URBIS

REVIEWS OF THE NSW CHILD PROTECTION SYSTEM 2008-2019: AN ANALYSIS OF KEY FINDINGS AND DEGREE OF IMPLEMENTATION

Prepared for

NSW FAMILY SERVICES INC (FAMS)

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ACRONYMS AND ABBREVIATIONS

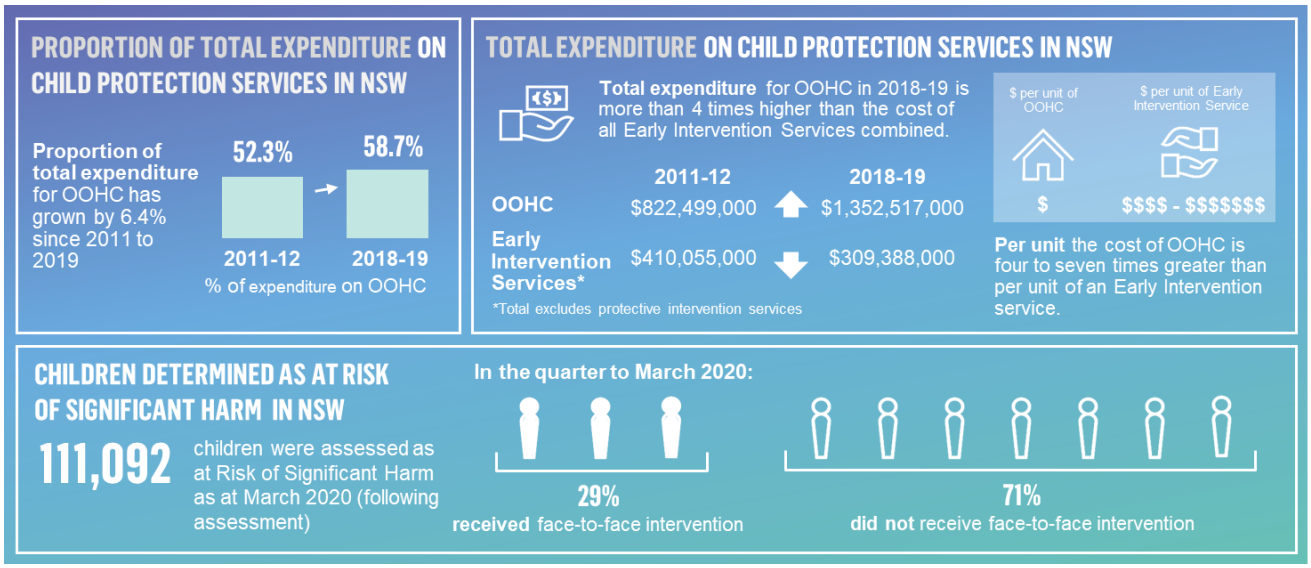
Acronym/abbreviation	Meaning
ACPP	Aboriginal Child Placement Principle
CCMRC	Central Coast MultiAgency Response Centre
DCJ	Department of Communities and Justice
DoCS	Department of Community Services
FACS	Department of Family and Community Services
KiDS	Key Information and Directory System
KTS	Keep Them Safe
NGO	Non-government organisation
NSW	New South Wales
OOHC	Out-of-home care
PACT	Protecting Aboriginal Children Together
ROH	Risk of harm
ROSH	Risk of significant harm
SDM	Structured Decision Making
TFM	Their Futures Matter

EXECUTIVE SUMMARY

Despite extensive investment by the public sector, and reform across the child protection sector, too many children in NSW remain unsafe. In the year to March 2020, more than 110,000 children were assessed as at risk of significant harm, with only 29% of these children in this time period receiving a face to face intervention.[1] Simultaneously, the rate of children in Out-of-Home Care (OOHC) has been increasing for a decade, with spending on OOHC significantly outweighing that spent on targeted early intervention services.[2]

The NSW Committee on Children and Young People self-referred an inquiry into child protection and the social services system on 23 September 2020, with submissions to the inquiry due on 11 December 2020. In their role as an advocate for children and families, the Fams submission will argue that evidence-based early intervention and prevention services are key to supporting vulnerable children and families, with the potential to keep children and young people from entering the OOHC system. Furthermore, Fams will present evidence that while significant government and community investment is being made into the child protection system, funding remains focused on crisis care versus targeted early intervention services. Consequently, NSW is not seeing improvement of sustained and positive outcomes for children and their families.

To provide a strong evidence-base for the Fams submission, Urbis has undertaken a review of past inquiries into the NSW child protection system between 2008 and 2019, to determine the extent to which these inquiries have arrived at consistent findings and their recommendations have been implemented.



ABOUT FAMS

Fams advocate for better public policy, advising on how to achieve sustainable outcomes, and acting to help keep vulnerable children safe, and build strong and supportive families and communities. Children are kept safe by quality human services that help children and families when and where they need it. Specifically, Fams contribute to population outcomes through:

- Building skills and knowledge in outcomes-based frameworks to enable organisations to collect and use data to inform practice and collaborate to provide better results for clients, practitioners and organisations; and
- Systematic policy and advocacy to inform and enable the government to implement solutions that support vulnerable children, families and communities.

[1] DCJ (2020), Caseworker Dashboard March 2020 Quarter, https://www.facs.nsw.gov.au/__data/assets/pdf_file/0004/784903/Caseworker-Dashboard-March-2020-quarter-final.PDF

[2] Productivity Commission (2020), *Report on Government Services, Part F, Ch.16*, https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/community-services/child-protection/rogs-2020-partf-section16.pdf

KEY FINDINGS

Reviews of the NSW child protection systems between 2008 and 2019 consistently arrive at similar findings regarding the failings of the system	The four reports included in this review (Wood report 2008, Tune review 2016, Donnelly inquiry 2017, and Family is Culture 2019) all highlighted the significant failures of the NSW child protection system to adequately protect vulnerable children and families, despite decades of reform. Common findings related to: ▪ The need for the child protection oversight architecture to be simplified and improved. ▪ The volume of reports being unmanageable, with many children who are the subject of a suspected risk of harm report not receiving an appropriate response. ▪ That support for young people leaving OOHC must be sufficient to ensure they are able to transition to independence. ▪ The inadequate funding for early intervention and prevention services resulting in a system that is difficult to reorient from one of crisis response. ▪ The clear need to address the overrepresentation of Aboriginal children and families in the child protection system. ▪ That interventions and investments must be evidence-based. ▪ The need for workforce capacity to be strengthened and caseworkers to be adequately supported to do their job.
Less than two-thirds of recommendations from the reviews have been fully or mostly implemented	This review examined the implementation of recommendations contained within three reports (Family is Culture 2019 was excluded given the recency of this report). The NSW Government broadly supported the recommendations contained within the Wood report 2008 and the Tune review 2015. In relation to the Donnelly inquiry, the NSW Government supported some recommendations (12 of 28), although noted many key reforms already underway addressed many of those that were unsupported. In total, only 100 of 161 recommendations across the three reports have been mostly or fully implemented.
Recommendations not implemented are focused on independent oversight, early intervention, redesigning intake and assessment and whole-of-system reform	Across the three reports, there are several recurring themes in the recommendations, which broadly relate to: expanding early intervention services; strengthening independent oversight; redesigning/improving intake and assessment processes and practices; improving leaving care planning and support; and, building the evidence base for interventions that work to reduce entries into OOHC and improve outcomes for families. Recommendations that remain not implemented have immediate resourcing implications, and focus on boosting funding for early intervention, increasing independent oversight, redesigning intake and assessment and whole-of-system reform to reduce entries into OOHC.
Consistent findings and significant investment into implementation have not lead to the systemic change desired	It is beyond the scope of this review to determine why successive inquiries into the NSW child protection system that have arrived at broadly consistent findings have not had their recommendations fully implemented, or been able to catalyse significant systemic change. The problems are well understood, but there appears to be barriers, either in capacity, authority, will (or a combination of these), to implement all the recommendations as intended. As such, the capacity for reforms to achieve the ambitious objectives outlined in each report is limited.

