Trust in culture

A review of child protection in South Australia

Kate Alexander

November 2022

This review uses the term ‘Aboriginal’ to refer to people who identify as Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander. It is understood that this term is preferred by Aboriginal South Australians and the Commissioner for Aboriginal Children and Young People. The terms ‘children’ and ‘young people’ are used interchangeably to refer to all children and young people.

ACKNOWLEDGMENTS

Culture and Country

The following review is based on conversations that took place on Kaurna land. It acknowledges the Kaurna people as the traditional owners of the land and pays deep respect to their cultures, customs, resilience and wisdom. This review was written with great hope for Aboriginal children. May their rights to thrive in the love of family and connected to culture and Country be upheld with urgency and collective determination.

The children

While this review is about the system for all children in South Australia there are eight individual children at its centre. They are referred to by their names because those names are in the public domain and were mentioned constantly by the workforce throughout the review process. Six of the children have been the subject of inquests since 2010 – Chloe Valentine, Ebony Napier, Heidi Singh, Amber Rigney, Korey Mitchell and Zhane Chilcott. The other two children, Charlie and Makai, died recently. Their deaths have been reported extensively in the media and are the subject of a current and separate investigation.

The review recognises that the use of the children's names may be distressing for Aboriginal people.

The families

The review acknowledges the courage of family members who contributed their insights. This includes Belinda Valentine, grandmother of Chloe Valentine; Alina Flink, carer of Heidi Singh; Donna Rigney, mother of Yvette and grandmother of Amber and Korey; and Bella Rigney, sister of Yvette and aunt to Amber and Korey. The strength and resilience of these women in describing the saddest of experiences was remarkable, as was their generosity in sharing their hopes for other children to know love and safety.

The child protection workforce

This review relied on the insights of over 160 professionals who represent the child protection workforce in South Australia, both within the statutory system and the broader sector. All of them participated with great willingness, honesty and obvious dedication to their work. Their collective strength in advocacy for children was compelling and shone bright.

Front cover artwork by Lawson Dodd

Lawson Dodd is a young emerging artist/designer who aims to push the boundaries of First Nations artwork through his illustrations. He is a proud Kaurna/Narungga/ Ngarrindjeri man and likes to take a modern approach to his artwork while incorporating traditional customs and meaning. Lawson was the recipient of the NAIDOC SA Artist of the Year Award (2022) for his contributions to the community and the arts.

REVIEW AUTHORS

Reviewer: Kate Alexander's usual role is the Executive Director of the Office of the Senior Practitioner for the NSW Department of Communities and Justice. Kate has held this role since 2012 and her responsibilities include learning and development programs, the design and implementation of the NSW Practice Framework, child death reviews, and quality assurance across child protection and out of home care practice. In 2018 Kate was awarded a NSW Public Service Medal for outstanding service to families and communities. In 2010 she was awarded a Churchill Fellowship to research child protection systems in the UK, US and Norway.

Kate graduated as a social worker in 1992 and has worked in child protection ever since, spanning roles of therapeutic service delivery, statutory practice, management and executive positions. In 2004, Kate graduated with a masters in social work (family therapy) and is currently completing a PhD at Melbourne University. Her research is about child protection decision-making. Kate is also an Executive Fellow of the Australian New Zealand School of Government.

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Sarah graduated in 2005 from the University of Sydney with a degree in social work (with honours). In 2011, she completed additional postgraduate studies at the University of Sydney in human rights.

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EXECUTIVE SUMMARY

> If we think about it, save for the vagaries of birth, errant biology, class and status, or simply circumstance, we are all but a half step away from the 'other' families we describe as in need of service or 'at risk'. In the final analysis, it is not 'us' and 'them'. It is all of us. Together.
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> **Whittaker (1997)**[1]

BACKGROUND TO THE REVIEW

On 30 May 2016 in the South Australian town of Hillier, Steven Peet, a 28 year old non-Aboriginal man murdered two Aboriginal children, six year old Amber Rigney and her five year old brother Korey Mitchell. Steven also murdered the children's mother, Yvette Rigney. He was in a de facto relationship with Yvette and had been living with the family for about three months. Steven has since provided evidence that he first strangled Yvette following an argument in the early hours of the morning. Later that day he strangled the children after he heard a knock at the door. That knock came from two social workers from the South Australian Department for Child Protection (DCP). When the knock went unanswered, they walked around the house and knocked on the back door. The social workers could not hear anything from the house and eventually left. The bodies of Yvette, Amber and Korey were discovered later that day. Steven pleaded guilty to all three murders and is serving a 30 year sentence.

Amber and Korey, along with their older brother who was living with their paternal grandparents at the time, were known to the child protection system. Yvette had a history of trauma, problems with dependency on methamphetamines and there were worries about the safety of the children. Steven was not known to child protection, and there was little known history by police about his use of violence towards Yvette, the children or other women.

Five years later, commencing 31 May 2021, Deputy Coroner Anthony Schapel presided over nine days of inquest into Amber's and Korey's deaths. The inquest heard from three witnesses, all staff from DCP, and spanned 11 months, focusing solely on the role of child protection. There was no inquest into Yvette's death.

Deputy Coroner Schapel handed down his findings on 21 April 2022. He made four recommendations for the South Australian Government, all of which were publicly accepted.[2] The first recommendation called for a review of all coronial and other recommendations relating to child protection; the second called for a review of statutory obligations in the *Children and Young People (Safety) Act 2017* and how departmental practices align and comply with those obligations. In June 2022 the South Australian Government advised that it would appoint an external reviewer to undertake the first two recommendations, and would ensure that person had extensive knowledge of child protection systems. The terms of reference for the review reflect those two recommendations.

THE SYSTEM

The United Nations Convention on the Rights of the Child[3] recognises that children have a universal right to live free from all forms of violence and abuse. Australia is a signatory to this convention and has important obligations. It fulfils them primarily through the administration of state-based statutory child protection systems. The statutory system in South Australia is administered by the DCP.

Children and young people under the age of 18 make up almost 21 per cent of the population in South Australia.[4] Of those children one in four will be reported to DCP before their 10th birthday.[5] In September 2022, DCP received 8,417 notifications about children at risk, amounting to over 280 per day.[6] Moreover, the evidence tells a sobering story of disadvantage. A similar proportion of children in South Australia is growing up in families overwhelmed by increasing complexity. Poverty, problematic substance use, homelessness, domestic and family violence, intergenerational trauma and mental health are chronic problems. They rarely occur in isolation and inevitably leave their mark on the youngest members of society, many of whom have no voice. The system is struggling to meet mounting demand;[7] the rate of children entering care is higher than most other Australian states[8] and Aboriginal children are grossly over-represented.[9]

THE REVIEW APPROACH

What mattered most was that this review heard from the people doing the work by someone who understands the complexities of it. It took an Appreciative Inquiry approach (see section 3.7) and it listened to the workforce, both in the statutory system and the broader sector. That included visits to DCP offices and the Child Abuse Report Line, facilitating discussions at a heads of industry forum, senior executive meetings, managers' meetings and team leader meetings – all in all over 160 people. It also included a half day workshop with DCP social workers, and conversations with Aboriginal leaders and practitioners, researchers, academics and many sector partners. Those conversations centred on the perspectives of the workforce, at all levels, about the recommendations, changes and reforms that they believe have, or have not, made a difference to their quality of work for children. The review also included meetings with some of the family members of the children who are at the centre of this review because of their tragic deaths. The meetings focused on family members' experiences and insights, which were invaluable and offered with great generosity and courage.

The review has been undertaken from a place of respect, for the many reviews before it and in progress, and it seeks to provide a useful pause. A pause to reflect on what's working and to take stock of what is needed next.

CHILD DEATHS ARE ONE WINDOW TO THE SYSTEM

When children die as a result of abuse or neglect, and were 'known to child protection', the system needs to demonstrate accountability and transparency. It needs to look, with frank, fearless and laser-like focus, at its own practice and be open about any shortcomings. The community and government must be able to place their trust in such processes, and by and large they are already in place in South Australia. At the same time child deaths cannot be the only window through which the system is judged. The expectation that it will be able to prevent all child deaths is not realistic. No child protection system, whatever its quality, is able to do that.

Society rarely holds other workforces to the same sort of expectations. When patients die unexpectedly in hospitals there are processes to determine quality of care, but those processes are left in the trusted hands of health officials and experts to administer. When women are killed by their partners, including men who had known histories of violence, it is typically recorded as a domestic violence death and it would be unlikely for the media to hold the police accountable. When people with chronic mental health problems die by suicide it would be unusual for the community to call for the sacking of those working in psychiatric care. Robust processes of inquiry, morbidity and mortality review committees and root cause analysis methods are instigated within other departments in response to tragedies of this nature. What stands out as different is that those processes operate with the trust of government, media and community. And that trust extends to enabling those systems to course correct as needed, at the direction of their leaders.

When all the responsibility for child deaths lands on the child protection system it serves a purpose for the broader community and sector. It means not having to sit with the uncomfortable truth about the reality of hardship faced by many families, or the responsibility for more intractable problems, including poverty and intergenerational trauma. Most concerning of all is that when the focus is only on what child protection did or did not 'predict and prevent' it sets the system up to fail. All the best opportunities for improving the safety of children early sit with other sectors. Sharing responsibility across the broader arena is critical, but it has to be resourced adequately and it has to share a common vision when it comes to responsibility for children.

CHILD PROTECTION WORK HAS CHANGED SIGNIFICANTLY

Australia's early responses in the name of child welfare reflect a shameful period of history characterised by racist, interventionist policies, the impacts of which are rooted firmly in the trauma held by Aboriginal people today.

The discovery of the 'the battered baby syndrome' in the 1960s by an American paediatrician[10] led to the development of 'professional' child protection services across high income countries. Sometimes referred to as 'the second wave of the child rescue movement'[11] the 1970s saw the rapid development of statutory systems and legislation across Australia. The predominant reporting was about children alleged to have been hurt by physical or sexual abuse. The forensic mandate to 'investigate incidents' was fit for purpose.

Skip ahead to the changing nature of child protection in 2022 in South Australia. Reports about children at risk from physical and sexual abuse make up roughly 20 per cent of

those coming in the door.[12] Yet the remaining 80 per cent of reports are no less worrying. They bring to life the reality of modern society, which will always have a struggling class. When chronic, entrenched and all pervasive problems of poverty, drug use, inequality, unemployment, homelessness, poor mental health and domestic violence are endemic, children pay the price, usually in the quietest and saddest of ways. They are often not safe and they are definitely not thriving. An investigatory approach is not best fit for purpose for these children. They are not at risk because of 'incidents'; rather, they live with the impacts of cumulative harm. Those impacts are much less about broken bones and much more about their constant worry, fear, shame or loneliness. The most common understanding of child protection work by the general public is that its main task is to assess risk and to predict harm. In truth, that task is merely the first step and undoubtedly the easier one to take. The harder step is working out what to do next. Contemporary and quality child protection serves children best with those two steps taken together confidently – professional assessment followed quickly by skills, relationships and partnerships with children at the centre and families armed around them with the support, motivation and respect to change.

Social workers who have given their whole careers to child protection, and over that time have worked with the same families whose children cycle in and out of the system spanning three or more generations, invariably describe a common reflection – that it is rare to be told by any of those children, young people and adults that they were grateful to have been in state care. Much more common is a consistent voice of yearning to have known a childhood with one's own people. There will always be children for whom statutory powers for removal are needed but decisions to use them must be understood as the very last resort. Working to keep this group of children in the minority is not only morally right – there is unequivocal evidence that it costs government and society a whole lot less in the short and long term.

THE CHILDREN AT THE CENTRE

The terms of reference for this review do not include a formal examination of the effectiveness of the system response to the eight children whose deaths are at its centre but, rather, on the reviews and inquiries that followed. Six of those deaths have been the subject of extensive review, and the critique reflects the system response close to, or in some cases well over, a decade ago. The two recent deaths are the subject of current investigation. Noting these caveats, it is the opinion of this review that there were concerns about the quality of assessment, relationship building and holistic case planning in the way DCP and the broader sector responded to the safety of each of the children.

Six of the children died in the care of family. A common factor across the stories is that each family appears to have been isolated from broader systems of helpful family and community support. No one in their extended network, including their community and professional sector, had eyes firmly on the safety of the children, nor on the impact of parental drug use, violence and poor mental health. These children needed quality assessment, skilful case planning, a network of adults to provide safety – and failing that, the exercise of statutory powers for court-ordered rehabilitation and care (preferably with family).

The other two children, both Aboriginal, died in care. Equally, there are concerns about the system response. Those concerns reflect the challenges across all of Australia's child protection systems in providing stable and quality care to adolescents who are

disconnected from family and culture and who behave in ways that reflect the pain of that disconnection.

Both children died in situations of great distress. Heidi Singh, 14 years old, was in an emergency care placement. One evening she was notably upset and her behaviour was escalated. Her carers did everything they could to console her and respond to her obvious agitation but were unable to stop her from running away. Heidi climbed a pole at the local railway station and was electrocuted. Zhane Chilcott, 13 years old, was in a residential care facility when he hung himself in the cupboard in his bedroom. It was the 18th placement he had been in since being removed from his family as a baby. He left a suicide note telling his mother that he loved her, it was not her fault and he wanted to be with her, not in care.

A SCRUTINISED SYSTEM

The child protection system in South Australia has been the subject of a great deal of scrutiny. This became increasingly clear in complying with the review's first term of reference, which was to consider all coronial and other recommendations made about the child protection system since 2010. It was an onerous task because the number of recommendations the system has current responsibility for is 811.[13] Child deaths and other adverse events, especially those that have attracted media attention, have frequently been met with formal reviews as well as inquests and other forms of official inquiry. Over the last decade this included three different royal commissions, five major and highly publicised inquests, three public reviews, standing committees and official reports. During that time, South Australia has also introduced new legislation and undergone significant machinery of government changes. Alongside all of this review focus and continual change sits a high level of external oversight, monitoring and formal investigation, which come with their own requests, through functions such as the South Australian Commissioner for Aboriginal Children and Young People, the Commissioner for Children and Young People, the Guardian for Children and Young People, the Child Deaths and Serious Injury Review Committee and the South Australian Ombudsman.

What stands out in reading the commentary, findings and recommendations of all those past reviews and inquiries is the amount of dedicated, expert and professional thinking, critique, analysis and research that has focused on the South Australian system. Excellent minds, well-prepared evidence and thousands upon thousands of pages of material have been directed, in good faith, to the betterment of child protection services.

Top of that list is the Child Protection Systems Royal Commission in 2016 led by Margaret Nyland. Spanning two years, the Commission heard evidence from 381 witnesses, received 374 submissions, examined 10,800 documents, conducted 74 stakeholder engagements and made 260 recommendations. It led to many significant and positive changes, most especially the decoupling of the departments of education and child protection. It called for child protection expertise in leadership and it recognised the importance of early intervention services and knowledge. A standalone department was formed (DCP), headed by a chief and deputy with long and reputable experience in the work.

THE SYSTEM HAS WORKED EXTRAORDINARILY HARD

Following the handing down of the Nyland report a clear roadmap for reform was built. The new child protection department found its feet quickly, thriving under new leadership

and the prioritisation of child protection work and expertise. There were dedicated teams to oversee the implementation of the recommendations and a tremendous amount of change and reform was managed well. Departmental and sector leaders worked on the development of trust and partnerships across a strong collaborative sector. Significant progress was made. The Department of Premier and Cabinet established the Early Intervention Research Directorate, which was later transitioned to the Department of Human Services (DHS) along with direct service provision for family preservation work as well as indirect through contracting sector partners.

Over those years there are true indicators of improvement, including that DCP has managed to assess an increasing proportion of reports about children;[14] the sector and relationships across it have matured and are robust; Aboriginal practice leaders have a stronger voice and are influencing more of the practice; DCP launched a contemporary and quality Practice Framework in 2019; the early intervention sector has developed great research rigour; and the morale, as described by the workforce, has improved greatly.

THE PATTERN OF INQUIRY CONTINUES

At the commencement of this review there were three other current major reviews in train about different aspects of the same system. This includes a review of the *Children and Young People (Safety) Act 2017*; the independent inquiry into foster and kinship care; and an inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle. Since then two recent child deaths have occupied front page media attention. Both children were 'known to child protection'[15] and the media coverage has centred on and been critical of that system. In response, an independent investigation into those deaths was announced, to be led by a former police commissioner, reporting to the South Australian Premier by November 2022.

THE SYSTEM NEEDS A CIRCUIT BREAKER

Alongside real progress over recent years, and the significant dedication of leaders within DCP and the broader sector to implement recommendations, there have been constant pressures that continually divert the energy of the workforce, especially at senior levels, to new problems. It is hard to stay the course for consistent, continuous improvement when the first job of every day is to put out fires. It is even harder to be strategic and innovative, to hold to a vision, when the work is under constant criticism. Those leaders work hard to buffer their ranks and maintain momentum but the system has not had time to catch its breath. The episodic and unpredictable nature of crises, playing out in the media, is relentless and all consuming. And with them the announcement of further reviews and investigations, all of which takes its toll on the most essential ingredient in the system – the people knocking on the doors. Which, in turn, takes its toll on the children they serve.

The time to take stock, slow down, reflect, group and plan the next steps has never been more pressing. And the argument that the answers are to be found within the system, in the minds and expertise of people who know it the best and care the most, has never been easier to make.

ADDRESSING THE TERMS OF REFERENCE

The first term of reference was to review the implementation of recommendations for child protection since 2010. While the review has considered an enormous amount of

material, it has not analysed every single one of the 811 previous recommendations and their implementation, progress and efficacy in minute detail. Instead it has focused on those most relevant to the quality of the system.

The second term of reference, which is about the alignment of practice with statutory obligations, is broad and far-reaching. It has been addressed in the most pragmatic ways possible, noting the full review of the legislation currently underway. Aspects of the *Children and Young People (Safety) Act 2017* have been reviewed, yet its application by the workforce and the great majority of challenges in practice and service provision were understood more as reflections of practice culture than use of legislative powers.

The review makes five broad sets of observations, which are summarised below and described in detail throughout the review. Wherever possible those observations, as per the terms of reference, are aligned to the review of the recommendations for the system and the legislation that guides it. Because that process of organising information did not always flow neatly, and many who participated in this review process were not aware of the majority of recommendations but nonetheless wanted to have their say about the system they work in, an additional section was needed to capture a more formal appraisal of the implementation of recommendations.

OBSERVATIONS OF THE REVIEW

1. The child protection workforce has excellent, well-qualified people

Social workers, leaders and agency partners alike talk about their work with notable pride. They describe significant improvement in morale and direction since 2016 and express belief in their leaders and dedication to their vocation. They rate their levels of hope as high and attribute much of that to a change in the culture of the department that shoulders responsibility at senior levels. There were many examples provided that showed the importance of this united and deliberate leadership style.

In comparison to other Australian states the statutory workforce in South Australia boasts a relatively high proportion of qualified social workers.[16] This is a unique strength, in its potential for consistency and quality, alongside a strong evidence base about the value of the social work profession to outcomes for children and effectiveness of intervention.[17] That evidence includes that child protection staff with social work degrees score higher on measures of competency, skill, confidence and sensitivity than those with other degrees. The opportunity to capitalise on the potential of this workforce, through joint teaching programs and targeted recruitment of the top students, is strengthened by the fact that there are only two universities offering social work degrees in South Australia.[18]

Interagency partners are supportive – there is collective goodwill and a keen desire to refocus the system. The relationships across the sector at senior level have been nurtured and are strong and essential. A Commissioner for Aboriginal Children and Young People has been appointed with the knowledge, cultural wisdom and expertise to lead the thinking on family preservation work. The Australian Centre for Child Protection Excellence calls South Australia home and boasts some of the finest child protection minds in the country. The Centre's research expertise is second to none; its data reflects the plight of disadvantaged and at risk children and families unequivocally. It knows the children and it can describe the differing levels of intervention they need. The ingredients

for a strong system are at its foundation. Those ingredients are the people, from the newest social work graduate to the most senior leaders. The reins belong with them.

2. There needs to be a deliberate focus on Aboriginal children

Despite making up less than 5 per cent[19] of the population, Aboriginal children are grossly over-represented in areas of disadvantage. This flows to the child protection system. Seven of the eight children whose tragic deaths are at the centre of this review were identified as Aboriginal.[20] There has been a 116.3 per cent increase of Aboriginal children in care in South Australia over the last decade[21] and the number is trending up. Only just over half of those children are placed with family or kin. South Australia also has the highest rate of Aboriginal children on long-term guardianship orders, and the lowest rate of reunification for Aboriginal children compared with other Australian states and territories.[22] In investment, South Australia spends 8.8 per cent of the child protection budget on family support services and 3.4 per cent on Aboriginal Community Controlled organisations. Both rates of spending are lower than most other Australian states and territories. And lastly, the application of the Aboriginal and Torres Strait Islander Child Placement Principle, which has legislative provision for culturally respectful and empowered work with Aboriginal families, is not consistent.

DCP has introduced some quality practice changes under Aboriginal leadership, including the Family Led Decision Making Framework and the *Taikurtirna Warri – apinthi* program which operates in six of its frontline offices.[23] *Taikurtirna Warri – apinthi* is a Kaurna expression for finding family and it is the only place to start. There is also promising and reliable evidence of approaches (including Family Group Conferencing, Family Finding and Family Led Decision Making) in DCP and the sector that keep children from entering care. The only problem is that the number of children and families receiving these services is far too low.

The trajectory of Aboriginal children into care has to be stopped in its tracks and it signals a call to arms. The evidence about the ways to do that is real and the appetite is strong. And the only way is with Aboriginal leaders and organisations at the table and a deliberate approach to investment so that the spending on Aboriginal children is proportionate to their representation in the system, not the population.

3. The system is under immense pressure

The recent spate of media reporting that has led to an increase in reports to the system is having a detrimental impact on morale of the workforce, despite best efforts of leaders to buffer it. There are examples of emerging risk averse behaviour by some sector agencies. Anxiety is high and it will derail sound decision-making and professional practice. The impacts of anxiety on decision-making have been well documented. It leaves its mark in many ways and always on children, including an increase in their separation from family. When social workers feel anxiety and pressure to predict and prevent deaths 'at all costs', their only option is to remove children, which addresses one risk while introducing a whole new one. The evidence base about the impacts of growing up in care is well established. Not to mention the fact that the care system is stretched to breaking point, residential services are rarely the answer and carers feel overworked and undervalued.

In England, the death of 'Baby P' in 2006 received extensive and highly critical media coverage. In the months following, the child protection service increased the number of

care and supervision court applications by more than 50 per cent.[24] Morale deteriorated, staff left and there were real difficulties filling their places.[25] Children need a system to make decisions about them that is not so fragile as to be influenced by anxiety, fear or front page news. The assessment of safety is not a nebulous pursuit. It cannot float in the wind to be swayed by different influences. It belongs in the hands of qualified professionals.

While there are strong approaches to child death reviews both internally to DCP and through existing oversight bodies, it is the opinion of this review that an additional cross-agency approach could be of great benefit. It should be convened by an independent mediator in the weeks following a death, attended by senior leaders across agencies, with provisions for full disclosure and the commitment to look not at whether their agency complied with policy and procedure, but instead at what could have been done that might have made a difference. A forum of this nature would assist in the development of shared understanding and responsibility and would reduce the potential for media and community to form simplistic explanations or pit one workforce against another. At the same time, and even more importantly, the windows to determine quality of practice need to be opened much wider through transparent and cross-agency quality assurance mechanisms.

4. An urgent strategy is needed to balance the system

The spending in the system reflects a serious imbalance. Almost 80 per cent of funds are directed to out of home care. The spending on early intervention and intensive family support is the lowest of all Australian states and territories.[26] This imbalance is set against clear evidence that investing in quality early intervention and family preservation work stems the flow of children into the care system.

Equally, the data describes a bottleneck. Many children are not receiving a service and the longer they wait the higher the risk. The recent reform work that followed the Nyland report, in diverting families to DHS and partner agencies for family support work, and the provisions in the legislation to enable this diversion, was well intended but is not working as hoped. Children bounce between systems, the referral pathways are clogged and the workforce is overwhelmed with the tasks of sifting, sorting and prioritising reports instead of getting out and seeing families. Add to that some examples of disparity in pay with social workers in DHS earning more than their counterparts in DCP. There is no position in the system that is not important but an intentional strategy is needed to keep the best and the brightest with the children where the complexity is greatest.

The narrative about the work and the stories that are in the public domain cry out for balance. The outcomes for children who are thriving because of the way the system supported their family need to be promoted and celebrated. The examples of Aboriginal families who were partnered with, and respected for their expertise to organise safety around their own children, need to be sung from the rooftops. And when those children are loved in family, thriving in culture and learning at school they need to be counted as stories of economic success as well as outcomes of morally just and evidence informed approaches.

The dedication and skill of the workforce belongs on display. Social workers who contributed to this review described recent examples of being sworn at, abused and blamed for ‘killing children’ by complete strangers in the street. They said this has

happened when they have forgotten to remove their DCP lanyards in public. In particular, when asked about her hopes for this review one social worker said:

> I just want to be respected to the same level as teachers, nurses, police and ambulance officers.

This comment was particularly poignant because she had earlier been part of a conversation that demonstrated outstanding practice to reunify children with their mother. They had been in care for over a year and the reunification required tenacious skill and excellent interagency relationships. Child protection workers in South Australia should not have to hide who they are in public and they should not have to hope for basic respect.

At the same time, an urgent strategy is needed to address complexity. South Australia has the highest methamphetamine use in the country. One of four children live below the poverty line. Domestic and family violence is at an alarmingly high level; mental health problems are on the rise and there is a housing crisis. Add to that nearly three years of a global pandemic and the pressure on struggling families is undeniable. The impact of all of these problems, which usually thrive in combination, are felt by children in so many more ways than the system is resourced to see, hear and know. It has to be tailored to meet the needs of families with multiple and complex problems and that means true attention to the data, adequate resourcing and critical partnerships with Health, Education and Police. Early intervention is of paramount importance, as is an urgent strategy to attend to the cohort of families whose children have been reported over and over, whose problems saturate and sap resources, yet are not reducing.

5. Practice should be elevated and strengthened to greater consistency

The South Australian system has three different approaches to the assessment of safety of children. The first is Structured Decision Making (SDM) which is a case management suite of tools relied on by DCP to guide and give consistency to decisions. As reports come into the system through the Child Abuse Report Line, DCP uses an SDM screening tool to determine the type of response needed. If it is determined the child needs a statutory response it is sent to a DCP office for assessment. That next stage of work is guided by the SDM safety, risk and risk reassessment tools. Well followed, in the hands of skilful practitioners, they are helpful to structure the process of assessment over time, to articulate concerns, separate concepts of safety and risk, and measure change.

If the screening determines that the level of safety for the reported child can be diverted for a family preservation or early intervention services the report is sent to DHS. This is where the second approach to assessment comes in. Upon receiving the report, DHS undertakes its own assessment, relying on a risk categorisation approach. That assessment includes considering the one undertaken by DCP and it is not unusual for it to arrive at a different view about safety, and the report frequently then goes back to DCP.

The third approach to assessment is undertaken by DCP for children reported at risk in care. With the state as their parent, those children have increased vulnerabilities that require a different appreciation of the threshold for risk yet that threshold appears out of alignment, and characterised by a more overly cautious assessment, from the one DCP relies on for the general population. While the approach to children in care concerns is built on an SDM tool it is nonetheless different in its approach, understanding of safety and language. Add to this that the feedback about the current approach to safety in care

concerns is that it leaves carers feeling 'investigated and undervalued' over the assessment of concerns that may be trivial, unfounded or that would respond much better to supportive casework rather than formal investigation.

These challenges are not all as simple as they sound, nor are their origins necessarily in poor design. As already stated, the intent of the Nyland report to promote the development of quality, quarantined and specialised early intervention services outside of the statutory system was well founded. The problem is that the system has been increasingly flooded by volume.

There are also other problems. The process of reports moving between DCP and DHS involves frequent double handling. Two government agencies applying two different assessment approaches, relying on two different evidence bases that are known to arrive at different outcomes reflects a questionable use of resources and a level of over-engineering. It also means the opportunities for consistency of thinking, professional and trusted articulation of safety and the respect for common understanding have not been realised. Add to that, the safety and risk assessment approaches of both DCP and DHS are not particularly transparent to an outsider looking in. At the same time the resourcing of this assessment work can run over days or weeks and takes place in offices, in front of computers and over phones, and often leads to the child not receiving a service because workers entrusted with protecting them are all at capacity.

The best chance for quality decision-making of the workforce is to make every effort to increase consistency; promote strong implementation of tools; have quality assurance over their use; and insist on common language, terminology and understanding. The South Australian Government would be better placed, in response to future child deaths, if its practice and 'science of quality assessment' had been elevated in the public domain and if it could trust and describe robust processes that have been applied by suitably qualified practitioners. With the greatest of respect to DHS and the obvious hard work, evidence and intellect that has been at the foundation of its assessment approach, it does not make good sense to this review that the non-statutory arm of government should be in a position to appraise the assessment outcomes of the statutory arm. The place in the system that holds the ultimate authority and expertise on assessment needs to be DCP.

These five sets of points summarise a great deal of information. And they reflect two themes which are seemingly in contradiction but are nonetheless true. The first is that great progress has been made and the South Australian workforce at all levels should take pride in that. The second is that the system needs urgent attention. It needs to rebalance and refocus so that it gets to the children that need it the most and brings to them a just, evidence informed, skilful and consistent use of statutory powers.

NEXT STEPS

With the ever constant awareness of the number of recommendations still in progress for South Australia this review was loathe to add to that list. Instead, it makes only three recommendations and five sets of considerations alongside them. Those

recommendations and considerations have been made for the South Australian Premier, Minister for Child Protection and the Chief Executive DCP to determine the next steps.

A DELIBERATE STANCE OF HOPEFULNESS

From the outset this review was determined to be hopeful. While there is very real concern about the system, and it has been weighed down by some of the saddest of stories, the need for hope cannot be overstated. The workforce is review weary and review wary. It is not likely to engage in dialogue that only focuses on what's not working. Yet to deliberately take an optimistic stance has not been at all difficult. With sincere respect to all the previous reviews and inquiries, and the fine minds and people of integrity who led them, the opportunity for this review is different because it is the first that has been led by child protection experience and expertise and it is the first that has centred on the voices of the workforce. That difference is also apparent across some of the other current inquiries – including that the review of the application of the Aboriginal and Torres Strait Islander Child Placement Principle is led by an Aboriginal leader, the inquiry into foster and kinship care is led by a child protection researcher and the review of the legislation is led by the department that depends on it. These appointments, in concert, signal a different and hopeful approach.

The child protection system in South Australia is neither alone nor unique in the challenges it faces. It would be uncharacteristic and falsely confident for any statutory child protection system following the recent media coverage in South Australia to conclude that it was immune from the practice and system weaknesses these tragic stories have revealed. More characteristically, many working in the child protection 'trenches' and those responsible for their supervision and system management feel empathy for their interstate colleagues, quietly knowing 'it could have happened on our patch'. This is not to say that strong practitioners do not believe in their work or trust in their systems – quite the opposite. It is the 'knowing in their bones that this work matters' that drives them every day, provides the courage to knock on the doors of some of the most impoverished homes to bear witness to the bleakest of predicaments and partner with some of the most overlooked people. That knowing is at the heart of good child protection work and it unites strong systems. It is not a lack of belief that fuels the collective empathy of the child protection workforce in the wash up of high profile child deaths; it is the knowledge that the risks in child protection are the same the world over. There is no fail-safe prevention of children being hurt by those entrusted with their care and there is no simple solution to the diverse challenges in providing a quality and enduring response to family disadvantage and risk.

Yet South Australia is unique in the opportunities before it, as a relatively small state with the right people at the table and considerable progress already made. The workforce is united by notable hope, even right now with strong outside forces nipping at the heels of that hope. If the intellect, collective energy, infinite skill and wisdom of the whole workforce can be united in a single vision with shared responsibility, vulnerable children in South Australia will reap the rewards by being made safer. And the state can lead others across the country in its courage to tackle the real problems head on with a world-class approach.

TRUST IN CULTURE

The final word is about the title of the review. It took a long time to come to mind. Its working title 'Stay the course' did well to honour all the progress made and the current work in good hands. Yet it fails to reflect the inequality that is writ large in the data. It fails to deliver the call to arms that's needed.

Trust in the love of the oldest culture on earth for its own children and its infinite wisdom to find ways and people to make them safe. Trust in the culture of well-qualified and supported child protection practice. Trust in the culture of strong leadership and cross-agency partnerships that are making a difference. And most of all, trust in family and its culture of belonging. It's a basic human right of all children.

This review is written with deep respect for the work of child protection in South Australia and trust in its culture.

Kate Alexander, PSM, BSW, MSW

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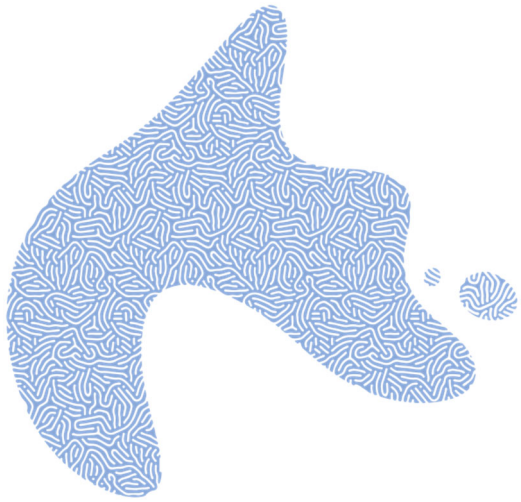
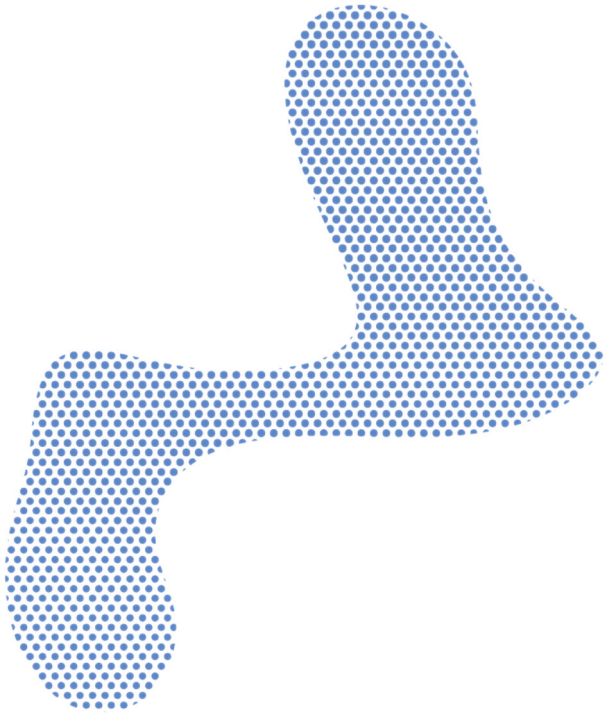
1 Whittaker, J. (1997). Intensive family preservation work with high risk families: Critical challenges for research, clinical intervention, and policy. In *International perspectives on family support*, ed. Hellinckz, W., Colton, M. J., & Williams, M. 124–139. Areana.
2 The Minister for Child Protection told the media that the government would 'accept and implement' all four recommendations on 22 April 2022. The third recommendation was for an assessment of resources to be made following this review and the fourth was for the Chief Executive to remind staff of certain statutory obligations.
3 United Nations Convention on the Rights of the Child (UNCRC, 1989) Article 19.
4 Australian Bureau of Statistics (ABS). (2022). *National, state and territory population.* Table 8: Estimated resident population, by age and sex – at 30 June 2021.
5 BetterStart. (2017). Child Protection in South Australia Research Report October 2017. https://dhs.sa.gov.au/services/cfss/EIRD/academic-research
6 SA DCP. Reported notifications and screened-in notifications table listed on 'Reporting and statistics' page. https://www.childprotection.sa.gov.au/department/reporting-and-statistics
7 In the five year period between 2016/17 and 2020/21, the number of notifications made about children increased by 51.3% (from 52,979 to 80,175). Of these, screened-in notifications increased by 79% (from 21,546 to 38,473). SA DCP website, 'Reporting and statistics' page.
8 In 2020–2021, South Australia's rate per 1,000 of Aboriginal children in out of home care was second only to Victoria and for non-Indigenous children is higher than all other states. Productivity Commission (2022). 'Child protection services' in *Report on government services 2022*, Table 16A.2.
9 BetterStart (2017).
10 Dr Henry Kempe's seminal research saw him nominated for the Noble Peace Prize for interpreting medical evidence of untreated broken bones in infants.
11 Scott, D. (1995). The social construction of child sexual abuse: Debates about definitions and the politics of prevalence. *Psychiatry, Psychology and Law*, *2*(2), 117–126.
12 BetterStart. (2017).
13 The methodology section in Part 3 explains how this number was calculated.
14 SA DCP website, 'Reporting and statistics' page.
15 This is common terminology for how the media and others refer to children who have had a history of child protection intervention or reports made about them to the system.
16 Estimated to be as much as 80% of the statutory workforce, which is higher than other Australian states – for example in NSW the proportion of social workers in the workforce is 30%.
17 Chabot, M., Fallon, B., Tonmyr, L., MacLaurin, B., Fluke, J., & Blackstock, C. (2013). Exploring alternate specifications to explain agency-level effects in placement decisions regarding aboriginal children: Further analysis of the Canadian Incidence Study of Reported Child Abuse and Neglect Part B. *Child Abuse and Neglect, 37*(1), 61–76.
18 The universities of Flinders and South Australia. In comparison NSW has eight universities.
19 South Australia is home to 369,658 children. Of them, 18,187 (4.9%) identify as Aboriginal. Australian Institute of Health and Welfare (AIHW). (2022). *Child protection Australia 2020–2021*. Table P3. https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2020-21/
20 Chloe Valentine, Heidi Singh, Amber Rigney, Korey Mitchell, Zhane Chilcott, Charlie, Makai.
21 South Australia also has the second highest rate of Aboriginal children entering care compared with other Australian states and territories.
22 Only 7% according to the SNAICC (2021) *Family Matters Report 2021*.
23 Elizabeth, Playford, Woodville, Blair Athol, St Marys and Noarlunga.
24 Hall, E., & Guy, J. (2010). The Baby Peter effect and the increase in s31 care order applications. Children and Family Court Advisory and Support Service (CADCASS).

