandmother to child). This is despite the fact that the Aboriginal family members had shown strong interest in having the child live with them (as indicated by prior court action even before DoCS became involved).

The legal centre client has indicated that DoCS aren't keeping them informed or inviting them to meetings and don't seem interested in even talking to them. All phone contact with DoCS has been negative and unproductive.

CASE STUDY 9

After an Aboriginal mother died in childbirth, her child was immediately placed by DoCS in the shared care of her Aboriginal grandparents and one of the mother's cousins and his non-Aboriginal wife. The Aboriginal grandparents had a formal record of successfully fostering a significant number of children in the past and were well respected in the local community, whereas the younger couple had a history of domestic violence between them.

The Children's Court made orders that the child should live with the Aboriginal grandparents. DoCS thought that the child should live with the younger couple, but did not give reasons for why this should be so and in fact was dismissive of the domestic violence indicators. The younger couple appealed the decision and the Court later placed the child with the younger couple.

The male in the younger couple continued to beat his wife and they soon split up, resulting in the child remaining with the non-Aboriginal ex-wife and no regular contact with the Aboriginal community. The Aboriginal grandparents see the child once per month, which is not enough to maintain contact with their family and their culture.

In some instances extended members of family of a child in need of care don't even know they have a right to seek leave to appear in the care proceedings. Often they will contact a CLC for advice after the care proceedings have been finalised, only to be told they had this right.

Many of our clients also have low levels of literacy and/or poor oral communication skills, which hamper their ability to engage with DoCS and the court system. Even if a family member is aware of their right to become a party to the proceedings they may be very apprehensive to attend the Children's Court, especially if they or a family member were removed themselves.

For many Indigenous people the history of removal of children stemming from the government policies of the Stolen Generation era continues to impact on their perception of DoCS. There are instances of DoCS workers not understanding why Aboriginal parents were reluctant to engage with DoCS, which leads to their children being placed with a non-Indigenous carer.

CASE STUDY 10

An Aboriginal mother suffering from post-natal depression and long term domestic violence had previously had two other children removed by DoCS and had since had no further contact with

those children despite her efforts to gain contact. The removal of her children by DoCS marked the fourth 'Stolen Generation' in her family. This history made it difficult for the mother to engage with DoCS.

The DoCS caseworkers did not appear to recognise and certainly did not address the cultural, mental health and domestic violence sensitivities present in this case. The mother's fear and mistrust of DoCS and her avoidance of their processes was used as evidence against her. There was no genuine commitment to the Indigenous participation principle under section 12 and alternative dispute resolution under section 37. Evidence of prior alternative action required under section 63 contained in the affidavit was misleading and tokenistic. The client was informed of what was going to happen and this was recorded in the affidavit as consultation. The affidavit did not reflect real engagement with the principles of participation or prior alterative action. Rather it read like a tick list with no substance behind the steps taken and was ultimately misleading.

As a result her third child was placed with a non-Indigenous carer.

The Breaking the Silence Report commissioned by the NSW Government and released in 2006 identified 119 recommendations to address child sexual assault in Aboriginal communities. A significant part of the findings and recommendations of the report focused on the role of child protection agencies in this context.

The Breaking the Silence Report found that child sexual assault was a significant issue in Aboriginal communities, but that it was not well understood in the community leading to a culture of silence and denial. Abuse is rarely reported with factors such as complex extended families, geographic isolation, and poor response from child protection agencies contributing to this.

Some of the recommendations of he Breaking the Silence Report include:

- Establishing an Aboriginal Child Sexual Assault Coordination Unit;
- Expanding Family Violence Prevention Legal Services;
- Providing a comprehensive education strategy in the community;
- Establishing policies that deal with family violence and child sexual assault in an holistic way;
- Following up reports of child abuse within 48 hours;
- Increasing access to crisis accommodation to provide a safe place for women and children who disclose;
- Developing community based sex offender programs for offenders aged between 10 and 17; and
- Providing comprehensive resources for health services.