1. INTRODUCTION

Urbis was commissioned by Fams to undertake a rapid review of inquiries, reports and reviews conducted into the NSW child protection system from 2008 to 2019 ('the review'). The review focuses on the degree of consistency of key findings and the evidence of implementation (or otherwise) of key recommendations.

This draft report presents the findings of the review.

1.1. OOHC REVIEWS 2008-2019

The NSW child protection system has been the subject of multiple inquiries, reports and reviews for over 20 years. The four most significant of these since 2008 are the focus of this review and are listed below.

- Report of the Special Commission of Inquiry into Child Protection Services in NSW (2008) ('Wood report')
- Independent Review of Out of Home Care in New South Wales (2016) ('Tune review')
- General Purpose Standing Committee No. 2 report on the role of the Department of Family and Community Services in relation to child protection (2017) ('Donnelly inquiry')
- Independent Review of Aboriginal Children and Young People in Out of Home Care (2019) ('Family is Culture').

Collectively, these reports have made 286 recommendations aimed at strengthening the child protection system and improving outcomes for children and families in NSW. All recommendations are listed in Appendix A.

1.2. THE RESEARCH TASK

In September 2020, the Parliamentary Committee on Children and Young People established a new inquiry into the effectiveness of the NSW child protection and social services system in responding to vulnerable children and families ('2020 inquiry'). The 2020 inquiry will examine:

- How vulnerable children and families are identified and how the current system interacts with them including any potential improvements, particularly at important transition points in their lives
- The respective roles, responsibilities, including points of intersection, of health, education, police, justice and social services in the current system and the optimum evidence based prevention and early intervention responses that the current system should provide to improve life outcomes
- The adequacy of current interventions and responses for vulnerable children and families and their effectiveness in supporting families and avoiding children entering out of home care
- The child protection intake, assessment, referral and case management system including any changes necessary to ensure that all children assessed as being at risk of significant harm receive a proactive and timely in-person response from child protection staff
- The availability of early intervention services across NSW including the effectiveness of pilot programs commissioned under Their Futures Matter program
- The adequacy of funding for prevention and early intervention services
- Any recent reviews and inquiries
- Any other related matter.[3]

In view of the number of recent reports and recommendations addressing these issues, Fams engaged Urbis to undertake research to answer the following question:

> ***To what extent have NSW inquiries since 2008 into out-of-home care arrived at consistent findings, and what evidence exists that recommendations have been implemented?***

[3] Committee on Children and Young People (2020), *Inquiry into the child protection and social services system: Terms of reference*, https://www.parliament.nsw.gov.au/ladocs/inquiries/2620/Inquiry%20into%20the%20child%20protection%20and%20social%20services%20system%20-%20ToR.pdf

The primary purpose of this review is to provide an evidence base to inform Fams' submission to the 2020 inquiry.

1.3. OUR APPROACH

Prior to commencing our desktop review, Urbis worked with Fams to develop the research question and confirm the reports for inclusion in the review. Given the time available, reports from jurisdictions outside of NSW and conducted prior to 2008 were excluded.

An analytical framework was then developed to ensure each report was analysed consistently and methodically. Recommendations from each of the four reports were recorded and coded. The codes are based on Urbis' model for systems analysis, which sets out the key enablers of complex human service systems. The codes are presented in Table 1 below.

Table 1 – Recommendation codes

Enabler	Description
Governance	Operational up to strategic
Pathways	How people move into, through and out of OOHC and adjacent services
Services	The OOHC and adjacent services that are available
Communities	How the system or service leverages community strengths or addresses gaps
Theory	Including practice theories, models
Workforce	Including pipeline, distribution, capability, capacity
Tools	To help workforce apply theory
Data	Including coal face capture and systemic utilisation
Infrastructure	Including building, transport, technology

Following this coding exercise, we gathered evidence to establish the implementation status of key recommendations. Evidence was obtained through a search of publicly available sources including legislation, ombudsman reports, audit reports and government documents and websites.

Key sources included:

- Ombudsman's report: Keep Them Safe? Special report to Parliament (2011)
- Ombudsman's report: Are things improving? (2014)
- Auditor-General's report: Transferring out-of-home care to non-government organisations (2016)
- Auditor-General's report: Their Futures Matter (2020)

Based on the evidence gathered, the recommendations were classified as either 'implemented', 'not implemented' or 'undetermined'. Recommendations that have been mostly implemented were classified as 'implemented'.

Finally, the research team conducted an internal analysis workshop to identify and confirm the key findings underpinning the recommendations. From here, we were able to draw conclusions about the consistency of key findings across the four reports.

Limitations

The following limitations should be considered when reading this report:

- The implementation status of 13 of 111 recommendations from the Wood report could not be determined. This is likely due to the age of the report and the nature of these recommendations, which mostly relate to policies, guidelines or processes that have been superseded.
- As Family is Culture was only completed in 2019, there is limited evidence regarding implementation of most of its recommendations beyond the NSW Government's response. The implementation status of these recommendations has not been assessed.
- There were some instances where recommendations met the scope of more than one code. In these instances, we identified the most relevant code.
- Urbis determined the implementation status of recommendations based on publicly available evidence. It was beyond the scope of this review to explore the implementation status of each recommendation more deeply.
- This review did not assess the outcomes generated through the implementation of recommendations.

1.4. STRUCTURE OF THIS REPORT

This report is structured as follows:

Section 1: Introduction introduces the research task and our approach.

Section 2: The findings of the reviews provides a summary of each review including key findings, government response and a discussion of the degree of consistency between the reports.

Section 3: Implementation of review recommendations provides a summary of evidence of implementation of key recommendations and analysis by recommendation type.

Section 4: Summary of research findings provides a concluding analysis of the research question and the implications for Fams in preparing its submission to the 2020 inquiry.

Appendix A provides a list of all recommendations from the four reports, including recommendation type and implementation status.

Terminology

The department responsible for child protection in NSW has undergone three machinery of government changes since 2008. At the time of the Wood report it was the Department of Community Services (DoCS) and at the time of the Tune review, the Donnelly inquiry and Family is Culture it was the Department of Family and Community Services (FACS). It is now the Department of Communities and Justice (DCJ). For ease, we refer to the department as DCJ except when quoting or referencing a specific finding or recommendation.

2. THE FINDINGS OF THE REVIEWS

This section provides a summary of each review including the origination, terms of reference, duration, membership, number of recommendations, government response and key findings.