25 Macleod, S., Hart, R., Jeffes, J., & Wilkin, A. (2010). The impact of the Baby Peter case on applications for care orders (LGA Research Report). National Foundation for Educational Research.
26 Some 78% of funding goes to out of home care and less than 4% is spent on intensive family support services. Productivity Commission (2022), Table 16A.8.





1 OVERVIEW

We must organise around our best hopes
not our worst fears.

Turnell (1999)[1]

1.1 TERMS OF REFERENCE

The Reviewer shall conduct a review of:

1. All coronial and other recommendations relating to child protection in the State of South Australia since 2010 and the implementation of the same.
2. All statutory obligations contained within the *Children and Young People (Safety) Act 2017* and the extent to which practices within the Department for Child Protection, and other State government agencies as may be appropriate, align with those statutory obligations.

   With respect to point 1, the Reviewer will include consideration of the most appropriate lead agency(s) for the ongoing implementation of coronial and other recommendations.
   Upon completion of the Review, a Report shall be provided to the Premier of South Australia, the Minister for Child Protection and the Chief Executive of Child Protection.
   Without limiting the scope of the findings, the Report should support an assessment to be made to ensure that all statutory obligations under the *Children and Young People (Safety) Act 2017* are fully resourced to enable those duties and obligations to be carried out.

1.2 SUMMARY OF RECOMMENDATIONS AND CONSIDERATIONS

This review was determined not to make a long list of formal recommendations. There are two reasons for this. Firstly, the awareness that since 2010 there have been over 800 recommendations made about the child protection system in South Australia. While many of those recommendations have led to improvements in the system's response to children, others are still in progress, alongside an extensive reform program. Secondly, the workforce trusts its leaders and interagency partnerships at a senior level are strong.

Part 4 of this review highlights research that suggests recommendations are most effective when they are developed in consultation and through collaboration with those responsible for implementation.

It is obvious that there is much expertise in the system and clear, frequently consistent, ideas about what needs to change. To that end the review makes only three recommendations, as well as a set of considerations.

As the review was requested by the Premier of South Australia, the Minister for Child Protection and the Chief Executive of DCP, the recommendations are to be considered by them. Considerations are listed below the recommendations, in sets that align with the five observations of the system made by this review. Each set describes considerations that aim to impact positively at the level of the whole sector and DCP.

Some of the considerations will require investment, or reallocation of resources, to implement. This review is not in a position to make recommendations about resourcing; those decisions belong with government.

RECOMMENDATIONS

1. Establishment of the South Australian Child Protection Expert Group

This group should be formed quickly and made up of the people best suited to address the current concerns in the system and capitalise on the current progress. It should be led by DCP, signalling trust in its child protection expertise, and informed by this review and, in equal measure, the four others currently underway. The group will need to consolidate the findings and recommendations of them all and prioritise which ones to implement.

The group should be established so that it:

- is recognised and trusted as the authorising environment for system change and reform, with the mandate to decide what to do in the event that some recommendations from the current reviews may overlap, contradict or duplicate
- provides a genuine opportunity to use the levers of funding at the group's discretion, with the intent of fully resourcing the duties and obligations necessary to carry out statutory obligations under the *Children and Young People (Safety) Act 2017* (as per the terms of reference)
- is representative of the workforce, including Aboriginal leaders, social workers, leaders, researchers and DCP executive and includes representation from the Department of Treasury and Finance
- is sponsored and trusted by government and given the time to think, plan and build; the progress of the group cannot be derailed by any new crisis

- is the joint responsibility of the Minister and the Chief Executive. The possibility of an independent facilitator, external to the system with child protection expertise, should also be considered in establishing the governance arrangements.

The group should be formed with acknowledgement that it sits over the top of other current committees (e.g. the ***Safe and well*** reform) and consideration will be needed as to whether it replaces some of the other current reform strategy groups.

The group should be informed by stakeholder groups, including the importance of those with lived experience. Its members need to be highly qualified and appointed via an expression of interest process where they are required to demonstrate child protection experience, relevant qualifications, knowledge and credibility. Well established and equipped, the group will give confidence to government and community alike. It will provide reassurance that it has line of sight to quality, and mechanisms and research capabilities at its disposal to provide regular, transparent reporting on a variety of indicators of effectiveness of the system for children.

The terms of reference for the group, its intended duration and options for monitoring and evaluating its progress should be determined by the Minister and Chief Executive.

2. Merge the functions of DHS into DCP so that all of government child protection services are under the one Minister, executive and governance structure

This recommendation has been given a great deal of thought and has been informed by a wide variety of views and evidence. It should not be interpreted to mean that the services provided by DHS, or the significant research expertise it has established, is not valued. Rather the recommendation should be understood as the most strategic way to:

- elevate the expertise of the statutory child protection agency
- reduce duplication and inefficiencies
- prioritise the learning and development needs of the whole workforce through consistent strategies
- ensure only one safety and risk assessment approach is used by government for children who have been reported and that approach is transparent, evidence based and its quality is monitored
- remunerate the workforce in equitable ways that provide incentive for the most skilled and experienced to work with the families whose children are at the highest risk.

The merge would address the observations of the review that the intent of the Nyland recommendations to divert work to the early intervention sector, and thereby reduce demand on the statutory system, has not been met.

Finally, the strongest argument about the importance of this recommended merge is that it addresses the critical need for the government, sector and community to place their trust in the child protection system so that it can stay its course of current reform. The best way to build that trust is to elevate the expertise and professionalism of the work with the statutory system as the lead authority, under one government department and one Minister.

If agreed to, this recommendation will impact the DHS workforce. Strong communication strategies will be useful to reassure staff that their roles, functions and services will continue to be of high value.

3. Rely on the Senior Executive Group within DCP for internal reform initiatives

DCP has a strong and collaborative Senior Executive Group. It is already working on a reform agenda. It is well suited to take the considerations made about its department and determine the best course of action in response. The Minister and Chief Executive are best placed to determine the monitoring and reporting arrangements for this work.

CONSIDERATIONS

Observation 1: The child protection workforce (described at 5.1)

For the South Australian Child Protection Expert Group to consider

- The importance of a clear communication strategy, at the conclusion of this review process, that provides a summary of its observations and reinforces and promotes the stability of leadership across the agency, especially given the recent anxiety in the system.
- Opportunities to quickly address any disparity in remuneration between DCP and DHS child protection practitioner positions. Longer term strategies to provide financial and hierarchical incentive for skilled and experienced staff to stay in direct practice should also be considered.
- A partnership with the Centre for Child Protection Excellence and the schools of social work at the two South Australian universities to design an industry wide capability-based workforce development strategy to equip the child protection workforce with high level and contemporary child protection skills and knowledge. This strategy should build on the positive partnerships that are already in place, consider options for targeting, and providing incentive to the highest ranked students, and will require investment. Ideally it should also involve DCP and sector leaders contributing to the social work degree teaching program, the creation of a formal pipeline for students and new child protection electives for third and fourth year students that are prerequisites to joining the DCP workforce.

For the DCP Senior Executive Group to consider

- Options for resourcing a comprehensive and contemporary skills and knowledge based entry level program for new social workers and case managers.
- Options for further supervision and practice leadership training for managers and team leaders.
- Enhancement of the current supervision strategy to provide clear messages about expectations and accountability, alongside monitoring of compliance measures that reflect that supervision has taken place and also to consider its quality.
- Options to use the current review of the legislation to remove the requirement for residential staff to undergo psychological testing.

Observation 2: There needs to be a deliberate focus on Aboriginal children (described at 5.2)

For the South Australian Child Protection Expert Group to consider

- Options for deliberate and vastly increased investment in early intervention and family preservation services for Aboriginal families. The spending on Aboriginal children and services should be proportionate to their representation in the system, not the population. This will require extensive planning and should include the further expansion of Family Group Conferences (both in the sector and a unit within DCP that encourages and supports frontline staff to promote use of FGCs).
- The findings and recommendations of the Commissioner for Aboriginal Children and Young People's review into the application of the Placement Principles to inform future planning, investment and strategies to increase the participation of Aboriginal people in decision-making about their children.
- Opportunities to meet the needs of Aboriginal people through coronial processes and formal inquiries. This should include consideration of restorative justice approaches, led by Aboriginal mediators, and options to ensure Aboriginal leaders provide cultural expertise and advice to any analysis of concerns or data that is about Aboriginal children and families.

For the DCP Senior Executive Group to consider

- Opportunities to rely on the current review of the legislation to make mandatory the use of Family Group Conferences for all families where Aboriginal children have been assessed as unsafe. Importantly, this would mean that no Aboriginal children can be presented before for the Youth Court seeking assumption of care orders in the absence of a Family Group Conference having taken place.
- Further work on the SDM tools to ensure cultural sensitivity, including consideration of protective factors through a cultural lens. This work should also include collaboration with Queensland and NSW on the current work improving their assessment approaches to better reflect the needs, strengths and protective factors of Aboriginal families and reduce potential for bias.

Observation 3: The system is under immense pressure (described at 5.3)

For the South Australian Child Protection Expert Group to consider

- Cross-agency approaches to address the recent increase in notifications following child deaths. This needs to include strategies for escalation of genuinely urgent matters, shared responsibility and accountability.
- Strategies across agencies and the government sector to challenge the single narrative in media reporting.
- That in the event of adverse events shared media statements are issued across government agencies that present a united commitment and position.
- A cross-agency approach to child death reviews relying on full disclosure and shared responsibility.

Observation 4: The system needs to find its balance with urgency (described at 5.4)

For the South Australian Child Protection Expert Group to consider

- Opportunities to address the problems with referral pathways and duplication of work between two governments agencies (this will be dependent on government acceptance of recommendation 2, as above). This is a complex task, but one that will be made easier because there is already much reform work and thinking in train by DHS, reliant on quality data and strong relationships united by a common goal.
- Opportunities to work with the media and community to promote the work of child protection, its people, diversity, rewards and success stories. This could include options for celebrating outstanding workers with a Premier's Award for child protection expertise celebrated in the media.
- Strategies to address the most at risk families in the system with deliberate investment of time, resources and skilled workforce; as well as strategies to make the best use of efficient referral pathways so that as many families as possible receive early intervention services when they need them.

Observation 5: The expertise of child protection practice should be elevated and strengthened to greater consistency (described at 5.5)

For the South Australian Child Protection Expert Group to consider

- Ways to gradually shift terminology to reflect developments of thinking in contemporary child protection work – including moving from investigation to assessment, and from incidents to chronicity and pattern of harm.
- Development of a comprehensive quality assurance approach to safeguard the process of safety and risk assessment. This would mean that the Minister and Chief Executive would receive quarterly reports about the quality of decision-making about children at risk. This data would provide a much more useful window to view the effectiveness of the system than individual child deaths.

For the DCP Senior Executive Group to consider

- Updating the SDM approach so that it reintroduces the family strengths and needs assessment tool as a mandatory step before case planning, goal setting and risk determination.
- Elevating and promoting SDM and making it more transparent, with stronger quality assurance, to safeguard its use.
- Addressing the very real concerns about the approach to assessing safety of children in care – this needs to include aligning the approach with SDM and it should be undertaken in consultation with Professor Arney, aligning to the findings and recommendations of her current review.
- Governance and structural arrangements to elevate and safeguard practice, reviews and decision-making. This should include consideration of combining some units and changing the structure so that the lead practitioner reports outside the operations arm of the agency.

1.3 HOPES FOR THE REVIEW EXPRESSED BY THE WORKFORCE

Throughout stakeholder meetings and consultations, participants were asked to describe their hopes for this review process. Below is a selection that summarises the main themes.

That it builds credibility for the work of child protection	Manager DCP
That it shows the passion and care of child protection staff	Social worker DCP
That it helps us all stay the course. We are making progress but when in crisis there is no time to drive reform.	Leader Non-government organisation
That it works as a circuit breaker; the system needs to feel supported not attacked	Leader Government agency partner
That it gives DCP the resources and funds to be able to be effective	Leader Government agency partner
That its messages help staff who have left return to the work	Manager DCP
That it understands our work, that it is listened to and that social work is truly reflected	Team leader DCP
That it ensures front end child protection staff are remunerated well	Manager Non-government organisation
That social workers get to feel proud of what they do and people with experience of the system are respected for what they can offer	Family member
That it recognises the expertise and skill of child protection workers. Reviews by non-CP expertise only lead to simplistic solutions.	Leader Non-government organisation
That the review is read by the media and the community and it helps them to understand and respect this complex system	Leader Non-government organisation
That it promotes awareness that department heads who have an appetite for innovation need to be given the space and time for it	Leader Non-government organisation
That it describes the need for a tolerance for risk and is realistic about expectations	Leader Non-government organisation
That it's met with deep political will and the commitment of funding	Leader DCP
That is recognises the intergenerational trauma and multi problems that families are experiencing as well as what has changed over time	Leader Non-government organisation
That it has an increased focus on prevention and support for families	Leader Government agency partner
That it gives recommendations about what needs to stop	Leader Non-government organisation
That it points out the woeful under funding for early intervention services	Leader Non-government organisation
That it calls out that the system has moved on from the time of the Royal Commission; that the Department is well structured and has all the parts and people it needs	Leader Non-government organisation
That it says that deaths will happen however hard we work	Team leader DCP

1 Turnell, A., & Edwards, S. (1999). *Signs of safety: a solution and safety oriented approach to child protection casework*. Norton.

2 THE SYSTEM

We are all caring for Country
together whilst the nori watches
over you as a protector.

Ngarrindjeri Elder
Uncle Major 'Moogy' Sumner

2.1 THE STORIES OF THE SIX CHILDREN

The following information focuses on the six children who died and were the subject or coronial processes since 2010. All of the information has been taken from sources that are publicly available.

Four of the six children – Heidi Singh, Amber Rigney, Korey Mitchell and Zhane Chilcott – were from the Ngarrindjeri nation. This Aboriginal nation contains 18 different language groups and its lands and waters extend 30 kilometres up the Murray from Lake Alexandrina, the length of the Coorong and the coastal area to Encounter Bay. Ngarrindjeri people fished in the rivers, lakes and seas using nets, spears and traps.

'Nori' means 'pelican' in Ngarrindjeri language and the word 'Ngartji' is used to describe particular animals and plants that are the totem or special friend of Ngarrindjeri people. To care for Ngartji is to care for Country. Ngarrindjeri people have a special responsibility to care for their Ngartji.

CHLOE VALENTINE

Chloe was four years old when she died from head injuries in 2012. Her injuries were caused by riding a motorbike three times her weight, which she fell from and was crushed by, at the insistence of her mother and mother's boyfriend.[1]

Her mother, Ashlee, was still a child herself when Chloe was born and had a chronic addiction to methamphetamine. Ashlee was frequently homeless and was a victim of repeated violence. Chloe was the subject of 22 reports to Families SA and was described consistently as neglected, physically and emotionally. Chloe was present when her

mother was assaulted; she had no stable home (there were at least 15 different homes in her life, all mostly squalid, not to mention a variety of substandard care arrangements she was left in); and she was often unwell and often alone.

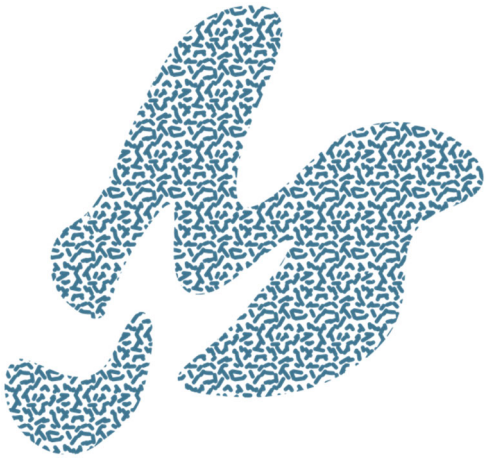
There was absolutely no evidence provided at the inquest that Chloe was ever safe in her mother's care.

Perhaps the saddest and most telling information about Chloe was provided by her respite carer – a woman who obviously loved Chloe, cared for her often and generously (there were times when she took Chloe for an arranged weekend and still had her four to five weeks later) and always handed her back reluctantly. She described a time when Chloe was two and was handed into her care with terrible nappy rash. The carer said she was 'absolutely astounded' when she saw the extent of the rash, describing it as 'an inch and a half to two inches down each leg and extremely red'. She put Chloe in a bath to try and start some healing, knowing it would be painful. She recalled:

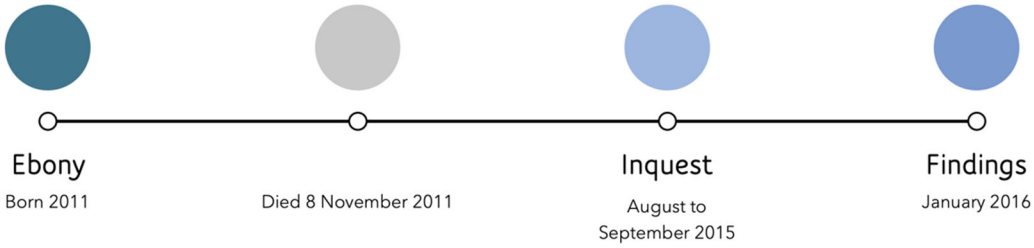
> **She just, in typical Chloe fashion, went to sit down in the bath. You could see that it was not comfortable for her and then that look came across her face as if to say, oh well, get on with it, just do it. She was very much, I think, used to the fact that things hurt … Chloe just took it all in. I think one of the things I found with Chloe over the years was that she understood that you were trying to help. She was very much a 40 year old in a two to three year old body.**

Chloe's grandmother Belinda Valentine provided her insights to this review. She gave examples of the way Chloe took on responsibility and showed maturity well beyond her years. Belinda said that Chloe loved her mother and acted protectively towards her. She added that in, 'her own way', Ashlee loved Chloe dearly, but was not mature, safe or well enough to care for her on her own.

The standout themes from Chloe's story are common to many of child death reviews in both Australia and other jurisdictions – the system's inability to allocate all cases for assessment and ongoing work; superficial practice; and a lack of sophistication and expertise in assessing addiction, neglect and violence. The Coroner made 21 recommendations at the conclusion of the inquest.



EBONY NAPIER



Ebony was four months old when she died in November 2011 from blunt force head trauma. The details of Ebony's post-mortem are highly distressing. In the words of the forensic pathologist, Ebony was 'mercilessly and serially brutalised'. In addition to her head injuries, Ebony had multiple injuries to her spine, rib cage and upper and lower limbs. She had 48 old healing rib fractures and four recent rib fractures. There were new fractures observed on the sites of older fractures. Her finger and toe fractures were consistent with squeezing or stomping. Her injuries were believed to be deliberately inflicted.

The evidence was clear Ebony's injuries had occurred at the hands of her parents. They were both young and had their own child protection histories. The inquest revealed that Ebony's mother was the victim of extreme violence by Ebony's father. He had become increasingly paranoid and would keep the unit where they were living locked and dark and would prevent Ebony's mother from answering the door or going outside.

The inquest focused on information sharing – both between agencies and with other jurisdictions; the impact of drug use on a parent's behaviour; the process of assessment for non-accidental injuries; and the case closure process within the (then) child protection department. Similar concerns were expressed to those by Coroner Johns in the case of Chloe Valentine about the legislation not being used as intended. Sixteen recommendations were made at the conclusion of the inquest.

HEIDI SINGH

Heidi was aged 14 years when she was found, deceased, at a train station near an electricity pylon. Her cause of death was electrocution. When Heidi died she was under the care of the Minister and living in emergency care accommodation that was staffed by contracted rotating commercial carers.

Soon after she was born, and at the request of her mother, Heidi moved to live with a non-Aboriginal couple, Wolter and Lyn Flink, whom Heidi called 'Nana' and 'Poppa'. Heidi's mother knew Wolter and Lyn through the local community and had previously asked them to care for her older daughter, Emily, who was four years old when Heidi was born.

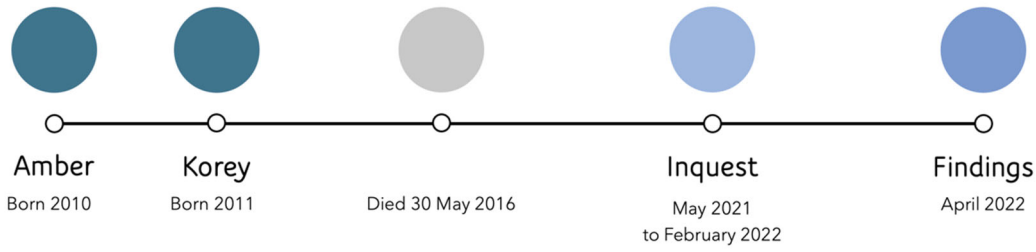
At the age of three, Heidi was diagnosed with foetal alcohol spectrum disorder. By the age of six she was prescribed medication to assist in the management of challenging behaviours.

When Heidi was 13 she experienced the death of the three adults most significant to her – 'Nana' and 'Poppa' due to poor health and her mother due to a drug overdose. Heidi moved to live with family friends but when her behaviour became too challenging and they felt unable to keep her safe, they contacted Families SA. During this time Heidi had needed to be hospitalised repeatedly for challenging and harm-based behaviours including aggression, violent outbursts, and self-harm. In June 2014 Heidi entered the interim care of the Minister for Child Protection. She died 10 weeks later.

Heidi's kinship aunt (the daughter of Alina Flink) contributed to this review. She described Heidi as 'loving' and 'creative'. Two days before she died Heidi visited Alina and spent time with her and her children. Alina described this time with Heidi as 'one of the best visits' and that Heidi seemed happy and connected. During the inquest Heidi was described as 'showing maturity and growth' and was 'open, positive and optimistic about her future'.

The Coroner who conducted the inquest into Heidi's death focused on the lack of collaboration and 'silo' driven approach taken by all; the level of support and services provided by CAMHS, the Child and Adolescent Mental Health Service; and the use of emergency care and staffing. The Coroner also focused on insufficient efforts made by Families SA to connect Heidi to kin, extended family and culture and to follow the Aboriginal and Torres Strait Islander Child Placement Principle. At the conclusion of the inquest five recommendations were made by the Coroner.

AMBER RIGNEY AND KOREY MITCHELL



The executive summary provided detail about the awful circumstances in which six year old Amber and five year old Korey were killed by their mother's partner.

Amber was enrolled at school but was not attending regularly. The inquest heard descriptions of Amber being dropped outside school late, having to make her own way to the office to sign in and waiting alone in the school office for a taxi to collect her at the end of the day. She was described as 'tired and struggles with day to day tasks due to lack of concentration and ability'. Evidence provided at the inquest also indicates that Amber and Korey were exposed to parental drug use, violence and neglect.

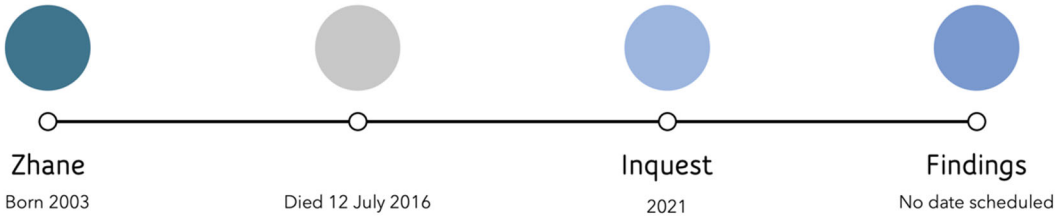
In the lead up to Amber and Korey's deaths, there were ongoing proceedings at the Federal Circuit Court. While these proceedings were mainly about the custody of Amber and Korey's older brother, an independent children's lawyer had been appointed to represent the interests of all three children and there were growing concerns about the

safety of Amber and Korey. DCP continued to 'respectfully decline to intervene in these proceedings'.

At the conclusion of the inquest the Coroner referred to recommendations made in previous coronial inquiries, particularly those about the mandatory obligations imposed by legislation and the statutory powers available to child protection workers to intervene when children are at risk. The Coroner made four recommendations including those discussed that led to this review.

Amber and Korey's grandmother Donna Rigney and their maternal aunt Bella Rigney participated in this review process (see also section 5.2). The brought photos of the children with their mother Yvette and spoke about their bubbling and happy dispositions.

ZHANE CHILCOTT



Zhane died in circumstances of suicide on 12 July 2016 aged 13 years. Zhane was removed from his mother's care before his first birthday and lived under a guardianship arrangement. His time in care was characterised by instability. Zhane lived in 18 different placements, including foster care, emergency commercial care and residential care. When he died he was placed in a residential care unit at Morphett Vale.

The Inquest into Zhane's death considered his experience under the Guardianship of the Minister and the significant concerns about the level of care and support he was provided. The Coroner heard evidence in 2021. The date the inquest findings will be handed down is not yet known.

2.2 THE STORY OF THE SYSTEM 2010–2022

The terms of reference for this review focus on the system post-2010. Even before then, South Australia's child protection system was well familiar with the process of inquiry and review. In 2003, **Our best investment: A state plan to protect and advance the interests of children** (the **Layton review**) made 206 far-reaching recommendations for an overhaul of the system. Five years later, in 2008, the **Children in State Care Commission of Inquiry: Allegations of sexual abuse and death from criminal conduct** (the **CISC Inquiry**) considered the experiences of children who had been sexually abused or died as a result of criminal conduct in state care and made 54 recommendations. During the CISC Inquiry, a large amount of evidence was received regarding the abuse of children on Anangu Pitjantjatjara Yankunytjatjara lands. In response, the legislation that had established the CISC Inquiry was amended to add a second inquiry examining the abuse of children on the APY lands. The **Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A report into sexual abuse** (the **APY Lands Inquiry**) followed and made a total of 46 recommendations.

The major reviews since 2010, on which the focus of this review will remain, are summarised below.

ROYAL COMMISSION REPORT OF INDEPENDENT EDUCATION INQUIRY

During the period when child protection joined with education in the Department for Education and Child Development (DECD), the **Royal Commission 2012–2013 Report of Independent Education Inquiry** (the **Debelle Inquiry**) took place. It was requested by the Minister for Education and Child Development who appointed Supreme Court Justice, Bruce Debelle, to consider the events and circumstances surrounding the arrest and later conviction of an employee of an Out of School Hours Care Service on charges of child sexual assault. The Debelle Inquiry concluded in June 2013 and made 43 recommendations for the South Australian government.

THE ALLEN REVIEW

Two weeks after the Debelle Inquiry was finalised, on 3 July 2013, the Minister for Education and Child Development announced a further review of DECD. Former Victorian Education Department chief Peter Allen led this review, producing **Measures to improve operations and culture of the Department of Education and Child Development** (the **Allen review**). It made 14 recommendations.

THE FIRST HYDE REVIEW

In June 2014, South Australian police arrested Shannon McCoole, who was charged with offences of sexual abuse of young children and offences relating to the production and dissemination of child pornography. McCoole had been employed directly by Families SA and via a commercial care agency, both positions providing him with access to children in residential care settings.

Malcolm Hyde AO, a former South Australian Police Commissioner,[2] was tasked by the Minister for Education and Child Development to complete a review into the residential care workforce and its human resources practices. This took place in August and September 2014. It was not made public but is understood to have highlighted operational risks and identified significant deficits in Families SA policies and practices

particularly human resource management within the residential care directorate. The review made 49 recommendations and an implementation project commenced in early 2015 to make the recommended changes.

SELECT COMMITTEE

In May 2014, the Legislative Council of the Parliament of South Australia appointed a State Parliamentary Select Committee to inquire into and report on statutory child protection and care. In June 2015 the Legislative Council instructed the Committee to amend and expand its terms of reference. The Select Committee tabled its first interim report on 23 September 2015 in accord with the first terms of reference. This review contained 40 recommendations. The second interim report was tabled in May 2017 and **Final Report** containing a total of 43 recommendations was released in November 2017.

CHILD PROTECTION SYSTEMS ROYAL COMMISSION

The arrest of McCoole was also the catalyst for the Child Protection Systems Royal Commission which was established in August 2014 to investigate child protection in South Australia.

It is worth noting that around this time there was some confusion in the community about inquiries and where to direct submissions. The Nyland report notes the initial response to the call for submissions was 'disappointing' but commented that its establishment coincided with hearings by the federal Royal Commission into Institutional Responses to Child Sexual Abuse, the call for submissions by the State Parliamentary Select Committee as well as being further exacerbated by the coronial inquiry into the death of Chloe Valentine which commenced on 14 August 2014.[3]

Commissioner Nyland and her team examined the laws, policies, practices and structures in place for children at risk of harm, abuse or neglect. The Commission heard evidence from 381 witnesses, received 374 submissions, examined 10,800 documents and conducted 74 stakeholder engagements. Two years later, in August 2016, **The life they deserve: Child Protection Systems Royal Commission Report** (the **Nyland report**) containing 260 recommendations was delivered to the South Australian Government. In November 2016, the government released its response to the Nyland report in ***A fresh start***. Annual progress reports were released publicly in June 2017 and June 2018.

INQUEST INTO THE DEATH OF CHLOE VALENTINE

See Part 2.1 for full information.

FORMATION OF THE DEPARTMENT FOR CHILD PROTECTION

In advance of her report's release, Commissioner Nyland recommended that Families SA should be established as a department in its own right and separated as a standalone department. This recommendation would enable planning for the organisational changes and reforms being proposed in the Nyland report and was accepted by the South Australian government. The Department for Child Protection (DCP) was formed in November 2016 following the appointment of a new chief executive in October 2016.

Over the period of review (2010 to date) the statutory child protection arm of the South Australian government (now DCP) has undergone several moves and name changes as

determined by government priorities. This scale of change is not dissimilar to the experience of statutory child protection systems in other jurisdictions, but important to remember when considering the pressure on the system as a whole, and its response to recommendations.

INQUEST INTO THE DEATH OF EBONY NAPIER

See Part 2.1 for full information.

ROYAL COMMISSION INTO INSTITUTIONAL RESPONSES TO CHILD SEXUAL ABUSE

In December 2017, the **Royal Commission into Institutional Responses to Child Sexual Abuse** delivered its final report. It was the last of four reports that produced a total of 409 recommendations, 256 of which were for the South Australian Government.

NEW LEGISLATION INTRODUCED

In October 2018, implementation of the South Australian *Children and Young People (Safety) Act 2017* was complete. The new legislation presented the legal framework for a new child protection system and incorporated many of the recommendations made in the Nyland report. The new legislation enshrines principles for early decision-making supporting permanency and stability, gives children and young people a greater say in decisions that affect their lives, fully articulates the Aboriginal and Torres Strait Islander Child Placement Principle, strengthens Family Group Conferencing provisions and embeds increased rights for carers. Provisions for a review of the Act is embedded in section 169. This review is now taking place, led by DCP, and is due by 26 February 2023.

INQUEST INTO THE DEATH OF HEIDI SINGH

See Part 2.1 for full information.

CHILD PROTECTION STRATEGY RELEASED

In December 2019 the South Australian Government released the whole-of-government child protection strategy **Safe and well: Supporting families, protecting children**. From 2020 onwards, the government has produced a single annual report to address the recommendations made in both the Nyland report and the Royal Commission into Institutional Responses to Child Sexual Abuse.

THE RICE REVIEW

In September and December of 2020, two men were sentenced in the District Court for sexual offences against girls who were under guardianship of the Chief Executive DCP. On both occasions, the Minister for Child Protection was unaware of the offending until after sentencing. In response to concerns about the adequacy, or lack of, reporting procedures in place for DCP, particularly in relation to allegations of sexual offending, the Attorney-General appointed former district court judge Paul Rice QC to complete an independent review. In February 2021, the **Report of Independent Inquiry** (the **Rice review**) was made public with six recommendations for the South Australian Government.

SOUTH AUSTRALIAN DUAL INVOLVED PROJECT

During the completion of this review, the Guardian for Children and Young People released the **Final Report of the South Australian Dual Involved Project** (the **SADI Project**) in June 2022. It details the experiences and needs of children and young people who are involved with both the child protection and youth justice systems in South Australia. This report makes 15 recommendations for the South Australian government.

INQUEST INTO THE DEATHS OF AMBER RIGNEY AND KOREY MITCHELL

See Part 2.1 for full information.

INQUEST INTO THE DEATH OF ZHANE CHILCOTT

See Part 2.1 for full information.

DEATH OF CHARLIE

Charlie[4] was a six year old girl who died on 15 July 2022 in Munno Parra. Police announced that special taskforce 'Prime' would be established to investigate her death. Available information suggests Charlie died from conditions of neglect and suspected malnutrition. Her five siblings were removed after Charlie's death. Reports had been received about serious levels of domestic violence. Charlie's father had been in prison at the time of her death on convictions of violence against her mother. Several government departments including DCP, DHS and Education had worked with the family on risks of neglect, school absenteeism and the father's use of violence.

DEATH OF MAKAI

Makai[5] was a seven year old Kaurna-Narungga Aboriginal boy who died at hospital on 10 February 2022. At the time of Makai's death health issues had been identified but not linked to any overarching concern.

Makai had been living with his father and was one of six children his father cared for at the time of his death. His mother told media that Makai was a 'lovely little boy, happy-go-lucky. Full of energy'.

In July, the media announced that after a 'cursory' look at records from child protection and health South Australian police had determined that a criminal investigation was required.

On 1 August 2022, it was announced that Makai's death would also be investigated by Taskforce Prime, as a case of suspected criminal neglect causing death. On the same day, the Department of the Premier and Cabinet announced that former Police Commissioner Malcolm Hyde would lead a 'combined review of multiple government agencies and their interactions with the families of both Charlie and Makai'. The statement further said that the review would be undertaken as quickly as possible while working co-operatively with Taskforce Prime.

THE PATTERN OF INQUIRY CONTINUES

Alongside this review are others in current progress that also consider aspects of South Australia's child protection system:

- a review of the *Children and Young People (Safety) Act 2017* led by DCP
- an inquiry into foster and kinship care under section 169A of the *Children and Young People (Safety) Act 2017* led by Dr Fiona Arney
- an inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle led by the Commissioner for Aboriginal Children and Young People April Lawrie
- an independent review of the two child deaths at Munno Para and Craigmore led by former South Australian Police Commissioner Malcolm Hyde
- the inquest into the death of Zhane Chilcott – awaiting findings.

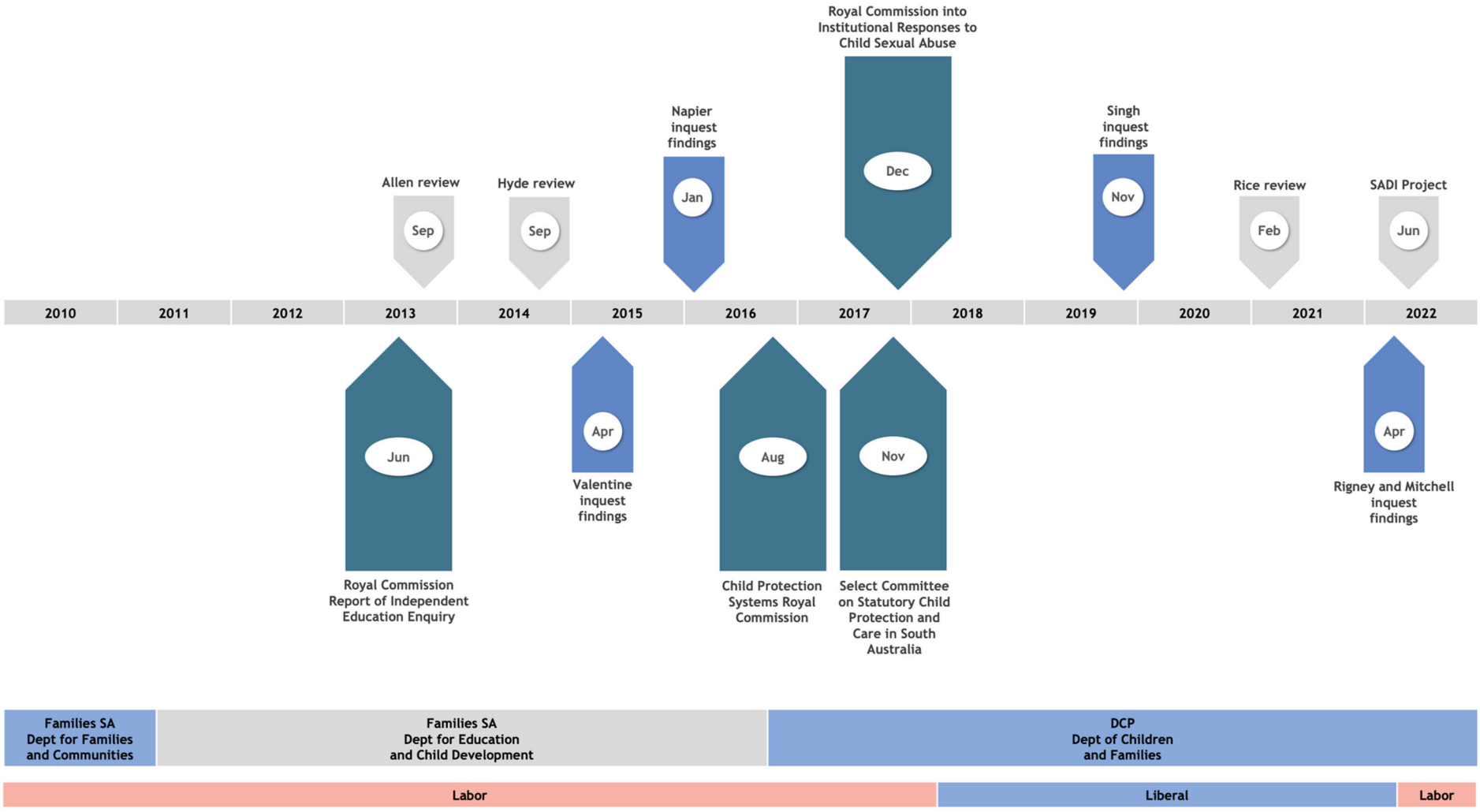


Figure 1: **Timeline of inquests, reviews, inquests and royal commissions**

2.3 HOW THE SYSTEM WORKS TOGETHER TO PROTECT CHILDREN

There are several government (and non-government) agencies in South Australia that provide services to the children and their families who are known to the child protection system:

- Department of Human Services
- Department for Health and Wellbeing
- Department for Education
- South Australian Housing Authority
- South Australia Police
- Attorney-General's Department
- Department of the Premier and Cabinet
- Department of Treasury and Finance.