Specifically in relation to DoCS and its response to child sexual assault in Aboriginal communities, the report found that many Aboriginal people continue to fear and mistrust DoCS and the current service

system has not been successful in overcoming the wrongs of the past or in building trust with communities.

It also found that there were insufficient stable out-of-home care placements available for Aboriginal children and young people and identified the importance of DoCS thoroughly assessing and monitoring out of home care placements to ensure they are safe for children *before* a child is placed there; and where a stable 'kinship' out of home care placement exists, to provide adequate financial and practical supports to enable it to continue. The report made specific recommendations for DoCS to implement (recommendations no 22 – 39) including calling for DoCS to increase the number of Aboriginal employees, provide greater support for those employees and ensuring that all employees received cultural awareness training.

Recommendation 5:

We recommend the Commission consider the need for placing a positive obligation on DoCS to establish at first instance the cultural background of a child in need of care. This obligation can include:

- Requiring all out of home care placements for Indigenous children to be assessed and managed by Indigenous agencies that are adequately funded and resourced. We refer the Commissioner to the Victorian model for consideration, as referred to above.

- Indigenous foster carers and Indigenous family/kinship carers be provided with adequate support and resources.

In the event that placement of an Indigenous child continues to be overseen by DoCS then we recommend the Commission consider:

- DoCS being legally obliged to identify and contact members of the child's family/kinship group to facilitate their participation in the assessment and court process;

- DoCS workers being provided with comprehensive cultural awareness training which includes the impact of past government removal polices on Indigenous communities;

- DoCS employing more Indigenous workers who are both internally and externally supported and supervised; and

- Making decisions to place an Indigenous child with a non-Indigenous carer independently reviewable by an independent body staffed by Indigenous child protection experts. We consider that this independent body should have the legislative power to request judicial review of a Children's Court decision if it is of the view that the decision was not in the best interests of the child.

We further recommend that the Commission call for distinct funding to be allocated to implement the recommendations made in the Breaking the Silence Report.

Contact Orders

Principle 9(g) in the Act states that if a child is placed in out of home care the child is entitled to retain relationships with people significant to the child or young person. However, section 7 of the Act clearly states that this principle does not confer any right or entitlement enforceable at law.

It is the experience of our clients that frequently DoCS and the Children's Court do not even consider contact orders to ensure that a child maintains a relationship with their family and community. Rather, it seems that responsibility is given to individual parents or family members to seek contact orders. We consider that in some instances it is not physically possible for family members to attend court, for example; they may be in custody or don't have the financial means to travel to court. This means that often no contact orders are made and that the arrangement of contact is being left to the management and control of the DoCS caseworker or the foster carers. Sadly this results in minimal contact or no contact at all.

Lack of contact or minimal contact is especially damaging for Indigenous children who are placed with non-Indigenous foster carers. As SNAICC reports:

> Aboriginal and Torres Strait Islander children in out of home care placements that cut them off from their family, culture and spirituality are at great risk of psychological, health, development and educational problems. They suffer as children and later as adults from the grief and loneliness of not belonging. They are also being denied their rights as Aboriginal and Torres Strait Islander people.[6]

Some of the case studies referred to in the section immediately above illustrate the failure of DoCS and the Children's Court to ensure contact.

CASE STUDY 11

An Aboriginal infant is removed from her Aboriginal mother who has serious drug problems. The father of the child is unknown. Unfortunately none of the mother's family was able to take in and care for that child (some had health issues or were fostering other children) but nonetheless want to be able to have regular contact with the baby. The infant was placed with a non-Aboriginal foster carer. No contact orders were made and the issue of contact was left to the family to arrange with the foster carer. Numerous attempts are made by the maternal grandmother and maternal aunts to have contact with the child, but the foster parent is largely un-cooperative. Contact is very rare and the child has not bonded with any of his extended family and thus also has limited contact with the larger Aboriginal community and his culture.

A child placed in out of home care, as a matter of right, must be able to have contact with her/his family members unless that family member poses a risk to that child. It is our submission that the legislation needs to be amended to confer an enforceable legal right to a child to have contact with family members.