2.1. THE WOOD REPORT 2008

Overview

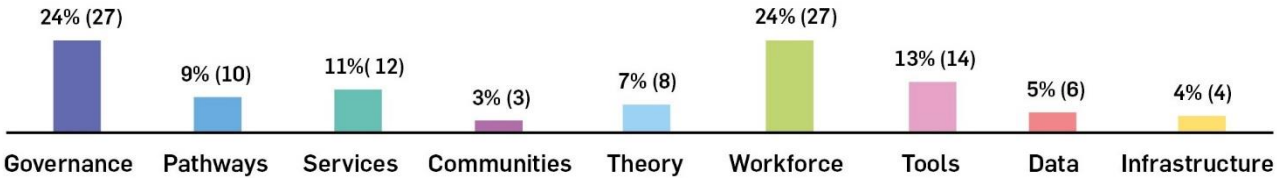
In November 2007, Justice James Wood AO, QC was commissioned to chair an inquiry to determine what changes were required to cope with future levels of demand in the NSW child protection system.[4] The inquiry was established following the deaths of two children in unrelated incidents who were the subject of reports of suspected risk of harm to the DoCS.[5]

The terms of reference required Justice Wood to examine, report on and make recommendations in relation to:

- The system for reporting of child abuse and neglect, including mandatory reporting, reporting thresholds and feedback to reporters
- Management of reports, including the adequacy and efficiency of systems and processes for intake, assessment, prioritisation, investigation and decision-making
- Management of cases requiring ongoing work, including referrals for services and monitoring and supervision of families
- Recording of essential information and capacity to collate and utilise data about the child protection system to target resources efficiently
- Professional capacity and professional supervision of the casework and allied staff
- The adequacy of the current statutory framework for child protection including roles and responsibilities of mandatory reporters, DoCS, the courts and the oversight agencies
- The adequacy of arrangements for inter-agency cooperation in child protection cases
- The adequacy of arrangements for children in out of home care
- The adequacy of resources in the child protection system.[6]

The inquiry was conducted over 12 months by Justice Wood and 10 staff seconded from nine NSW government agencies.[7] The final report was provided to the NSW Governor in November 2008 containing 111 recommendations. Figure 1 below provides a breakdown of the Wood report recommendations categorised according to the analytical framework.

Figure 1 – Breakdown of Wood report recommendations



[4] Special Commission of Inquiry into Child Protection Services in NSW (2007), *Terms of Reference*, https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/Child-Protection-Services-in-New-South-Wales-listing-438/c6f68ee38d/Terms-of-Reference-Special-Commission-of-Inquiry-into-Child-Protection-Services-in-NSW.pdf

[5] NSW Ombudsman (2009), *The death of Dean Shillingsworth: Critical challenges in the context of reforms to the child protection* system, https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0017/3356/Special-Report-Shillingsworth-Dec-09.pdf, 1.

[6] Special Commission of Inquiry, *Terms of Reference.*

[7] Special Commission of Inquiry into Child Protection into Child Protection Services in NSW (2008), *Volume 3*, https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/Child-Protection-Services-in-New-South-Wales-listing-438/fa9d0f6dc9/Volume-3-Special-Commission-of-Inquiry-into-Child-Protection-Services-in-NSW.pdf, 1078.

Key findings

Key findings of the Wood report are summarised in Table 2 below.

Table 2 – Key findings of the Wood report

Governance	There are opportunities to simplify oversight mechanisms to enhance transparency and accountability.[8] There is a need for greater collaboration and coordination between agencies and organisations who provide services to at risk children and young people and their families.[9] The current funding system is duplicative and unsustainable. Non-government organisations can play an expanded role in providing services to at risk children and young people and their families.[10]
Pathways	Risk of harm reports are increasing and there is not sufficient resourcing to manage the current volume.[11] From 2001/02 to 2007/08 there was a 90 per cent increase in child protection reports.[12] In the same period, the number of reports involving Aboriginal children more than tripled and the proportion of reports involving Aboriginal children rose from 11.5 per cent to 18.3 per cent.[13] Mandatory reporters are generally not notified of the outcome of their reports and so will make multiple reports about the same child which then creates an additional burden for DoCS.[14] Too many children and young people subject to a suspected risk of harm report do not receive an appropriate response.[15] In 2007-08, 13 per cent of reports should have been referred to an agency other than DoCS and 21 per cent of reports assessed as needing further assessment received none.[16] Of those that did receive attention from DoCS, one third did not receive a face-to-face visit.[17] In many instances, young care leavers do not receive the support they need to achieve independence.[18] As a result, this cohort is at an increased risk of experiencing unemployment, homelessness and mental illness relative to their peers.[19]
Services	Early intervention is critical to reducing the number of children in OOHC.[20] Existing services are not sufficiently funded nor integrated to achieve this objective.[21] There are a growing number of children in OOHC.[22] These children do not receive the support and care they need in relation to health, education and leaving care planning.[23] There is also a need to develop different types of placement options that are appropriate for vulnerable communities.[24]

[8] Special Commission of Inquiry into Child Protection Services in NSW (2007), *Volume 1*, https://www.dpc.nsw.gov.au/assets/dpc-nsw-gov-au/publications/Child-Protection-Services-in-New-South-Wales-listing-438/cf8f20dbaf/Volume-1-Special-Commission-of-Inquiry-into-Child-Protection-Services-in-NSW.pdf, Ch.23.

[9] Ibid, Ch.24.

[10] Ibid, 25.

[11] Ibid, Ch.6.

[12] Ibid, Ch.5.

[13] Ibid, Ch.5.

[14] Ibid, Ch.6.

[15] Ibid, Ch.8.

[16] Ibid, Ch.8.

[17] Ibid, Ch.8.

[18] Ibid, Ch.20.

[19] Ibid, Ch.20.

[20] Ibid, Ch.7.

[21] Ibid, Ch.7.

[22] Ibid, Ch.16.

[23] Ibid, Ch.16.

[24] Ibid, Ch. 16.

	There are a lack of services available to support children, young people and parents with a disability.[25]
Communities	Existing services and programs do not adequately address the needs of Aboriginal children and families.[26] There is a need for targeted responses to consider the complex and interweaving factors influencing disadvantage experienced by the Aboriginal community including the cumulative effect of intergenerational trauma.[27]
Theory	The key risk factors influencing demand for child protection services can be understood in terms of child risk factors (younger age, disability, chronic or serious illness, behavioural problems), parental/family risk factors (mental health, domestic violence, substance abuse, poor parent-child interaction, single parent status and low parent education levels) and social or environmental risk factors (low socio-economic status, stressful life events, lack of access to medical care and child care, parental unemployment, isolation and homelessness).[28] Domestic and family violence is a significant child protection risk factor.[29] From 2005/06 to 2007/08, domestic and family violence was the most commonly reported issue in reports made to DoCS, accounting for approximately one quarter of all reports.[30] Children and young people who experience child abuse and neglect and significantly more likely to come into contact with the criminal justice system.[31]
Workforce	Building capacity in the child protection workforce is an important enabler to improve outcomes for at risk children and their families. Challenges that limit the capacity of DoCS to deliver high quality casework services are largely a result of the nature of the crisis driven environment and include high workloads, staff shortages (especially in rural and regional areas), high turnover and poor treatment of caseworkers by DoCS.[32]
Data / Infrastructure	DoCS' use of emerging information and communication technology is limited, and data quality and availability can be improved.[33]

Government response

The NSW Government's formal response to the Wood report, released in March 2009, was Keep Them Safe: A shared approach to child wellbeing (KTS). KTS outlined the NSW Government's plan to implement the key recommendations of the Wood report, most notably in relation to raising the reporting threshold for reporting from suspected risk of harm (ROH) to suspected risk of significant harm (ROSH), transferring OOHC services to NGOs, expanding funding for prevention and early intervention services and improving cooperation between agencies to better support vulnerable children and families. The objective of the $750 million reform program was to "radically change the way that government and the community deal with child safety and wellbeing to build a stronger, more effective child protection system".[34]