The South Australian *Children and Young People (Safety) Act 2017* is the primary legislation that guides statutory work of child protection in South Australia. In addition, there are other key pieces of legislation that support the work, structures and systems of child protection and are referred to throughout this review, including the:

- *South Australia Coroners Act 2003*
- *South Australian Ombudsman Act 1972*
- *South Australian Children and Young People (Oversight and Advocacy Bodies) Act 2016.*

SAFE AND WELL: SUPPORTING FAMILIES, PROTECTING CHILDREN

Child protection is a key priority of the South Australian government. ***Safe and well: Supporting families, protecting children*** is South Australia's plan for supporting families. It provides a framework for all government agencies, non-government partners and the community to understand how the government will organise and prioritise to keep vulnerable children and families safe. ***Safe and well*** organises system level reform across three focus areas: supporting, protecting and investing.

Safe and well also brings together the findings from two significant Royal Commissions: the Child Protection Systems Royal Commission and the Royal Commission into Institutional Responses to Child Sexual Abuse to create a connected, coordinated and pragmatic reform approach.

DEPARTMENT OF HUMAN SERVICES

The Department of Human Services (DHS) is the lead government agency in South Australia for early intervention, safety and wellbeing of children, disability, domestic violence, youth justice and screening services.

Highly relevant to this review is that DHS is responsible for leading reforms and early intervention services within the supporting focus area of ***Safe and well*** and has responsibility for the Early Intervention Research Directorate (EIRD) and the Child and Family Support System (CFSS).

DHS funds and delivers a range of early intervention services for South Australian families under the CFSS. The design of this system was directly informed by research and evidence gathered by the EIRD. Services delivered range from community capacity

building through to intensive case management for families with high level safety concerns. Four population groups are the focus of intervention, as identified by research, and include infants at risk; young parents; adolescents with complex trauma; and Aboriginal families with multiple and complex needs.

2.4 EXISTING OVERSIGHT BODIES FOR CHILDREN AND YOUNG PEOPLE

The *Children and Young People (Oversight and Advocacy Bodies) Act 2016* establishes and guides several key independent oversight bodies that have functions to monitor and advocate for the children and young people of South Australia. These independent bodies include the:

- Commissioner for Aboriginal Children and Young People
- Commissioner for Children and Young People
- Guardian for Children and Young People in Care
- Child Development Council
- Child Death and Serious Injury Review Committee.

The Commissioner for Aboriginal Children and Young People and the Commissioner for Children and Young People both have powers available via the *Oversight and Advocacy Bodies Act 2016* to make recommendations on matters related to the rights, development and wellbeing of children and young people at a systemic level.

The Child Death and Serious Injury Review Committee (CDSIRC) was established under Part 4 of the *Oversight and Advocacy Bodies Act 2016*[6] and can review cases in which children die or suffer a serious injury. Under legislation the committee is able to make and monitor the implementation of recommendations for the purpose of avoiding or preventing child deaths and injuries. The Act specifies which cases should be reviewed and states that the committee should not review cases where it could compromise an ongoing criminal investigation or that is the subject of a current or pending coronial investigation.

In 2021, CDSIRC reported that in the 16 years from 2005 to 2020, there were 1712 children and young people who died in South Australia. Of them, 473 (28 per cent) were known to the child protection system, which equates to just under 30 children per year. The analysis of data by CDSIRC also shows that of these 473 children who died and were known to the child protection system, 227 (48 per cent) lived in the most disadvantaged areas.[7] [8]

Data provided to this review from DCP shows that in the financial year 2021–22 there were 32 children in South Australia who were known to DCP before they died. Eleven of the 32 children were identified as Aboriginal.[9]

A five year report by CDSIRC of child deaths between 2016 and 2020 shows that of 476 children who died, most were from natural causes (339 children or 71 per cent). This was followed by transport deaths (37 deaths or 8 per cent) and suicide (25 deaths or 5 per cent).[10] Of the total number of children who died, fewer than 2.5 per cent of deaths (11 children) were due to circumstances of a deliberate act or neglect.[11]

The South Australian Ombudsman also plays a role in monitoring child protection and in December 2017, became the lead agency responsible for the investigation of complaints about child protection services.[12] The Ombudsman is independent from government and has legislated powers, most notably the *South Australian Ombudsman Act 1972.*

2.5 THE CHILD DEATH REVIEW PROCESS

In Australia, each state or territory has legislated obligations for statutory child protection and review of child deaths. The authorising environment is different in each state or territory depending on legislation and involves both government agencies and/or independent oversight bodies.

DCP does not have a statutory obligation to review its own involvement with children who have died. Rather it has policies and procedures in place to review cases internally via its Adverse Event Program. The criteria of the program includes:

- the death or serious injury of the child or young person occurred during the delivery of services provided or funded by DCP; or
- when child protection / adolescent at risk concerns have been notified to the department within the previous three years; and
- the [adverse event] panel has agreed that a review may result in meaningful learning and associated practice or systems improvements.

DCP Adverse Events Program reports quarterly to an internal Quality, Safeguarding and Operations Subcommittee and half yearly to the external function of CDSIRC.

DCP recently established a Significant Incident Reporting Unit (SIRU)[13] in response to recommendations made in the Rice review. The SIRU is responsible for receiving coordinating and monitoring all significant incident reports centrally within in DCP. The SIRU reports to the Minister for Child Protection on child deaths, contentious issues and matters subject to significant news coverage.

2.6 THE ROLE OF THE CORONER

The primary role of the Coroner is to establish the cause and circumstances of events prescribed under the *South Australia Coroners Act 2003*. If a Coroner determines that an inquest will be held, they are then empowered by the Act to give their findings in writing and make recommendations that may prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.[14]

In Australia, each state or territory has its own regime controlling coronial processes, including the making of recommendations. In recent years, coronial law and policy reform has taken place across Australia and other jurisdictions including the UK, Canada and New Zealand.[15] All coroners in Australia possess the statutory power to make coronial recommendations, yet the requirement to implement or even respond to these recommendations is not legislated or mandated in all jurisdictions.

South Australia does have a mandated requirement to respond to recommendations made by a Coroner. Under section 25(5) of the *Coroners Act 2003,* government ministers are required to provide a report before each house of Parliament detailing the actions taken or proposed in response to the recommendations that have been made, or outlining

the reasons for no action and forward a copy of the report to the State Coroner. The *Coroners Act 2003* specifies that this:

> **must happen within 8 sitting days of the expiration of 6 months after receipt of a copy of recommendation resulting from an inquest.**

1 Chloe's mother and mother's boyfriend were convicted of manslaughter after Chloe died.
2 Former SA Police Commissioner Malcolm Hyde is currently undertaking an investigation of two recent high profile child deaths that occurred in February and July 2022.
3 Child Protection Systems Royal Commission. (2016). *The life they deserve: Child Protection Systems Royal Commission Final Report*. Government of South Australia, p. 618.
4 Charlie's full name is not known. She is referred to as 'Charlie' because that is how she is referred to in the public domain. Her story is not a focus of this review because we have not had access to the current investigation.
5 Similar to Charlie, Makai's story is not a focus of this review because we have not had access to the current investigation.
6 Prior to this the Child Death and Serious Injury Review Committee was established under the *Children's Protection Act 1993*.
7 This information was gathered by matching postcodes of the children who died with the Index of Relative Socio-Economic Disadvantage (IRSD) and the Socio-economic Indexes for Areas (SEIFA) as developed by the Australian Bureau of Statistics.
8 CDSIRC. (2021). *2020–21 Annual Report of the South Australian Child Death and Serious Injury Review Committee*.
9 Data provided by Quality and Practice in DCP.
10 CDSIRC. (2022) Five-year data summary. https://cdsirc.sa.gov.au/five-year-data-summary/
11 ibid.
12 Prior to this all child protection complaints went to the Health and Community Services Complaints Commissioner (HCSCC).
13 The Significant Incident Reporting Unit (SIRU) was launched in September 2021.
14 Section 25(2) of the *Coroners Act 2003*.
15 Studdert, D. M., Walter, S. J., Kemp, C., & Sutherland, G. (2016). Duration of death investigations that proceed to inquest in Australia. *Injury Prevention: Journal of the International Society for Child and Adolescent Injury Prevention, 22*(5), 314–320.
Bray, R., & Martin, G (2016). Exploring fatal facts: current issues in coronial law, policy and practice. *International Journal of Law in Context, 12*(2), 115–140.
Moore, J. (2016). *Coroners' recommendations and the promise of saved lives*. Edward Elgar.

3 METHODOLOGY OF THE REVIEW

> Effective interventions require much more than a good heart and a commitment to children's welfare. It is exceptionally complex work that requires talented practitioners who have high level interpersonal skills and the requisite knowledge and support.
>
> **Lonne et al. (2009)**[1]

3.1 AIM AND SCOPE

This section provides an overview of the review approach.

As already mentioned, the terms of reference are to conduct a review of:

1. All coronial and other recommendations relating to child protection in the State of South Australia since 2010 and the implementation of the same.
2. All statutory obligations contained within the *Children and Young People (Safety) Act 2017* and the extent to which practices within the Department for Child Protection, and other State government agencies as may be appropriate, align with those statutory obligations.

> What this inquest has highlighted, however, is the folly of governments ignoring coronial and other recommendations.
>
> **Deputy State Coroner Schapel**
>
> **Findings into the deaths of Amber Rigney and Korey Mitchell, 21 April 2022**

To respond to the first term of reference, and address the clear concern expressed by Deputy State Coroner Schapel (above), recommendations were first identified. A total of 811 recommendations were identified that have been made for child protection in South Australia since 2010. The process for how this was done is described below. The task of reviewing the implementation of recommendations was more complex and required two processes.

Firstly, the implementation of recommendations was measured against publicly reported information, and that which was provided to the review by DCP. A complete list of the

recommendations identified, with accompanying information about their implementation status, is at Appendix 1. Part 4 outlines the results of this analysis.

Secondly, the review aimed to gain a deep understanding of whether the recommendations have been implemented as intended, and whether they are leading to improvements to the system. This required a more complex and nuanced understanding of implementation, and is considered in Part 5 alongside the second term of reference about the alignment of practice with statutory obligations.

The review formed the understanding that the second term of reference is intended to meet the recommendations made by Deputy State Coroner Schapel as below.

> I recommend that a complete review be conducted in relation to all of the statutory obligations contained within the *Children and Young People (Safety) Act 2017* so as to ensure that practices within the Department align with those statutory obligations. Such a review should consist of an examination of all documented and undocumented internal Department procedures so as to ensure they comply with all statutory obligations contained within child protection legislation.
>
> **Deputy State Coroner Schapel**

This term of reference speaks to the review of statutory obligations but extends the recommendation of the Coroner to consider all State government agencies. The term of reference does not specifically address the Coroner's concerns about documented and undocumented procedures.

The scope of the second term of reference could extend broadly to the role of all South Australian government in protecting the children of South Australia. Where relevant the review has commented on practice by other government agencies but the focus has remained on DCP, which has primary responsibility for statutory child protection.

This review was determined to hear from the child protection workforce, alongside the consideration of legislation, policy and procedures, data and stakeholder consultation. This approach provided the review with broad insights and evidence on which to base observations and recommendations that respond to the complex question of implementation.

3.2 THE IMPACT OF OTHER REVIEWS TAKING PLACE

As mentioned earlier, four other reviews are currently in progress and one inquest is awaiting conclusion. They include:

- a review of the *Children and Young People (Safety) Act 2017*
- an inquiry into foster and kinship care under section 169A of the *Children and Young People (Safety) Act 2017* led by Dr Fiona Arney
- an inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle led by the Commissioner for Aboriginal Children and Young People April Lawrie

- an independent review of child deaths at Munno Para and Craigmore led by former South Australian Police Commissioner Malcolm Hyde
- the inquest into the death of Zhane Chilcott. Zhane was a 13 year old Aboriginal boy who died by suicide in 2016. Zhane was in state care at the time of his death. The inquest has heard all the evidence yet is awaiting the Coroner to hand down the findings.

The awareness of, and respect for all this inquiry work, influenced the approach of this review and the attention it gave to those parts of the child protection system under current critique. Each of the other reviews, as above, have their own terms of reference, which have also been considered. Furthermore, meetings were held with each of the lead reviewers to discuss the functions of their respective reviews. This assisted the process of methodology and commitment to keep the focus where it will be more useful.

The review of the *Children and Young People (Safety) Act 2017* is in its consultation phase with a final report due by the end of February 2023. The consultation has been extensive and will result in detailed and specific findings that relate to the current legislation since its implementation. This review focuses on how practice[2] within DCP and other parts of government supports the intent of the legislation in its current form. The observations and recommendations made about the child protection system should be considered within the scope of this review, acknowledging the potential for future amendments to the legislation.

The inquiry into foster and kinship care has included specific examination of complaint mechanisms, consultation processes, transparency and availability of documentation and the adequacy of internal procedures and arrangements that ensure partnerships and rights are upheld as they relate to foster and kinship care. To that end, this review does not make detailed analysis about the foster and kinship care system, nor does it include the perspectives of foster and kinship carers and the peak bodies and organisations that represent them. This was covered by Dr Fiona Arney in her inquiry and her detailed findings will be reported to the Minister for Child Protection later this year.

The inquiry into the application of the Child Placement Principle, led by the Commissioner for Aboriginal Children and Young People, will consider how the Principle is applied in the removal and placement of Aboriginal children in out of home care. This inquiry is in its consultation phase and is expected to conclude towards the end of 2023. The terms of reference include consideration of recent and current policies, practices and procedures.

The two deaths being examined by Malcolm Hyde are not in the scope of this review. At the time of writing, that investigation was not complete so its findings have not been considered within the terms of reference

3.3 IDENTIFICATION OF RECOMMENDATIONS

From the outset of this review there was awareness of the many recommendations of the Nyland report as well as those from the four coronial inquests. With more research it came to light just how many relevant reports, inquiries and reviews were also in scope. This meant that the number of recommendations to be considered grew quickly.

Since 2010, 811 recommendations have been made in the inquests, royal commissions, reviews and inquiries that have taken place in South Australia relating to child protection. The inquiries were identified through research and reading about South Australia's child

protection system and recommendations from each collated. The exact number from each inquiry and how they were identified is described in Appendix 1.

From a total of 811 recommendations, the review determined that 747 recommendations were in scope and able to be analysed in terms of their implementation. The recommendations not included in scope relate mainly to those where information was unavailable or not the responsibility of DCP to implement. As already mentioned, this review has not been able to analyse all 811 previous recommendations, their implementation, progress and efficacy in minute detail. Rather it has concentrated on the ones most relevant to the current progress of the system.

Part 4 of this review considers the implementation of recommendations from the perspective of how they have been *addressed* by government responses and public reporting. These responses contribute to other insights about governance, oversight and how recommendations are managed.

Part 5 of this review includes considerations about how recommendations have been *implemented*. Examples are used, where relevant, that were provided by the workforce or from material examined.

3.4 REVIEW OF DOCUMENTS

The insights, observations and considerations detailed in this review have relied upon the perspectives of the South Australian workforce, as well as consideration of extensive documentation.

A detailed list of the documents that were relied upon is at Appendix 2. In summary, the documents fall into the following categories:

- Documentation relating to coronial inquests (findings, statements from expert witnesses)
- Inquiry papers
- Public documents reporting on the response to and implementation of recommendations
- Policy and procedure documents provided by DCP
- Other documents provided by DCP that provide information about structure, organisation and systems
- Data reports
- Research and literature reviews
- Information obtained from relevant professionals involved in South Australian child protection.

3.5 INCLUDING THE FAMILIES

As already mentioned, this review came about because of the recommendation made by Deputy State Coroner Schapel following the coronial inquest into the deaths of six year old Amber Rigney and five year old Korey Mitchell.

Within the scope of the timeframe of this review, five inquests have been held about the deaths of six children. In August 2022, letters were sent to the family members and carers of the five children whose inquests have been concluded,[3] alerting them to the

review and inviting them to meet with the reviewer and share their experiences (see Appendix 3).

DCP and the Aboriginal Legal Rights Movement (ALRM) assisted with the process of contacting family members whose contact details were not known. ALRM has supported one of the families to meet with the reviewer. Relatives of Chloe Valentine, Heidi Singh and Amber Rigney and Korey Mitchell participated in the review process in meetings took place between 7 and 20 October.

3.6 PERSPECTIVES OF THE WORKFORCE

Guided by determination to hear from the child protection workforce and bring its voice to the forefront, as many conversations as could be held within the timeframe, were organised through facilitated forums, interviews and focus groups.

The following provides an overview of wide range of the workforce whose voices influenced this review. A complete list is in Appendix 4.

- A total of 14 meetings with senior management and executive staff within DCP
- Two meetings with academic and research experts
- Meetings with each of the four reviewers who are leading various inquiries and reviews into child protection and out of home care in South Australia.
- Eight forums and focus groups involving 125 people were held with:
  - DCP Offices
  - DCP Child Abuse Report Line (CARL) staff
  - DCP Managers group
  - Government partners
  - Heads of Industry forum
  - Non-government partners
  - DCP Senior Executive Group
- Meetings were held with key oversight bodies including the:
  - Commissioner for Children and Young People
  - Commissioner for Aboriginal Children and Young People
  - Guardian for Children and Young People
  - South Australian Ombudsman.

The Heads of Industry forum allowed consultation with non-government organisations that work in the child protection sector and included representation from 20 non-government organisations.

3.7 AN APPROACH INFORMED BY APPRECIATIVE INQUIRY

The approach to consultation was informed by the use of Appreciative Inquiry. It is a strengths-based approach that focuses on what is working well. Instead of focusing on problems, Appreciative Inquiry leads those involved in discussions to identify and discover what is working well and invites people to describe stories of success and positive experiences.

When used within the context of evaluation, Appreciative Inquiry offers a perspective and approach that can result in meaningful and useful results.[4] Research into the use of Appreciative Inquiry has shown that it can have the most potential to contribute to

evaluation in specific contexts.[5] Some examples, believed to be relevant to this review, included previous evaluations that have failed; where there is a fear or scepticism about evaluation; when dialogue is critical to moving the organisation forward; when relationships among individuals and groups have deteriorated; and that there is a sense of hopelessness.

For the purpose of this review, and within the context of a short timeframe, the strengths-based approach of Appreciative Inquiry was the best fit to frame questions and focus discussion.

Some examples of the questions that were relied on in leading the consultation process with groups and forums included:

- What has your agency found most helpful about the process of review and inquiries of child protection in South Australia?
- What recommendations stand out as for having improved the system's response to children?
- What do you value most about DCP and the work they do to protect the safety of children and young people?
- What does your agency rely on to do its part to keep children and young people safe?
- What do you hope to see in this review?
- How do you know that you've made a difference?
- What makes you hopeful about the work you do?

A common criticism of Appreciative Inquiry is that it can ignore or deny problems. This is not the case and instead seeks to encourage people to first identify what is working well. The problems people experience always come to light and enter discussion, but can be approached and viewed differently when considered alongside strengths. Some examples of questions we asked to ensure the process of review covered people's worries were:

- What recommendations did not hit the mark?
- What are your biggest worries about the child protection system?
- If you had immediate powers to change the system, what would you change?

3.8 LIMITATIONS

There were limitations to this review which need mention.

The review was completed within four months. This was a short amount of time to consider and attend to very broad terms of reference.

The review makes many observations about the system response to Aboriginal children. Wherever possible Aboriginal staff, leaders and family members were consulted, however a limitation of the review is that the critique is written by a non-Aboriginal reviewer.

The timespan of inquiries examined, from 2010 to now, impacted the amount of detail and attention that could be given to each inquiry and its relevant recommendations. Not all of the 811 recommendations were examined in close detail, first because of the review's own time limitation but also because it became quickly apparent that this was not what would be most useful or helpful to the system. Recent inquiries and the recommendations that

correlate strongly to the review's observations of the workforce have received greater focus and attention.

Knowledge of the other reviews taking place helped to focus the attention of this review and avoid unhelpful overlap. Knowing that other reviews had a specific focus on foster and kinship care, the application of the Aboriginal and Torres Strait Islander Child Placement Principle and that a five year review of the legislation had commenced has resulted in those areas receiving less attention from this review.

Some records sought by this review were not available or were not located in time. This included documentary evidence for all of the government responses to recommendations. Some of the reasons for this can be attributed to machinery of government changes and documents being protected or restricted to cabinet-in-confidence.

1 Lonne, B., Parton, N., Thomson, J., & Harries, M. (2009). *Reforming child protection.*
2 Practice encompasses procedures in documented and undocumented form as referenced by the Deputy State Coroner as well as the systems and structures that support it.
3 Because Zhane Chilcott's inquest has not concluded a decision was made not to approach his family.
4 Coghlan, A. Preskill, H., & Tzavaras, T. (2003). An overview of appreciative inquiry in evaluation. *New Directions for Evaluation*, 100, Winter.
5 ibid.

4 IMPLEMENTATION OF THE RECOMMENDATIONS

> When we try to pick out anything by itself, we find it hitched to everything else in the Universe.
>
> **John Muir (1911)**[1]

The review has identified a total of 811 recommendations that have been made about the South Australian child protection system since 2010. This section considers the implementation of those recommendations, focusing specifically on the 747 that are in scope for this review (see 3.3 and Appendix 1 for more detail).

The information below describes the implementation of recommendations according to how they have been ***addressed*** by the South Australian government. It relied on the acknowledgement and responses of the government at the time of each inquiry, supporting documentation received from DCP during this review and information on public websites and in the media. Details of all this information can be found at Appendix 1. Lastly, the section also includes relevant research about the role of inquiries in shaping child protection systems; implementation and effectiveness of recommendations; and discussion about the role of coronial inquests and factors that influence recommendations made by Coroners. This evidence is considered alongside commentary about how the government in South Australia has responded to the various inquiries since 2010, as well as identification of the patterns observed in research.

Measuring the implementation of recommendations is a difficult task. Research in Ireland by Buckley and Nolan from 2013 identified the difference between the process of ***addressing*** recommendations and ***implementing*** them. They define implementation as the process that gives effect to the recommendation and acknowledge that determining whether recommendations have become fully operational requires an understanding of the day to day experiences of staff.[2]

Understanding whether the intent of a recommendation has been met, and whether it has become operational and impacted the day to day experiences of those it was intended for, requires greater analysis and understanding. Observations that relate to this more complex understanding of implementation are discussed at Part 5.

4.1 THE ROLE OF INQUIRIES IN SHAPING THE SYSTEM

Research on the role of inquiries, and their influence in shaping child protection systems, demonstrates positive outcomes when recommendations are accepted by government and facilitate change.[3]

There is also significant evidence about the negative impacts of major child protection inquiries. Australia research[4] described the impacts in the 'aftermath of inquiries', including increased staff turnover, increases in notifications about children at risk, reduction of Aboriginal children being placed with family and an erosion of family support services in favour of tertiary intervention.

Recent research in the UK is of great relevance to this review. The research was based on a consultative approach, bringing together experts from past and current inquiry teams alongside academics, members of the judiciary, police, social work and health professionals, and government officials for a four day summit to reflect critically on the aims and outcomes of inquiries and consider alternatives.[5] The research found that some inquiries had a positive impact on policy, practice and the raising of public awareness, yet there was little evidence of overall effectiveness when considering the time, money and resources. The discussion and key findings included:

- that reports were often very long and there was a danger they would not be read
- long lists of recommendations can be unhelpful
- the importance of the narrative and ensuring that any learning impacts practice
- that the needs of victims and survivors remain pivotal in the process
- that inquiries are only one source of evidence in child protection practice and cases where things have gone wrong should be considered alongside evidence where children are protected
- political drivers for inquiries are linked to the media and public demand and politicians often call for an inquiry as they wish to be perceived to be 'doing something'
- needing to ensure that public inquiries are conducted efficiently.

THE ECONOMIC COST OF INQUIRIES

The true financial cost to governments of inquiries and reviews into the child protection system is difficult to measure. The Royal Commission into Institutional Responses to Child Sexual Abuse is estimated to have cost the Australian government half a billion dollars.[6] The Australian Institute of Health and Welfare 2020–2021 annual report on child protection[7] detailed 36 inquiries into child protection services across Australia since 2010. The cost of these ongoing inquiries contributes to both the economic cost of child abuse and neglect in Australia and generate media interest, increasing public interest and awareness of child protection issues.

4.2 THE ORIGINS OF EACH INQUIRY

Large scale public inquiries usually happen in response to a serious adverse event, such as a child death or serious injury or abuse. This pattern is not unique to Australia. When Professor Eileen Munro completed her independent review of child protection in England in 2011, she noted the unusual nature of her review being planned rather than reactive. Professor Munro commented that because the review was not called in response to a

child death or adverse event it took place without an 'emotionally-charged atmosphere' around it. She further stated that the majority of reform to child protection over the past 40 years had taken place in a 'clamour for change', when the UK government was under pressure due to the public's attention on a high profile serious incident.[8]

Table 1 shows the events that have led to the inquiries, reviews, inquests and commissions that have taken place in South Australia since 2010.

Table 1: List of inquiries, reviews and inquests since 2010 by precipitating event and who each was conducted by

Year	Title	Precipitating event	Conducted by
2013	Debelle Inquiry	The arrest and conviction of an employee of an out of school hours care service at a suburban school in Adelaide on charges of sexual assault against a child in his care	Supreme Court Justice
2013	Allen review	In response to the Debelle Inquiry, the Minister for Education and Child Development commissioned a review to recommend organisational changes that would prevent future systemic failings	Former chief executive of the Education Department
2014	Hyde review	Sexual abuse of multiple children in residential care by a Families SA staff member; concerns about the residential care workforce, particularly the human resources practices	Former police commissioner
2017	Select Committee	Children in out of home care and the management of foster care	Select members of the Legislative Council of South Australia
2016	Nyland report	Sexual abuse of children by a staff member, substantial community disquiet and adverse publicity around Families SA	Former Supreme Court judge
2015	Valentine Inquest	Death of a child	State Coroner
2016	Napier Inquest	Death of a child	Deputy State Coroner
2017	Royal Commission into Institutional Responses to Child Sexual Abuse	Sexual abuse of children in out of home care	Membership contained former Supreme Court judges, senators, commissioners, psychiatrists with a variety of backgrounds
2019	Singh Inquest	Death of a child	Deputy State Coroner
2021	Rice review	Sexual abuse or criminal offences against children in out of home care and the Minister for child protection was not informed until after sentencing	Former district court judge
2022	Rigney and Mitchell Inquest	Death of a child	Deputy State Coroner
2022	SADI Project	The over-representation in detention of children and young people from residential care placements	Guardian for Children and Young People

Table 2: List of the current inquiries, reviews and inquests by precipitating event and who each is conducted by

Year	Title	Precipitating event	Conducted by
2022	Review of the *Children and Young People (Safety) Act 2017*	Planned in legislation	DCP (internally led)
2022	Inquiry into foster and kinship care	Planned in legislation	Academic researcher with child protection expertise
2022	Inquiry into application of the Aboriginal and Torres Strait Islander Child Placement Principle	In response to data about Aboriginal children in the child protection system and community concerns	Commissioner for Aboriginal Children and Young People
2022	Independent investigation of child deaths by Malcolm Hyde	Two child deaths	Former police commissioner
2022	Inquest into the death of Zhane Chilcott	Child death	State Coroner

It is interesting to note that the majority of inquiries that have taken place in South Australia since 2010 have been in response to a significant adverse event – child deaths and serious sexual abuse. They were all led by a reviewer outside the child protection system and have, as research suggests, resulted in long lists of recommendations.

This trend appears to have shifted with the current reviews underway; two were planned and not in response to a serious adverse event and there is a shift towards reviews being led by people with significant child protection expertise.

4.3 ACKNOWLEDGEMENT BY GOVERNMENT OF RECOMMENDATIONS MADE

INITIAL RESPONSE BY THE SOUTH AUSTRALIAN GOVERNMENT TO RECOMMENDATIONS

Table 3 shows the initial response by the government to the 747 recommendations in scope. It relies on the following categories:

- **Accepted:** all elements of the recommendation were supported.
- **Accepted in principle:** the government was supportive of the intent or merit of the policy underlining the recommendation, but did not necessarily support the method for achieving the policy.
- **Further consideration:** further analysis is required for the government to determine its position.
- **Split:** The recommendation contained several parts and the response by the government varied according to each part.
- **Not accepted:** the recommendation was not supported.
- **No information available:** the review could not locate this information. Further information about the circumstances in relation to each review and its recommendation is at Appendix 1.

Table 3: Initial acknowledgement and response by government to recommendations made per inquiry

	Accepted	Accepted in principle	Further consideration	Split response	Not accepted	No information available
Coronial inquests	24		1			22
Debelle Inquiry	43					
Nyland report	196	60			4	
RCIRCSA*	102	75	64	13	2	
Allen review	14					
Select Committee						43
Rice review	6					
SA Ombudsman	45					
GCYP^	33					
TOTAL	**463**	**135**	**65**	**13**	**6**	**65**

* Royal Commission into Institutional Responses to Child Sexual Abuse
^ Guardian for Children and Young People

It is evident that the majority of recommendations (463 or 62 per cent) made via inquiries since 2010 have been accepted by government in its initial acknowledgement. There are also a large number accepted in principle (135 or 18 per cent). This review could not locate a response to 65 recommendations (9 per cent). Only six (less than one per cent) of the recommendations were not accepted.

It is also evident when looking at the results this way that recommendations made in the Debelle Inquiry, Allen review, Rice review and by the South Australian Ombudsman and the Guardian for Children and Young People were all immediately accepted in government's initial response.

Responses by the government to the Nyland report and the Royal Commission into Institutional Responses to Child Sexual Abuse are more varied and include recommendations that were accepted in principle or required further consideration before decisions could be made.

This review did not have information about an initial response by the government to the Select Committee report. While there was no official public response to the recommendations made after the inquests into the deaths of Ebony Napier and Heidi Singh this review has been provided with information to show they were mainly accepted and actions to implement them have been taken. This information and the current status of all coronial recommendations is shown in Figure 2.

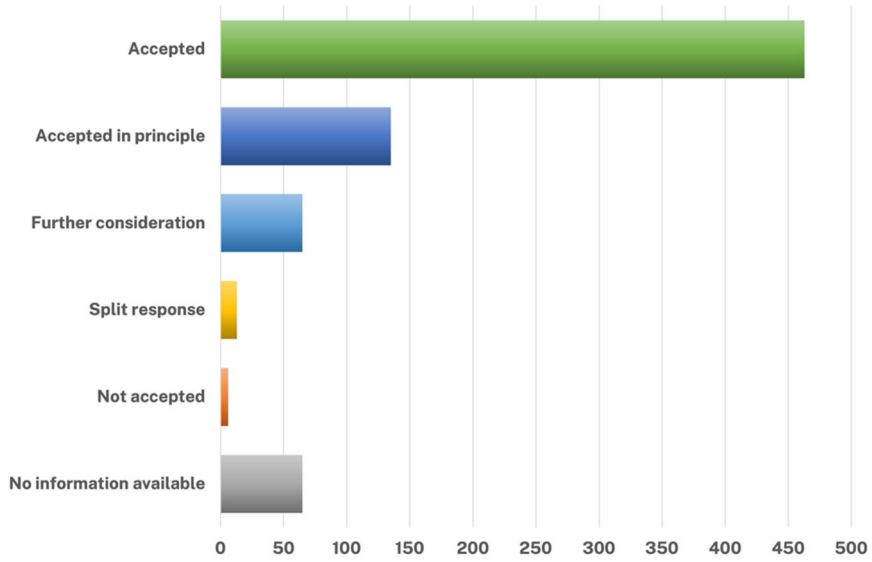


Figure 2: Total number of all inquiry recommendations, by status

CURRENT STATUS OF IMPLEMENTATION OF RECOMMENDATIONS

Figure 3 in turn shows the current status of government responses to each inquiry by proportion of their acceptance status.

It is clear that the government has done an enormous amount of work to track and implement the recommendations that have been made. Implementation is complete for 582 (78 per cent) of recommendations, five (less than 1 per cent) are partially complete and 86 (12 per cent) are in progress.[9] The number of recommendations not accepted (seven) remains less than 1 per cent of the total number that have been made.

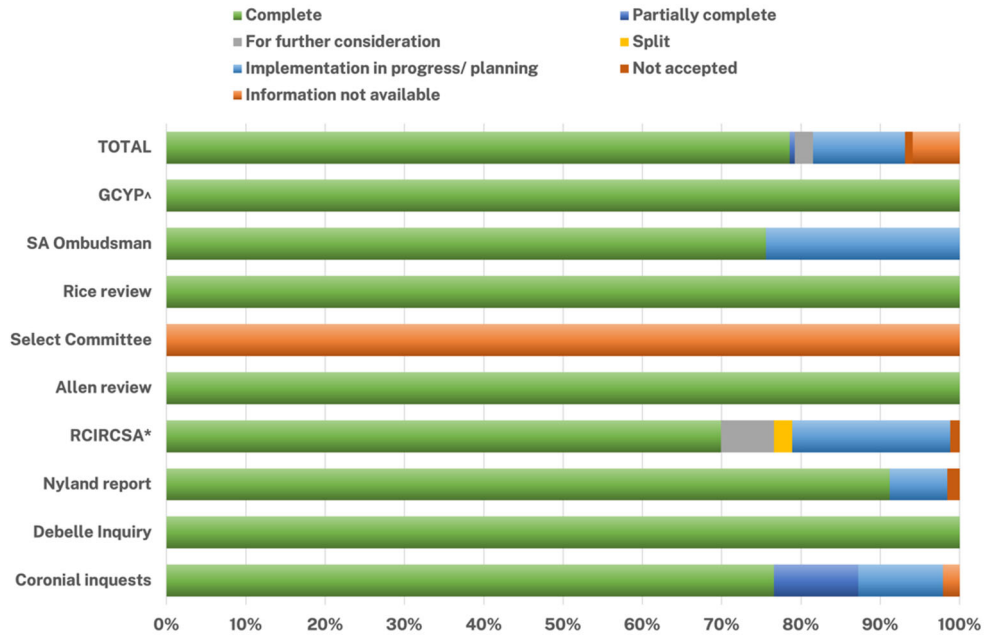


Figure 3: Current status of implementation of recommendations

^Guardian for Children and Young People
*Royal Commission into Institutional Responses to Child Sexual Abuse

IMPLEMENTATION OF NYLAND REPORT RECOMMENDATIONS

The Nyland report made 260 recommendations after two years of significant investment and a comprehensive investigation into the laws, policies, practices and structures in place for child protection systems in South Australia. The amount of information and reporting that has been made available publicly in response to the work of the government to implement those recommendations is significant.

The requirement to report annually on the implementation progress of the Nyland recommendations is specified within section 156 of the *Children and Young People (Safety) Act 2017*. This requirement has been adhered to with apparent rigour by the government. After its initial response in ***A fresh start*** progress reports have been published annually since 2017. The recommendations from the Nyland report had a separate focus before being combined with the recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse and reported on together under the reform approach outlined in the whole-of-government child protection strategy, ***Safe and well: Supporting families, protecting children***.

It is interesting to note the strict adherence to reporting that has been achieved by government in response to the recommendations made in the *Nyland report*. Recommendation 260 outlined a clear process for responding to and monitoring implementation, as well as making this accessible publicly and online. The subsequent embedding of this requirement in legislation has no doubt helped to ensure this process was observed.

An overview of how the recommendations from the Nyland report have progressed and how they have been reported by government is reflected in Table 4 and Figure 4.

As mentioned earlier, there were 60 recommendations that government initially accepted in principle. They have since moved along the continuum from not yet commenced, to planning, implementation and completion. At the time of writing this review, 237 recommendations were complete, 19 were being implemented and four recommendations remained not accepted.