Recommendation 6:

We recommend the Commission consider:

- Calling for amendments to the Act that would make it a requirement of the Court that contact orders must be made for contact with members of family/kinship group, unless there is a risk of harm, if an Indigenous child is placed in out of home care with a non-Indigenous carer.

[6] SNAICC, Policy Paper "Achieving Stable and Culturally Out of Home Care for Aboriginal and Torres Strait Islander Children" (2005) at page 9.

- That the management and placement of an Indigenous child in need of out-of-home care be done by an appropriately funded and resourced Indigenous agency, which is best placed to understand and ensure that Indigenous children maintain contact with their families and communities.

- That DoCS provide distinct funding to cover the costs of contact visits and ensure there are sufficient resources to enforce them.

Where an Indigenous child's placement is not being overseen by an Indigenous agency we recommend that:

- There be a positive obligation on DoCS to identify and contact members of the child's family/kinship group and to facilitate their participation in the court process.

- Once a contact order is made there be a positive obligation on the out of home care agency overseeing the placement (whether it be an Indigenous agency or DoCS) to ensure that the foster carers and the family members are adequately resourced to enable contact to take place easily.

(V) ACCOMMODATION FOR YOUTH

It is well know that there is an over representation of wards of the state in the juvenile justice system[7] and that there is an established link between children who have been involved in the care and protection system and juvenile justice[8]. The reasons behind this include a lack of resources, poor coordination between agencies, inadequate guidelines, few specialised staff and a lack of information and representation for children.

One further significant reason for the over representation of wards of the state appearing in the juvenile justice system is the increasing number of cases in which young people are refused bail from Juvenile Justice Centres due to a lack of available accommodation and limited assistance from DoCS. Taking into the account the 'welfare' approach adopted by the Children's Court, a Children's Court Magistrate will often grant conditional bail to a young person with the condition being that they "reside as directed by DoCS and Department of Juvenile Justice (DJJ) and not be released until appropriate accommodation has been found". Nearly 50 percent of children in detention centres are on remand.[9]

When appropriate accommodation cannot be found by relevant bail intake officers within the DJJ, they are accordingly reported to DoCS. Where that particular young person has an existing care relationship with DoCS, there is a mandate for DoCS to become involved in locating appropriate accommodation.

However, while many of the young people who appear before the Children's Court are in need of care, they do not always have a formal relationship with DoCS. In such situations, it is been a practice of DoCS not to assist in finding accommodation, despite formal notifications being made. Magistrates therefore have no power to direct DoCS to take responsibility, regardless of the legal status of the child.

CASE STUDY 12

[7] Community Services Commission, *Turning Victims into Criminals Report* (1996).
[8] See for example: Community Services Commission *The drift of young people in care to Juvenile Justice* (1995)
[9] NSW Law Reform Commission, *Young Offenders*, Report 104, Sydney (2005), p 231.

A young male teenager repeatedly breached his bail by not residing at his parent's residence. The young person's parents were known to be alcoholics and the young person had repeatedly absconded from the residence. Notifications had been made to DoCS, but no assistance was forthcoming, given that the young person was 16 year old. When the young person wasn't able to meet bail due to DoCS not assisting to find suitable accommodation, the Magistrate became so frustrated with the lack of DoCS cooperation, he directed that a DoCS officer from the local DoCS CSC appear in the court by that afternoon in order to address the issue of accommodation.

Where there is a lack of accommodation options and limited assistance from DoCS, the young person is forced to remain in custody.

The unnecessary detention of young people due to lack of accommodation alternatives sourced by DoCS, is inconsistent with the principle of detention being a last resort, as reflected in the juvenile justice legislation and in the United Nations Convention on the Rights of the Child.