[25] Special Commission of Inquiry, *Volume 1*, Ch.21.
[26] Ibid, Ch.18.
[27] Ibid, Ch.18.
[28] Ibid, Ch.4.
[29] Ibid, Ch. 17.
[30] Ibid, Ch. 17.
[31] Ibid, Ch.15.
[32] Ibid, Ch. 3.
[33] Ibid, Ch.2.
[34] NSW Government (2009), *Keep Them Safe: A shared approach to child wellbeing*, https://www.victimsservices.justice.nsw.gov.au/sexualassault/Documents/report_keep-them-safe.pdf, 1

2.2. THE TUNE REVIEW 2016

Overview

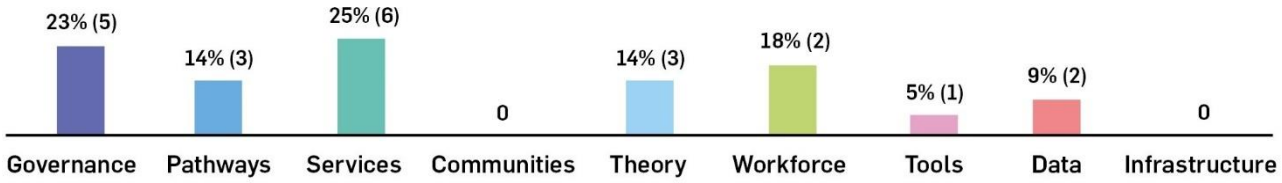
In November 2015, the NSW Government commissioned David Tune AO PSM to conduct an independent review of OOHC in NSW. The review was established in response to the increasing number of children entering OOHC, the unsustainable costs to the budget and the limited effectiveness of previous reforms.[35]

The purpose of the review was to:

- Create a future vision and long-term strategy for OOHC
- Understand the demand drivers for OOHC, including entry and exit pressures on the system
- Propose solutions for the unsustainable growth in the number of children in OOHC and the OOHC budget
- Understand the causes and propose options to reduce the overrepresentation of Aboriginal children in the OOHC system and the poorer outcomes for many of these children
- Review the Side by Side approach and the ongoing appropriateness of programs funded by the Keep Them Safe reforms.[36]

An interim report[37] was provided to the NSW Government in March 2016 containing several short-term measures to address immediate risk and to reduce the number of children in OOHC. The final report was provided in July 2016 and made available to the public in June 2018. It contained 22 recommendations focused on whole-of-system reform to OOHC, child protection and early intervention services. Figure 2 below provides a breakdown of the Tune review recommendations categorised according to the analytical framework.

Figure 2 – Breakdown of Tune review recommendations



Key findings

The key findings of the Tune review are summarised in Table 3 below.

Table 3 – Key findings of the Tune review

Governance	The shared approach to child wellbeing outlined in KTS has not achieved its objectives as programs and interventions lack an overarching logic.[38] FACS holds primary accountability for vulnerable families but other agencies are responsible for areas like health and education that can affect change.[39]
Pathways	There is considerable unmet demand in the system. Only one third of ROSH reports receive a face to face assessment and nearly three quarters of reports are closed without action (including cases where the level of risk is assessed as high or very high).[40]

[35] Tune, D (2016), *Independent Review of Out of Home Care in NSW*, https://www.acwa.asn.au/wp-content/uploads/2018/06/TUNE-REPORT-indepth-review-out-of-home-care-in-nsw.pdf, 10.

[36] Ibid, 10.

[37] The interim report is not publicly available but is referenced in the final report and in Their Futures Matter.

[38] Tune, *Independent Review of OOHC in NSW*, 21.

[39] Ibid, 23.

[40] Ibid, 15,43.

	The current system architecture has created a focus on referral instead of response.[41]
Services	The system is heavily crisis driven. In 2015-16, the NSW Government spent approximately $1.86 billion on services for vulnerable children and families.[42] More than half of this was spent on OOHC services instead of early intervention and prevention services.[43] Key drivers of demand for OOHC services include mental illness, substance misuse, socioeconomic disadvantage and family violence.[44] Existing interventions and responses do not adequately address the complex and intersecting nature of these issues and as a result, demand is increasing.[45] The number of children in OOHC is rising and the system is unsustainable.[46] The average yearly cost of caring for a child is lower in the NGO sector ($27,000) than in FACS care ($41,000).[47]
Communities	Aboriginal children continue to be overrepresented in the system.[48] There is a need for a stronger focus on the long-term life outcomes of vulnerable children and young people and their families to improve service alignment and collaboration among the relevant agencies.[49]
Theory	Interventions are not well aligned to the evidence. Significant funding is allocated to programs and services that have not been evaluated.[50]
Data	There is a need to collect, analyse and use data from across the system to better understand the drivers of service demand and to inform decision making.[51]

Government response

In 2016, the NSW Government established Their Futures Matter: A new approach (TFM) in response to the Tune review. TFM outlined the Government's commitment to establishing a whole-of-government early intervention approach by implementing the following enablers of reform: applying an investment approach to service delivery; shifting investment to evidence based services and interventions; develop an outcomes framework for vulnerable children and families in NSW; and identifying current funding for vulnerable children and families across government agencies.[52] The Government allocated $190 million over four years to deliver the TFM reform program.[53]

2.3. THE DONNELLY INQUIRY 2017

Overview

In May 2016, the General Purpose Standing Committee No.2 self-referred an inquiry to examine and report on the role of the Department of Family and Community Services (FACS) in relation to child protection. The

[41] Tune, *Independent Review of OOHC in NSW*, 21.
[42] Ibid, 23.
[43] Ibid, 23.
[44] Ibid, 23.
[45] Ibid, 23.
[46] Ibid, 12.
[47] Ibid, 14.
[48] Ibid, 23.
[49] Ibid, 23.
[50] Ibid, 23.
[51] Ibid, 75.
[52] NSW Government (2016), *Their Futures* Matter, https://www.childabuseroyalcommission.gov.au/sites/default/files/WEB.0189.001.1036.pdf, 8-11.
[53] Ibid, 12.

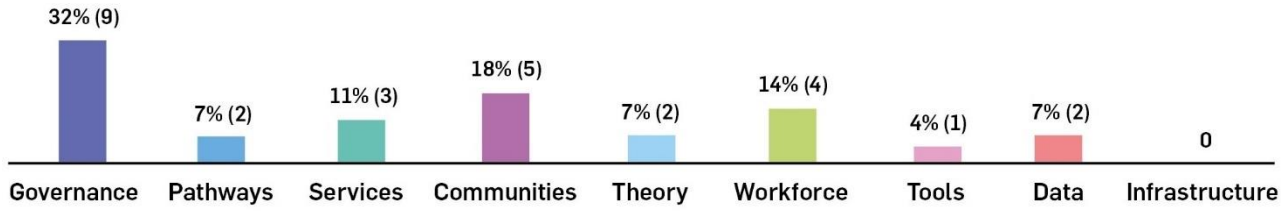
inquiry was established in response to concern about the number of children in OOHC and the failure of successive governments and reforms to drive systemic change.[54]

The terms of reference included:

- The capacity and effectiveness of systems, procedures and practices to notify, investigate and assess reports of children and young people at risk of harm
- The adequacy and reliability of the safety, risk and risk assessment tools used at Community Service Centres
- The amount and allocation of funding and resources to the Department of Family and Community Services for the employment of casework specialists, caseworkers and other frontline personnel and all other associated costs for the provision of services for children at risk of harm, and children in out of home care
- The amount and allocation of funding and resources to non-government organisations for the employment of casework specialists, caseworkers and other frontline personnel and all other associated costs for the provision of services for children at risk of harm, and children in out of home care
- The support, training, safety, monitoring and auditing of carers including foster carers and relative/kin carers
- The structure of oversight and interaction in place between the Office of the Children's Guardian, Department of Family and Community Services, and non-government organisations regarding the provision of services for children and young people at risk of harm or in out of home care
- Specific initiatives and outcomes for at risk Aboriginal and Torres Strait Islander children and young people
- The amount and allocation of funding and resources to universal supports and to intensive, targeted prevention and early intervention programs to prevent and reduce risk of harm to children and young people
- Any other related matter.[55]

The inquiry was conducted over 10 months by the chair, the Hon. Greg Donnelly, and six members of the General Purpose Standing Committee No. 2. The final report, tabled in March 2017, made 28 recommendations. Figure 3 below provides a breakdown of the Donnelly inquiry recommendations categorised according to the analytical framework.