Table 4: Summary of progress on recommendations 2017–2022

Year	2017	2018	2019	2020	2021	2022
Status	**Progressive total ➔**					
Completed	36	76	164	210	222	237
Implementing	63	113	67	39	33	19
Planning	85	51	24	7	1	
Not yet commenced	72	16	1			
Not accepted	4	4	4	4	4	4
TOTAL						**260**

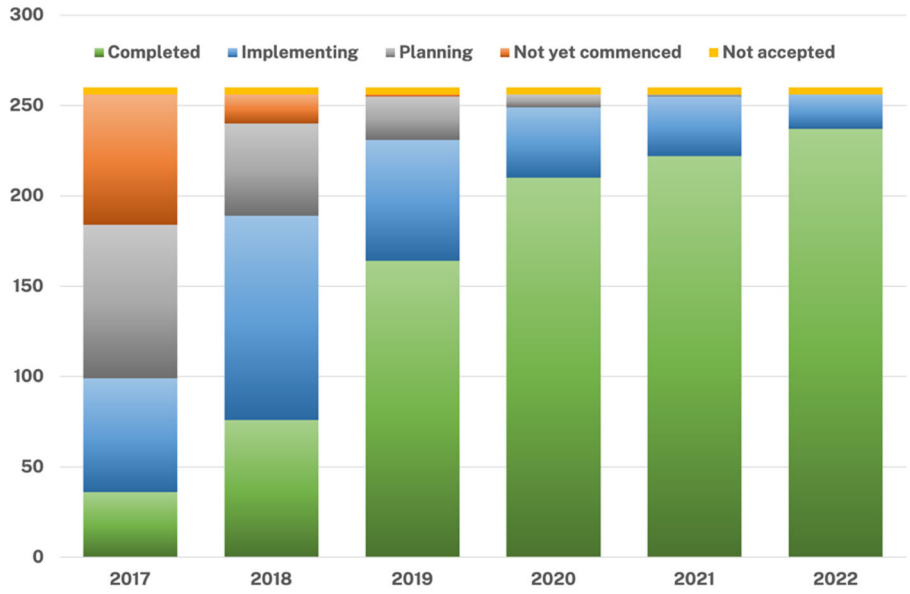


Figure 4: Cumulative progress on number of recommendations completed, 2017–2022

4.4 PREVIOUS RESEARCH TO MEASURE THE IMPLEMENTATION OF RECOMMENDATIONS

The interest in the implementation of recommendations made for child protection in South Australia is not a new area of research. Within the period of review, two studies have considered the implementation of previous recommendations made for child protection, in South Australia, and Australia more broadly. An overview of the relevant findings is summarised below.

The Parenting Research Centre research project on the implementation of recommendations

In 2015, the Parenting Research Centre (PRC) completed research for the Royal Commission into Institutional Responses to Child Sexual Abuse that considered:

- What extent previous inquiry recommendations, as nominated by the Royal Commission, were implemented?
- What factors determined or contributed to, or were barriers to, the successful implementation of recommendations?
- If there was any relationship between these factors.

The findings are in the report titled the *Implementation of recommendations arising from previous inquiries of relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse*.[10] The PRC considered a total of 288 recommendations that had been selected by the Royal Commission from 67 inquiries. Thirty-two of them were from four inquiries specific to South Australia. These inquiries were all pre-2010, so do not overlap with this review, yet the findings are interesting when considering the implementation of recommendations. The South Australian reviews captured in the PRC report include:

2003 *Our best investment: A state plan to protect and advance the interests of children* (the Layton review)

2003 *Report of the Joint Committee on Immunity from Prosecution for Certain Sexual Offences*. Second Session, Fiftieth Parliament 2002–2003, Parliament of South Australia (28 May 2003, Hon. G. E. Gago, Chairperson)

2008 *Children in State Care Commission of Inquiry: Allegations of sexual abuse and death from criminal conduct* (the CISC Inquiry)

2008 *Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A report into sexual abuse* (the APY Lands Inquiry).

Overall, PRC found that the majority of recommendations had been implemented in full (48 per cent) or partially (16 per cent), that 21 per cent were not implemented and the status of 14 per cent of recommendations could not be determined.[11]

Specifically, for the 32 recommendations from the four South Australian inquiries, the report identified that 11 had been implemented in full, 10 were partially implemented, four had not been implemented and for seven recommendations the status could not be determined.

Overall, the PRC report found that implementation was affected by the date of the inquiry, the type of reform required and the subject matter of the recommendation. Systems-type recommendations were the most likely to be implemented and the lowest implementation rate related to recommendations for legislative or law reform.

The report identified a number of factors that contribute to successful implementation, as well as barriers to implementation.

Table 5: Summary of findings from the PRC report *Implementation of recommendations arising from previous inquiries of relevance to the Royal Commission into Institutional Responses to Child Sexual Abuse*

Factors contributing to successful implementation	Factors identified as barriers to implementation
Clarity of vision	Policy concerns
High-level leadership	Difficulty implementing whole-of-government recommendations
Engagement with media	An inability to implement reforms across or outside jurisdictions
Early and ongoing consultation with stakeholders	Challenges in implementing multiple reforms
Alignment between the intent of the inquiry, the spirit of the recommendations and the implementation process	Conflicting legislation
A holistic approach to drafting recommendations	Organisational culture
Recommendations drafted with specificity and flexibility	Resource limitations
Recommendations that are outcome-focused and achievable	Political resistance to long-term / preventative / early intervention strategies
Evidence-based recommendations	
Mindfulness of capacity issues	
Jurisdictional collaboration	

Factors contributing to successful implementation	Factors identified as barriers to implementation
Agency collaboration and coordination	
Government oversight bodies	
Staged implementation	
Tracking and evaluation of implementation	

The Australian Centre for Child Protection report to the Child Protection Systems Royal Commission on the implementation of recommendations

In 2016, to assist with the work of the Nyland report, the Australian Centre for Child Protection (ACCP) was funded to conduct a review of the implementation of recommendations from four previous inquiries relating to child protection in South Australia.[12] The scope of this review included three of the same inquiries that the research by the PRC had, but considered each of the 349 recommendations that had been made, not just those selected as the PRC research had done. The four inquiries considered in the ACCP report were:

2003 *Our best investment: A state plan to protect and advance the interests of children* (the Layton review)

2008 *Children in State Care Commission of Inquiry: Allegations of sexual abuse and death from criminal conduct* (the CISC Inquiry)

2008 *Children on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Commission of Inquiry: A report into sexual abuse* (the APY Lands Inquiry)

2013 *Royal Commission 2012–2013 Report of Independent Education Inquiry* (the Debelle Inquiry).

The review by ACCP identified that the intent of only the CISC and the Debelle inquiries had been 'generally met', that it was difficult to ascertain the status of many recommendations from the Layton review and that many of the recommendations from the APY Lands Inquiry remained outstanding. Notably, the ACCP commented that the lack of a legislated requirement to report on the implementation of recommendations from the Layton review and the sheer number of recommendations likely contributed. Overall the key findings from this review noted the following useful points for consideration when making recommendations:[13]

- The more targeted the inquiry the more likely recommendations will be implemented.
- The broader the terms of reference, the less likely that all recommendations will be implemented.
- The importance of keeping key stakeholders and the media informed and involved before recommendations are handed down
- That recommendations are more likely to be implemented where some form of accountability framework and monitoring processes are in place.

DEPARTMENT OF CHILDREN AND YOUTH AFFAIRS REVIEW OF RECOMMENDATIONS FROM INQUIRY REPORTS IN RELATION TO CHILD PROTECTION FAILINGS IN IRELAND

Earlier reference was made to the 2013 research by Buckley and O'Nolan. It examined the recommendations from five inquiries between 1993 and 2010 that occurred in response to the serious abuse and/or deaths of children in Ireland.[14]

Buckley and O'Nolan determined that inquiry recommendations had acted as a mechanism for some positive change but also noted that recommendations had become too numerous, predictable and repetitive. They described a 'recommendation fatigue' which has developed in recent years and proposed a consultative, collaborative approach to developing recommendations. This would ensure recommendations are evidence-based, informed by expert knowledge, promote ownership and increase the likelihood that they will be feasible and realistic.

DIFFICULTIES IN DEFINING IMPLEMENTATION

Research in Canada (2008) also pointed to the inherent difficulties of defining implementation.[15] Implementation can range from an announcement that a government accepts a recommendation, to declaring policy change, passing legislation or allocating funds to a new service or program. This research described the second methodological problem that is making a connection between a recommendation and the action that follows.[16]

AN EXAMPLE OF THE DIFFICULT TASK OF MEASURING IMPLEMENTATION

These inherent difficulties are best illustrated through an example relevant to this review. The Nyland report refers to a recommendation made in the 2008 CISC Inquiry about every child and young person being allocated to a social worker and having monthly face-to-face contact regardless of the stability or nature of the placement. While the recommendation was accepted by government, evidence obtained by Commissioner Nyland was that this contact between children and their social workers was not occurring. A new recommendation (77) was made in the Nyland report that repeated the same intent:

> **Ensure every child or young person in care has an allocated caseworker who has face-to-face contact with them once a month at a minimum.**

The government's initial response was to accept this recommendation in principle. It has now been accepted and implemented in full. An explanation of implementation provided by government is that:

> **The DCP Manual of Practice provides practice guidance on case worker responsibilities to regularly meet with the child or young person. The Manual of Practice outlines that the level of contact the case worker has with the child or young person should be driven by an assessment of the child or young person's needs.**

This is a pragmatic and sensible response by DCP and one suited to the changing demands of child protection work. It reflects the need for professional judgement because there will be children whose needs are such that monthly meets will not be

enough and others who will need less frequent contact. At the same time, it is impossible to fully assess the full implementation of this recommendation without conducting an audit of files for all children and young people in care.

4.5 RECOMMENDATIONS MADE FOLLOWING THE PROCESS OF CORONIAL INQUESTS

A literature review was undertaken to further understand the process by Coroners of making recommendations, their implementation and effectiveness.

The function of the Coroner to make recommendations can be beneficial to the public health system and contribute to public health, safety and the prevention of avoidable deaths.[17] At the same time, the function of the Coroner to make recommendations is also cited by researchers as under researched and poorly understood.[18] The impact of recommendations will always be determined both by their quality and suitability and secondly, the extent of their implementation.

RESEARCH ABOUT THE ACTIONS TAKEN BY AGENCIES IN RESPONSE TO CORONIAL RECOMMENDATIONS

An extensive study was undertaken by Jennifer Moore in New Zealand (2016) to determine the actions that organisations take in response to recommendations made by Coroners.[19] Moore outlines an argument to show that the preventative potential of coroners is undermined when recommendations are not implemented by organisations. Her study focused on a set time period, finding that 20 per cent of recommendations were rejected, that 31 per cent were accepted and/or implemented and almost half (49 per cent) were supplanted.

The term 'supplanted recommendations' refers to the notion that recommended actions are already in place. Moore[20] found half of the recommendations were supplanted because organisations had already taken remedial action. Three reasons were suggested for this: inadequate consultation, that organisations act in anticipation of findings, and delays in the coronial process. This study, and the high number of supplanted recommendations, highlights the importance of consultation as well as the considerable length of time taken for the coronial process and the subsequent issuing of recommendations.

Moore's finding was that 20 per cent of recommendations were rejected by organisations. She describes the main reasons for this, which were found to be consistent with international research, including:

- Recipient organisations had not received or were unaware
- Incorrectly targeted; recommendations were well intentioned but misdirected to either the wrong part of or wrong organisation
- Not evidence-based
- Not logistically or economically viable
- Unclear; poorly worded, structured or do not provide clear instructions about the action required
- Contained adverse comments
- Erroneous law; included reference to incorrect or redundant law, recommended unnecessary amendment to law

- The recommended action was already in place
- Response was not required by law.

DURATION LENGTH OF THE INQUEST PROCESS

Little is publicly known about the causes, extent and length of time it can take for a Coroner to investigate a death, produce findings and make recommendations. Australian research (2016) found the average length of time for an inquest to be 19 months and that one quarter of inquests take up to three years.[21] This can have adverse effects on the families of the deceased and those with interest in the findings and it could prolong the public's exposure to risks that could be diminished by appropriate remedial recommendations.

For each of the six children who died within the scope of this review, there was a substantial period of time between their death, the process of the inquest and subsequent findings being released.

Figure 5 shows clearly that these five inquests, with one still in progress and the findings yet to be delivered, have far exceeded both the average 19 month and three year period found in research. It is also evident that the length of time taken for inquests to occur and conclude for children known to child protection in South Australia has increased.

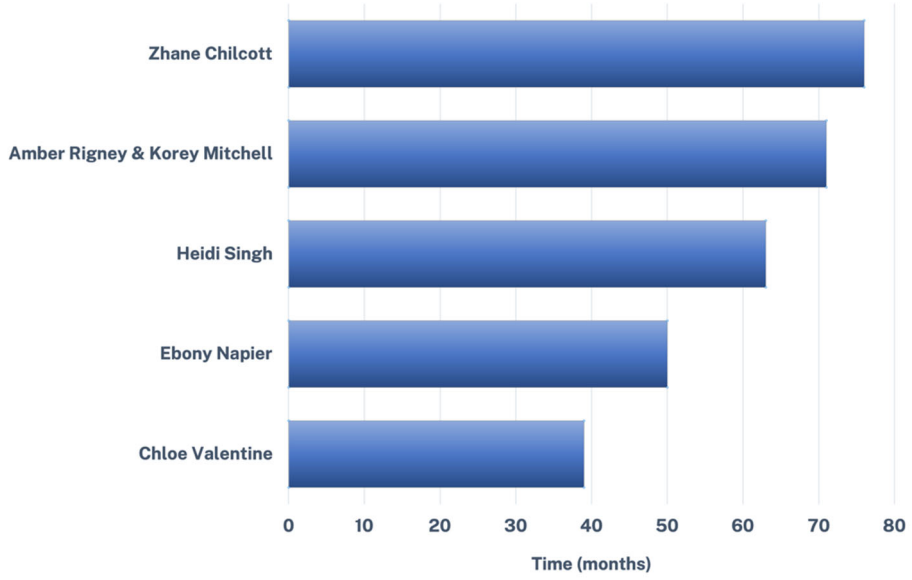


Figure 5: Length of time from date of death to inquest conclusion (months)

The point to be made about the delays is not one of criticism of the South Australian Coroner nor the process of inquests (which highlight resourcing issues that exist across the system). The role of the Coroner and the importance of its function is not in scope for this review nor under debate. Instead the point made about delays is to support the need for a strong systems approach to child death review to be in place between government agencies. If such a process was in place and able to be activated quickly after the death of a child it would provide reassurance to the community that government was acting to review and course correct as needed. Done well, such a process could result in the

Coroner needing to invest less in systems exploration at the time of inquest because that the outcomes of the systems approach could be provided in evidence. This option is discussed further in Part 5.3.

THE REQUIREMENT TO RESPOND TO CORONIAL RECOMMENDATIONS

Research in Australia has found that recommendations are more likely to be implemented when a mandatory reporting environment exists and when the responses are required to be made public.[22] However, the research is equally clear that even when systems are in place to monitor the responses to and implementation of coronial recommendations, there are issues with implementation.

A study completed in Victoria analysed the responses to Coronial recommendations in the first three years newly introduced mandatory response regime and found that the power of, and potential for, the Coroner to make meaningful contributions to public safety was substantially compromised.[23] The study analysed response letters by organisations to the Coroner's recommendations and found that ambiguity in the writing was strongly associated with lack of implementation. There was also a high proportion of responses indicating the recommended action had taken place prior to the recommendation being received, as well as a number of responses that could not be analysed due to being driven by a 'soft' recommendation such as an agency being asked to 'review', 'consider' or 'continue' an action.[24]

The recent select committee on the coronial jurisdiction in NSW noted that many inquiry participants raised lack of oversight of coronial recommendations as an issue. In NSW there is no legislative requirement mandating a response to coroner recommendations. Instead, a Premier's Memorandum is in place that sets out a process for ministers and government agencies only to respond to coronial recommendations. Even with this arrangement, the select committee report noted that responses are often late or not provided at all.[25]

THE REQUIREMENT TO RESPOND IN SOUTH AUSTRALIA

As mentioned earlier, South Australia does have a mandated requirement to respond to recommendations made by a Coroner. This was introduced in June 2021 and should ensure future recommendations are responded to publicly and have an increased level of oversight. However, as evident through the research, other barriers to implementation still exist even when a requirement to report and respond is in place.

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5 OBSERVATIONS OF THE REVIEW

> Workers need to be supported in every case to enter a state of mind and readiness to engage intimately with the child and parents and assisted afterwards to make sense of what they have just experienced.
>
> **Ferguson (2016)**[1]

5.1 THE CHILD PROTECTION WORKFORCE

When this review refers to the workforce it means the broad group of people across the system in South Australia, statutory and non-statutory, who provide child protection and out of home care services. The review focused on the perspectives of this workforce and was fortunate to hear from over 160 individuals.

Many recommendations have been considered from past reviews and inquiries that relate to the workforce. The ones of most relevance to the observations of this review are discussed below.

LEADERSHIP

> We are not a department of blame – we are a department of accountability. At the end of the day, I'm the most accountable person in the Department as the chief executive.
>
> **Cathy Taylor, Chief Executive DCP**

Recommendations 6 to 8 of the Nyland report were about leadership of DCP. Specifically:

> Appoint a Chief Executive of the new department who has strong leadership skills and recognised credibility in child protection work, and who has a direct line of ministerial responsibility. (Recommendation 6)
>
> Implement a structure in the new department that reduces the hierarchies between leadership and front-line workers. (Recommendation 7)
>
> Establish a refreshed leadership in the new department with emphasis on the attraction and retention of leaders who have recognised credibility in child

> protection work, and who have the capacity to lead a major reform of organisational culture. (Recommendation 8)

It is the opinion of this review that the implementation of these recommendations has been highly successful. In fact it was notable just how frequently participants in focus groups and meetings raised their respect for the leadership of DCP. The consistency of this respect extended into conversations with sector agencies, as well as groups with frontline DCP social workers where there were no managers present. In these instances there were no reasons for people to place their respect and gratitude on the record, other than the obvious one that it was most genuine.

This consistency of this positive commentary falls into the following themes.

Leadership that shoulders responsibility

The child protection workforce in South Australia talk frequently about previous highly publicised child deaths. Staff refer to the children who died by first name often and this stood out in all meetings across all levels. It is completely understandable that the workforce would remember such tragic stories but it was also apparent that staff have been deeply affected by them and the critique that followed. In contrast, the workforce describes a very different leadership since 2016, particularly in the way it responds to adverse events and child deaths in the public domain. A common example provided was the Chloe Valentine inquest in 2014 and the sense of blame experienced as a workforce. Staff were quick to point out the difference now and how the culture has changed significantly.

> The Department is the 'most stable it's ever been. It is functioning with the most focus, strong support and the best structures.
>
> **Manager, DCP**

Another example of media reporting the workforce talked about was the pregnancy of a 13 year old girl who had been assaulted by a known sex offender in 2020. Due to a breakdown in reporting procedures, the Minister and DCP executive were not informed of the criminal offence against this girl, or her pregnancy, until after the sentencing occurred. The media headlines ran along these lines:

> Child protection chief refuses to say who knew about sexual assault of girl in state care.[2]

Chief Executive Cathy Taylor was quoted as saying:

> At the end of the day, the most senior person who's ultimately accountable for this work is myself.

Several staff mentioned this story and described a common reaction to it. They said that it meant a great deal to them that they have a leader who takes responsibility rather than apportions blame and that her leadership gave them hope that the reality of their work and its very real challenges were understood.

These examples must not be understood as leadership that enables 'cover ups', or promotes lack of accountability and transparency. Equally, they are examples that reflect much more than 'nice to have' leadership, or leadership that is good for morale. What the

examples and perspectives of the workforce demonstrate is leadership that is essential for quality practice to thrive.

> When the chief executive said publicly 'I am responsible', it meant everything to staff.
>
> **Manager, DCP**

Leadership that provides a buffer

It was also obvious that the DCP leadership style has been set at the top. The Chief Executive, Deputy Chief and Senior Executive Group have set a tone that runs through the agency. In workshops with frontline social workers, team leaders and managers, participants were asked about their level of hope for their work on a sliding scale, with 10 being the highest. Staff consistently assigned numbers that were higher than expected, given the current pressure on the system. Nearly all staff provided a number above 5 and more often it was around 8. Given the level of media reporting and external pressure on the system, this measure of hope across the workforce reflects very well on leadership at all levels. One senior social worker described it by saying:

> I work hard to support my staff to put their Teflon coats on, we have to be their buffer for all the blame we get in the public.

and yet another described it with reference to a private and public perceptions:

> We are hopeful in our own world because we see and believe in the work we do together and we are proud of that, but it's very different in the public sphere.

Leadership that extends across the sector

Several individual meetings were held with interagency partners to inform this review (see Appendix 4). In addition, there was an invaluable opportunity to facilitate an open dialogue session with 26 sector leaders at the heads of industry forum. Three points stood out across these discussions. Firstly, there was collective and strong support for DCP leadership. It was obvious that sector partners wanted their recognition on the record. Secondly, there are strong, smart and dedicated leaders across the child protection system in South Australia, united by an all abiding belief in the work. Thirdly, it is obvious that a lot of work has gone into robust relationships that have matured over the years. The group advocated strongly for the trust and blessing of government, and the public, to stay the course together on all the progress that has been made and all the reform that is in train. At the conclusion of the forum, leaders were asked to provide one statement each that captures their hopes for this review. The responses reflected consistency and much of what has already been said – leaders are proud of the progress they have made, insightful about what needs to change and determined to take the next steps together.

Leadership that knows its people

Although DCP is a relatively small department it was nonetheless noticeable how many staff spoke about their leaders by name and relayed stories of their impact. What stood out is that staff have experienced leadership that leaves them feeling valued, heard and their work seen and understood. Examples provided include staff awards for quality practice, support provided by managers at all hours of day and night, and celebration of positive outcomes for children.

Leadership that is working for Aboriginal staff

> Without the strong leadership and courageous approaches, both internal and external, I would not be **working here today.**
>
> **Aboriginal Leader, DCP**

This review calls out the very real need to improve the system response to Aboriginal children and address disparity. At the same time Aboriginal staff members who provided their insights and experiences described their work, innovation and approaches with pride. They described leadership that respects, trusts and relies on their cultural expertise and authority.

An example of this leadership was provided to the review. It was about a recent meeting of the Community Services Ministers in Canberra, along with the national Aboriginal Leadership Group, to agree on the first five year action plans for the new National Child Protection Framework. The first action plans were co-designed with the Aboriginal Leadership Group. They described the action plans as a:

> historical milestone in a shared journey with governments to improve outcomes for Aboriginal children and young people and increase self-determination for our communities.

Chair of the Aboriginal Leadership Group, Aunty Muriel Bamblett along with Catherine Liddle CEO of SNAICC recognised South Australia's, Deputy Chief Executive DCP and her team for playing a critical role in leading the negotiations.

CHILD PROTECTION AS A STANDALONE DEPARTMENT

Recommendation 5 of Nyland was to:

> move the office of child protection and the functions of Families SA out of the Department for Education and Child Development to establish a separate department that has the business of child protection as its primary focus.

There was not a single person who participated in the review process who did not support the effectiveness of this recommendation. The support for the move was unanimous, and the commentary about why it has been important centred on all that appears to have been intended in reading the Nyland report. Feedback focused on the development of pride and expertise in the work, building of infrastructure and professional systems, and the growth of professional identity. The amount of work to establish the systems, structures, accountability mechanisms, contractual arrangements and delegations of a new department, to name just a few examples, has been tremendous and from all accounts has been managed sensibly, thoughtfully and well.

> No longer are we the poor cousin of Education.
>
> **Social worker, DCP**

The most common points provided in support of South Australia having its own standalone child protection department included:

- there is a Minister dedicated for child protection
- Government has committed to budget and staffing levels
- the department and leadership are stable
- there is a positive culture of improving practice
- there is a commitment to sharing responsibility and risk
- the structure is functional and has accountability
- strong partnerships exist and there is a commitment to continuing to build them
- there is genuine commitment to doing better for Aboriginal children and families.

> We have more professional systems in place now and dedicated resourcing for them. Our resources were swallowed up when we belonged under bigger departments.
>
> **Manager, DCP**

It is the opinion of this review that one of the most successful outcomes of the Nyland report was the build of DCP. Its development of expertise, creation of professional and accountable structures and momentum of work in growing internal and external relationships based on trust and respect, in a relatively short time frame, should be commended.

HUMAN RESOURCE MANAGEMENT

> Right now the system is anxious and there is lots of busy work. There are really skilled staff leaving because of fatigue, and being constantly blamed in the media. It is easy to jump when there are good opportunities elsewhere.
>
> **Manager, non-government organisation**

The human resource functions of DCP, under the various iterations and structures of government, has been the subject of scrutiny and review for many years. During the period when statutory child protection was delivered under the Department of Education and Child Development, recommendations from the Debelle Inquiry and Allen review focused on developing a strong and flexible workforce; professional handling of allegations of misconduct by employees guided by clear policies and procedures; and the establishment of clear communication systems. The Hyde review focused on the residential care workforce and the more recent Rice review in 2021 considered critical event procedures and internal reporting lines and disciplinary processes. Many of the recommendations from these four reviews focused on improvements to the workforce and human resource management processes. Some recommendations were repeated in more than one of the reviews or referred to for action or further work. An example of this is Recommendation 2 of the Rice review:

> That Recommendation 12 of the Allen Report be implemented (which outlines when and how the Child Protection Minister should be informed of serious incidents).

Two recommendations of the Nyland report focused on human resources were:

> **Establish a human resources unit in the Agency that has sufficient specialist expertise and resources to develop and implement strategic workforce plans and to manage operational demands to ensure high quality child protection practice. (Recommendation 21)**
>
> **Require the Agency to develop attraction and retention strategies specific to building workforce sustainability in regional areas, including the use of financial incentives for staff. (Recommendation 222)**

In response to these recommendations, and at its own direction, DCP has developed a strong human resource strategy. It is obvious that a great deal of work has been concentrated on building this strategy, with expertise in staffing and quality and transparent systems. Despite these efforts there are constant pressures, as described below.

- **Retention:** The challenges associated with retaining a qualified child protection workforce are certainly not unique to South Australia. At a recent meeting of lead child protection practitioners across all Australian states and territories the issue of retention was the highest on the list of shared concerns, particularly post-pandemic. The turnover rate in 2021–2022 for DCP was 16.8 per cent, which is the highest level it has reached. This is of particular concern when separated by classification – with turnover rates highest in operational positions (those known as OPS that do not require a degree qualification). The problems of staff turnover are obvious, impacting on lost time in training and mentoring, loss of knowledge, the constant rebuilding of partnerships and impact on morale of the remaining workforce.
- **Staffing levels:** The Nyland report drew attention to persistent vacancy levels that existed across all levels of the (then) child protection agency and focused on the pressures on staff to work beyond their capacity. Nyland also commented on difficulties experienced through the Royal Commission in obtaining accurate data on vacancy levels. DCP provided clear data to this review, reflecting that approximately five per cent of funded positions are vacant across the department.
  Throughout conversations with the DCP workforce to guide this review several participants made positive comments about the development of the human resource function and its strategy. Also of note is that Aboriginal staff currently make up five per cent of the total head count. While this remains the same proportion as was identified by Nyland, the number of Aboriginal staff has increased in line with the actual number of positions.
- **Remuneration that reflects the value of the work:** There is promising work in train across government led by the Office of the Commissioner for Public Sector Employment, to consider strategies for the recruitment and retention of the workforce across government. Despite this, DCP staff provided some worrying examples about losing social work staff to positions in the sector and DHS because of disparity in pay. Staff across government are paid according to the South Australian Public Sector Enterprise Agreement, however, the level is determined by the individual agency. DCP staff are very aware about levels of remuneration offered elsewhere, particularly DHS, Education and Health. Social workers in DCP are responsible for assessing risk in the most complex situations with families that are frequently afraid and involuntarily. While positions in DCP, as well as across the broader sector, require highly skilled and educated staff none more so than the

workforce ultimately responsible to make decisions about children. This is of obvious concern and addressed in the considerations at the end of this section.

RESIDENTIAL CARE WORKFORCE

The Human Resource unit in DCP has maintained a continual focus on residential care recruitment, employment and the ongoing professional development of this workforce. The continued reliance on residential care, means the workforce is large and requires constant recruitment to manage both its growth and turnover.

Residential care is managed both by DCP and non-government agencies. This review has heard comments about the difficulties associated with recruiting and retaining skilled workers and the shortage of workers. At the heads of industry forum, this challenge was raised and one leader said:

> **There is not an endless supply of resources. There is an end point where staffing and resources will run out. We are at that point.**

The review also heard clearly and unanimously from this senior group, as well as from other staff in other forums, about a particular recommendation from Nyland that that has been implemented but has not been effective. Recommendation 138 of Nyland is:

> **Recruit child and youth support workers in accordance with the 2016 recruitment model, including a requirement that all applicants for those positions undergo individual psychological assessment.**

Leaders described that the implementation of this recommendation has been an intrusive 'blanket approach', with huge financial costs, negative personnel implications and has been of little benefit.

This requirement (for psychological assessment of staff) has also been embedded in the legislation under section 107 of the *Children and Young People (Safety) Act 2017*. It is the opinion of this review it should be taken out of legislation and instead become a policy position, where it can be considered and used as needed.

INFORMATION SHARING

Many recommendations have been made in previous inquiries about information sharing. These include specific recommendations to address processes about how information about known or suspected sex offenders is shared (Debelle Inquiry), ensure inter-agency meetings are held to discuss families at risk (Coronial Inquest into Ebony Napier's death), updates to the information sharing guidelines and large-scale recommendations to introduce a uniform national child protection structure (Coronial Inquest in to the death of Ebony Napier) or to incorporate the information sharing guidelines into law (South Australian Ombudsman).

Statutory obligations that support information sharing

Part Three of the *Children and Young People (Safety) Act 2017* provides a strong framework to enable information sharing between agencies that work with children and young people. In particular, section 152 allows prescribed persons and bodies (including government agencies and state authorities) to share prescribed information where this

will assist the recipient to perform functions relating to children and young people or manage any risk to children and young people.

In response to a recommendation made after Chloe Valentine's inquest, in June 2019, the Chief Executive, DCP made a change that authorises DCP employees to disclose any information held by DCP where the disclosure of that information is necessary to protect a person of risk of serious harm.

Within the current review of the legislation there is a commitment to strengthen the Act and provide for an additional exception to the prohibition on the disclosure of personal information if the disclosure is reasonably required to lessen or prevent a serious threat to the life, health or safety of a person or persons.

Information sharing guidelines and the Interagency Code of Practice

DCP has formal protocols, arrangements and referral pathways in place with Police, Education, Health, Housing and DHS to support collaborative work in providing support to children, young people and families. These are well described in the Information Sharing Guidelines and the Interagency Code of Practice. The ISG provide a consistent statewide process for how government and non-government agencies should share information where there is a risk to the safety or wellbeing of a child or young person and the ICP describes how agencies and organisations work together to investigate suspected harm to children and young people.

It is also mandatory for all DCP staff to complete an online Information sharing and confidentiality training program within four weeks of commencing employment.

Information sharing in practice

Overall, comments from the workforce during this review process indicated that information sharing is working well. They report that it is now:

> much easier to get information from other services and to talk about families we are working with and worried about.

The South Australian Ombudsman also commented that 'information sharing has matured and developed and agencies recognise the need for a holistic approach'.

PROFESSIONAL DEVELOPMENT OPPORTUNITIES FOR THE DCP WORKFORCE

There are several recommendations in the Nyland report that are specifically about the expertise, learning and development of DCP staff:

> Establish a learning and professional development unit in the Agency to lead training and professional development, for both professional and operational staff. (Recommendation 22)

> Require professional staff in the Agency to complete a minimum number of hours of professional development each year as a condition of their employment. (Recommendation 23)

> Invest in clinical management, supervision and practice improvement, including the development of a supervision framework. (Recommendation 27)

> Ensure that the Agency's practitioners in regional areas have access to ongoing professional development, through locally delivered training and videoconferencing. (Recommendation 221)
>
> Train Agency caseworkers to recognise and respond to the needs of children with disabilities, particularly in accessing and maximising support services offered by NDIS. (Recommendation 227)
>
> Identify key performance indicators on the cultural competency of the Agency's workforce, and regularly review the effect of these recommendations on that competency. (Recommendation 237)

The opinion of the review is that some strong steps have been taken toward the effective implementation of these recommendations. Further investment of resources would make the much needed difference to strengthen these steps.

> There is a fitness to practice issue. There are no shortage of students coming forward but they are not adequately equipped for the work.
>
> **Manager, non-government organisation**

Partnerships with the higher education sector

The Nyland report focused on the qualifications, skills and training of the child protection workforce in several ways. Most relevant to this review is recommendation 28:

> Establish formal and regularly evaluated relationships between the Agency and the tertiary education sector that are designed to:
>
> a. enhance student and academic knowledge and experience of child protection practice
> b. attract desirable graduates
> c. expand and focus child protection practice research
> d. ensure that the Agency and its staff are kept abreast of contemporary professional research and literature.

DCP has undertaken a great deal of work to meet these recommendations. This includes:

- The building of strong relationships with the university sector, and internally, to enhance pathways to employment for graduating social work students, and build the knowledge and understanding of foundational theories in child protection practice for new graduates entering the workforce.
- Strengthening approaches to growing a multi-disciplinary workforce through broadening the accepted qualifications for roles in child protection practice, and strengthening the disability support capability.
- An agreement reached in May 2020 with TAFE South Australia for the delivery of the Certificate IV in Child, Youth and Family Intervention for employment of the residential care workforce. This includes a reviewed and updated approach to the induction and orientation of this workforce.
- Commencing the planning and design phase for the implementation of a therapeutic model for residential care, which will include developing the skills and capability of the workforce to support the delivery of trauma-informed residential care services.

- Creating pathways for the employment of Aboriginal young people through offering traineeships with a Certificate III in Business Administration, and are planning to expand upon this to offer traineeships with a Certificate III in Community Services to improve employment pathways into direct service delivery settings.

DCP provision of internal training and development

The provision of regular training in the DCP Practice Approach has been well received by staff and its content is contemporary and evidence-based. The monthly online training is a strong initiative and an efficient way to provide regular and inspiring training across the state, both in metropolitan and regional areas. Staff also spoke positively about the recent initiative of 'practice packs' that come out monthly.

At the same time several staff spoke about the fact that they believe new social workers and case managers are not equipped for the reality of the work, the understanding of the legislation and the assessment and relationship skills needed for statutory child protection. The importance of an entry level skills and knowledge program was mentioned several times. All new staff are required to undergo mandatory training, but it is more of an induction to DCP, is short and not skills based. The review makes considerations about the importance of contemporary, consolidated entry level training, as well as the need for a specific package of training that targets emerging leaders stepping into roles of management. Both will be dependent upon additional resourcing.

Supervision

The DCP professional supervision framework is well written and clearly articulates the basis of good supervision, tailored to child protection practice. It aligns to the principles of the Practice Approach and there is recognition by leaders about the importance of regular and quality supervision. There has been training provided to supervisors and supervisees about supervision and it appears to have been positively received.

The response from staff in workshops on the subject of supervision was mixed. Some described examples where they rely on supervision for case direction, emotional support and guidance. Managers described the time they invest in supervision and the importance of it in supporting decision-making and quality practice. On the other hand, some frontline staff said that they would like more opportunities for formal supervision and some managers described the approach to the delivery of supervision is not consistent across units and highly dependent on individual leaders and the priority they place on it. There is also no formal system in place to measure and track if supervision is occurring or that mandates its importance.

Formal strategies to measure compliance with supervision strategies are important because they send a clear message about expectations. The challenge is to create measures of compliance that do not add an extra level of burdensome administrative overlay. At the same time, measures usually only capture that supervision has happened (which in and of itself is important) but not the quality of the meeting. There are ways to measure quality as well and the best place to start on that pursuit is to involve the workforce. The considerations at the end of this section address this point briefly.

Registration of social workers

A recommendation made by the State Coroner after the inquest into Chloe Valentine's death was:

> a measure be introduced which provides for registration of social workers.

New legislation was introduced under the leadership of the previous government in South Australia for the statutory registration of social workers. South Australia is the first jurisdiction in Australia to introduce legislation that makes registration of social workers a legal requirement. The *Social Workers Registration Bill 2021* (SA) passed South Australian parliament on 1 December 2021 and will commence on a date to be proclaimed.

There is still a significant amount of work to set up the framework of the registration scheme, including the establishment of a Registration Board, as set out in the Act. The registration board will be responsible for the decisions regarding the registration of social workers in South Australia. DCP will need to determine how this affects their current employees, recruitment and workforce.

OPPORTUNITIES TO FURTHER DEVELOP THE SOUTH AUSTRALIAN CHILD PROTECTION WORKFORCE

> Workforce planning should be guided by the overarching principle that child protection is complex work requiring appropriately qualified staff. The professional base of the child protection workforce could be expanded by employing professionally qualified staff from disciplines other than social work, but case management in child protection should be reserved for staff who have relevant tertiary qualifications and appropriate experience.
>
> ***The life they deserve***
> **Child Protection Systems Royal Commission**

The modern work of child protection is about partnering for change, working with groups and communities. It requires a unique and exceptional skill set alongside a well-developed knowledge base. Professor Eileen Munro (2011) identifies three primary areas of expertise required of the child protection workforce:

- The ability to build effective, caring relationships while keeping the safety of children at the forefront.
- Making sound, clear judgements and decisions through the skilled use of contemporary, evidence-based research.
- The knowledge and skills to help children, young people and families to solve problems, create needed changes and maintain their relationships.[3]

Alongside these abilities is the critical need for in-depth knowledge about child development, trauma, and issues that can lead to child abuse and neglect. Child protection practitioners also need cultural capability to work with a diverse client group, and understand the cultural strengths and capacities that can be used to build safety for a child. They need formal training and skills in critical reasoning, analysis and decision-making.

The attributes of a workforce with strong qualifications and attributes have been assessed, as shown in Figure 6,[4] against the Australian Government's Child Protection Productivity Commission Indicator Framework. It considers impact across the measures of equity, effectiveness and efficiency, and with the additional of workforce impacts.