Recommendation 7:

We urge the Commission to consider the following options to address this issue:

- That DoCS be mandated to assist in providing accommodation for all children and young people;
- That DoCS be mandated to assist children and young people to meet bail conditions for those who are in care or in need of care;
- That there be greater interagency cooperation between DJJ and DoCS regarding this issue e.g. liaison officers common to both DoCS and DJJ could be introduced to facilitate the crossover of jurisdictions;
- Adequate funding be provided to meet accommodation requirements of bail;
- Adequate funding be allocated to support a data system, which provides accurate and timely information to the Courts, Police and DJJ.

(VI) MANDATORY REPORTING

While recognising the importance of mandatory reporting in ensuring that children at risk do not remain so, we also note that despite the mandatory reporting there continues to be under-reporting.

CASE STUDY 13

A six-year-old child with a developmental disability had suddenly started displaying seriously disturbed behaviour partway through the year at primary school. The child was pushing other children to the ground, pulling his pants down and sitting bare-buttocked on the other child's face. The child was constantly pulling his pants down both in class and in the playground and would ask other children to touch his penis, despite numerous attempts by teachers to correct his behaviour and discipline him. The child was scaring other children with his behaviour to the extent that his mother was told he might be expelled to protect the other children. At the same

time the child's concentration and progress in class was deteriorating markedly, together with an acute increase in unruly, verbally abusive, violent and aggressive behaviour.

When the child's DoCS file was obtained pursuant to Freedom of Information legislation in relation to a claim for victims compensation, there was no indication on the file that the school had reported any of these incidents to DoCS. DoCS officers had in the past visited the family once but did not have the benefit of knowing what the child was doing at school. The DoCS informant is thought to have been a concerned neighbour.

The child later disclosed to his mother that a male occupant of the family home had repeatedly sexually assaulted him. This same male occupant had also been raping and bashing other family members in the home. The mother had been too terrified of the adult male in her home to make any disclosures about the child's behaviour at school at the time of the single DoCS visit. The child remains seriously psychiatrically disturbed.

CASE STUDY 14

A CLC is acting for seven children all of whom were sexually and physically abused by their father. The abuse was exceptionally violent and occurred on an almost daily basis. The six youngest children have significant behavioural problems as a result of the abuse. The younger children in particular have developmental problems. These children displayed psychological problems and signs of physical abuse while in the care of their father. They also were frequently absent from school.

The CLC has obtained the DoCS files for all of these children to assist with their respective victims compensation applications. There are no reports of any concerns about these children from their school, or any other anonymous individual. The abuse only came to the attention of DoCS when the two eldest victims, who were teenagers and staying with other family, decided to report the abuse to the police.

One of the reasons we believe this might be occurring is because the threshold for reporting (i.e. 'at risk of harm') is too low and susceptible to relatively minor incidents being reported which have significant ramifications in terms of protection actions that ensue once a child is reported to be at risk. This may make many mandatory reporters reluctant to report any incidents. We consider that identifying a higher threshold of risk may be a more effective approach in ensuring that children at risk do not continue to go un-reported than increasing the categories of mandatory reporting.

Recommendation 8:

We recommend the Commission consider raising the threshold for mandatory reporting to children at "significant risk of harm".

(VII) DOCS STAFFING AND RESOURCES

One of the most important steps to ensure the proper implementation of the Act is ensuring that adequate financial and human resources are developed and allocated to implement the measures necessary for achieving the Act's objectives. This includes ensuring that DoCS staff are adequately resourced and

provided with the appropriate skills and training, including in specialist areas.

Capacity of DoCS staff

We are aware that there is a high level of turnover amongst DoCS staff meaning parents and children have to deal with several different caseworkers during their relationship with DoCS. The approach of new caseworkers is often inconsistent with previous work undertaken, resulting in parents and children having to deal with different decisions made by different caseworkers. The following Case Study 15 illustrates the impact on the children involved, and prevalence of multiple changes in case plans and caseworkers.

CASE STUDY 15

Louise is a mother in her early 30s coping with the psychological effects of domestic violence and health complications stemming from obesity. She has four children under the age of six, three of which were fathered by Fred. Fred was a perpetrator of domestic violence and had a long term, incurable acquired brain injury, of which DoCS was well aware. Louise left the father and suffering depression due to the after-effects of domestic violence, severely neglected her children.