Figure 3 – Breakdown of Donnelly inquiry recommendations



Key findings

Key findings of the Donnelly inquiry are summarised in Table 4 below.

[54] General Purpose Standing Committee No.2 (2017), *Child Protection*, https://www.parliament.nsw.gov.au/lcdocs/inquiries/2396/Final%20report%20-%20Child%20protection.pdf, ix.

[55] General Purpose Standing Committee No.2 (2016), *Terms of Reference*, https://www.parliament.nsw.gov.au/lcdocs/inquiries/2396/Terms%20of%20Reference%20-%20GPSC%20No%202%20-%20Inquiry%20into%20Child%20Protection.pdf https://www.parliament.nsw.gov.au/lcdocs/inquiries/2396/Final%20report%20-%20Child%20protection.pdf

Table 4 – Key findings of the Donnelly inquiry

Governance	Additional external oversight of FACS' practices and procedures, such as complaints handling, should be considered.[56] Contracting arrangements with NGO providers of OOHC services need to be strengthened and oversight of these providers needs to be enhanced.[57]
Pathways	The number of child protection reports continues to rise despite the threshold for reports being raised to suspected risk of significant harm.[58] As a result, many children do not receive an appropriate response.[59] Less than one third of children reported to be at risk of significant harm receive a face to face assessment.[60] There is a need to improve leaving care planning and support to help young people transition to independence.[61]
Services	Greater investment in early intervention and prevention services is needed to reduce entries into OOHC and improve outcomes for children and families.[62]
Communities	The number of children in OOHC is increasing, with Aboriginal children and children with a disability continuing to be overrepresented.[63] Carers need to be better trained and supported to care for children in OOHC.[64] There are issues in court processes that must be addressed to better support children and families.[65] These include a lack of strength-based evidence presented to the court, parents being pressured to consent to orders, a lack of consideration of the impacts of removal and a lack of access to legal assistance.[66]
Theory	Aboriginal children and families are significantly overrepresented in the child protection system and there is no evidence that current approaches are addressing this trend.[67]
Workforce	Building the capacity of the child protection workforce is critical to improving outcomes for vulnerable children and families.[68] FACS needs to do more to address high caseworker workloads and to ensure the health and wellbeing of staff.[69]

Government response

The NSW Government's formal response to the Donnelly Inquiry was released in September 2017. The document provided a detailed response to each recommendation and outlined key reforms already underway including TFM, Permanency Support Program, Targeted Earlier Intervention and ChildStory.[70] Of the 28 recommendations, 12 were supported by the Government.[71] The recommendations supported mostly related to updating and improving systems, processes and resources.

[56] General Purpose Standing Committee No.2, *Child Protection*, Ch.8.
[57] Ibid, Ch.5.
[58] Ibid, Ch.3.
[59] Ibid, Ch.3.
[60] Ibid, Ch.3.
[61] Ibid, Ch.6.
[62] Ibid, Ch.2.
[63] Ibid, Ch.5.
[64] Ibid, Ch 4.
[65] Ibid, Ch.4.
[66] Ibid, Ch.4.
[67] Ibid, Ch.7.
[68] Ibid, Ch.9.
[69] Ibid, Ch.8.
[70] NSW Government (2017), *Response to Report 46 of the Legislative Council Portfolio Committee No.2 – Child* Protection, https://www.parliament.nsw.gov.au/lcdocs/inquiries/2396/Government's%20Response%20-%20Child%20Protection.pdf, 3-5.
[71] Ibid, 6-17.

2.4. FAMILY IS CULTURE REPORT 2019

Overview

In September 2016, Professor Megan Davis was appointed to chair an independent review into Aboriginal and Torres Strait Islander Children and Young People in Out of Home Care in NSW. The review was commissioned by the NSW Minister for Family and Community Services in response to growing concerns about the disproportionate number of Aboriginal children in OOHC. It is the first review conducted in NSW to specifically examine these issues.

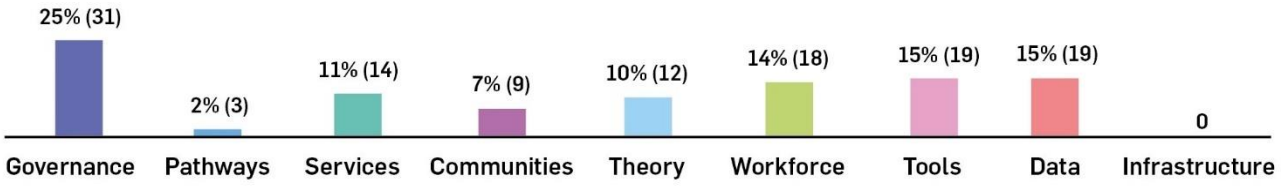
The terms of reference required Professor Davis to oversee an independent review aimed at improved implementation of the Aboriginal and Torres Strait Islander Child and Young People Placement Principle, see, Part 2, Children and Young Persons (Care and Protection) Act 1998 (NSW) (the Act) and especially s 13 of the Act, with respect to the following matters:

- Identify the reasons for the high and increasing rates of Aboriginal and Torres Strait Islander Children and Young People in Out of Home Care in NSW
- Develop strategies designed to reduce the number of Aboriginal and Torres Strait Islander Children and Young People currently in Out of Home Care and entering care including improving pathways to family reunification.[72]

The final report, Family is Culture, was released in November 2019. It made 125 recommendations to the NSW Government to improve outcomes for Aboriginal children and families in the state.

Figure 4 below provides a breakdown of the Family is Culture recommendations categorised according to the analytical framework.

Figure 4 – Breakdown of Family is Culture recommendations



[72] Independent Review of Aboriginal Children and Young People in OOHC (2019), *Family is Culture*, https://www.familyisculture.nsw.gov.au/__data/assets/pdf_file/0011/726329/Family-Is-Culture-Review-Report.pdf, xi.

Key findings

Key findings of Family is Culture are summarised in Table 5 below.