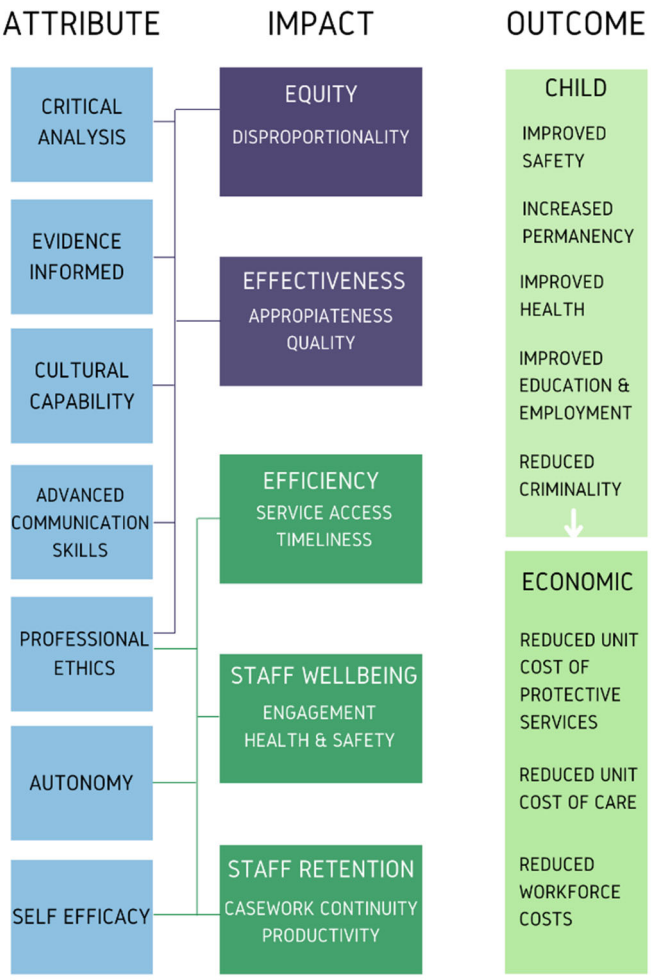

Figure 6: Attributes of a workforce with strong qualifications and attributes against the Child Protection Productivity Commission Indicator Framework[5]

Opportunities to develop a consistently qualified workforce

As a small state South Australia has a relatively high proportion of qualified social workers (estimated to be close to 80 per cent), and only two universities[6] offering social work degrees. By contrast the statutory workforce in NSW has roughly 30 per cent social work trained staff and 10[7] universities that offer social work degrees. This point is not made to discredit practitioners in the system with other qualifications, rather it points to an opportunity. Achieving consistency of practice is an easier task through a workforce with a common vocation. There are several studies that indicate that in comparison to other qualifications, those with a social work degree were better prepared on in knowledge, performed better in their roles, scored higher on measures of job-related

competencies and had higher levels of skill, confidence and sensitivity when working with families.[8] Research also reflects that there is a decreased likelihood that children will be taken into care when their case manager is a qualified social worker.[9] [10]

Additionally, South Australia is home to the Australian Centre for Child Protection Excellence. All of this points to a unique opportunity to develop an industry wide workforce development strategy, with the two universities and the Centre for Child Protection Excellence. Such an approach needs two arms – the prerequisite learning through a quality social work degree that is tailored to child protection work, as well as entry level and continuous learning once in the system.

Benefits of qualifications

Staff with more formal education are more likely to have attitudes that reflect contemporary evidence and are more likely to be aware as to how their attitudes impact on their decision-making – for example, in responding to domestic violence within a family.[11] [12] [13] Attitudes are particularly important to the work of child protection because safety and risk assessments are not based on hard data nor value free knowledge. Workers are frequently confronted with situations for children and decisions that are value laden and evoke strong feeling in conditions of high ambiguity.[14] There is clear evidence that workers' attitudes contribute to both their risk assessments and intervention recommendations[15] and their willingness to ask about violence. These are essential components to the provision of evidence informed interventions – a key priority of DCP.[16] While much of this evidence links capability with the social work degree, it shows the impact that skills, expertise and knowledge can have on outcomes for children and families.

A child protection worker's higher level of education is consistently one of the most important factors that contribute to staff job satisfaction and retention[17] [18] – especially for social work qualified staff [19] [20] [21] where there are strong links between professional commitment to child protection work and the social work values of social justice.[22] Research shows that staff with a bachelor's or master's degree are less likely to stay in a child protection role if their qualifications are not recognised by their organisation.[23] [24]

A 2016 study carried out by the Australian Institute of Family Studies into the wellbeing of child protection workers across Australia found that autonomy and self-efficacy were two of the critical predictors of wellbeing and retention of child protection staff.[25] The study noted that central to both factors was increasing the expertise of staff. These factors are also pivotal to functional efficiencies, reducing process and managerial burdens by having staff with the capabilities to exercise sound judgement and work with autonomy.

Perspectives of the workforce

At the meeting with the industry heads the question was asked about whether the South Australian workforce, across both statutory and broader sector, is adequately trained and equipped for the work. There were 26 participants and not one of them believed this to be true. Critically, all leaders were eager to couple this view with great respect for the workforce. Indeed their perspectives were not heard as a criticism of the people in the system; rather, as a wish for the preparation within formal qualifications to be more tailored to child protection and an increase in resources to enable continuous learning and skill development.

For the South Australian Child Protection Expert Group to consider

- The importance of a clear communication strategy that reinforces and promotes the stability of leadership across the agency, especially given the recent anxiety in the system.
- Opportunities to quickly address any disparity in remuneration between DCP and DHS child protection practitioner positions. Longer term strategies to provide financial and hierarchical incentive for skilled and experienced staff to stay in direct practice should also be considered.
- A partnership with the Australian Centre for Child Protection Excellence and the schools of social work at the two South Australian universities to design an industry wide capability-based workforce development strategy to equip the child protection workforce with high level and contemporary child protection skills and knowledge. This strategy should build on the positive partnerships that are already in place, consider options for targeting, and providing incentive to the highest ranked students, and will require investment. Ideally it should also involve DCP and sector leaders contributing to the social work degree teaching program, the creation of a formal pipeline for students and new child protection electives for third and fourth year students that are prerequisites to joining the DCP workforce.

For the DCP Senior Executive Group to consider

- Options for resourcing a comprehensive and contemporary skills and knowledge based entry level program for new social workers and case managers.
- Options for further supervision and practice leadership training for managers and team leaders.
- Enhancement of the current supervision strategy to provide clear messages about expectations and accountability, alongside monitoring of compliance measures that reflect that supervision has taken place and also to consider its quality.
- Options to use the current review of the legislation to remove the requirement for residential staff to undergo psychological testing.

5.2 THERE NEEDS TO BE A DELIBERATE FOCUS ON ABORIGINAL CHILDREN

> Proportionally we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are alienated from their families at unprecedented rates. This cannot be because we have no love for them. And out young languish in detention in obscene numbers. They should be our hope for the future.
>
> **Uluru Statement from the Heart**

This section of the review describes the importance of the whole system in South Australia making deliberate, planned, collective and long-term steps to address the stark over-representation of Aboriginal children in all areas of disadvantage, but most particularly the care system.

A notable observation across the many review and inquiries into the South Australian system since 2010 is that the number of recommendations made, specific to address inequality of Aboriginal children, has not be relative to the size or pressing nature of the problem

DISADVANTAGE AND OVER-REPRESENTATION

South Australia is home to 369,658 children. Of them, 18,187 (4.9 per cent) identify as Aboriginal.[26]

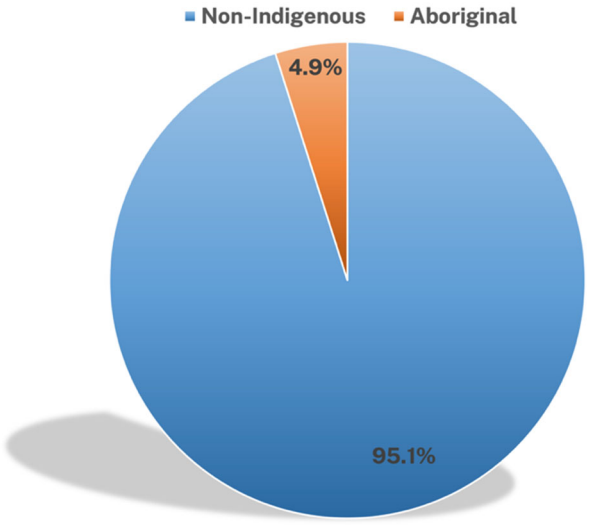

Figure 7: Proportion of children in South Australia who are Aboriginal

Aboriginal children and young people are grossly over-represented in all areas of disadvantage in South Australia, including that:

- they are 32 more times likely to be in detention than non-Aboriginal children[27]
- one in six (16 per cent) of live babies born to Aboriginal mothers during 2016 were low birth rate, a higher rate than the 12.5 per cent recorded nationally for all Aboriginal children
- close to 50 per cent enrolled in the first year of school in 2018 were assessed as having a learning disability.[28]

Involvement with statutory child protection

> The rate of notification for Aboriginal children appears to have increased at a faster rate than for non-Aboriginal children. The belief that if effort is applied in the mainstream system, the benefits will flow on for Aboriginal families, is not borne out by these observations. The consequences of inter-generational trauma remain unaddressed.
>
> **Commissioner Nyland**

The over-representation of Aboriginal children in disadvantage continues with their contact with the child protection system and has been well documented through a variety of research articles and reports. Despite making up just under 5 per cent of the population, in 2020–2021 Aboriginal children accounted for 28 per cent of screened-in notifications[29] assessed by DCP. Fifteen per cent of Aboriginal children have had a substantiated[30] child protection report by the age of three years, and one quarter have had a substantiated report by the time they are 18 years old.[31]

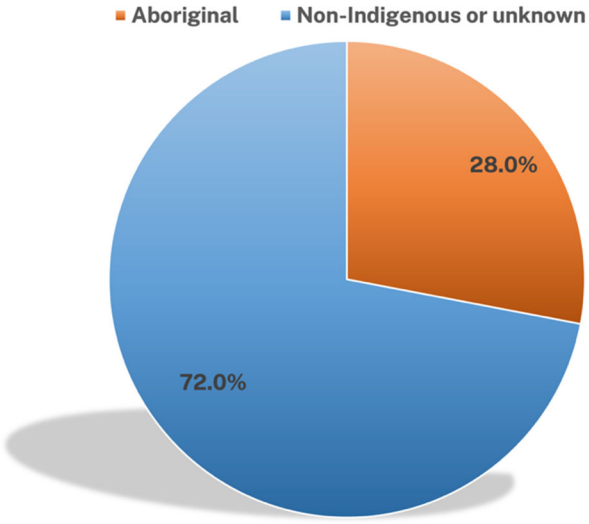

Figure 8: Proportion of screened-in notifications that are about Aboriginal children

This over-representation of Aboriginal children in reports to child protection is not unique to South Australia. It is a problem in very state and territory in Australia and there are several reasons for it, as documented in research. That includes troubling findings about over reporting of Aboriginal children based on racist assumptions in communities[32] and bias in assessment and decision-making approaches and attitudes of the workforce.[33] The over-representation also reflects the reality of disadvantage, disconnection and trauma of Aboriginal people. One sobering example, nationwide, is that Aboriginal women are 32 times more likely to be hospitalised because domestic violence than non-Aboriginal women. The impacts on the children of these women are obvious. There are many other examples. Not least of which is the trauma and disconnection for Aboriginal people resulting from the Stolen Generations which continues to impact on disadvantage. This includes poverty, assimilation policies, intergenerational trauma and discrimination.[34]

Aboriginal children in care

> I don't want to be in care, I want to be with you Mum. It's not your fault I did this. It's my

choice. You will always be in my heart. I love you.

Suicide note written by 13 year old Zhane Chilcott before his death in 2016

Sadly, the disadvantage continues with Aboriginal children in care. Aboriginal children are 10 times more likely to be in care than their non-Aboriginal peers.[35] In South Australia, at 30 June 2021, 37 per cent of the children in care are Aboriginal.[36]

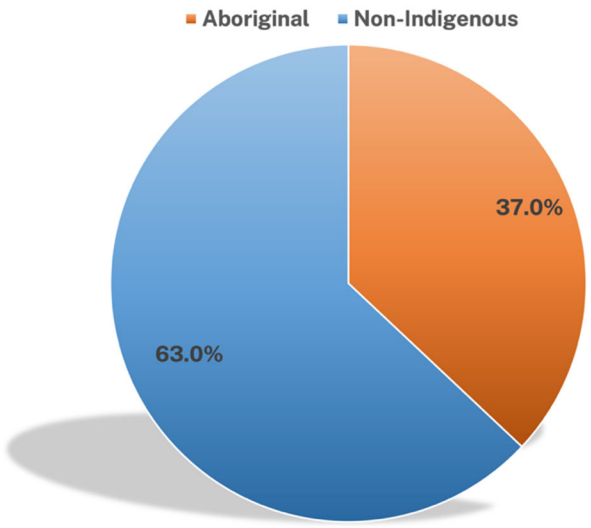

Figure 9: Proportion of children in out of home care who are Aboriginal

Equally alarming, between 2011 and 2021 there has been a 116.3 per cent increase in the number of Aboriginal children in care. At 30 June 2021, this is a rate of 90 Aboriginal children per 1,000 in care. It contrasts sharply with non-Aboriginal children in care at a rate of 7.7 per 1,000.[37] If the rate of removal continues it is predicted that there will be a rate of 140 of over 1,000 Aboriginal children in care by 2030.[38]

This data paints a most concerning picture that needs urgent attention across the whole system.

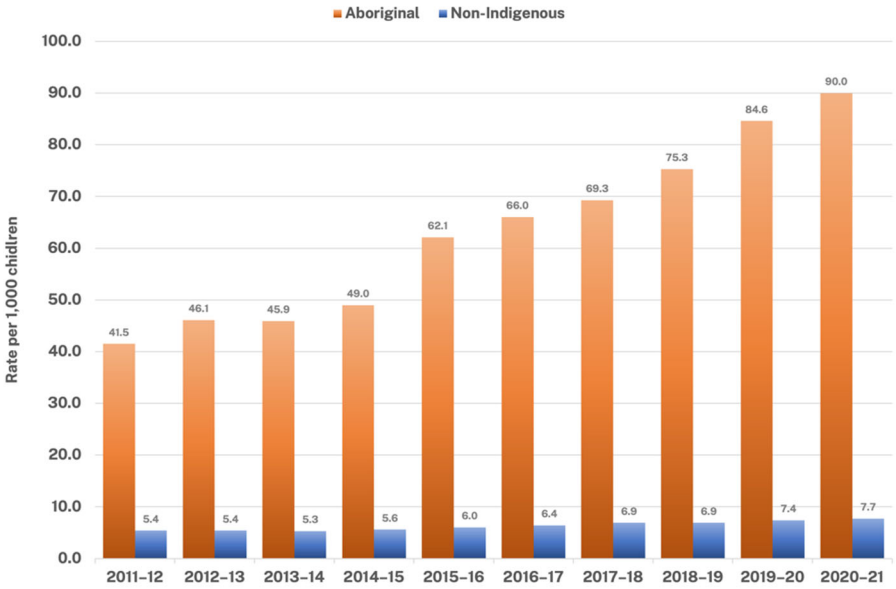

Figure 10: Rate per 1,000 of Aboriginal and non-Indigenous children in out of home care in South Australia

Financial investment

In terms of financial investment, and in comparison to other Australian states and territories, South Australia has the:

- second highest rate of Aboriginal children entering care
- highest rate of Aboriginal children on long-term guardianship orders
- lowest rate of reunification for Aboriginal children (7 per cent).[39]

Lastly, South Australia invests the second lowest proportion of expenditure on family support services (8.8 per cent) and the third lowest proportion of expenditure on Aboriginal Community Controlled Organisations (3.4 per cent).[40]

THE RESPONSE TO ABORIGINAL CHILDREN OF PREVIOUS REVIEWS AND INQUIRIES

As mentioned, of all the 811 recommendations considered for this review the number that are specifically about Aboriginal children is not proportionate to their disadvantage nor representation in the system.

With respect to the inquests into the deaths of four Aboriginal children,[41] only one (Heidi Singh) made findings and recommendations about service provision and quality of culturally appropriate practice with Aboriginal children.[42] There were no recommendations specific to culture in the inquests into the deaths of Amber Rigney and Korey Mitchell, nor Chloe Valentine.[43]

There were also no recommendations about cultural practice or work with Aboriginal children and families in the Debelle Inquiry, Allen review or Rice review. The Select Committee and the Royal Commission into Institutional Responses to Child Sexual Abuse did include some recommendations that aimed to promote and support kinship care and the use of the Aboriginal and Torres Strait Islander Child Placement Principle.

The Nyland report was the exception. It provided a set of recommendations that give a dedicated focus to improving services and safety for Aboriginal children, as demonstrated by the quote above and the examples in the following pages.

In reviewing those recommendations collectively, and the responses to them, alongside the exercise of legislative provisions available in the *Children and Young People (Safety) Act 2017*, the following points stand out as most relevant.

Family Group Conferencing

Recommendations 67 and 68 of the Nyland report are about the introduction of 'family care meetings' and amendments to the *Children and Young People (Safety) Act 2017* to support their use.

These recommendations, accepted in full by DCP, have been highly effective and implemented via a contractual arrangement with Relationships Australia South Australia (RASA) to conduct Family Group Conferences[44] (FGC). FGC started in January 2020 as a two year trial, with an emphasis on cultural safety and responsiveness for Aboriginal families. DCP has continued to extend access to Aboriginal families by funding an Aboriginal-specific FGC service, initially in the northern suburbs and more recently extended to other areas delivered by Aboriginal Family Support Services (AFSS).

Sections 21–27 in Chapter 4 of the *Children and Young People (Safety) Act 2017* contains the statutory obligations that are in place with regard to FCG (complies with the intent of Nyland's use of the term family care meetings).

A quality FGC allows the family to make decisions in a way that reflects their traditions and culture. FGCs have been practiced in a wide range of different cultural contexts and research has shown their adaptability.[45] Importantly FGCs offer a culturally sensitive model. In the hands of a skilful facilitator they reinforce the importance of identity, culture and relationships within families in respectful and empowering ways.[46]

FGCs aim to give power and responsibility back to family and community and build a different relationship with the statutory system. Research on the effectiveness of FGCs shows high levels of satisfaction from participants (children, family members and service providers).[47] An English study found that children offered an FGC were more likely (than with traditional child protection approaches) to be placed with extended family and that placement was more likely to be stable.[48]

The potential for FGCs to lead to positive outcomes for children at risk in families of all cultural backgrounds is significant, yet none more so than for Aboriginal children. This is because of the way FGCs work to respect culture, bring together extended family that may have been disconnected from the children, and attend to the fear or mistrust of government services that many Aboriginal families feel when their child is reported to the child protection system.

Research also confirms that FGCs produce high levels of agreement on plans centred on the safety of children.[49] Moreover, FGCs lead to positive because:

- the relationship between family and social worker is a key protective factor for children and FGCs have great potential to strengthen that relationship
- studies show that FGC plans frequently include both family provided resources and supports and requests for formal services from a range of agencies

- children are more likely to attend FGCs than other more traditional approaches and once present participate more effectively.[50] The coordinator may identify an advocate or support person for the child, most commonly from within the family group, to ensure their voice is heard.

> Children's participation is real. They talk and everyone listens. A good FGC sets up safety and respect for children.
>
> **FGC facilitator, RASA**

Of significance, research findings also indicate that the conversion rate of referrals to FGCs is lower in jurisdictions where FGCs are not required by law and coordinators work outside the statutory agency.[51]

In 2021, 199 families in the child protection system participated in a FGC. DCP confirms that 92 per cent of those families have continued to care for their children in safety. Half of those families were Aboriginal.

Practice leaders from RASA were consulted with to inform this review. They described that their approach to FGCs is centred on Aboriginal practice leadership. The conversation was most hopeful and helpful. Not only did it reflect the strong evidence base from other jurisdictions about the value of FGCs in keeping children with family safely, it equally reflected the development of unique and local Aboriginal practice leadership and authority.

> Aboriginal family and community need to brought to the table, to be trusted for their knowledge and relationships, to organise safety around their own children.
>
> **Aboriginal practice leader and FGC facilitator, RASA**

In addition, conversations with DCP social workers and managers as part of this review confirmed their support for the importance of FGCs for Aboriginal children. Across all meetings there was only one example provided that reflected a negative experience of an FGC. Listening to that story it was clear that the issue was the facilitation of the particular meeting, not the approach itself. Every other conversation provided unequivocal support for FGCs as an effective, successful and socially just way to work with Aboriginal families.

Alongside this strong level of support, two consistent concerns about FGCs were expressed. Firstly, there are not nearly enough facilitators to refer to and the number of families that receive an FGC is low. And secondly, child protection staff commented that FGCs can take a long time to organise. The concern about scale and access is real and addressed in the considerations at the end of this section. The issue about the time and FGC takes to organise is more complex. On one hand, given the importance of a well-planned FGC with the right people at the table, alongside the very real potential to keep children safe with family and not in the care system, the issue of time is minor when weighed against the benefits. It takes time to find relatives and to prepare them. And it takes time to lay the groundwork with respectful relationships with people who may have very good reason to be afraid of the statutory system. On the other hand, the reality for

some families that DCP works with is that there can be situations where children have been assessed as unsafe in the immediacy and an urgent response is needed to prevent removal. Options for being guided by the strong Aboriginal leadership in DCP in the use of Family Finding and Aboriginal Led Decision-making are important approaches that can also be relied upon at these times. None of these approaches (FGCs, Family Finding and Aboriginal Led Decision-making) should be understood as mutually exclusive. They are all important and complimentary options that belong in a suite of evidence informed ways to work with Aboriginal families that honour their expertise.

The ways practice and statutory obligations support Family Group Conferences

Recommendation 67 of the Nyland report is about amendments to legislation to support the use of FGCs (referred to in the report as FCMs). The *Children and Young People (Safety) Act 2017* has been amended accordingly. Yet, it is the opinion of this review that it does not go far enough. The Act should be further amended to reflect a stronger message and preferably a mandated requirement (this is addressed in the considerations).

For example, 67a states that:

> the Agency should **consider** causing an FCM to be convened whenever it is of the **opinion** that a child is at risk but the risk **appears capable** of being addressed at an FCM.

The language used by Nyland was not as strong as this review would recommend. Firstly, 'consider' leaves it entirely to the discretion of the social worker working with the family. By contrast, in New Zealand once a social worker has formed a belief the child needs care or protection, they must refer to a coordinator for an FGC. Secondly the wording 'the risk appears capable' is ambiguous. In practice, it could be interpreted that the social worker is responsible to make a judgement about the capability of the family to lower the risk, or the risk itself to respond well to family support. The problem is that the social worker will not be well placed to make that sort of judgement because they will often not know the wider family, their resources and strengths. FGC coordinators frequently identify family members the social worker has not met, which is one of the strengths of the approach (and why it takes preparation time).

Current legislation reflects the recommendation made in the Nyland report, although was worded differently, yet it too could be strengthened.

Section 22 of the Act states:

> if the Chief Executive or the Court suspects that a child or young person is at risk and that arrangements should be made in relation to their care ... then the Chief Executive or the Court **may convene** a family group conference in respect of the child or young person.

The language of 'may convene' leaves the choice in the hands of the social worker or case manager. Ideally the use of an FGC should be mandated in legislation.

Application of the Aboriginal and Torres Strait Islander Child Placement Principle

> In this case a 14 year old Aboriginal child died alone, without ever knowing her own culture and community. She languished in Emergency Care without the assistance of a dedicated team with Families SA to focus on Aboriginal children in state care and the Aboriginal Placement Principles. She died without the chance to be supported in her time of need by a loving foster family and without access to a skilled

> therapeutic support. In my view, it is deeply shameful.
>
> **Deputy State Coroner, Jayne Basheer, in her findings into the inquest of Heidi Singh**

The Aboriginal and Torres Strait Islander Child Placement Principle was developed in recognition of the harm and suffering caused by the forced removal of Aboriginal and Torres Strait Islander children from their families, communities and culture.[52] In South Australia, the Principle is enshrined in the *Children and Young People (Safety) Act 2017* to:

- enhance and preserve Aboriginal and Torres Strait Island children's connection to family and community, sense of identity and culture;
- recognise and protect the rights of Aboriginal children, family members and communities in child welfare matters; and
- support self-determination in and to reduce the disproportionate representation of Aboriginal children in child protection systems.

The Child Placement Principle has five themes: Prevention, Partnership, Placement, Participation and Connection. The provisions are strong and clearly written, albeit are not included in the legislation. The *Children and Young People (Safety) Act 2017* reflects guidance to include Aboriginal children, families and communities in decision-making. It requires that children are placed with their families, communities and culture. Its elements span both prevention of entry to out-of-home care and reunification to ensure culturally connected placements.[53]

The importance of the Principle has been upheld by three review processes:

1. The Nyland report, which recommended:

   Review practice guidance, funding arrangements and the range of declared agencies to ensure that a recognised Aboriginal agency is consulted on all placement decisions involving Aboriginal and Torres Strait Islander children, in accordance with the provisions of section 5 of the *Children's Protection Act 1993*. (Recommendation 189)

2. The inquest into the death of Heidi Singh, with Coroner Basheer recommending:

   full implementation of Nyland which pertain to matters directed at Kinship care and promotion of the Principle.

3. The final report of the Royal Commission into Institutionalised Responses to Child Sexual abuse, which recommended:

   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. (Recommendation 12.20, Final Report)

At 30 June 2021, the number of Aboriginal children and young people placed in accordance with the Child Placement Principle was 1,092 (65.2 per cent of Aboriginal children who entered care in that year). This is a slight improvement from the previous year (977 children or 63.7 per cent in 2020).[54]

It is the opinion of this review that DCP has demonstrated commitment to the Principle and awareness of its value to the cultural identity and safety of Aboriginal children. In meeting with the Director, Aboriginal Practice Unit for DCP the amount of work and effort undertaken in recent years to encourage the use of the Principle across DCP was apparent. This includes clear recognition of the Principle in guidance that has been developed and is provided to staff about Family Led Decision Making and Family Finding (discussed further in the next section). That guidance is practical, clearly written and easy to follow, showing the dependencies and importance of all these approaches in every stage of work with Aboriginal children and their families.

At the same time, there was a significant proportion of Aboriginal children (about 35 per cent) in 2021 who were not been placed into care with adherence to the Principle. The feedback from Aboriginal leaders who were consulted with during this review process is that the problem lies in the poor application of the principle, more than the principle itself.

To that end, problems with the application of the Principle reflects a number of factors, which will most properly be addressed through the other current inquiries, most importantly the inquiry into the application of the Principle, but also the review of and inquiry into foster and kinship care.

While acknowledging the proper scope of the above reviews to address any concerns about the provisions of the legislation to improve use of the Principle, this review makes one comment about the *Children and Young People (Safety) Act 2017* and its emphasis on culture. It should be strengthened. Its focus leans heavily toward processes and activities of statutory social workers without enough recognition of family responsibility and the importance of culture. With the exceptions of the sections in the Act that outline Family Group Conferences and the Principle,[55] the importance of the role of family to develop children's cultural identities should be stronger.

The next table is taken from the Family Matters Report 2021. It shows the limitations of the South Australian legislation to:

- recognise self-determination of Aboriginal people;
- recognise consultation/participation of Aboriginal people as a decision-making principle; and
- require consultation/participation of Aboriginal people for all significant decisions.

It also shows that the *Children and Young People (Safety) Act 2017* has more limitations, than equivalent legislations in other Australian states, in its requirements for children to express their views and perspectives. While the Act does mandate the participation of children it does not provide strong stipulation around the importance of how children's voices will be relied on in the way some of the other states do.

	Aboriginal and Torres Strait Islander self-determination is a recognised principle in the Act	Aboriginal and Torres Strait Islander people's participation and/or consultation is a decision-making principle in the Act	Consultation/participation of an Aboriginal and Torres Strait Islander agency (external) is required for all significant decisions	Consultation with an external Aboriginal and Torres Strait Islander agency is required prior to placement decisions	Input from external Aboriginal and Torres Strait Islander agencies is expressly required in judicial decision-making	The Act mandates that a child has meaningful opportunities to express their views and for those views to be given due weight in the decision-making process
ACT	No	No (Participation requirements not specific to decision-making)	No (Submissions considered)	No	No (Limited input requirement for long-term orders)	Yes (Does not stipulate how children's views will be responded to and taken into account in all processes)
NSW	Yes	Yes	Yes (Required by principle, but no enabling process is specified)	Yes	No	Yes
NT	Yes	Yes	No	No	No	Yes
QLD	Yes	Yes	Yes	Yes	No	Yes
SA	No	No	No	Yes	Yes (For placement decisions only)	Yes (Does not stipulate how children's views will be responded to and taken into account in all processes)
TAS	Yes	Yes	No	No	No (Evidence and submissions)	Yes
VIC	Yes	Yes	No (Required by agreed protocol, but not legislation)	Yes	Yes (For permanent care orders only)	Yes (Does not stipulate how children's views will be responded to and taken into account in all processes)
WA	Yes	Yes	No	Yes	No	Yes

GREEN – Legislation aligned RED – Legislation not aligned GREY – Limited / significantly qualified alignment

Figure 11: Alignment of state and territory child protection legislation with elements of participation

Source: *Family Matters Report 2021*, Table 7, p. 120

Family Finding, Family Led Decision Making and Cultural Mapping

> Family Finding is a public health project. We see the family in front of us, instead of searching for one we like better.
>
> **Kevin Campbell, founder, Family Finding**

Recommendation 190 of the Nyland report called for DCP to establish a dedicated Family Scoping Unit. Family Finding is a model developed by Kevin Campbell in the United States that seeks to connect children with family and other supportive adults who will love and care about them in the immediate and throughout their lives. Children are vulnerable to experiencing isolation and loneliness without those sustaining connections and relationships. Family Finding reinforces the importance of emotional permanency for children and the sense of security and belonging that enduring relationships can provide. This in turn builds resilience and better prepares children for adulthood. The approach encourages practitioners to work with urgency, seek permanent belonging, support family driven processes and develop clear goals. It is of benefit to child protection practice with all children. Its potential for Aboriginal children is obvious.

Recently, DCP has developed the *Taikurtirna Warri – apinthi* program. Upon listening to the description of the program from an Aboriginal practice leader, and in reading the material that describes it, what stands out is how unique it is in its cultural adaption of the Family Finding model. *Taikurtirna Warri – apinthi* is a Kaurna word for finding family. While the formal procedure is still in draft it steps out processes for mapping safety and mapping for placement. It describes an *Aboriginal child and young person thinking circle* which is described as:

> **an Aboriginal led, rapid and agile response pathway that supports *Taikurtirna Warri – apinthi* practitioners in their mapping work by facilitating the sharing of cultural and community information.**

The 'thinking circle' acts as an Aboriginal governance group, is held every fortnight and is attended by Aboriginal practitioners in DCP trained in the approach. The guidance is clear and empowering. Importantly, the governance for the program sits with the Aboriginal Practice Directorate. The significance of this cannot be overstated.

> There are Aboriginal children in care who are hunting for scraps of their culture. Cultural mapping and family finding makes such a difference to them.
>
> **Leader, non-government organisation**

In the manager and caseworker forums held with DCP staff several people mentioned the benefits of the recently formed Family Finding team. A social worker in particular described how she had relied on this team to assist her to locate family for a young Aboriginal child and how successful this had been.

Recommendation 188 of the Nyland report was to:

> review procedures to streamline the sources of internal cultural advice to the Agency

and recommendation 191 was to:

> provide all practitioners in the child protection system with training, support and clinical supervision to give them the knowledge, skills and techniques to work effectively with Aboriginal children and families, including, where appropriate, the specific skills required to work effectively in remote Aboriginal communities.

All the work of the Aboriginal Practice unit and its development of resources, support and guidance to staff reflects compliance with these recommendations very well. The recommendations appear to have made a positive impact and DCP has committed to them with diligence and cultural authority.

Assessment

There are unique considerations in the way safety and risk is assessed for Aboriginal children and this is a growing area of interest and subject of research across Australia. Part 5.4 addresses the importance of culturally specific approaches to the way South Australia conducts is safe and assessments, and lists considerations that are intended to benefit practice with Aboriginal children.

APPOINTMENT OF A COMMISSIONER FOR ABORIGINAL CHILDREN AND YOUNG PEOPLE

A Commissioner for Aboriginal Children and Young People was appointed in October 2018. Initially the position did not come with statutory powers, but this has since been rectified via amendments to the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

The Commissioner is empowered to undertake a range of functions related to Aboriginal children and young people and is the only independent body, at a systemic level, created solely to promote the rights, development and wellbeing of Aboriginal children and young people within South Australia. This includes developing culturally safe and informed strategies and promoting Aboriginal voice with regard for the safety and wellbeing of all Aboriginal children and young people. With complementary functions, the Commissioner works alongside other independent bodies including the Commissioner for Children and Young People, Guardian for Children and Young People in Care, Child Development Council, and the Child Death and Serious Injury Review Committee.

This appointment is a significant achievement for the South Australian system. The Commissioner herself has long standing experience in direct child protection practice and advocacy. Her appointment has obviously brought much hope to Aboriginal and non-Aboriginal staff across the sector.

IMPACT ON AND INVOLVEMENT OF ABORIGINAL LEADERS AND FAMILY MEMBERS IN REVIEW AND REFORM PROCESSES

> I came into care in 1967. The year this country gave my people the vote.
> Yvette was a good mother before she got on the drugs. She loved those kids and they loved her.
>
> **Donna Rigney, grandmother of Amber Rigney and Korey Mitchell**

Five of six of the children who were subject of inquests that informed this review (Zhane Chilcott, Amber Rigney, Korey Mitchel, Heidi Singh and Chloe Valentine) were identified as Aboriginal. In only Zhane's inquest was there expert evidence provided by an Aboriginal leader[56] (April Lawrie, Commissioner for Aboriginal Children and Young People). The significance of an Aboriginal leader of such importance to children giving evidence at this inquest cannot be overstated. It reflects the emergence of a positive priority of the Coronial process to be informed by Aboriginal expertise, cultural guidance and insights.

Aboriginal leaders and practitioners who were consulted to inform this review described that they experienced the recent inquest into the deaths of Amber Rigney and Korey Mitchell as deeply distressing. They talked about the impact of the media that was experienced as mother blaming, child protection blaming and simplistic. They also described a strong sense of injustice about the fact that there was almost no commentary focused with sensitivity on the fact that the children's mother, an Aboriginal woman with a history of trauma, was murdered as well as her children, by a non-Aboriginal man.

There has been energy and commitment by DCP and the broader system to increasing Aboriginal leadership promoting, recruiting and developing Aboriginal staff in DCP and the sector. At the heads of industry forum, that informed aspects of this review, questions were asked about the hopes of leaders from this review process. Many of the hopes expressed by leaders across the system were about genuine participation of Aboriginal people, true partnerships, Aboriginal led decision-making and proper investment into early intervention. The consistency of those responses and the genuine manner in which they were offered was compelling.

Of great significance is the current review into the application of the Aboriginal and Torres Strait Islander Child Placement Principle by April Lawrie, Commissioner for Aboriginal Children and Young People. Of all the reviews and inquiries undertaken about the child protection system this is the first one led by an Aboriginal person.

Donna Rigney, maternal grandmother of Amber Rigney and Korey Mitchell, was also consulted with as part of this review. She was accompanied by her youngest daughter, sister of Yvette and aunt to the children. Seven years on from the murder of Amber and

Korey, as well as their mother Yvette, the grief of these two brave women was raw and palpable. Donna brought photos of the children to the meeting and took time to describe them for the people they were, their hopes and struggles. Neither Donna nor her daughter attended the inquest. They have also chosen not to read the report into its findings. They were clear that it was not a forum or report that they felt would be helpful to them, best expressed by the words 'Why would we want to stir all that pain up?' Donna spoke about her memories of the children, their bubbly natures and happy personalities. She also described that Yvette was a 'good mother' before she developed an addiction to drugs. This included examples that when the children were very small and Donna described Yvette as 'an old school mum' who insisted the children sit at the table and eat their dinner. Listening to these examples it was clear that Donna wanted them on the record. She did not deny any of the problems that came with Yvette's problematic drug use, rather she was resisting the one-sided view of her that has been painted in the media.

Donna herself grew up in state care. She was removed from her mother aged four, and most of her children have had periods in care. Donna gave her permission for her words and insights to be quoted in this review. Her courage was inspiring.

One of the carers of Heidi Singh was also consulted with during the review process. Alina Flink was the daughter of the couple that cared for Heidi from birth until she was 10. Alina also cared for Heidi until her behaviours became so challenging that she needed to be moved into emergency care. Similarly, Alina has not read the inquest findings into Heidi's death and only participated in the inquest to provide evidence. She spoke with warmth and fondness for Heidi, as well as her wishes for the system to cater better to Aboriginal children with disability and mental health problems. Alina's insights were much appreciated.

The State Coroner in NSW has recently established a new process for inquests into Aboriginal deaths in custody. This includes restorative justice meetings with family members within six months of the death, led by an independent mediator, with full and frank disclosure of information by government services to the family. Each of these processes starts with a smoking ceremony, and other important traditional rituals of respect and grief are recognised. The considerations at the end of this section highlight the opportunities for South Australia to explore options for review processes that meet the needs of Aboriginal families.

INSIGHTS FROM THE WORKFORCE

> **The system of the courts, legislation, government and services, despite their best intent and effort, do not function in a manner sympathetic to the needs of Aboriginal people, children, culture and beliefs.**
>
> **Manager, DCP**

Throughout all the consultations and meetings that informed this review, the concerns about Aboriginal children, their over-representation and the need for more investment in quality early intervention and family preservation work in partnership with Aboriginal Community Controlled Organisations (ACCOs) were made repeatedly by DCP and sector partners alike. The most common theme across these conversation, as summarised well

by the quote above, is that there are not nearly enough Aboriginal led, easily accessible and well resources services for which to refer Aboriginal children and families.