All the children were subsequently removed by DoCS and the three older children were placed with the father. A care order was sought in favour of the father by DoCS until the children reached 18 years. The mother opposed this but the Court instead gave parental responsibility to DoCS and ordered that the children to remain in the father's care under a supervision order. The father later re-partnered and perpetrated violence on his new wife and her children. Eventually the children were removed from the care of the father due to the violence and placed with the mother.

Multiple changes in case workers and internal inconsistencies characterised the ensuing contact and residency arrangements for all four children. For example, one week a decision was made to restore the youngest child to the mother, but the following week another worker stated there was no such proposal and refused to even consider it.

Eventually the three older children were removed from the father due to the violence in the home and were returned to mother. The level and method of contact with the violent father has been inconsistent and destabilising for the children.

We consider that there is a systemic failure of DoCS caseworkers to address issues of domestic violence, sexual assault, cultural difference, disability and mental health issues in the course of their casework, which has detrimental impacts on both parents and children.

The following Case Study 16 illustrates how inadequate training of DoCS workers in cultural difference, domestic violence and sexual assault matters can result in inappropriate assessments and placements being made for the children and inadequate support being provided to the parents.

CASE STUDY 16

A Muslim mother suffering from post-natal depression called DoCS asking for assistance. The mother was sexually assaulted by her cousin, which resulted in pregnancy and the birth of the child. DoCS convened a case conference at which the perpetrator/father of her child was present.

There was no consideration by the DoCS caseworker of the power imbalance and trauma this might cause, to the extent that the caseworker questioned the mother about the sexual and physical assault in front of the perpetrator. The mother was highly emotive in her response, and her difficulties were made worse by her language difficulties. Pressure was then placed on the mother to agree for the child be placed in the care of the father.

The caseworker displayed cultural ignorance, hostility and racism against the client as well as ignorance of post-natal depression issues. The caseworker responded to the mother's emotional outburst by attempting to take out a personal AVO as well as an AVO on behalf of the child against the mother. Both applications were dismissed in the Local Court. During contact visits the mother was not allowed to speak in her native tongue and hostility and racism was displayed through DoCS case management.

Similarly, Case Study 17 below demonstrates the need to develop the capacity of DoCS workers to accommodate the needs of people with disabilities, particularly in terms of ensuring interpreters are available for communications barriers through language or disability.

We consider that training for workers in this area would also increase procedural fairness and ultimately outcomes for children of parents with disabilities.

CASE STUDY 17

DoCS removed the children of an Aboriginal mother with a hearing impairment. The police initially accused her of being drunk at the time of removal, as they could not understand her. Later discussions about contact occurred with DoCS and an interpreter was not used. The client was left confused and uninformed about contact arrangements and other aspects of the process. It was here that the CLC became involved. The CLC brought the issue of an interpreter to DoCS attention after which an interpreter was used occasionally in communications.

Recommendation 9:

We recommend the Commission consider the following:

- Providing increased and regular training for all DoCS staff, particularly caseworkers, on recognising and dealing with domestic violence, cultural differences, disability and mental health issues. We suggest that external agencies who have expertise in these issues could be invited to participate in the design and delivery of the training.

- Implement the UN Committee on the Rights of the Child recommendation to:

  > [P]rioritise budgetary allocations to ensure implementation of the economic, social and cultural rights of children, in particular those belonging to disadvantaged groups, such as indigenous children, "to the maximum extent of….available resources[10]

We hope this information has been useful for your deliberations on these matters.

[10] Concluding Observations Australia 20/10/2005, CRC/C/15/Add.268, para 18.

Should you require any further information or clarification please do not hesitate to contact Alison G Aggarwal, CCLCG Advocacy and Human Rights Officer, (Alison_aggarwal@clc.net.au; ph: 9212 7333).

Yours faithfully,

Jessica Cruise
Co-Convenor, Law Reform and Policy Committee
Combined Community Legal Centres Group (NSW) Inc.