Table 5 – Key findings of Family is Culture

Governance	There is a lack of transparency in the child protection system and existing oversight bodies and mechanisms are insufficient and ineffective in practice.[73] Key issues include a poor internal complaint handling process, the existence of 'for profit' OOHC providers, the lack of regulation by the Office of Children's Guardian and the lack of enforcement action.[74] The Children's Court can take a more active role in ensuring FACS adheres to the legal requirement to consider alternative options to avoid removal such as Parental Responsibility Contracts, Parent Capacity Orders, Temporary Care Arrangements and Family Group Conferences.[75]
Pathways	Existing safety and risk assessment approaches are not appropriate for Aboriginal children and families.[76] Restoration rates for Aboriginal children and families are too low despite the NSW Government's policy position that restoration is the preferred option.[77] Children who are removed from their families are more likely to experience neglect and disadvantage relative to others their age. This must be taken into account in court proceedings.[78]
Services	Investment in early intervention services is not sufficient to change the system focus from reactive to proactive support.[79] Funding for services should be commensurate with the overrepresentation of Aboriginal children in OOHC.[80]
Communities	There is a need to implement the right to self-determination in child protection and OOHC systems.[81] There is a need to improve processes and practices within the Children's Court to improve outcomes for Aboriginal children and families.[82] Attention should be directed to improving the quality of evidence, increasing independent oversight of proceedings and cultural planning for Aboriginal children.[83] The adoption of Aboriginal children is not a culturally accepted practice and there is considerable opposition to this within the Aboriginal community.[84]
Theory	Poor removal practices, such as using police or removing children without warning, can exacerbate distress and trauma for vulnerable children and their families.[85] The evidence base needs to be strengthened in relation to prenatal and newborn removals to ensure targeted responses can be designed effectively.[86]

[73] Independent Review of Aboriginal Children and Young People in OOHC, Ch.8.
[74] Ibid, Ch.8
[75] Ibid, Ch.11.
[76] Ibid, Ch.12.
[77] Ibid, Ch.21
[78] Ibid, Ch.14.
[79] Ibid, Ch.9.
[80] Ibid, Ch.10.
[81] Ibid, Ch.7.
[82] Ibid, Ch.23.
[83] Ibid, Ch.23.
[84] Ibid, Ch.22.
[85] Ibid, Ch.13.
[86] Ibid, Ch.10.

	The Aboriginal Child Placement Principle (ACPP) has not been effectively implemented in NSW. There is evidence of inconsistent interpretation and application of the ACPP in addition to widespread non-compliance.[87]
Workforce	Caseworker training should be improved to ensure a strong understanding of the cyclical nature of involvement in the child protection system and the complexity of intergenerational trauma.[88] There is a need to increase awareness of care criminalisation among judicial officers to ensure all complex risk factors are considered during sentencing.[89]
Data	Government departments should engage in partnership with Aboriginal people in the collection and interpretation of data that concerns them.[90]

Government response

The NSW Government response to Family is Culture was released in July 2020. Rather than responding to each recommendation, the document categorises the recommendations into three overarching themes and outlines initiatives, planned or underway, that address these themes. The themes and initiatives are:

- Strengthening oversight and enhancing accountability for Aboriginal children in care by creating a new Deputy Children's Guardian for Aboriginal Children and Young People, commissioning independent reviews and establishing an Aboriginal Knowledge Circle.[91]
- Achieving better care outcomes and upholding the ACPP by establishing an Aboriginal Outcomes Taskforce within DCJ, improving data collection, developing stronger casework policy and practices and enhancing services and supports for Aboriginal families.[92]
- Changing care and protection legislation by conducting a focused review of the Children and Young Persons (Care and Protection) Act 1998, commencing in 2024.[93]

[87] Independent Review of Aboriginal Children and Young People in OOHC, Part E.

[88] Ibid, 179.

[89] Ibid, Ch.15

[90] Ibid, Ch.2.

[91] NSW Government (2020), *NSW Government response to Family is Culture Review Report*, https://apo.org.au/sites/default/files/resource-files/2020-07/apo-nid306779.pdf, 3

[92] Ibid, 4.

[93] Ibid, 5.

2.5. DISCUSSION OF FINDINGS

While the reports reviewed vary somewhat in their focus, all were established in response to growing concerns about the number of children in OOHC in NSW and the apparent failures of the system to improve outcomes for vulnerable children and families. This section discusses the degree of consistency of key findings in the reports according to the analytical framework.

Governance

Across the reports, there was a common finding that governance arrangements needed to be strengthened, although the specific issues raised varied.

The Wood report highlighted the complexities of existing oversight mechanisms and identified opportunities to streamline processes and functions to enhance transparency and accountability in the child protection system. Wood also emphasised the importance of interagency collaboration and cooperation for improving outcomes for children and families. The Tune review found that the reforms introduced to implement the Wood recommendations with respect to governance did not lead to significant improvements. Tune noted that interagency coordination was failing because "families have needs that cross government silos" and agencies aren't held accountable for outcomes.[94] In essence, Tune's position was that interagency coordination isn't enough, there is a need for a whole-of-government approach which holds agencies accountable for outcomes. The Donnelly inquiry's findings were broadly consistent with the Wood report, that independent oversight of child protection services and practices needed to be improved. Family is Culture took a similar stance but was much more critical of existing oversight bodies and mechanisms as being insufficient and ineffective in practice.

Pathways

Our review identified a high degree of consistency across the reports in relation to pathways in and out of OOHC services.

The first common finding was that the volume of reports of suspected ROH/ROSH reports was unsustainable and unmanageable. This was a key focus of the Wood report, which identified an opportunity to reduce the number of reports by raising the threshold from ROH to ROSH. The Tune review cited evidence that while raising the threshold to ROSH led to a decline in the total volume of reports, many children and families who were the subject of a report still did not receive an appropriate response from FACS. The Donnelly inquiry and Family is Culture made similar findings and highlighted the small proportion of children who receive a face to face assessment. A key distinction was that Family is Culture emphasised safety and risk assessment approaches as needing to be more appropriate for Aboriginal children and families.

The second common finding relating to pathways was the need to improve leaving care planning and support. This was identified as an area of key concern in the Wood report, the Tune review and the Donnelly inquiry, all of which documented evidence of the poor outcomes experienced by many young care leavers.

The third area of consensus, stressed in both the Donnelly inquiry and Family is Culture, was that the NSW Government should focus more attention on restoration as the preferred placement option.

Services

The need to improve access to prevention and early intervention services was one of the strongest and most consistent findings across the reports. All found that existing services were inadequate (in terms of availability and/or eligibility) and that funding was not commensurate with the size of the problem. It is important to note that consistent findings have not always translated into consistent recommendations. For example, the Wood report recommended an expansion to existing prevention and early intervention programs such as Brighter Futures and the Tune review recommended that Brighter Futures be redesigned to better align with evidence. By contrast, the Donnelly inquiry called for long-term contracts to guarantee funding for early intervention services as well as a one-off injection of funds to shift the crisis driven focus. Family is Culture proposed for the NSW Government to increase financial investment in early intervention support as a long-term investment to prevent entries into OOHC.

The second finding consistent across multiple reports relates to the drivers of demand for OOHC services. The Wood report and the Tune review both emphasised the need for services to address child protection risk factors such as mental illness, substance misuse and family violence.

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[94] Special Commission of Inquiry, *Volume 1*, i.

Communities

Common findings with respect to addressing gaps in the community included the need to improve outcomes for Aboriginal families and the need to improve practices and processes in the Children's Court.

Evidence of overrepresentation and poor outcomes experienced by Aboriginal children and families in the child protection system was documented in all four reports. This provides another example of consistent findings not necessarily resulting in consistent recommendations. While all reports identified the overrepresentation of Aboriginal families as a significant challenge, the strategies proposed to address it varied significantly. For example, a recommendation made by the Wood report advocated that the NSW Government consider targeted measures to support Aboriginal communities such as income management, night patrols and boarding houses. By contrast, the Donnelly inquiry and Family is Culture recommended a stronger focus on Aboriginal self-determination, while Tune made no specific reference to Aboriginal communities in his recommendations.