At the same time, there were also positive comments made about progress, including the:

> progressive work DCP has done with ACCOs in allowing them to do kinship care. (Non-government organisation leader)

In meeting with CREATE, the peak body for young people in care, recognition was provided about the increased number of Principal Aboriginal Consultants recently employed by DCP. CREATE also stated that the recognition of lived experience of Aboriginal people for employment entry was a positive step in diversifying the workforce and honouring cultural wisdom and insights. Lastly, CREATE recognised that a good proportion of Aboriginal staff were involved in the development of DCP's Reconciliation Action Plan.

Lastly, there was a consistent message from non-government organisation partners that reflected positively on the recent work between ACCOs and DCP, particularly in kinship care.

ABORIGINAL STAFF IN CHILD PROTECTION

> To truly address the over-representation we must start to change the narrative and that doesn't mean we leave Aboriginal children and young people in unsafe conditions but find the safety that does exists in Aboriginal families – just keep looking.
>
> **Aboriginal Practice Lead, DCP**

At 30 June 2021, DCP employed 121 employees who identify as Aboriginal. This number is fairly stable compared with recent years.[57]

Part 3 of this review describes the impact of child deaths on child protection staff across the sector and the immense pressure the system is under. The impact on Aboriginal staff is even more profound. When Aboriginal children die in situations of abuse and neglect, or in care or by suicide, it is of great distress to Aboriginal staff for many reasons, not least of which is that they frequently know the young person or their family. The director of the Aboriginal Practice unit described several examples of the support behind the scenes that her unit provides to Aboriginal staff in the days following such tragedies. This has included debriefing, smoking ceremonies and minutes of silence.

The unique challenges for Aboriginal staff who work in child protection, and the toll it takes, needs to be recognised by statutory systems in Australia in ways that promote wellbeing, provide culturally appropriate supervision and respect. DCP has taken many steps in the right direction since it became a standalone child protection agency, guided by an apparent and deliberate focus. Further investment in Aboriginal practice leadership positions and cultural awareness training for non-Aboriginal staff would be ideal to build on the steps that have been taken.

For the South Australian Child Protection Expert Group to consider

- Options for deliberate and vastly increased investment in early intervention and family preservation services for Aboriginal families. The spending on Aboriginal children and services should be proportionate to their representation in the system, not the population. This will require extensive planning and should include the further expansion of Family Group Conferences (both in the sector and a unit within DCP that encourages and supports frontline staff to promote use of FGCs).
- The findings and recommendations of the Commissioner for Aboriginal Children and Young People's review into the application of the Placement Principles to inform future planning, investment and strategies to increase the participation of Aboriginal people in decision-making about their children.
- Opportunities to meet the needs of Aboriginal people through coronial processes and formal inquiries. This should include consideration of restorative justice approaches, led by Aboriginal mediators, and options to ensure Aboriginal leaders provide cultural expertise and advice to any analysis of concerns or data that is about Aboriginal children and families.

For the DCP Senior Executive Group to consider

- Opportunities to rely on the current review of the legislation to make mandatory the use of Family Group Conferences for all families where Aboriginal children have been assessed as unsafe. Importantly, this would mean that no Aboriginal children can be presented before for the Youth Court seeking assumption of care orders in the absence of a Family Group Conference having taken place.
- Further work on the SDM tools to ensure cultural sensitivity, including consideration of protective factors through a cultural lens. This work should also include collaboration with Queensland and NSW on the current work improving their assessment approaches to better reflect the needs, strengths and protective factors of Aboriginal families and reduce potential for bias.

5.3 THE SYSTEM IS UNDER IMMENSE PRESSURE

> In being so concerned with scandals and tragedies in a variety of institutionalized and community settings, the media have portrayed the nature of child maltreatment in ways which deflect attention from many of its core characteristics and causes. A focus on the media is important because of the power the media has to help transform the private into the public, but at the same time, to undermine trust, reputation, and legitimacy of the professionals working in the field.
>
> **Lonne and Parton (2016)[58]**

Part 5.3 reflects observations about the system at the current time, in recognition of recent high profile deaths. It is not intended to be alarmist but it does seek to amplify some very real and current concerns about the emerging impact on the workforce, and therefore the children it serves.

THE ROLE OF THE MEDIA AND ITS INFLUENCE ON CHILD PROTECTION

Child abuse and neglect is a problem for the whole of society and the media plays a key role in the way it is portrayed in the public domain. On the positive side, media coverage can raise public understanding and increase community awareness about the need to report concerns about children. It can educate about the reality of the work and it can challenge attitudes. Balanced reporting can lead to compassionate understanding about the impacts of trauma, disadvantage, addiction and family violence. Other positive benefits can include the pressure that results in provision of significantly higher resources to develop services and address problems. A study completed in New Zealand noted that the Coroners interviewed commented that the media play an important role in publicising the health and safety messages of coronial recommendations.[59] This point is reflected in the large amount of public interest demonstrated by the frequency of media items about coronial inquiries.

Mostly, however, media attention on child protection work is in the aftermath of a catastrophic event and it invariably leads to impacts that are not positive. Understandably, the death of a child, particularly in circumstance of abuse or neglect,

will provoke strong emotion and in turn, the need for an explanation or someone to be held accountable can result. The intensity of this reaction can often place pressure on government to respond and influence the need for reform.[60] This can lead to the increasing politicisation of child abuse, often expressed through calls for inquiries, which in turn have contributed to systems becoming risk averse and punitive in their orientation.[61]

Furthermore, the media can influence staff morale negatively, both individually and across organisations. A study looking at three months of newspaper articles about social workers in the UK found that child protection was the most dominant form of social work featured, that there were more negative portrayals than positive, and that cases of child abuse and neglect were viewed not as resourcing or societal issues but as social workers 'failing to act'.[62] Negative perceptions of social workers can affect recruitment and retention, with the consequences of enormous loss of resources and human potential for child protection system.[63]

Media can be particularly harmful when it promotes the damaging impact of thinking that:

> **every risk is calculable, every problem solvable and every death is chargeable to some professional's account.**[64]

High profile child deaths can weaken the identity of a child protection service and emotionally affect field practitioners, causing feelings of distress, poor communication with management, less confidence and lowered morale amongst the workforce.[65] [66]

> The organisation of news is not geared up to the needs of the socially powerless.
>
> **Cottle (2000)**

Australian research undertaken in 2020[67] considered the 'hierarchies of attention' that enable news professionals to prioritise and attend to certain voices, stories and frames in reporting on the many events that compete for news attention. The research cites the problem with media that 'identifies an individual villain who is the cause of a socially significant problem'. It considered the portrayal of stories throughout the Royal Commission into Institutional Responses to Sexual Abuse to determine which stories and themes received most coverage. The findings were that attention to clerical sexual abuse and the role of powerful church officials, was amplified to ' top volume' in news coverage, with the effect of overshadowing other cases and obscuring the voices of people deemed less newsworthy. Moreover, the research found that children from marginalised groups, including Aboriginal victims and survivors, children with a disability, and from culturally and linguistically diverse backgrounds were more likely to experience sexual abuse in residential 'care' and schools, yet some of the case studies involving these children were among those that received the lowest volumes of news coverage.

> I just want to be respected to the same level as teachers, nurses, police and ambulance officers.
>
> **Social worker, DCP**

As a small state the focus of the media on the child protection system in South Australia has been particularly relentless. The great majority of reporting has been highly critical of the system, attributing blame for its perceived inability to predict and protect. This criticism has included personal attacks, including calling for staff to be sacked. This particular headline in 2015 is a good example of this point:

> The **beleaguered** boss of the **broken, flawed** Families SA department will not disclose whether any of the social workers who **botched** the Chloe Valentine case have been **disciplined or sacked**.[68]

> The media gets the balance wrong and there is never any fairness to the real story or how hard we work. As managers we often need to remove newspapers from the office, act to protect staff, reassure them to show them 'we've got this.
>
> **Manager, DCP**

In addition to blaming the child protection system, the media has also frequently been overly simplistic in its understanding of the reality of lives for many struggling families and highly critical of them. One example of this was in 2016 when the *Daily Mail* wrote about the murder of Amber Rigney, Korey Mitchell and their mother Yvette Rigney under the sensationalised headline:

> Mother who was murdered by her partner along with her two children beat her son with a broom and starved them as she spent all her money on methamphetamines

Underneath that headline was seven bullet points that mostly focused on the mother. Aboriginal leaders and academics have challenged this simplistic, mother blaming reporting, including this commentary:

> By privileging episodic framing (individual problems) instead of thematic framing (society's role in addition to individual problems), research shows the attribution of responsibility towards the victims, otherwise known as victim blaming, increases.[69]

The perpetrator of the triple murder was not mentioned until the sixth bullet point.

Impact on morale and culture of practice for child protection staff in South Australia

The media was mentioned in every single focus group, meeting or interview that informed this review. The following examples stood out:

- At one DCP child protection office a group of 20 staff participated in a focus group. They were asked to imagine that they woke up the following day with full and

magical powers to change the system, with unlimited access to resources and abilities to make whatever changes they wanted to improve outcomes for children. They were then asked to describe the very first thing they would do. Over one-third of staff said they would change the way the media reported their work.

> I am out there knocking on doors and families are asking me why we couldn't save Charlie. Even my friends and family ask me questions about Charlie. It wears me down.
>
> **Social worker, DCP**

- Senior managers and team leaders at DCP described the lengths they go to in supporting their staff through periods of intense criticism in the media. They were clear that it impacts morale, increases anxiety and lowers respect in the public domain.
- Frontline workers described the impact of the recent portrayal of the death of Charlie. In fact this little girl was spoken about, by name, in most meetings. Examples were provided about the disrespectful comments and accusations they have dealt with from families they work with, community members and in their own personal networks. Staff described a weariness in having to defend their work and their colleagues. Importantly and powerfully they also spoke with compelling hope, a strong sense of vocation and belief in their work in response to other questions as part of this review. What was clear is that local and senior leaders (as discussed in Part 5.1) have done their best to buffer, protect and respect these staff. Close relationships of professional support within the office sustain them but these efforts do not mitigate the impact of the constancy of criticism.

> We like to say that child protection is everyone's business. Until something goes wrong and then it all lands on us.
>
> **Social worker, DCP**

- Social workers described they have changed their habits so as not to be recognisable in public. This includes remembering not to carry their laptop bags and wear their lanyards, both of which are easily recognisable as DCP to the community. One social worker (as quoted in the executive summary) described being sworn out in the street and abused for 'killing children'. It was obvious by the reactions of the group to this sort of experience was not a one off.

Impact on interagency relationships

Several DCP staff described worries that recent media attention on high profile deaths have led to an increase in reporting and some unnecessary tension between partner agencies. These are best described by one participant who said 'even our interagency partners back away from us', while another said 'everyone is operating in anxiety and that means out all the responsibility falls onto us'. Staff also expressed concern that 'politics were playing out' in some of the recent media. Several mentioned their disappointment that the media was airing tensions between government agencies and further described that this impacted on trust at local level.

DCP staff told the review that in recent months, since the media reporting about the two high profile child deaths, they have received an increase in notifications. A social worker at the CARL described her observations about the increase and change in recent notifications:

> Everyone was keen to pass on concerns, however ill formed or lacking proper information.

> The media has forced a response recently; there is an anxiety that is escalating things to a high level that has never been felt before.
>
> **Head of a non-government organisation**

There was also strong sentiment expressed by interagency partners about the need to shape a different narrative for the media, a desire for balanced reporting and collective accountability and a concern about the impact of current reporting.

Impact on families

Belinda Valentine, grandmother of Chloe, provided her insights and experiences to inform this review. She spoke of the importance of the child protection sector and broader community respecting the perspectives and unique knowledge of people with lived experience of the system. Belinda's dedication and drive to influence the system for the better for other children stood out, as well as her remarkable resilience. Belinda said that whenever there have been child deaths in the media with extensive coverage she and her family have been contacted relentlessly. One particular example was the media that followed one of the recent deaths and Belinda's phone rang all day from a variety of media outlets, as well as others outside her home with cameras requesting an interview. Equally, Donna Rigney (see also section 5.2) described her distress at the way the media portrayed her daughter and how she and her family have avoided following, and connecting with, any media about child protection stories for the pain it causes.

ARRANGEMENTS FOR OVERSIGHT

Recommendations 245–255 of the Nyland report refer to the establishment and function of the oversight bodies for child protection and young people in South Australia.

As mentioned, there is a strong level of oversight in South Australia – including the Guardian, Children's Commissioner, Commissioner for Aboriginal Children and Young People and the Ombudsman. In the case of child deaths there are internal review processes established within DCP, the Child Deaths and Serious Injury Review Committee (CDSIRC) and the role of the Coroner. This oversight arrangement is described in detail earlier in Part 2 of the review.

The Commissioner for Aboriginal Children and Young People was also appointed in October 2018 after successful advocacy and lobbying by First Nations communities.

Recommendation 137 of Nyland:

Legislate for the development of a community visitors' scheme for children in all residential and emergency care facilities.

This recommendation was accepted and implemented by the government. Chapter 9 in the *Children and Young People (Safety) Act 2017* provides for the scheme and the Guardian for Children and Young People was appointed as the Child and Young Person's Visitor in 2018. We were told during this review that an absence of funding for this program led to the resignation in 2021 of former Guardian for Children and Young People, Penny Wright. In April 2022 the current government committed funding to re-establish the program and Shona Reid was appointed as the CYP Visitor. The intent of Nyland's recommendation cannot be implemented without a guarantee of ongoing recurrent funding. Indeed, the practice of the role cannot align with the statutory obligations contained in the Act. Without accurate knowledge of resourcing availability, this review can only suggest that consideration be given to this issue in the current review of legislation.

Response to child deaths

There have been no specific recommendations made since 2010 about the process of child death review. The *Children and Young People (Safety) Act 2017* is silent on the function of child death review – the function and role of the CDSIRC is contained in Part 4 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

The importance of quality review processes following child deaths of children known to the system cannot be overstated. There are already solid processes in place in South Australia to review child deaths and oversight arrangements. What is apparently lacking is a trust in the community that those processes are adequate, which leads to the appointment of additional and external review processes and investigations. The recent announcement that major crimes will be investigating two child deaths has caused anxiety across the workforce. This is not to say that external reviews do not have their place and exploration of what happened must occur in transparent and accountable fashion. What matters is the communication to staff, and their opportunity to contribute their perspectives.

In 2016, following the death of a 21 month old boy, the Queensland Family and Child Commission (QFCC) was asked to oversee reviews being completed by three different government agencies about their involvement with the little boy and his family before he died. In 2017, the QFCC released a report, ***A systems review of individual agency findings following the death of a child***, with detailed findings about areas for improvement in policy, organisation, workforce and collaboration. The overall recommendation made was 'for the Queensland government to consider a revised external and independent model for reviewing the deaths of children 'known to the child protection system'', a contemporary child death review system that links together all their agencies involved with a child, regardless of different models of service delivery or culture.[70]

Legislation has since been introduced establishing a new child death review model that requires agencies involved in service provision to the child protection system to conduct internal system reviews and a new independent Child Death Review Board.

It is the opinion of this review that South Australia would be well placed to trial an interagency approach to child death reviews along the lines of the Queensland example alongside the example in section 2.2 about restorative justice approaches to inquests in

NSW. A cross agency approach, convened by an independent mediator in the weeks following a child's death, attended by senior leaders across agencies, with provisions for full disclosure and the commitment to look not at whether their agency complied with policy and procedure, but instead, look at what could have been done that might have made a difference. A forum of this nature would assist in the development of shared understanding and responsibility and it would reduce the potential for media and community to form simplistic explanations or pit one workforce against another.

The other advantage of an approach like this is that it would provide the Premier and Minister for child protection with a very strong and consistent message to be able to rely on when there is media pressure for comment about child deaths. The response would be to refer with confidence to a senior, cross government group that will be convened as a matter of urgency to review the system response, highlight any shortcomings and to provide a full and thorough report to the government.

For the South Australian Child Protection Expert Group to consider

- Cross-agency approaches to address the recent increase in notifications following child deaths. This needs to include strategies for escalation of genuinely urgent matters, shared responsibility and accountability.
- Strategies across agencies and the government sector to challenge the single narrative in media reporting.
- That in the event of adverse events shared media statements are issued across government agencies that present a united commitment and position.
- A cross-agency approach to child death reviews relying on full disclosure and shared responsibility.

5.4 THE SYSTEM NEEDS TO FIND ITS BALANCE WITH URGENCY

> No matter what the theoretical model by which one human being attempts to be of help to another, the most potent and dynamic power for influence lies in the relationship.
>
> **Pearlman (1972)[71]**

This section summarises observations of the South Australian child protection system under the theme of balance. It focuses on five main areas; resourcing and investment; out of home care; the complexity of South Australia's children and families; development of the early intervention and family preservation sector; and challenging the single narrative in the public domain.

RESOURCING AND INVESTMENT

The spending on the South Australian child protection system reflects a significant imbalance. The Productivity Commission report from 2022 shows that 78.1 per cent of all child protection spending in South Australia is on out of home care.[72]

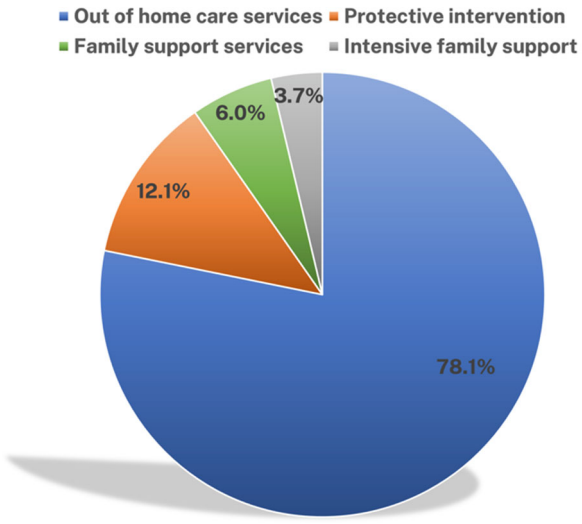

Figure 12: South Australia's real expenditure on child protection services 2020–21

In addition, South Australia spends a lower amount than other states and territories per child (0–17 years) in all three streams of protective intervention, family support services and intensive family support services. Of total spending:

- 12.1 per cent is on protective intervention, which is 30.2 per cent lower the national average
- 6 per cent is on family support services, which is 21.9 per cent lower than the national average
- 3.7 per cent is on intensive family support, which is 29.8 per cent lower than the national average.

The spending on early intervention and intensive family support is the lowest of all Australian states and territories.[73] This imbalance is set against clear evidence that investing in quality early intervention and family preservation services stems the flow of children into the care system.

This disparity in spending was a strong and consistent topic of conversation with interagency partners and heads of agencies throughout the process of this review. This included the Ombudsman, both the CCYP and CACYP and Guardian. All were united on the view that more money needed to be spent on early intervention, prevention and family support services.

The point is not that South Australia should suddenly reduce its spending on children in care. Those children are the responsibility of the state and their wellbeing needs to continue to be of high priority. The imbalance in spending reflects a complex problem and one that is a product of past as well as recent practice. For example, the origins of the growth in and spend on residential care services, frequently for adolescents whose behaviours are challenging, date back to when those young people entered the care system. Instead the point is that the imbalance needs to be meet with a concentrated and deliberate effort at the front end of the system, accompanied by whole-of-government and sector commitment because the success of early intervention work often takes years to be evident in the data.

OUT OF HOME CARE

The Nyland report made many recommendations aimed at improvements for children and young people in out of home care. These recommendations included:

- policies and procedures for case planning and support (Recommendations 80–82)
- how children and young people in care access and receive necessary services (Recommendations 74–76)
- the recruitment and ongoing support of foster and kinship carers (Recommendations 106–108, 110–126)
- contact arrangements (Recommendations 72 and 73)
- the residential care system (Recommendations 145–150)
- the management of concerns, complaints and oversight (Recommendation 184)
- adoption (Recommendation 157)
- leaving care support (Recommendations 158–171).

Past inquiries such as the Select Committee and individual recommendations made by the South Australian Ombudsman and Guardian for Children and Young People also have made several recommendations that are specific to the needs of children and young people in care such as including their voices in decision-making, case planning and the management of behaviour and concerns.

DCP and the non-government sector have undertaken a great deal of work to address the recommendations made in the Nyland report that relate to out of home care and the current inquiry into foster and kinship care, by Professor Fiona Arney, will examine much of this work and its effectiveness. The feedback from the workforce about out of home care service provision was mixed. Several staff spoke positively about improvements to residential care, strengthened guidance for case planning and contact arrangements, as well as the build of formal and professional systems to manage a variety of complaint processes. The area of concern that was spoken about frequently was support for young people leaving care and the need for dedicated resources to promote the prioritisation of this work.

Complexity of need of the population of children in care

Children in care in South Australia have needs that quality out of home care needs to attend to, including that:

- more than half of children in care have moderate to high needs[74] and require specialist support services, therapy and intervention
- approximately 25 to 30 per cent of children in care have a disability or significant developmental delay[75] and need specific support services, early intervention, medical and holistic support
- a third of children are Aboriginal and need to be connected to family, cultural identity and Country.

The following tables reflects the number of children per 1,000 on care and protection orders, and in out of home care by Australian states and territories.

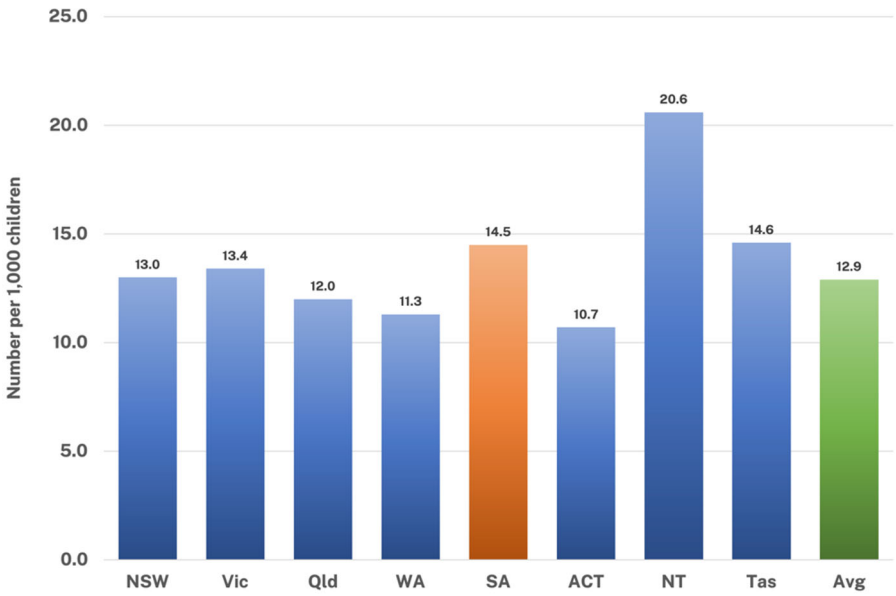

Figure 13: Comparison by jurisdiction, number per 1,000 of children on care and protection orders, 2020–21, at 30 June 2021[76]

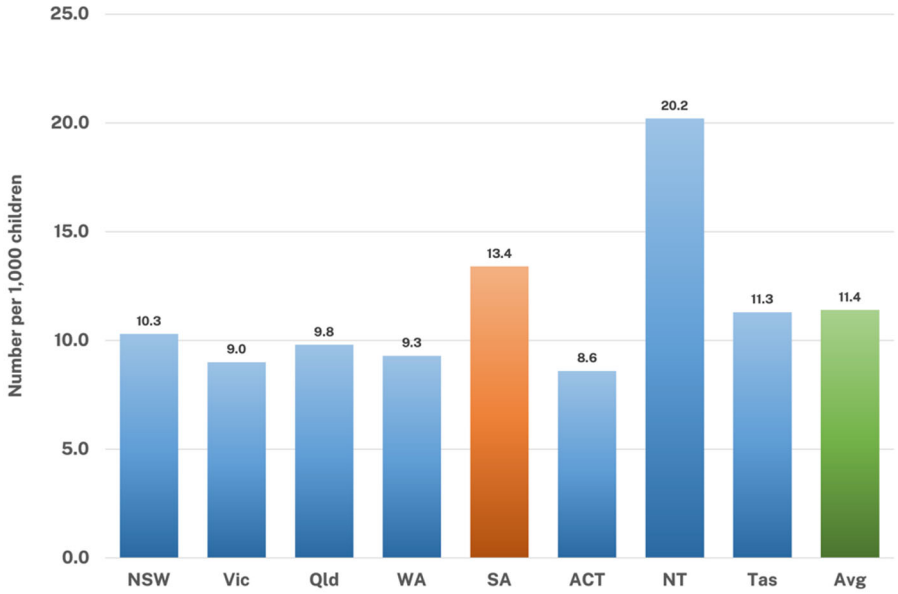

Figure 14: Comparison by jurisdiction, number of children per 1,000 in at least one out of home care placement per year, at 30 June 2021[77]

Figure 15 was developed from data in the Australian Productivity Commission report. It shows that South Australia spends the second highest amount on out of home care per child of any state or territory in the country, and is significantly higher ($1,354) than the national average ($800).[78]

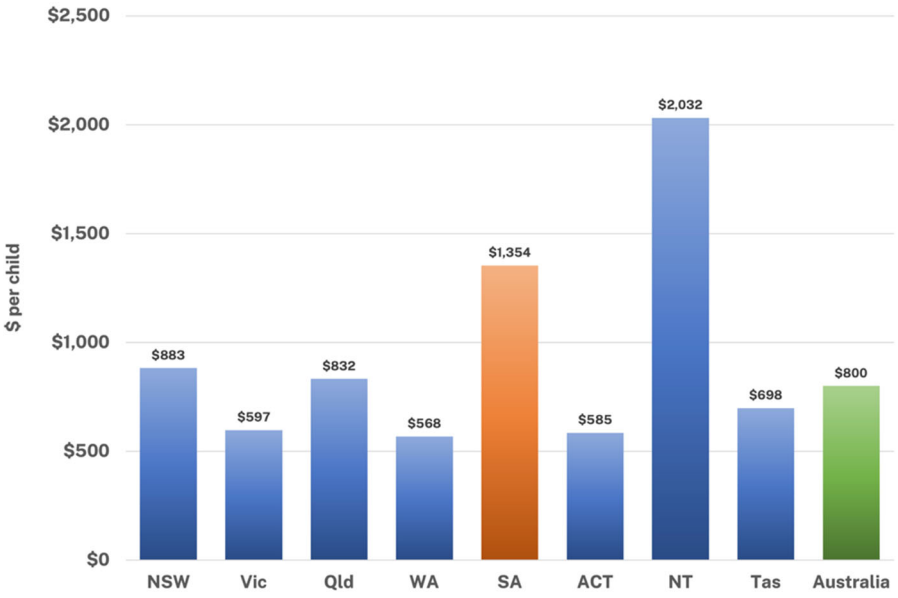

Figure 15: Australian state and territory comparison of care services, real expenditure per child 0–17 in the population 2020–21

At the same time South Australia has the highest reliance on residential care in Australia, almost double the national average, and expenditure on residential care services (59.6 per cent) is higher than non-residential care services (40.4 per cent).

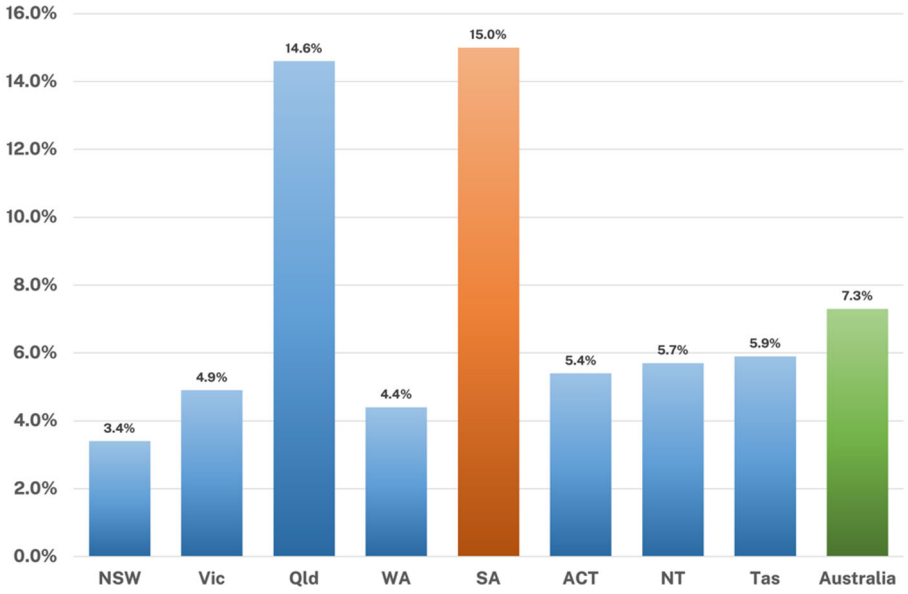

Figure 16: Comparison by jurisdiction, proportion of children in out of home care who are in residential care at 30 June 2021[79]

These figures have been included to give a quick visual sense of the challenges, as well as provide some comparisons with other Australian systems. They need to be viewed with caution because different states have different ways of counting. For example, other states may sometimes rely on commercial or emergency placements for hard to place adolescents, which can include hotels in situations of last resort, instead of residential care which does not show up in the data.

Disability

Of the recommendations considered in this review, there are only a small number focused on disability. The Royal Commission into Institutionalised Responses to Child Sexual Abuse included recommendations about better collection of data that identified disability, ensuring sexual abuse prevention education resources are targeted and adequate assessment of children with disability entering out of home care.

Commissioner Nyland paid specific attention to the needs of children and young people with disability, particularly how they are cared for in out of home care and how the newly launched National Disability Insurance Scheme (NDIS) provided opportunities for their care. Recommendations 223 – 230 of the Nyland report focused on increasing the capacity of DCP to recognise and respond to children with disability, improvements to training and record keeping about a child's disability and ensuring eligible children and young people were referred to the NDIS for support. There was also recommendations about specialist disability foster care placements and the development of guidelines for carers when decision-making about NDIS supports for children in their care.

In discussions for this review, senior members of the workforce expressed that there has been an:

> **increased focus on children with disability since the implementation of the Nyland recommendations, that 25 per cent of children in out of home care have a NDIS plan in place and disability is not ignored.**

The review was also told by a senior leader an observation they have made since the introduction of the NDIS. They reported that some families, who lost their supports and do not meet the criteria for NDIS support, have now come to the attention of DCP. This gap in services has resulted in families ending up in the statutory system when they were able to manage with their previous services.

DCP has expanded its disability program and now has a multidisciplinary team of staff available across each region to support case workers in accessing NDIS and ensuring plans meet the needs of children and young people. A dedicated therapeutic team has also been established to focus on addressing the specific needs of children and young people with disability and developmental delay in residential family based care.

Internal training is provided by DCP, with support from Disability Program staff to ensure caseworkers are appropriately skilled to recognise and respond to the needs of children with disability. DCP ensures children and young people with disability needs are supported, where possible through the provision of specialist foster carers and specialist residential care placements, which require both a trauma and disability informed response.

AN URGENT STRATEGY IS NEEDED TO ADDRESS COMPLEXITY

The Nyland report highlighted concerning evidence of a child protection system overwhelmed by volume and complexity. Since then a great deal of quality research has been undertaken which shows the demands on the system and the needs of families. The word 'complex' is used so often in child protection systems in Australia that it would be rare to hear a challenge described, or to read a safety assessment about a child, without the terms 'complex' or 'complexity' appearing over and over. The term is used so often that there is a risk that its true meaning is lost or diluted. And at the same time no other word works as accurately to reflect the plight of disadvantaged and at risk children in South Australia, as well as the critical need for tertiary and primary prevention and intervention services across the whole government and non-government sector.

In 2019/20 there were over 75,000 notifications to DCP. Of them, 70 per cent were about children who had previously been reported.

South Australia's 2021 ***Report Card for children and young people***[80] reflects the complexity and disadvantage well, as evidenced by the following examples:

- In 2020, 25.2 per cent of children and young people aged under 20 years in South Australia were estimated to be living in the most disadvantaged socio-economic circumstances. This compares with an Australian average of 18.3 per cent of children.
- Children and young people with disability made up 16.7 per cent of all children and young people in South Australia in 2017/18. Nationally, children and young people with disability made up 13.2 per cent of all children and young people in Australia in 2017/18.

- In 2020, 55.6 per cent of young South Australians (aged 15–19 years) who responded to Mission Australia's Youth Survey indicated that they felt personally concerned about family conflict. Their levels ranged from feeling slightly concerned to feeling extremely concerned.
- On any school day, 20.2 per cent of Aboriginal students, more than one out of every five, were not at school.

Equally, data from the DHS ***Early intervention progress, learnings and challenges***[81] report from October 2022 highlights further examples of complexity and disadvantage:

- 50–70 per cent of contact with child protection services comes from the most socially disadvantaged areas in South Australia.
- 40 per cent of children born in 2001/02 were notified by age 18 years, compared with 26 per cent of children born in 1991/92.
- For every 100 children in out of home care, 58 were born to young first time mothers; 67 per cent of these mothers had their own child protection experience and 23 per cent had been in out of home care.
- Of children reported in 2016 aged less than 12 months, 37 per cent had three or more indicators of complexity (26 per cent substance abuse, 43 per cent mental health, 24 per cent domestic violence, 61 per cent intergenerational child protection history, 54 per cent poverty). This compares starkly with children who were not reported before the age of 12 months where only 1 per cent had three or more indicators of complexity.

DEVELOPMENT OF THE EARLY INTERVENTION AND FAMILY PRESERVATION SECTOR

The commentary in this section relates most to the recommendations from the Nyland report for diversion of reports to early intervention and family preservation services. The focus in this section is on how reports are made and enter the statutory system and how the balance of work is managed between early intervention and prevention services and statutory child protection.

The executive summary and Part 5.5 comment on some notable inefficiencies in the way reports about children needing a service flow between DCP and DHS. The commentary in Part 5.5 is focused on assessment, specifically the use of two different approaches and the replication of work. The information below is focused on mandatory reporting and referral pathways.

Early Intervention Research Directorate

Recommendation 50 of the Nyland report called for the establishment of an Early Intervention Research Directorate (EIRD). The recommendation outlined the need for a Prevention and Early Intervention Strategy that is updated at least every five years to identify service models that have proved effective in promoting the health, safety and wellbeing of children in South Australia and to inform decisions about government funding to prevention and early intervention services. Further, the recommendations reflect the importance of a robust and rigorous approach to research in order to assist with negotiations with federal and local governments about service need and design; coordinate funding priorities; establish research partnerships and fund evaluations of

innovative service models; and focus on prevention and early intervention investment priorities.

The EIRD has been successful in developing the knowledge, research and evidence to inform whole-of-government thinking about service provision to early intervention. Relatively speaking it is a new service but the benefit of locally-commissioned research and evaluation that is specific to the South Australian community and context is invaluable. The evidence produced by research should continue to be used to inform future decisions about spending and services.

Alternate referral pathways – diverting families to early intervention and prevention services

Quite rightly the Nyland report was concerned about the under investment in services for at risk families. One way this problem was attended to was through a recommendation that encourages the system to rely on existing networks of mandatory reporters, who have regular contact with children and families, to refer directly to relevant agencies and avoid the need for mandatory notification.

This recommendation was to:

> **Amend the *Children's Protection Act 1993* to permit mandated notifiers to discharge their obligations by: reporting to the Agency's Call Centre (Child Abuse Report Line); or to designated child wellbeing practitioners, or by referral to a child and family assessment and referral network where the notifier believes a child's circumstances would be adequately attended to by a prevention or early intervention program. (Recommendation 56)**

This recommendation was accepted in principle and the government has recorded it as complete.

The Nyland report

Figure 17 shows how Nyland's proposed model would work, with assessment and referral networks assuming prominent roles in providing family support services. It relied on the introduction of Child and Family Assessment and Referral Networks and aimed to divert families from the statutory system.

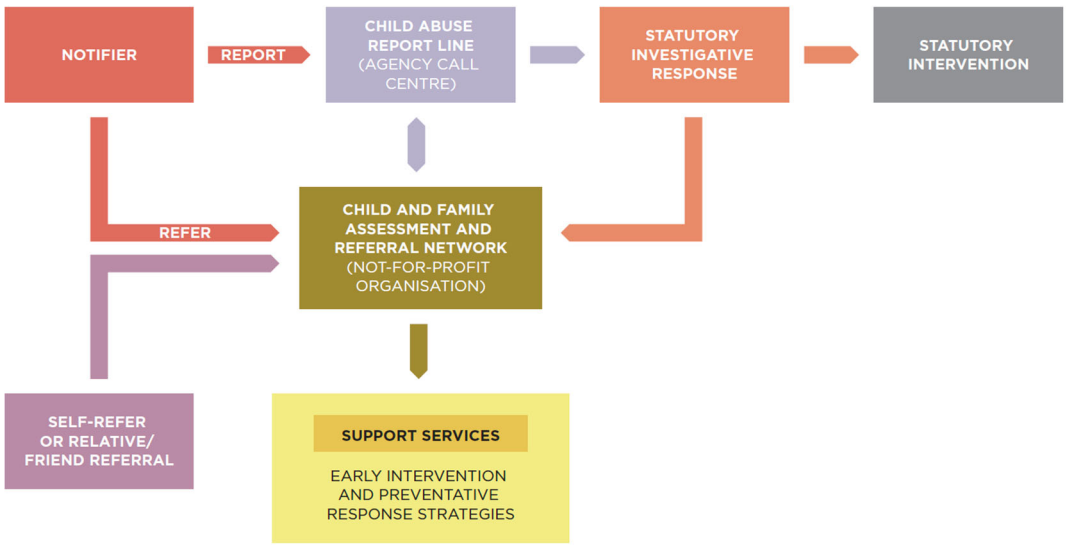

Figure 17: Nyland's proposed reform model of the child protection system

Source: *The life they deserve*, Figure 8.6, p. 173

What was planned by government

In *A fresh start*, the government's response to Nyland, the sequence in Figure 18 was used to show the new child protection system being designed. A major feature was a new 'front door', the Child Safety Pathway which consisted of a multiagency assessment unit (MAAU) model. This model would be based at CARL and include practitioners from Health, Education, Police, DHS and Correctional Services.[82] The MAAU was to go live in July 2017 and be monitored by the EIRD for evaluation.

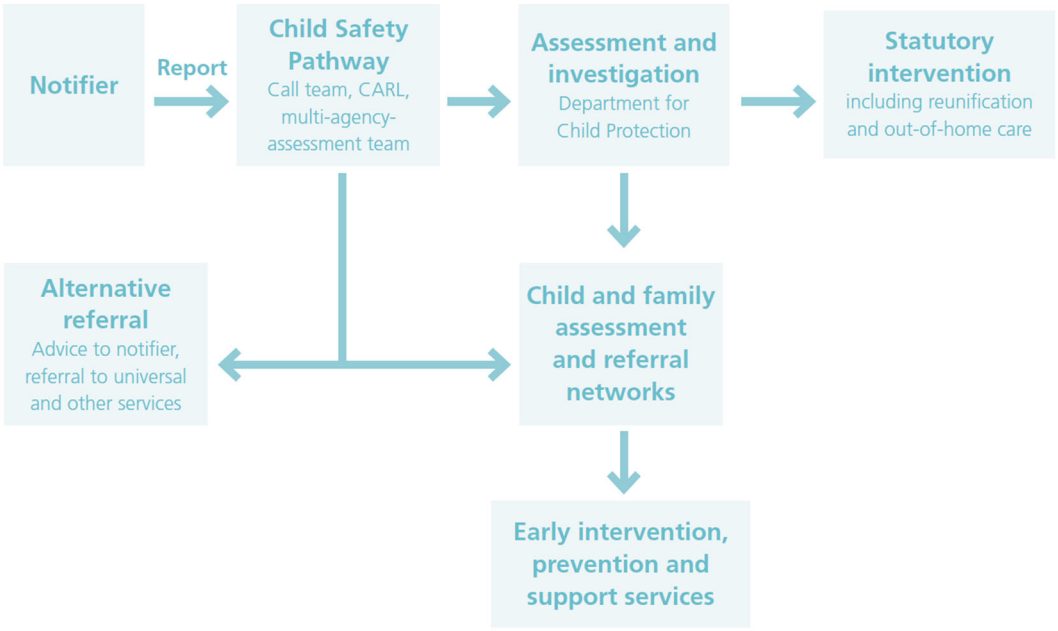

Figure 18: Design of a new child protection system

Source: *A fresh start*, p. 22

It is also important to consider how legislation was written and how current practice has developed in response.

Section 31 of the *Children and Young People (Safety) Act 2017* concerns mandatory reporting. It outlines the process for making reports when a 'person suspects on reasonable grounds that a child or young person is, or may be at risk'. The methods for notification are:

a. making a telephone call via CARL
b. making an electronic notification
c. reporting their suspicion to a person of a class, or occupying a position of a class, specified by the Minister by notice in the Gazette
d. reporting their suspicion in any other manner set out in the regulations for the purposes of this paragraph.

The Act in its current form does not provide alternate options to a notifier as suggested in Nyland's recommendation and continues to direct them towards reporting straight to the statutory system. It does allow for additional means of notification to be added later, through a ministerial notice published in the Gazette.

A centralised triage line, Pathways, has been established to provide a single point of entry across the system and an alternative pathway to the Child Abuse Report Line for families that do not require a statutory response. The development of Pathways and ensuring families receive the right services is a reform priority and articulated in the *Roadmap for Reforming the Child and Family Support System 2021–2023* (the Roadmap) released by DHS in September 2021. This review acknowledges the strength of this existing reform work and the dedicated thinking and planning that has been invested to date. The Roadmap is based on robust data and evidence but as can be seen below, there are issues with the current referral pathways and inefficiencies in the duplication of work that exists between DCP and DHS.

Mandatory reporting

Part of the evidence for Nyland's concern and recommendation for alternate referral pathways was the rising number of notifications, yet relatively stable number of screened-in notifications requiring a response.

Figure 19 shows the volume of calls and electronic notifications received by DCP's Child Abuse Report Line (CARL), next to the number that are recorded in the system as a notification, and the proportion of those that are screened in over the past five years.[83] The reports that are screened out are called a 'Notifier Only Concern' and recorded in the system. While screened-in notifications have increased, so too have the total contacts to the CARL (via phone and eCARL). The issue of unnecessary processing and workload to manage concerns that do not meet the risk threshold has not been resolved.

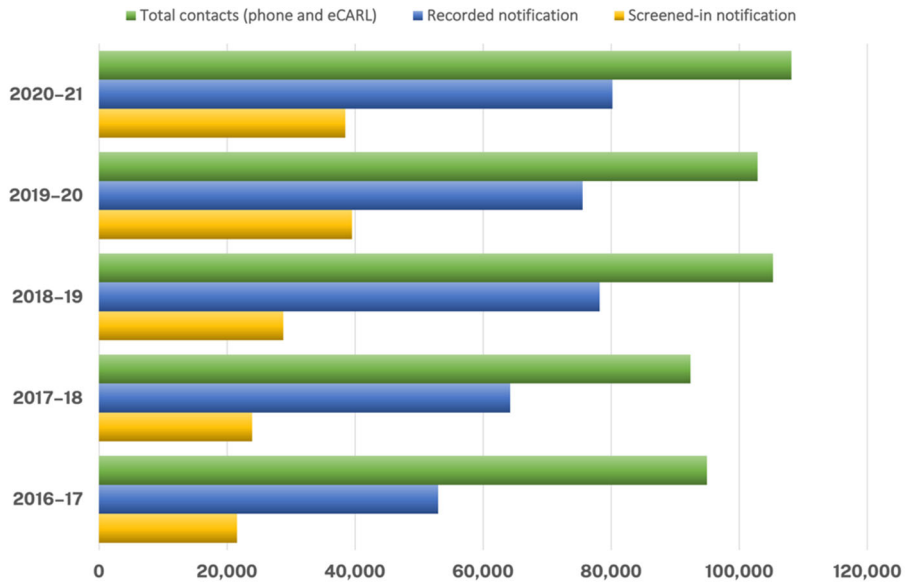

Figure 19: Child Abuse Report Line (CARL) contacts, by year

Nyland also provided data about where the majority of notifications came from. Sixty-two per cent of notifications in 2014/15 were from three other government agencies: Police, Education and Health.

Table 6 shows where notifications came from in 2021/22. The three main groups of notifiers have remained as Education, Police and Health and together are now the source of 70 per cent of all notifications.

Table 6: Notification sources in 2021 and 2022

Notification source	Number	Proportion of total
School/pre-school	31,848	35%
Police	21,656	24%
Health	11,115	12%
Non-government organisations	10,006	11%
Other government	8,729	9%
Family/friend/neighbour	8,127	9%
TOTAL	**91,481**	**100%**

The Nyland report made several sensible suggestions about mandatory reporting and the functioning of CARL. These include:

- investing in the professional development of staff (Recommendation 34)
- implementing a call back feature (Recommendation 35)
- ensuring CARL is never left unattended and there are minimum staffing levels in place (Recommendation 37)

- and recording notifications directly into an electronic system and getting rid of paper-based log sheets (Recommendation 41).

Feedback from staff was that these recommendations have worked well and been helpful.

A less useful recommendation that staff spoke about was the need to assess eCARL notifications within 24 hours. This is a performance benchmark that drives practice yet staff told the review that the majority of eCARL reports are 'low end risk'. Furthermore staff described how reports are often received from other government agencies with minimal information that does not reach the threshold of risk, yet requires processing and attention by a staff member, taking up valuable time that could be spent on phone calls and responding to notifiers directly. Call centre staff also described that 'when there are adverse events, eCARL blows up'). While the majority of eCARL reports are made by government services, eCARL is available online for any person to register and make a report.

The solution to these issues is not resolved by removing the performance benchmark which was recommended to ensure concerns about children are responded to promptly but by looking at the reasons why so many reports are coming to the call centre, either electronically or via phone, that do not meet the threshold and do not require statutory intervention.

Recommendations were made by Nyland to address this issue:

> **Ensure the Agency regains control of, and strictly oversees, mandatory notification training, including creating and updating an appropriate training package and a mandatory notifiers' guide, and regularly auditing training to ensure fidelity. (Recommendation 43)**

This would make this training compulsory for categories of mandatory reporters (Recommendation 44), restrict access to eCARL to notifiers who have completed mandated notifier training (Recommendation 45), including an interactive mandatory reporter guide at the start of eCARL (Recommendation 46).

There is a mandatory reporter guide available but it is not interactive and is a document that needs to be opened, read and understood. It is not attached or available on the same web page as eCARL – which is available for any person to use.

> **Other agencies need more training about child protection – professionals are told in training not to further raise issues and discuss but only to make notification and report yet this would be better for children and families within those existing relationships. (CP staff)**

After considering all the material and listening to the views of the workforce, both statutory and non-statutory, it is the opinion of this review that the intent of Nyland's recommendations about alternate referral pathways and mandatory reporting have not been supported adequately in the legislation, nor in the operations of practice.

Response to screened-in notifications

Two recommendations made by the Nyland report are still at implementation stage. These are about ensuring DCP responds to all notifications, either directly, or by appropriate referral (Recommendation 61) and to phase out the closure of intakes and files due to a lack of resources (Recommendation 62). The difficult reality of child protection work is that demand will always exceed supply and these recommendations while hopeful, are not likely to be achieved in the foreseeable future. Section 32 of the current *Children and Young People (Safety) Act 2017* requires the Chief Executive DCP to assess all reports received and then provides a number of pathways for the government to formally respond. This includes enabling DCP to directly refer screened-in child protection notifications to other government agencies and non-government agencies to respond to the notification. This practice is known as 'Refer for Service' within DCP and is the practice of referring reports screened as requiring a 10 day response to DHS. These provisions (sections 32 and 33) were included in response to the recommendations of the Nyland report.

In practice, this happens at each local office when reports are transferred through from CARL. A supervisor has the responsibility to consider each one and determine next steps. Either the report needs an immediate response by DCP or it reflects a lower level of risk to the child's imminent safety and can be referred elsewhere – to DHS, via a centralised triage line, Pathways or to another service. If DHS is unable to accept the referral or if a family chooses not to engage with the services offered, the report is sent back to DCP, where it is often closed 'not proceeding – DHS referral declined'. Other reports that cannot be responded to will also be closed under this code.

The workforce described this process and made comments like:

> **there is multiple handling of reports and too much triage.**
>
> **[or] DHS opt in and opt out. They have no statutory powers and refer back. It's triple handling of families and sets the statutory arm up in an adversarial way.**
>
> **[or] there is a lack of capacity within DHS but we still need to try and refer even when we know there are no services before we close. (CP staff)**

Figure 20 shows what proportion of screened-in reports, over the last four years, that received an assessment from DCP, were referred to another service or were closed with the reason 'did not proceed'. Interestingly, the number that are referred for a service elsewhere (after having been screened in at CARL as meeting the statutory threshold for risk) are large, and much larger than the group receiving assessment by a DCP social worker. What it does not show is how many of the children and families that were referred for an alternate service actually accepted supports and engaged with the service. The review understands that this data is being gathered by BetterStart at Adelaide University and will assist in understanding more about what proportion of families notified are receiving a response. The review was told that:

> **once families are referred to DHS it all becomes voluntary. It's a voluntary service – so if they go out for an assessment and the family refuses, they make a notification back to us.**

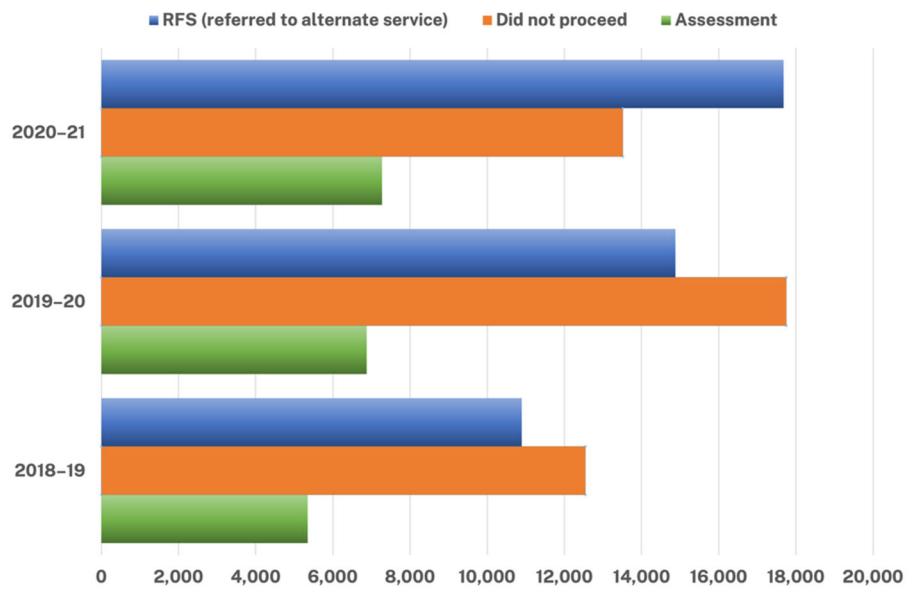

Figure 20: Total screened-in notifications, by response

Another way to consider this is the proportion of families that receive a face to face response from a DCP worker compared to the number of contacts that are dealt with by the CARL. Figure 21 does not consider those families that might receive a response from an alternate service such as DHS but clearly shows the process of triage and work that leads to assessment of children and families.

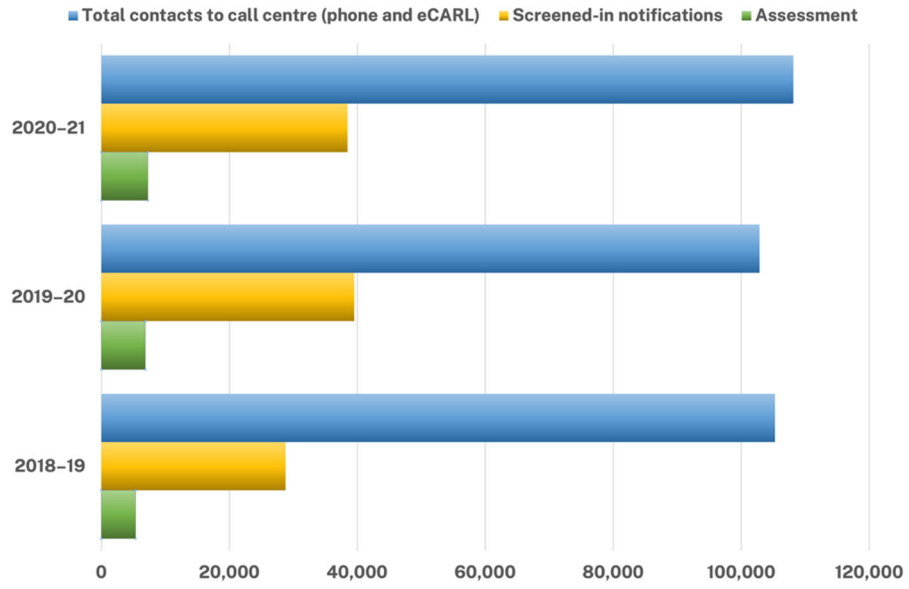

Figure 21: Families seen from screened-in notifications and contacts to CARL

It is the opinion of this review that the intention of the Nyland recommendations is not being met by the current structures and systems. In simple terms, the data describes a bottleneck. Reports about children are moving from CARL to a local office, to DHS and then back to DCP. Children are not receiving a service and the longer they wait the higher

the risk. If DHS is not able to provide a service, or does not support the assessment of DCP, then the report returns to the intake supervisor who is ultimately responsible for it. Hours of precious time have been invested by people whose skills would be better used in direct work, not to mean administrative overlay of prioritising reports.

CHALLENGING THE SINGLE NARRATIVE

Part 5.3 of this review describes the current pressures on the system and the impact on frontline staff, in particular with the way the media portrays the work of child protection. Examples about the way this pressure and public commentary following the recent and widely publicised child deaths has effected DCP staff are described in that section and the executive summary.

This review has made the point often that child protection work is hard and challenging. It requires great skill, intelligence and commitment. At the same time it can be immensely rewarding. If the only description of the work in the public domain is a critical one, or one that lacks hope, it follows that there will be an impact on the system's potential to attract new workers.

The narrative about the work and the stories that are in the public domain cry out for balance. The outcomes for children who are thriving because of the way the system supported their family need to be promoted and celebrated. Child protection workers in South Australia should not have to hide who they are in public and they should not have to hope for basic respect.

> You get to the point where you just don't tell people in the public what you do for a job.
>
> **Social worker, DCP**

A large scale Australian study by Lewig in 2013[84] identified three key factors associated with a resilient child protection workforce: clarity of mandate, being older and having hope. Practitioners who were very clear about their role were found to be more resilient to work stress, worked with more autonomy and were more positive about their work. While this study reflects practitioners' self-perception, their clarity of role is obviously influenced by the messages from their agency and from the broader system. Most would agree that the best use of a teacher's time is in front of a class, and most would agree that midwives come to work to deliver babies. Their definitive roles and the tricks of their trade – teaching and birthing – are clear, measurable and quantifiable while the importance of their skill set is universally accepted. DCP has developed a strong Practice Approach which clearly sets out the principles of the agency and serves e to define and clarify roles. Any opportunity to extend this understanding more broadly should be taken enthusiastically.

The second of three key elements identified in Lewig's study on the resilience of the workforce is the hope and belief of practitioners in the potential of their role to make a difference. This in turn is impacted by community expectations, critique and respect.

For the South Australian Child Protection Expert Group to consider

- Opportunities to address the problems with referral pathways and duplication of work between two governments agencies (this will be dependent on government acceptance of recommendation 2, as above). This is a complex task, but one that will be made easier because there is already much reform work and thinking in train by DHS, reliant on quality data and strong relationships united by a common goal.
- Opportunities to work with the media and community to promote the work of child protection, its people, diversity, rewards and success stories. This could include options for celebrating outstanding workers with a Premier's Award for child protection expertise celebrated in the media.
- Strategies to address the most at risk families in the system with deliberate investment of time, resources and skilled workforce; as well as strategies to make the best use of efficient referral pathways so that as many families as possible receive early intervention services when they need them.

5.5 THE EXPERTISE OF CHILD PROTECTION PRACTICE SHOULD BE ELEVATED AND STRENGTHENED TO GREATER CONSISTENCY

> Language is not neutral, it is loaded with meaning. It communicates to others how we as individuals, and as representatives of an organisation, interpret, evaluate and make sense. Being aware of the language we choose and the way in which we use it can be critical in determining whose view of 'reality' we are accepting, what power relations we wish to reinforce, what kind of world we wish to adopt, and the type of social work we wish to create.
>
> **Hawkins et al. (2001)[85]**

This section is about child protection practice across the South Australian system, most particularly the assessment of children's immediate safety and future risk. It refers to related recommendations from previous reviews and inquiries and is informed by the perspectives of the workforce and the review of material.

ASSESSMENT OF SAFETY AND RISK

Few decisions are as important as those that lead to the use of statutory powers to remove children from their families. There is copious evidence about the inconsistency, subjectivity and fallibility of child protection decision-making.[86] Frequently, decisions are made under intense time pressure,[87] are based on narrow or limited information, and are biased toward or influenced by that which is more readily available.[88] The impact of those decisions is significant.

Statutory systems need to rely on robust approaches to decision-making. While acknowledging that tools and case management approaches will only ever be as good as the skills and knowledge of the people using them, they have an important role to play. Quality, evidence-based tools and approaches, which have been well implemented alongside a tertiary qualified workforce, assist in promoting consistency, equity and transparency of decision-making. Families whose children are reported at risk should be confident that they will receive a consistent response from the system, regardless of the practitioner who is allocated to work with them or the part of the state in which they live.

All Australian states and territories have unique, frequently custom built, approaches to the assessment of children's safety and risk. South Australia, Queensland and NSW rely on Structured Decision Making (SDM).[89]

The Nyland report considered the issue of assessment in detail and several of its recommendations are discussed in the following pages.

The approach by DCP to safety and risk assessment

Recommendation 58 of the Nyland report stated:

> **Provide the Agency's practitioners with training, support and supervision to equip them to make realistic assessments of risks, particularly in areas of chronic maltreatment, cumulative harm, social isolation, drug and alcohol abuse, mental health, family violence, and attachment and care needs of young children, to consider the views of children and to develop appropriate safety plans.**

This recommendation focuses on the importance of assessment and it positions training, support and supervision as the important factors to its pursuit of quality. In order to consider DCPs response to this important recommendation, an overview of its approach to assessment is needed.

DCP was the first state in Australia to adopt SDM. It is a case management system with a suite of empirically based decision-making tools. The system guides decisions according to specific criteria, applied uniformly in conjunction with professional judgement. The latter is important because it means practitioners can 'override' an outcome if they do not agree with it and come to an alternate conclusion. SDM has a well-established evidence base[90] and relies on a qualified workforce skilled in relationship-based practice. While SDM has uniformity in its tools, each tool, and the suite itself, is customised by individual jurisdictions and is widely used internationally. The value of SDM is its structured and consistent approach that helps guard against biased responses and improves the consistency, equity and accuracy of decision-making.[91]

Terminology

Three observations stand out about the way the work of child protection is talked and written about in South Australia. Firstly, the responsibility to determine the safety of children, as enshrined in the legislation, is commonly referred to as 'investigation'. The term is used across the statutory system and the broader sector to describe the work and in the procedures that guide it. Secondly, the term 'incidents' is used frequently to describe children's experiences, for example the workforce was often referred to as being responsible to 'investigate incidents of child abuse and neglect'. Thirdly, there was a notable theme in almost all conversations that informed this review about 'risk tolerance' or 'risk appetite'. Examples include that the system was described as 'risk averse'; units or teams were described as 'holding' or 'tolerating' risk; or leaders were described in terms of their 'risk appetite'. The concept of safety and risk should not be changeable, nor dependent, on individuals, the work place culture or the political climate. Nor should it be reflective of anxiety in the system. Risk, in all of these examples, was mostly used to describe the predicament for children continuing in the care of their

families. It negates the very real evidence, referred to often throughout this review, that removing children from family introduces a whole other set of risks.

As a general term **investigation** is defined as 'the collection and analysis of evidence'. It was commonly used in child protection systems in recent decades. The term was fit for purpose then, remembering that statutory systems were established to respond to allegations that children had been physically and sexually abused and therefore systems were necessarily more forensic in nature. Such allegations require an investigatory response because a determination is needed as to whether a crime has been committed.

Assessment is defined as 'the act of assessing; appraising and evaluating'. It is a more contemporary term to describe the work of child protection, reflecting the change in reporting trends and needs of the children the system is intended to serve. Children reported at risk of sexual and physical abuse in South Australia, like other Australian states and territories, now make a much smaller proportion than children reported at risk because of the impact of their parent's problems, most predominately substance misuse, mental health and domestic violence. The children in these families are not usually at risk because of 'incidents'. They have not necessarily been hurt by wilful actions. Rather they are unsafe because of the pervasive impact of those problems on the parenting and care they receive. Those children need a system that assesses the cumulative harm to them by analysing the impact of family problems. That depends on a workforce with the skills and knowledge to assess safety and then to build relationship with families to motivate change.

Consider the example of a seven year old girl reported at risk because of domestic violence and parental substance abuse. Her safety will be best understood as a chronic pattern rather than incidents that need to be investigated. It is not the 'incidents' of her father's use of violence toward her mother that impact this girl her as much as the ongoing fear she lives with and the way that impacts every aspect of her family life. Equally, it is not the incidents of her mother's drug use but its overall impact on the care and attentiveness her mother is able to demonstrate. Determining that domestic violence and drug use is occurring is only the first step. What's needed is an understanding of why, and how the two problems co-exist, a motivating of trust and a partnership to create change and sustain safety. A worker with a mandate to assess safety and who works as an agent of change is much more likely to be successful than a worker who sees themselves as an investigator. And the same time, families will react accordingly to the two different styles being much more likely to form trust with the agents of change.

Assessment should not be understood a 'soft' approach, rather one that is more fit for purpose for the majority of children reported at risk. Indeed, done well assessment work centres the experience of the children at the heart of all work with families and uses it as a motivating force for parental change.

Lastly, continuing the theme that South Australia would be well served to move from a forensic style to a quality assessment one is this example provided by a group of DCP team leaders at one large metropolitan centre. They gave examples of their assessment work, which illuminated their thinking about best first steps with a family upon receipt of a report. They explained that if the report was about domestic violence or physical or sexual abuse they would routinely start by interviewing the child at school before approaching its parents. They further explained that if the concerns were about 'neglect or squalor' they would also interview the child first or they would visit the home unannounced so they could get a true sense of the problem before the family were

alerted and had time to clean up. This is a good example to highlight the differences in approach and the evidence that underpins the value of each with a presenting problem of this nature. It is not used to be critical of the workforce, their commitment to the safety of children is not in dispute. It is more that it is a good example of forensic thinking and some parts of the South Australian workforce are still a product of that way of thinking.

For allegations of physical and sexual abuse there is often sound reason to interview the child first, away from parents, because the process is about gathering information as to whether a crime has been committed. It is also believed to be the best chance for the child to disclose, without pressure from the parents in telling them what they can and cannot say. Yet this is not always the right path and it needs to be remembered that children who have been sexually abused have frequently been threatened, right from the first experience of harm, not to disclose. Being taken out of class at school by strangers may in fact work against their chances of disclosing and it may be an event they have been prepared for by being told never to disclose. This point sits alongside a strong evidence base that children are more likely to disclose over a period of time, most usually in the context of a trusting relationship.[92]

It is even less straightforward when the concerns are about neglect or domestic violence. Neglect is rarely understood in tangible terms, and it is not disclosed by children as incidents of harm. Asking a child to describe domestic violence may be placing them in a situation of danger. They may feel they are betraying their mother; they may feel ashamed or frightened of what their father will do. All of this may increase the likelihood that they will deny its existence. If the report is about concerns that the child is at risk because of the father's use of violence toward the mother (the most common form or domestic violence reporting) then a better place to start is with the mother. The children's safety is inextricably linked to her. It is not her behaviour or choices that are the primary cause of harm to the child and the relationship between mother and child is of critical importance. These examples reflect the way the workforce sees itself and prompts a simple question:

> **Is the job to catch people at their worst or get them to their best?**

This critique of assessment approach sits alongside the recognition of significant work in recent years by DCP to move its child protection practice to more contemporary approaches and the commendable development of the Practice Approach (discussed below) that strengthens the approach to assessment considerably. This includes new systems that have the potential to impact positively on examples above. For example, the case conceptualisation and strategy discussion tools in the Practice Approach have been well designed to assist the workforce to think through questions about who to speak with first, children or parents, or whether to call ahead or arrive unannounced. A general rule of thumb is to make decisions of this nature based on opportunities to build strong and respectful relationships with families. Doing so will call into question the benefit of gathering evidence of risk over the harm caused, however unintentionally, to the chances of families being open with and trusting of the system if they feel 'caught out'.

As already mentioned, there is a proportion of the reports coming into the system that do require a more forensic, investigatory response from the outset. South Australia has an approach to those reports that is fit for purpose through joint relationships with Police and other interagency partners. This approach involves collaborative work via 'strategy discussions' between involved government agencies and are guided by the Interagency Code of Practice.

Nyland recommendation 57 was for the government to:

> **Review procedures for strategy discussions to ensure they are convened promptly upon the receipt of notifications requiring investigation (and without delay when children present with physical injury). Discussions should include all relevant government and non-government participants and be re-convened as necessary.**

This recommendation was accepted and completed in 2016.

Assessment of family strengths and needs

A decision was made in 2012 by DCP to remove the family strength and needs assessment tool from the SDM case management suite. While a skilled practitioner will draw on strengths and needs continuously through every stage of work with families, a uniform, stepped out approach that requires attention to this aspect of assessment is fundamental to quality work. Without this stage, the workforce is assessing safety and risk and then making case plans and determinations without drawing out the family's strengths and needs to do so. Leaving out this stage can unintentionally reinforce deficit-based thinking because it means plans are centred on perceptions of safety and risk, not how the family describes what they need to change and the strengths they will rely on to do so. It also means the strengths and needs of families can be made invisible in recording.

In conversations with DCP staff they described that they do not need the Family Strengths and Needs Assessment because the recently introduced Practice Approach supports their assessments to focus on strength and need. This view was supported across several different conversations. It appears that staff were pleased that the SDM family Strength and Needs Assessment tool was taken from their approach and they describe confidence in the Practice Approach to support this work in a way that is better aligned to their approach.

Without negating the positive view of staff, it is not entirely accurate to say that the Practice Approach replaced the SDM one because the latter was removed several years before the former was introduced. What matters most is that attention is that the strengths and needs of families are being routinely and regularly asked about now, drawn upon and respected as critical to quality safety planning. Supporting families to lower risk to their children is much more likely to be achieved by working on shared goals that reflect the parents own insights and expertise. That is best done by harnessing strengths not focusing on weaknesses as a motivating force and must be based on what the family needs help with in order to change.

It is of no real difference to the opinion of this review whether the process of working with respect and curiosity to gather strengths and needs from families is guided by an SDM tool or the local Practice Approach. What matters is that the step needs to be **valued and taken routinely**. The advantage of it being taken as an SDM approach is that it can be made mandatory and the approach to safety and risk is then built in recognition of it and change is measured against it in a formal sense.

Agency of children

> Kids should be asked about stuff that's got to do with them … they can tell you stuff you would never think of cos you are not a kid.
>
> **Six year old girl, Kids Central Toolkit (Australian Catholic University)**

A quality assessment needs to balance the needs and rights of children to safety, acknowledge their resistance and include their perspectives. When a child has the ability to communicate, their insights about what it is like to live in their family must always inform quality assessments. Quality safety and risk assessments need to be informed by children's views about what they want to happen.

The *Children and Young People (Safety) Act 2017* includes the need for children and young people to be heard and have their views considered as a priority (section 8). The Act also includes the obligation for the views of children and young people to be heard and them given a reasonable opportunity to personally present these to the Court (section 62) and states that they should be involved in decision-making when they are in the Chief Executive's custody or guardianship.

When talking with the DCP workforce about their approach to assessment it was clear that staff valued the process of interviewing children to ascertain their safety. What was less clear was how those perspectives of children guide decision-making and how they are used to inform safety planning. The review is of the opinion that any improvement to the safety and risk assessment approach used in South Australia (addressed through considerations at the end of this section) should include a strong emphasis on children's perspectives. This would ensure children's voices are heard and understood from the first time they become involved with the statutory system and could be more easily included if it became necessary to approach the Youth Court and subsequent decisions.

Alongside this critique, were some lovely examples provided by DCP staff and the broader sector about the participation of children and young people. This includes **No Capes for Change**, which is a youth advisory group established by DCP for young people to have their voice heard and help improve the care system. The group is consulted on a monthly basis by policy makers, researchers and project officers to seek their advice. Recently executive of DCP met with the young people to gather their insights about the current review of the legislation.

DCP workforce perspectives on SDM

Despite the fact that SDM has a strong evidence base and following, it is not necessarily well regarded by the staff who use it in DCP. Only a handful of staff spoke about it positively and others described that they do not use it uniformly and do not believe it truly guides decisions. This was best explained by one social worker:

> We do our home visit and make our decisions while we are there and we talk to our manager and then later we come back and enter it into SDM.

Others described a more rigorous application of SDM, and further explained that it influences their thinking in a variety of ways they may not even be aware of because they are so familiar with the assessment domains.

An important concern expressed by the workforce was about the cultural equity for Aboriginal children through SDM processes. This concern has been raised in research, particularly in Queensland and is valid. The current design of SDM relied on in South Australia focuses the assessment on a primary caregiver which does not reflect the way many Aboriginal families are caring for children. There is also concern about the domains used in the assessment of safety and whether they adequately represent Aboriginal parenting and protective factors, as well as whether there is bias in the build of the tools.

Finally, the critique of SDM by the workforce needs to be understood alongside their collective enthusiasm for the DCP Practice Approach (discussed below). It was obvious that staff are much more conversant with, reliant upon, trusting of, and hopeful about their own Practice Approach. Ideally, practice is most likely to thrive and be of high quality if the workforce is trusting of both approaches to the way they make decisions about children and there is more deliberate integration.

Safety and risk as discrete concepts

The other observation about the way DCP talk about its assessment practice was that the terms 'safety' and 'risk' were frequently used interchangeably.

One of the main values of SDM is that separates safety and risk, leading the workforce to understand them as very different concepts in the process of assessment. The advantage is that practitioners are schooled to assess safety first: 'What can be done to support this mother to keep her children safe tonight?'

The task is less overwhelming, and this can positively impact the relationship with the family who will perceive they are being helped in the immediacy, with an intentional stance of preservation whenever it is safe to do so. The safety assessment tool assists practitioners to identify the immediate threat of harm to children and consider protective abilities to guide decisions about whether it is safe for children to remain in their parent's care.

The next stage is then about assessing the likelihood of future harm. It breaks the process down and helps practitioners focus on the presenting safety needs without being overwhelmed by the enormity of change needed longer term. For example, when practitioners are not assisted to separate the processes, they may be more likely to recommend removal action. An example is a mother whose children are reported because of their experience of their father's use of violence and her use of alcohol. The practitioner who approaches immediacy and longer term likelihood of harm as a combined assessment challenge could easily feel weighed by a sense that safety and parental change is not possible.

The DCP Practice Approach

Before the introduction of the Practice Approach in 2019, DCP relied on Solution Based Casework to guide its casework approach (alongside SDM). Recommendation 11 in the Nyland report called for a:

> formal review of Solution Based Casework (SBC) to critically examine whether the model is being used with fidelity to the original model in practice.

DCP undertook this review and identified that use of the model was irregular and inconsistent. On the basis of these findings made the decision to remove the model and replace it with its own Practice Approach.

The decision to stop using SBC was met with resounding approval by staff and their leaders. There was not a single person consulted with during this process of review who spoke in favour of keeping SBC. The DCP Practice Approach was developed in house and launched through a series of 'roadshow' events in 2019. It is best understood as a clear guide that draws together all the approaches needed to work in a contemporary, evidence – informed way with children at risk, alongside SDM and the legislation.

The response from the workforce about the Practice Approach was overwhelmingly positive, best summarised as:

- It is seen as uniquely DCP – this matters for morale and strong practice culture. The fact that it was designed and developed by DCP's own practice leaders, reflecting internal expertise and is a product of wide consultation with the workforce is definitely key to its success. 'Built by the workforce, for the workforce' is important when remembering that the workforce has been the subject of continual recommendations and directions from outside its own knowledge base and experience.

> The Practice Approach has been a game changer for the way it guides our practice.
>
> **Social worker, DCP**

- It supports assessment work with strong practice principles, attends to social justice and reflects contemporary thinking.
- It has clear guidance for different stages of the work. In spending a half day with a group of 15 DCP social workers the conversation focused on their approach to assessment. A couple of hypothetical case studies were used to centre the conversation. What was clear, without any prompting, was the frequency with which participants referred to the Practice Approach in supporting their work. This includes mention of the case conceptualisation and strategy discussion, as described above. One example provided was about children reported because of their experiences of serious domestic violence. The social workers described how both these approaches have improved their response by planning before meeting the family, looking at the history, convening meetings with Police and Health and determining best course of action in recognition of the safety risks to the children and their mother.

It is the opinion of this review that the DCP Practice Approach has had a most positive impact. Staff spoke favourably of the 'roadshow' series that 'brought the Approach ' to

their respective offices. There are also monthly online sessions to keep the principles of the Approach alive, material on the DCP website and monthly online training. Without a budget enhancement to have provided more rigorous training in the implementation of the Approach it appears that DCP has manager in creative and pragmatic ways to rely on it to breathe new life into, professionalism and hope into practice.

Summary of review feedback on DCP approach to assessment practice

DCP has undertaken a great deal of work to improve its approach to assessment in recent years. It has been strengthened by a contemporary Practice Approach, a strong and supported process to supervision and there are many and deliberate messages in all that to assist the workforce to move from forensic practices and to support relationship-based work with families. The practice approach of DCP, that has all been developed in house, is to be commended. It honours the intent of the Nyland recommendation because the supports for assessment, the training and the supervision that sits alongside it are all the products of hard work.

As the same time it is the opinion of this review that SDM in South Australia is not being used to its potential. Over the last 12 months the two larger states of Queensland and NSW have both invested considerably in their SDM approach, in particular recognition of criticism of SDM for its use with Aboriginal children. In Queensland, in response to concerns from Aboriginal communities, one of the SDM tools has been replaced by a locally designed tool. In NSW, the safety and risk assessment tools are in the process of major redesign alongside the introduction of the family strengths and needs assessment as a mandated step. That design work is led by Aboriginal governance and focuses on protective abilities unique to Aboriginal families and calibration of the risk assessment to balance for racial equity. There is great potential for South Australia to benefit from this work in the other states in the redesign of the tools.

The approach by DHS to safety and risk assessment

As already explained, South Australia has a unique capacity to refer work requiring statutory assessment to partner agencies. This means that DHS has a mandate to assess safety and risk for children at the lower levels of imminent safety. The approach taken to assessment by DHS is described in the 'Assertive Engagement Practice Guide'. This is available to all practitioners working in the Child and Family Support System and provides practical advice about how to assertively engage with children, young people and their families.