Three of the four reports highlighted practices and processes in the Children's Court as needing to be addressed to improve outcomes for vulnerable children and families. Family is Culture identified improving the quality of evidence, increasing independent oversight and cultural planning for Aboriginal children as three key areas for reform.

Theory

There was some consistency in key findings of this type across the reports.

The Tune review, the Donnelly inquiry and Family is Culture referenced to the need to align existing and future investments to evidence. The Tune review raised broad concerns in relation to the significant amount of funding directed toward programs and interventions that haven't been evaluated, while the Donnelly inquiry and Family is Culture referenced the need for evidence-informed decision making to improve outcomes for specific cohorts.

Workforce

Three of the four reports made a key finding with respect to strengthening the capacity of the child protection workforce.

The Wood report cited key challenges that limit the capacity of DoCS to deliver high quality casework services as the result of the crisis driven environment. The Donnelly inquiry's findings echoed this, highlighting the need for FACS to do more to address high caseworker workloads and to ensure the health and wellbeing of staff. Family is Culture's workforce findings were more oriented toward increasing awareness among caseworkers and judicial staff about the complex risk factors of involvement in the child protection system.

Data

Our review did not detect consistency across the key findings that related to data.

While the Wood report raised the importance of improving data quality and availability, this was mostly in relation to coalface capture rather than systemic utilisation. The Tune review and Family is Culture made the strongest findings in relation to data. The Tune review identified a need to establish a whole-of-government dataset to strengthen evidence-informed practice and policy and to better understand the drivers of demand for OOHC and other services. This is distinct from the key data-related finding of Family is Culture, which highlighted that Aboriginal people should be involved in the collection and interpretation of data that concerns their community. The Donnelly inquiry did not make specific findings in this area.

Tools and infrastructure

Tool and infrastructure-related findings were not consistent across the reports.

The Wood made no key findings concerning tools. With respect to infrastructure, Wood emphasised the need for DoCS to develop its information and communication capability. Our review did not identify key findings that related to tools or infrastructure from the Tune review, the Donnelly inquiry or Family is Culture. It is important to note that tools were referenced in all four reports, but we determined that these were not major focus areas or that these findings were more relevant to other codes. For example, all reports highlighted assessment tools as needing improvement, but this finding was more relevant to pathways.

3. IMPLEMENTATION OF RECOMMENDATIONS

This section summarises the implementation of recommendations across the Wood report, the Tune review and the Donnelly inquiry. As outlined at Section 1, the implementation status of most of the Family is Culture recommendations could not be determined and as such these have been excluded from the analysis.

3.1. DISCUSSION OF RECOMMENDATIONS

The Wood report made significantly more recommendations than both the Tune review and the Donnelly inquiry and so the scope of the recommendations was much broader. Key themes in Wood's recommendations include an expansion of early intervention services, a bigger role for NGOs, building capacity in the child protection workforce, strengthening interagency collaboration and simplifying oversight mechanisms. Wood also proposed multiple legislative amendments, including the shift from ROH to ROSH, and recommended updates to a range of guidelines and policies.

By contrast, many of the Tune review recommendations were more ambitious and systemic in focus. This closely reflects Tune's finding that "significant disruption of the system is needed to achieve the fundamental level of change required".[95] The 22 recommendations are grouped into five key reform areas: personalised support packages; the investment and commissioning approach; NSW Family Investment Commission; Keep Them Safe; and care allowance. Key themes include the importance of data and evidence in informing investments, the need to focus on outcomes for vulnerable families, and increasing opportunities for early intervention. Underpinning the recommendations is a vision to ensure that all children, young people and families receive help that is appropriate and specific to their needs to improve their life outcomes.[96]

The Donnelly inquiry's recommendations range from systemic and structural to specific and tactical. Many of the themes are consistent with those in earlier reports including in relation to early intervention and prevention services, strengthening governance and oversight and focusing on outcomes for vulnerable children and families. Notably, there is an emphasis on Aboriginal self-determination and restoration not evident in the recommendations of the Wood report or the Tune review. The inquiry reflected that it hoped the recommendations in the report would be "considered alongside the findings of previous reviews, to help shape future changes within the child protection system".[97]

Across the three reports, there are several recurring themes in the recommendations. These broadly relate to:

- Expanding early intervention and prevention services
- Strengthening independent oversight
- Redesigning/improving intake and assessment processes and practices
- Enhancing oversight mechanisms
- Improving leaving care planning and support
- Building the evidence base for interventions that work to reduce entries into OOHC and improve outcomes for families.

Our review found a mixed picture in terms of the implementation of recommendations. While most recommendations from the Wood report were implemented, less than half of those from the Tune review and the Donnelly inquiry have been addressed. It is important to note that this is likely to be at least partly due to the age of the Wood report, as there has been more time to implement recommendations.

Figure 5 shows the overall implementation of recommendations from the three reports.

[95] Tune, *Independent Review of OOHC in NSW*, 27.

[96] Ibid, 25.

[97] General Purpose Standing Committee No.2, *Child Protection*, 15.

Figure 5 – Implementation status of recommendations[98]

3.2. GOVERNANCE

Governance was the most common overarching theme across the three reports, accounting for 41 of the total 161 recommendations. Figure 6 summarises the implementation of recommendations that relate to governance.

Figure 6 – Implementation status of governance recommendations

Recommendations not implemented

Our review found around half (19) of the governance recommendations have not been implemented. Seven are from the Wood report, three are from the Tune review and eight are from the Donnelly inquiry.

Across these recommendations, there is a strong emphasis on the need to strengthen independent oversight of services and practices, including by expanding ombudsman and audit functions and commissioning independent investigations (Wood 8.2, 16.9, 18.1, 25.1 Donnelly 8, 12, 16, 21, 22). Examples include:

> ***Recommendation 18.1*** *Carer allowances should be reviewed periodically by an independent body and should more closely reflect the actual costs to the carer of providing care, according to the varying categories of need. (Wood inquiry)*

> ***Recommendation 12*** *That the NSW Government make legislative amendments to extend the performance audit function of the Auditor-General to include audits of all non-government organisations who have been provided with state funding to deliver child protection related services. (Donnelly inquiry)*

Other significant recommendations that have not been implemented include three from the Tune review relating to the establishment of a NSW Family Investment Commission as a statutory authority within the Family and Community Services cluster (3.1, 3.2, 3.3). The 2020 audit of TFM noted that the body that was created to implement this recommendation, the TFM Unit, is an administrative unit rather than a new independent statutory authority.[99] As such, this recommendation was classified as not implemented.

A similar recommendation from the Donnelly inquiry states:

> ***Recommendation 3*** *That the NSW Government establish a cross-sector body to direct the injection of additional funding for evidence based prevention and early intervention services, as provided for in recommendation 2, with this body to be comprised of key stakeholders including the NSW Children's Guardian, the NSW Ombudsman, the President of the Children's*

[98] Please note we have used a quantitative approach to illustrate the findings of qualitative data. While we acknowledge the number of recommendations in most of the reports do not justify a quantitative analysis, we determined that a visual illustration, as well as calculation of the proportion of recommendations implemented, would assist in conveying the findings.

[99] General Purpose Standing Committee No.2, *Child Protection*, 12.

Court of NSW, senior representatives from the NSW Police Force, Health and Education, as well as independents with relevant commercial experience. (Donnelly inquiry)

This recommendation was not supported by the Government.

Of the remaining governance recommendations that haven't been implemented, three focus on government roles and responsibilities (Wood 22.1, 22.3 Donnelly 14), one focuses on interagency practice (16.15) and one is a legislative amendment (Donnelly 7).