When a report is received at the Child Abuse Report Line (CARL) it is assessed using SDM tools to determine whether it is screened in according to a threshold of risk of harm and assigned a response priority timeframe. Once a report is determined to need a response (screened in) CARL send it to the local DCP office closest to where the reported child lives. It is then assessed again by the intake supervisor and a determination is given about whether the report can be responded to by DCP (more serious) or can be referred to a service in the Child and Family Support System (CFSS) via the centralised triage Pathways service, administered by DHS. When that happens, DHS applies its own assessment of the report, having access to the system used by DCP. This makes sense as the way DHS determines the suitability of its programs for the child that have been reported. Yet it does not make sense from the point of efficiency because it involves frequent double handling. More worrying is that DHS might arrive at a different assessment of safety and frequently is at capacity and sends the report back to DCP.

Two government agencies applying two different assessment approaches, relying on two different evidence bases, that are known to arrive at different outcomes, reflects a questionable use of resources and a level of over engineering. At the very least it calls for greater clarity about the purpose of each assessment, and what questions they seek to answer about the child who has been reported. Moreover, the resourcing of this assessment work can run over days or weeks and takes place in offices, in front of computers and over phones, and often leads to the child not receiving a service because workers entrusted with protecting them are all at capacity. It also places a lot of work on the intake supervisory at each DCP office (this is also discussed in Part 5.4).

More worrying however is the examples provided about the occasions where two different approaches led to two different assessment outcomes. It means the opportunities for consistency of thinking, professional and trusted articulation of safety and the respect for common understanding have not been realised. At a time when the child protection system is being criticised in the public domain, the expectations on it to remove all risk for children is high, and those on the outside of the work are critical of the decisions it makes, it would be helpful if the Minister and Chief Executive were able to describe a consistent transparent process to safety and risk assessment. It would serve a powerful message to those in the community or sector who critique the judgements of child protection, especially with the considerable benefit of hindsight, that decision-making is reliant on robust evidence-based approaches that depend on skilful practice by qualified practitioners. Two different approaches under two different government departments, that report to two different Ministers works against the grain and does comply with the Nyland recommendation 54:

> **Implement a simple, common assessment framework, such as Common Approach, for use by government and not-for-profit services who work with vulnerable children and families.**

It is the opinion of this review that the lack of consistency across approaches has been of detriment to the reputation of child protection work. The 'science' of assessing safety and risk for children, and the statutory mandate to do so, needs to be elevated, safe guarded and promoted in South Australia.

The role of DHS is discussed in detail in Part 5.4. It describes the opinion of this review that the way the two government agencies are working does not honour the intent of the Nyland recommendation. It also sets out a consideration that the child protection and family preservation services of DHS, and all that goes with them, should sit within DCP.

The best chance for quality decision-making of the workforce is to make every effort to increase consistency; promote strong implementation of tools and have quality assurance over their use; and insist on common language, terminology and understanding. The South Australian Government would be better placed, in response to future child deaths, if its practice and 'science of quality assessment' had been elevated in the public domain and if it could trust and describe robust processes that have been applied by suitably qualified practitioners. With the greatest of respect to DHS and the obvious hard work, evidence and intellect that has been at the foundation of its assessment approach, it does not make good sense to this review that the non-statutory arm of government should be in a position to appraise the assessment outcomes of the statutory arm. The place in the system that holds the ultimate authority on assessment expertise needs to be DCP.

APPROACH TO CONCERNS ABOUT SAFETY FOR CHILDREN IN CARE

Recommendation 174 of the Nyland report was about DCP's response to concerns about the safety of children in care, specifically to:

> review and implement the SDM care concern screening criteria tool for use by Call Centre practitioners.

This recommendation was rejected by government on the basis that previous trials of the SDM tool and actuarial assessment tools in general were found to be not appropriate and to result in inaccurate assessment.

DCP assesses concerns reported about children in care and relies on a different threshold than the one applied for children reported in the care of family. In theory this is how it should be. When the state is the legal parent of children, and those children are inherently more vulnerable because of their care status, and there are more statutory obligations, the threshold should be lower. However, the overwhelming sense is that it is currently too low. This means that trivial concerns about children in care are receiving a formal assessment rather than a casework response by a social worker who has a trusted relationship with the carers and children. This is problematic because of the impact on carers, children and the resources it drains.

There are very few examples of assessment tools designed to assess the safety of children in care across Australia and international jurisdictions. Almost all use an assessment tool that they also used for children who are still cared for by their birth families. Categories and definitions within the assessment tools were the same regardless of whether a child was in care or with birth parents. Similarly there is limited literature about specific assessment approaches, models or tools used to assess the safety of children in care. Most literature focuses on out of home care obligations to respond, or on child protection assessment models rather than on the best ways to respond.

The current inquiry into foster and kinship care by Professor Fiona Arney will focus on this area and is best placed to make recommendations.

QUALITY ASSURANCE

DCP has some well-developed approaches to quality assurance, including use of case reading tools to review assessment work. When asked about these processes staff described that they have found them helpful in the feedback they receive from practice leaders about their assessments.

At the same time, the approach taken to make decisions, the assessment on which they have been informed, is rarely described, including in evidence in inquests, in responses to the media and criticism. That has not helped build trust in the professionalism of the system or the evidence-based approaches it relies on. Ideally, any opportunity DCP can take to formalise, promote and elevate its approach to transparent review and quality assurance processes the better.

PRACTICE GOVERNANCE

The value for children in elevating, promoting and strengthening the expertise of child protection work needs no explanation. The value for the system, which in turn also impacts children, is in its potential to earn the trust and respect of the broader community, media and government. Ideally this would equate to the system not being derailed in response to adverse events, rather being trusted to stay the course on reform work and rely on transparent and accountable review processes (discussed in Part 5.3).

To this end, it is the opinion of this review that there are some changes that could be made to the structure and practice governance arrangements in DCP that would be helpful. This opinion is based on the observations that the training of the child protection workforce sits in one unit (human resources), the review of child deaths is undertaken by the lead practitioner in a different unit yet reports through to the executive director service system in operations, and the development of practice resources sit separately again, as does the Aboriginal practice unit. With great respect to the integrity of DCP leaders, there is a risk in the perception of a potential conflict of interest with adverse event reports being approved within operations. Most other Australian jurisdictions have either a reporting line outside of operations or to a higher level, so that the lead practitioner is the sign off.

The other importance about elevating practice is what Queensland Professor Karen Healy describes as providing 'financial and hierarchical incentives' for people to become expert in practice. Elevating the technical expertise of the work, and putting governance of independence around it, is important.

For the South Australian Child Protection Expert Group to consider

- Ways to gradually shift terminology to reflect developments of thinking in contemporary child protection work – including moving from investigation to assessment, and from incidents to chronicity and pattern of harm.
- Development of a comprehensive quality assurance approach to safeguard the process of safety and risk assessment. This would mean that the Minister and Chief Executive would receive quarterly reports about the quality of decision-making about children at risk. This data would provide a much more useful window to view the effectiveness of the system than individual child deaths.

For the DCP Senior Executive Group to consider

- Updating the SDM approach so that it reintroduces the family strengths and needs assessment tool as a mandatory step before case planning, goal setting and risk determination.
- Elevating and promoting SDM and making it more transparent, with stronger quality assurance, to safeguard its use.
- Addressing the very real concerns about the approach to assessing safety of children in care – this needs to include aligning the approach with SDM and it should be undertaken in consultation with Professor Arney, aligning to the findings and recommendations of her current review.
- Governance and structural arrangements to elevate and safeguard practice, reviews and decision-making. This should include consideration of combining some units and changing the structure so that the lead practitioner reports outside the operations arm of the agency.

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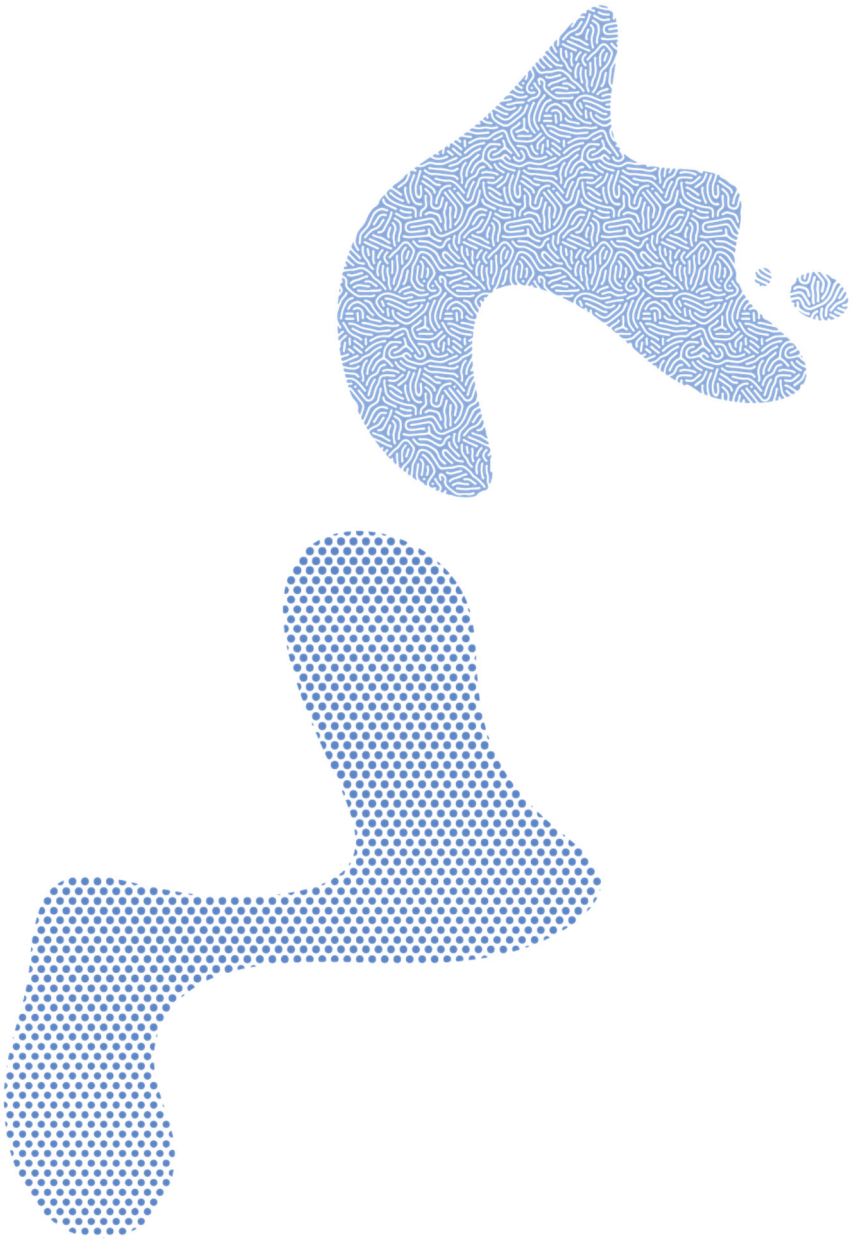
82 *A fresh start*, p. 22.
83 A notification is recorded when contact with CARL results in a report. If multiple contacts are received about the same child they are recorded in the same notification (usually for up to six weeks).
84 Lewig (2013).
85 Hawkins, L. Fook, J., & Ryan, M. (2001). Social workers use of the language of social justice. *British Journal of Social Work, 31*.
86 Best, N., Ashby, D., Dunstan, F., Foreman, D. and McIntosh, N. (2013). Improving child protection by integrating research evidence and clinical experience. *International Journal of Law Policy and the Family, 29*(3): 301–312.
87 Gambrill, E., & Schlonsky, A. (2001). The need for comprehensive risk management systems in child welfare. *Child and Youth Services Review, 23*(1): 79–107.
88 Munro, E. (1999). Common errors of reasoning in child protection work. *Child Abuse & Neglect, 23*(8): 745–58.
89 Victoria relies on a professional judgement model and Western Australia and Northern Territory use the Signs of Safety model.
90 D'andrade, A., Austin, M., & Benton, A. (2008). Risk and safety assessment in child welfare: Instrument comparisons. *Journal of Evidenced Based Social Work, 5*, 31–56.
91 Childrens Research Centre. (2019). SDM News, July 2019. National Council on Crime and Delinquency.
92 Sorensen, T., & Snow, B. (1991). How children tell: The process of disclosure in child sexual abuse. *Child Welfare: Journal of Policy, Practice and Program, 70*(1), 3–15.



A1 IDENTIFICATION OF RECOMMENDATIONS AND GOVERNMENT RESPONSES

Since 2010, there have been 811 recommendations made in the inquests, royal commissions and inquiries that have taken place in South Australia relating to child protection. This document provides an explanation of the process for identifying recommendations and where the government responses to them was located. Of the 811 recommendations, 747 were considered in scope for this review.

CORONIAL INQUESTS

Inquest	Total recommendations	Recommendations included in this review
Inquest into the death of Chloe Valentine	21	21
Inquest into the death of Ebony Napier	17	17
Inquest into the death of Heidi Singh	5	5
Inquest into the death of Amber Rigney and Korey Mitchell	4	4
Inquest into the death of Zhane Chilcott	Awaiting findings	
TOTAL	**47**	**47**

Identification of recommendations made

Four inquests have been held and concluded and the findings of one are yet to be delivered[1] since 2010, about six children who died. Four different coroners have conducted these five inquests.

Recommendations are contained at the end of each *Finding of Inquest* report, often in a new section with the heading 'Recommendations'. The word 'recommendation' is underlined with each new recommendation made. A total of 47 recommendations were made across the four inquests.

The recommendations from each Inquest are also recorded and reported annually in the State Coroner annual reports and can be accessed on the Courts Administration Authority of South Australia website. The publication of recommendations made by the Coroners Court pursuant to section 25 of the *Coroners Act 2003* is a requirement under section 39(2) of that Act.

The majority of recommendations states which government agency it is targeted toward, most being Families SA (now DCP). A few recommendations are addressed more broadly, either to multiple government agencies or even to 'the State Government'. Most of the

recommendations address a single issue however some are overarching. For example, a recommendation made in the Napier Inquest where the Coroner stated a:

> repeat of the recommendations made by the State Coroner of South Australia in the matter of the death of Chloe Lee Valentine.

All 47 recommendations have been included, regardless of who they were directed toward, and considered in this review as they have relevance for the child protection system as a whole.

Government responses

The response to the recommendations made in Chloe Valentine's inquest are on the DCP website on the page titled 'Historic inquiries and reviews'.[2] This review details the status of each recommendation and further information about how each recommendation has been actioned.

There was no public response by government to the recommendations at the time of the findings from the inquests into the deaths of Ebony Napier or Heidi Singh. DCP provided the review with a document titled 'Inquest recommendations table 2022' which details the status of each recommendation and actions that have been taken by government in response. This information has been used to show the current status of each recommendation.

ROYAL COMMISSIONS

Title	Total recommendations	Recommendations included in this review
Royal Commission Report of Independent Education Inquiry (Debelle Inquiry)	43	43
Child Protection Systems Royal Commission (Nyland report)	260	260
Final Report of the Royal Commission into Institutional Responses to Child Sexual Abuse	256	256
TOTAL	**559**	**559**

Debelle Inquiry

Identification of recommendations made

The Debelle Inquiry concluded in June 2013 and made 43 recommendations for the South Australian government. A full list of the recommendations is found in Chapter 16 of the report, which helpfully references where they are discussed within. A response to the recommendations is available on the South Australia Department for Education's website[3] and clearly assigns responsibility to responsible agencies. These recommendations were subject to research by the Australian Centre for Child Protection in 2016 and have been included in this review.

Government responses

The government response to the Debelle Inquiry is listed on the Department of Education website. The report assigns a responsible agency and status to each of the 43

recommendations. It is available at https://www.education.sa.gov.au/department/research-and-statistics/reviews-and-responses/debelle-report-independent-education-enquiry

Royal Commission into Institutional Responses to Child Sexual Abuse

Identification of recommendations made

In December 2017, the Royal Commission into Institutional Responses to Child Sexual Abuse delivered its final report. This was the final of four reports that produced a total of 409 recommendations; 256 of these recommendations were identified for the South Australian Government to action.

On 14 June 2018 the South Australian government released its response to the Royal Commission's final report along with updates on three previous reports of the Royal Commission. The responses can be located at https://www.childprotection.sa.gov.au/child-protection-initiatives/system-reform/royal-commission-institutional-responses-child-sexual-abuse

The responses to recommendations in these reports were used to identify the government's initial response to recommendations made.

Government responses

The state government reports annually on its progress implementing the Royal Commission's recommendations. Annual progress reports were released in November 2018 and 2019.

In December 2019 the South Australian Government released the whole-of-government child protection strategy ***Safe and well: Supporting families, protecting children***.

From 2020 onwards, annual reporting occurs under ***Safe and well***. The annual report outlines progress in implementing the combined total of 516 recommendations (256 from the Royal Commission into Institutional Responses to Child Sexual Abuse and 260 from the Nyland report) as well as progress that DCP leads across government with other agencies to achieve its child protection reform agenda. Reports are available at https://www.childprotection.sa.gov.au/child-protection-initiatives/system-reform/safe-and-well

Child Protection Systems Royal Commission

Identification of recommendations made

The report ***The life they deserve*** was delivered to the South Australian Government on 5 August 2016 and included 260 recommendations. The recommendations are included in a full list near the start of the report and also in small groups after each major section, where they have specific reference and that explains the reasoning and intent behind them.

Government responses

In November 2016, the government released ***A fresh start***, their response to the Nyland report, and accepted 256 of the 260 recommendations made.

Annual progress reports were released publicly in June 2017, June 2018 and June 2019.

From 2020 onwards, the government has produced a single annual report to address the recommendations made in both the Nyland report and the Royal Commission into Institutional Responses to Child Sexual Abuse.

The requirement to report annually on implementation progress of the recommendations from the Nyland report is specified within section 156 of the *Children and Young People (Safety) Act 2017* along with other annual reporting requirements for DCP.

REPORTS, REVIEWS AND INQUIRIES

Title of report, review or inquiry	Total recommendations	Recommendations included in this review
Measures to improve operations and culture of the Department of Education and Child Development (Allen review)	14	14
Review into the residential care workforce (Hyde review)	49	0
Parliament of South Australia's Select Committee on Statutory Child Protection and Care in South Australia	43 (40 made in the first interim report and 3 in the second)	43
Report of Independent Inquiry (Rice review)	6	6
Recommendations made by the SA Ombudsman following investigations completed under the *Ombudsman Act 1972*	45 from 12 investigations	45
Recommendations made by the Guardian for Children and Young People made under the provisions of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016* Guardian and Training Centre Visitor's Final Report of the South Australian Dual Involved Project: Children and young people in South Australia's child protection and youth justice systems	33 general recommendations 15 recommendations	33 general recommendations
TOTAL	**205**	**141**

The Allen review

Identification of recommendations

The Allen review made 14 recommendations for the executive and leadership of the Department of Education and Child Development (DECD). All 14 recommendations are found towards the end of the review and addressed to the Chief Executive. While this Department no longer exists in this form, the review sits within the scope of the timeframe outlined in the terms of reference. All 14 recommendations have been included in this review.

Government responses

The former Department for Education and Child Development did accept all the recommendations at the time of the review[4]. While a public response could not be located, the ***Department for Education and Child Development Annual Report 2013*** states that all 14 recommendations were accepted. This annual report is available at https://www.education.sa.gov.au/sites/default/files/decdannualreport2013.pdf

The Hyde review

A copy of this review was not made public at the time of its release and remains a cabinet-in-confidence document. In fact, the Nyland report refers to the delay experienced by staff within operational areas of DCP in receiving a copy. A request was made to DCP for a copy of the Hyde review by this review team. DCP reported that it has requested the review, and followed up that request but has not received a copy. To that end, the recommendations of this review are not able to be included within this review.

The Nyland report states that a project team was established within government, but outside of the Office for Child Protection, to address the recommendations made in the review and ensure they became embedded into practice and procedures.

The Select Committee

Identification of recommendations made

In total, 43 recommendations were made at the conclusion of the Select Committee's process. The recommendations can all be found in the final report of the Select Committee on Statutory Child Protection and Care in South Australia; the first appendix contains the 40 recommendations made in the first report and the second appendix contains three additional recommendations that were made in the second interim report. All 43 have been included in this review.

Government responses

A public response by government to the recommendations could not be located for this review. The review was informed that the former government did not provide a formal response to the Select Committee Report (noting it was quite close after Nyland).[5]

The Rice review

Identification of recommendations made

The Rice review made six recommendations for the South Australian government; four of these were specific to child protection and two were directed to the Attorney-General. All six have been considered within the scope of this review.

Government responses

The former government made public its acceptance of all recommendations. A media search was conducted and information located about the government's response to the Rice review in February 2021.[6]

South Australian Ombudsman

Identification of recommendations made

Recommendations for child protection made by the SA Ombudsman were located in two ways: via an appendix of recommendations that the Ombudsman had sent to DCP for the purpose of this review and on DCP's central recommendations management system.[7] Fifty-five recommendations from 12 investigations carried out by the SA Ombudsman were identified.

Government responses

Information about the progress of implementation was found in both the list provided by the SA Ombudsman, which had a status and explanation against each recommendation, as did the DCP's central recommendations management system.

The Guardian for Children and Young People

Identification of recommendations made

Recommendations made by the Guardian for Children and Young People are also recorded on the central recommendations management system which is monitored and managed by DCP's Quality, Safeguarding and Operations Subcommittee (QSOS). The recommendations register contains 32 recommendations made by the Guardian for Children and Young People for DCP.

The Guardian for Children and Young People also released the ***Final Report of the South Australian Dual Involved Project: Children and young people in South Australia's child protection and youth justice systems*** (SADI Project) in June 2022, which contains 15 recommendations.

Government responses

The status of each of the 32 recommendations made by the Guardian for Children and Young People for child protection is listed on the central recommendations management system and was available for the review.

The South Australian Government has publicly stated that they will 'carefully consider' the 15 recommendations made by the previous Guardian for Child and Young People, Penny Wright.[8] When asked, DCP said that it is anticipated that these recommendations will be entered onto the recommendations register and have oversight from QSOS once allocation and implementation planning has been finalised. They are not included in this review.

A2 KEY DOCUMENTS CONSIDERED

INQUEST AND RELATED DOCUMENTS

- Inquest into the death of Chloe Valentine
  Conducted by Mark Johns, State Coroner, South Australia
  Concluded 9 April 2015
- SA Government response to the Chloe Valentine Inquest, dated April 2015
  https://www.childprotection.sa.gov.au/__data/assets/pdf_file/0003/107238/coronial-inquest-chloe-valentine-implementation-recommendations.pdf
- Inquest into the death of Ebony Napier
  Conducted by Anthony Ernest Schapel, Deputy State Coroner
  Concluded 28 January 2016
- Inquest into the death of Heidi Singh
  Conducted by Jayne Samia Basheer, Deputy State Coroner
  Concluded 14 November 2019
- Inquest into the deaths of Amber Rigney and Korey Mitchell
  Conducted by Anthony Ernest Schapel, Deputy State Coroner
  Concluded 21 April 2022
- Affidavit of Sue Macdonald in the matter of the inquest into the deaths of Amber Rigney and Korey Mitchell
- Final Signed Affidavit of April Lawrie in the matter of the inquest into the death of Zhane Chilcott (dated 24 March 2022)
- SA Ombudsman SA (2018) *Redacted Final Report, Full Investigation – Ombudsman Act 1972* reference 2018/02813 regarding the issue of whether the agency erred by omitting to communicate with the complainant and his partner in respect of concerns relating to the care and protection of their late grandchildren

INQUIRY PAPERS AND RESPONSES

- Debelle, B. M. (2013)
  Royal Commission 2012–2013 Report of Independent Education Inquiry
  June 2013
- Allen, P. (2013)
  Report to the Minister for Education and Child Development on Measures to improve operations and culture of the Department of Education and Child Development
  September 2013
- Parliament of South Australia
  Interim Report of the Select Committee on Statutory Child Protection and Care in South Australia
  Legislative Council Second Session, 53rd Parliament, 2015
- Child Protection Systems Royal Commission (2016)
  The life they deserve: Child Protection Systems Royal Commission. Final Report
  Government of South Australia
- Parliament of South Australia
  Second Interim Report of the Select Committee on Statutory Child Protection and Care in South Australia
  Legislative Council Second Session, 53rd Parliament, 2017
- Parliament of South Australia
  Final Report of the Select Committee on Statutory Child Protection and Care in South Australia
  Legislative Council, Second Session, 53rd Parliament, 2015–2017
- Rice, P. QC
  Report of the Independent Inquiry
  9 February 2021
- DCP submission to the Rice review (document provided to review by DCP)

- Government's progress in implementing Rice review recommendations (document provided to review by DCP)
- Guardian for Children and Young People (2022)
  Final Report of the South Australian Dual Involved Project: Children and young people in South Australia's child protection and youth justice systems
  June 2022

SOUTH AUSTRALIAN GOVERNMENT

Public documents reporting on the response to and implementation of recommendations arising from the Child Protection Systems Royal Commission and the Royal Commission into Institutional Responses to Child Sexual Abuse

- *Child protection: A fresh start* – the government's response to the Child Protection Systems Royal Commission report: The life they deserve
  November 2016
- *Child protection: A fresh start* – progress report
  June 2017
- *Child protection: A fresh start* – progress report
  June 2018
- Royal Commission into Institutional Responses to Child Sexual Abuse
  Government of South Australia 2018 Annual Report
- Royal Commission into Institutional Responses to Child Sexual Abuse
  Recommendation update – December 2018
- *Getting it right early: South Australian Government's Prevention and Early Intervention Strategy for Child Abuse and Neglect 2018–2019*
- *Safe and well: Supporting families, protection children* – the Government of South Australia's strategy for keeping families and children safe and well
- Child Protection Systems Royal Commission – progress report; 2019 recommendation update
  September 2019
- Royal Commission into Institutional Responses to Child Sexual Abuse
  Government of South Australia 2019 Annual Report and 2019 recommendation update
- *Safe and well: Supporting families, protecting children 2020 annual report*
- Child Protection Systems Royal Commission – 2020 recommendation update
- Royal Commission into Institutional Responses to Child Sexual Abuse – 2020 recommendation status
- *Safe and well: Supporting families, protecting children 2021 annual report*
- Child Protection Systems Royal Commission – 2021 recommendation update
- Royal Commission into Institutional Responses to Child Sexual Abuse – 2021 recommendation status
- *Roadmap for reforming the Child and Family Support System 2021–2023*
- *Safe and well: Supporting families, protecting children 2022 annual report*
  Draft advance copy provided to this review, 6 September 2022

INTERNAL DCP DOCUMENTS

- A summary of external recommendations provided to Quality and Safeguarding for inclusion on the DCP recommendation register to date
- Adverse event reports
- All Staff Mandatory Training at a Glance Matrix
- CHC40313 Certificate IV in Child, Youth and Family Intervention

- Child Protection Systems Royal Commission and Royal Commission into Institutional Responses to Child Sexual Abuse 2020–2021 Responses (cabinet-in-confidence)
- Data about adverse events and referrals to CDSIRC
- DCP organisational structure
- DCP organisational structure – Senior Executive Group
- DCP Professional Supervision Procedure
- Interagency code of practice: Investigation of suspected harm to children and young people
- Interagency memo titled 'Urgent Child Wellbeing Program: Escalation'; refers to examples of memos provided by DHS to DCP about children at risk
- Quality, Safeguarding and Operations Subcommittee – Terms of Reference – approved 17 August 2021
- South Australian Ombudsman appendix of recommendations
- Summary of responses to the inquest recommendations – table provided 30 September 2022
- Summary of workforce data
- Supervision framework overview

Practice approach documents

- DCP Practice Approach Project; Project Report (December 2019 – June 2020)
- DCP Practice Approach Summary Guide
- DCP Practice Principles
- December 2020 Final Report
- Family Led Decision Making for Aboriginal Families Framework
- June 2020 Review Report
- March 2020 Review Report
- Practice Approach Closure Report
- Practice Approach Update Report – April 2022
- *Taikurtina Warri – apinthi* procedure
- ***The Aboriginal and Torres Strait Islander Child Placement Principle: A guide to support implementation*** (SNAICC)

Role descriptions

- AHP1 Social Worker, DCP Offices and Call Centre / PO1 Child Protection Case Manager
- Care and Protection Worker – OPS3/ OPS3 Case Worker, DCP Offices
- Practice Leader, DCP Offices
- Senior Practitioner AHP2
- Senior Social Worker AHP2 / Senior Child Protection Case Manager PO2
- Supervisor AHP3 / Signed PO3 Child Protection Supervisor, DCP Offices

DHS DOCUMENTS AND PRACTICE GUIDES

- Roadmap for Reforming the Child and Family Support System 2021-2023
- Assertive Engagement Practice Guide
- Safety Planning Practice Guide

ACADEMIC RESEARCH AND PAPERS

Information provided to review directly

- Professor Leah Bromfield
  Rethinking Child Protection: Responding to families with multiple and complex needs
  Queensland Health Annual Workshop for Child Protection Liaison Officers and Advisors
  15–16 September 2022
- Professor Leah Bromfield
  Rethinking child protection system design assumptions for families with multiple and complex needs | Tri-Peaks webinar
  Accessible at https://www.youtube.com/watch?v=Z6KTkP-jygM
- Department of Human Services
  PowerPoint slides: Early intervention progress, learnings and challenges
  October 2022

A3 LETTER TO FAMILY MEMBERS

Government of South Australia
Department for Child Protection
Executive Services

Level 1 East
31 Flinders St
ADELAIDE SA 5000

GPO Box 1072
ADELAIDE SA 5001

Tel (08) 8124 4185

www.childprotection.sa.gov.au

Reference No: DCP-F2022005430

[redacted]

Dear [redacted]

This letter has two purposes. Firstly to introduce myself to you. I am Kate Alexander, and my role is the Senior Practitioner for the child protection department in NSW. I have worked in child protection for many years, and have deep experience in engaging with families and systems to ensure that the voices and experiences of those who have experienced the child protection system are captured.

The other reason for writing to you is to let you know that I have been appointed to lead a review of recommendations into child protection in South Australia as recommended by the Deputy State Coroner.

The terms of reference for the review were determined by the Coroner and formalised by the Minister for Child Protection, the Hon. Katrine Hildyard MP. They include a review of:

1. All coronial and other recommendations relating to child protection in the State of South Australia since 2010 and the implementation of the same.
2. All statutory obligations contained within the *Children and Young People (Safety) Act* 2017 and the extent to which practices within the Department of Child Protection, and other State government agencies as may be appropriate, align with those statutory obligations.

The report is due to be finalised this year and will be provided to the Premier of South Australia, the Minister for Child Protection and the Chief Executive of the Department for Child Protection.

I would like to offer you the opportunity to share your experiences. This could be in person or over the phone. We are mindful that you may choose not to be involved or reminded of past events. However, if willing, your input would be helpful and appreciated. To reassure you, these conversations will be of a confidential nature, happen directly with me and if you prefer, names do not need to be used in any report or public documents.

I have asked the Department for Child Protection to send this letter to you on my behalf, as I do not have access to your confidential personal details. If you would like to make a time to talk to me please contact Paige Lagonicos on (08)8124 4197 or paige.lagonicos@sa.gov.au.

Thank you for your consideration.

Yours Sincerely

Kate Alexander
OFFICE OF THE SENIOR PRACTITIONER
NSW DEPARTMENT OF COMMUNITIES AND JUSTICE

29 August 2022

A4 MEETINGS AND CONSULTATIONS

INTERNAL DCP

- Cathy Taylor — Chief Executive
- Fiona Ward — Deputy Chief Executive
- Sue Barr — Executive Director Out of Home Care
- Sue Macdonald — Executive Director Service Delivery & Practice
- Kitty McLean — A/Director Quality and Practice
- Karen McAuley — Executive Director Strategy, Partnerships and Reform
- Billie-Jo Barbara — Chief Human Resources Officer
- Shirley Smith — Senior Manager Child Protection Reform
- Claire Simmons — Lead Practitioner, Quality and Practice
- Tina Armiento — Group Manager, Employee Relations, Human Resources
- Luisa Corbo — A/Director, Significant Incident Reporting Unit
- Tamara Grant — Manager, Quality and Safeguarding, Quality and Practice
- Tracy Rigney — Director Aboriginal Practice
- Akash Segal — Regional Director South
- Roger McCarron — Manager of DCP Office
- Supervisor — Child Abuse Report Line

ACADEMIA

- Dr Fiona Arney — (5 October)
- Leah Bromfield — Australian Centre for Child Protection (5 October)

FAMILY MEMBERS

- Belinda Valentine — Maternal grandmother of Chloe Valentine (7 October)
- Alina Fink — Carer of Heidi Singh (7 October)
- Donna Rigney — Maternal grandmother of Amber and Korey (19 October)
- Bella Rigney — Maternal aunt of Amber and Korey (19 October)

NON-GOVERNMENT

Relationships Australia

- Claire Ralfs — Chief Executive Officer (5 October)
- Sarah Decrea — Family Group Conferencing (5 October)
- Deb Lockwood — Executive Manager Children's Services (5 October)

CREATE

- Ashleigh Norton — State Coordinator (17 October)
- Lucy Watson — Community Facilitator (17 October)

OTHER GOVERNMENT

Department of Human Services

- Lois Boswell Chief Executive (18 October)
- Katherine Hawkins Executive Director, Inclusion and Reform (18 October)

OTHER

- Malcolm Hyde AO Former South Australian Police Commissioner (16 August)

FORUMS AND FOCUS GROUPS

Date	Who	Participants
21 September	DCP managers group	25
21 September	Government stakeholders (DHS, SA Health, SA Police, Education and DCP)	15
6 October	Elizabeth DCP Office	7
6 October	Blair Athol DCP Office	20
6 October	Child Abuse Report Line	3
7 October	Out of Home Care Heads of Industry forum	24
18 October	Senior Executive Group	13
19 October	DCP practitioners forum	15
TOTAL		**122**

INDEPENDENT OVERSIGHT BODIES

Date	Who	Participants
4 October	South Australian Ombudsman	Wayne Lines, Ombudsman Steven Strelan, Deputy Ombudsman Benjamin Authers, Manager
11 October	Commissioner for Aboriginal Children and Young People	April Lawrie, Commissioner Virginia Leek, Principal Policy Research Advocacy Officer
12 October	Commissioner for Children and Young People	Helen Connolly, Commissioner Monique Bianchi, Principal Policy and Research Officer
20 October	Guardian for Children and Young People	Shona Reid, Guardian for Children and Young People Alicia Smith, Senior Policy Officer Courtney Mostert, Senior Advocate

NON-GOVERNMENT GROUPS REPRESENTED AT THE HEADS OF INDUSTRY FORUM

- Aboriginal Family Support Services
- Ac.care (Anglican Community Care)
- Anglicare SA
- Autism SA
- Baptist Care (SA) Incorporated
- Centacare Catholic Country SA Limited
- Centacare Catholic Family Services
- Community Living Options Inc.
- EBL Disability Services
- HenderCare Foundation
- InCom Pro
- Junction Australia
- Key Assets
- Kornar Wilmil Yunti (KWY) Aboriginal Corporation
- Life Without Barriers
- Lutheran Care SA
- Relationships Australia SA
- SYC Ltd
- Uniting Care Wesley Bowden
- Uniting Communities
- Uniting Country SA

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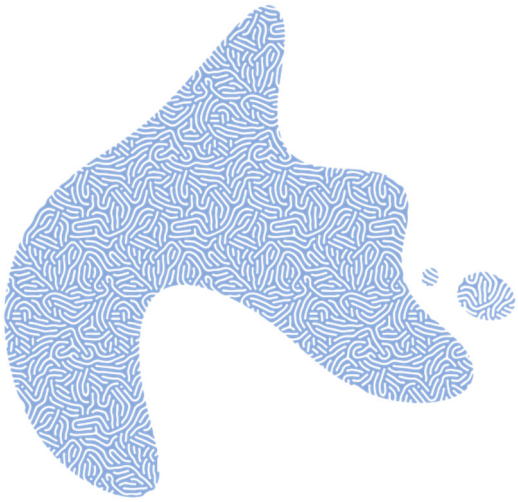
1 The findings of an inquest into a 13 year old Aboriginal boy who died in July 2016 while under guardianship and living in out of home care.
2 DCP website. 'Historic inquiries and reviews'. https://www.childprotection.sa.gov.au/child-protection-initiatives/system-reform/audits-and-reviews
3 SA Department for Education website. 'Debelle report – independent education inquiry'. https://www.education.sa.gov.au/department/research-and-statistics/reviews-and-responses/debelle-report-independent-education-enquiry
4 This information was provided to the review in an email from staff at DCP.
5 This information was provided to the review in an email from staff at DCP.
6 INDAILY. (2021). 'Child Protection Department's child sex abuse reporting a "mess"'. Quote: 'The Government says it will start implementing all six recommendations immediately'. 16 February 2021. https://indaily.com.au/news/2021/02/16/child-protections-departments-child-sex-abuse-reporting-a-mess/
7 Recommendations made by the SA Ombudsman are recorded by DCP on a central recommendations management system monitored and managed by DCP's Quality, Safeguarding and Operations Subcommittee (QSOS).
8 INDAILY. (2022). 'New SA child protection watchdog appointed'. 8 July 2022. https://indaily.com.au/news/2022/07/08/new-sa-child-protection-watchdog-appointed/



TRUST IN CULTURE

A REVIEW OF CHILD PROTECTION IN SOUTH AUSTRALIA NOVEMBER 2022