Recommendations implemented

Around half (n=20) of the governance-related recommendations have been implemented. Most of these (n=13) are from the Wood report. Focus areas include legislative amendments (Wood 11.1, 23.1, 23.3, 23.4), interagency coordination and/or agency roles and responsibilities (Wood 16.10, 21.2, 21.4, 23.5, 24.1 Donnelly 28) and funding for child protection services (Tune 2.1, 4.1).

Key recommendations include:

> ***Recommendation 24.1*** *The legislation governing each human services and justice agency should be amended by the insertion of a provision obliging that agency to take reasonable steps to coordinate with other agencies any necessary decision making or delivery of services to children, young persons and families, in order to appropriately and effectively meet the protection and care needs of children and young persons. (Wood inquiry)*

> ***Recommendation 2.1*** *Develop and implement an investment and commissioning approach. Implementation should occur in stages, starting with children and young people in OOHC and families whose children are at imminent risk of entry to OOHC. (Tune review)*

The Government introduced legislation to implement recommendation 24.1 of the Wood report in 2009. With regard to recommendation 2.1 of the Tune review, a 2020 audit of TFM found that although the liability model is not yet applied across all vulnerable families, the Government has taken steps to develop the investment and commissioning approach.[100]

Other recommendations that have been implemented relate to the structure of the Department (Wood 23.6, 24.4).

Recommendations not determined

The implementation status of two governance-related recommendations from the Wood report could not be determined. Both are very broad recommendations that could not be assessed within the time frame. For example, recommendation 10.3 states:

> ***Recommendation 10.3*** *DoCS should remain as a single department with a centralised Helpline, it should be divided into regions which are aligned with other key agencies and each region should contain such number of CSCs as are appropriate for the level of demand within the region. (Wood report)*

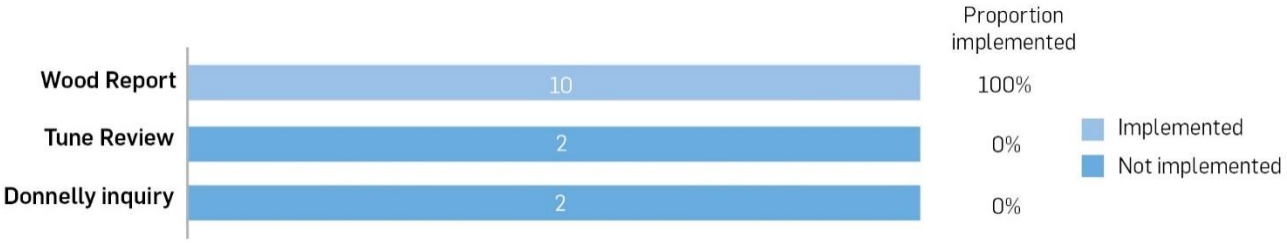
While this review found evidence that the Helpline was centralised, it was not possible to assess whether the number of CSCs was appropriate for the level of demand.

3.3. PATHWAYS

Eleven recommendations concerning how people move into, through and out of OOHC and adjacent services were identified through this review. Figure 7 summarises the implementation of these recommendations.

[100] Audit Office of NSW (2020), *Their Futures Matter*, https://www.audit.nsw.gov.au/sites/default/files/documents/Their%20Futures%20Matter%20-%20PDF%20Report.pdf, 23

Figure 7 – Implementation status of pathways recommendations



Recommendations not implemented

Five of the recommendations relating to pathways have not been implemented. The most significant of these relate to redesigning the intake, assessment and system navigation architecture to enable better responses for children and families to reduce entries into OOHC (Tune 4.3, 4.4). The principles of the redesign that Tune envisioned include reducing the duplication of services between statutory and non-statutory pathways and increasing opportunities for early intervention.[101] The 2020 audit of TFM found that the business case for the redesign, known as 'Systems Transformation', has been in development since in 2017 but is yet to be implemented.[102]

Other recommendations not implemented include a provision that requires the Children's Court to consider the known risks of harm of removal (Donnelly: 9), specific measures to improve leaving care planning and supports (Donnelly: 15) and ceasing new entries into the placement category of 'supported care without an order' (Tune: 5.1).

Recommendations implemented

The majority (n=9) of recommendations under this theme have been implemented, all from the Wood report. The most significant of these relate to raising the threshold for reporting from suspected risk of harm to suspected risk of significant harm (6.2, 10.1, 10.2). The NSW Government implemented this recommendation under the Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009 as part of the KTS reform agenda.

Other recommendations that have been implemented include increased funding for alternative dispute resolution (12.1), legislative amendments to streamline court processes (13.3, 13.4) and increased support for young people leaving care and their carers (20.2, 20.3).

3.4. SERVICES

There are 21 recommendations from the three reports that relate to OOHC and adjacent services that are available. Figure 8 summarises the implementation of recommendations that relate to services.

Figure 8 – Implementation status of services recommendations

Recommendations not implemented

Eight recommendations under this theme have not been implemented. The most significant of these relate to the Donnelly inquiry's calls for a specific one off injection of funding for prevention and early intervention services (2) and for future funding contracts for these services to be provided for at least five years (1).

[101] Tune, *Independent Review of OOHC in NSW*, 27.

[102] Audit Office of NSW, *Their Futures Matter*, 17.

Recommendation 1 was not supported and recommendation 2, while supported, did not result in any additional funding in the budget.[103]

Of the remaining recommendations that haven't been implemented, three relate to the proposal put forward in the Tune review to introduce personalised support packages for vulnerable children, starting with children in OOHC (1.1, 1.2, 1.4). While the Government has committed to implementing these recommendations, the 2020 audit of TFM found that personalised support packages have been trialled but with limited reach. At present, the numbers of children accessing the packages represent a very small proportion of the target cohort.[104]

The Donnelly inquiry also recommended that the Central Coast MultiAgency Response Centre (CCMRC) model be funded and implemented in areas of NSW. The CCMRC was subject to an evaluation in 2018 but this review did not find evidence that the model has not been implemented at any additional locations.

Recommendations implemented

More than half (n=12) of recommendations under this theme have been implemented. One of the most significant is from the Wood report and advocates for the transfer of OOHC services to NGOs (16.2). The NSW Government commenced this process in 2012 and intends to transfer all children in statutory care by 2022.[105] The Wood report also endorsed health, developmental and education assessments for all children and young people entering care (16.3, 16.6, 16.8). These reforms were implemented with the establishment of the OOHC Health Pathways program and OOHC Coordinators.

Another key recommendation relates to the expansion of a range of early intervention and prevention services including Brighter Futures, family preservation services, Integrated Case Management and Staying Home Leaving Violence (10.5). Many aspects of this recommendation were implemented under KTS.

Closely related to this, the Tune review recommended that some areas of Brighter Futures, Intensive Families Services and Whole of Family Teams be redesigned to better align with evidence (4.2). This was based on Tune's finding that these programs had not been proven to be effective through independent evaluation and therefore were not well aligned to the evidence-based service continuum.[106]

The remaining recommendations address the need for services to be appropriate for vulnerable cohorts including Aboriginal families (18.4), children with challenging behaviours (16.13), and children with a disability (16.13). For example, recommendation 21.6 states:

> ***Recommendation 21.6*** *Consideration should be given to the establishment of a suitable mediation process for those cases where the Department of Ageing, Disability and Home Care considers that services are needed for a child or young person with a disability and the parents or carers of such child or young person are not acting in their best interests in relation to the provision, or non-acceptance, of those services. (Wood Report)*

The 2010 MoU between Community Services and Ageing, Disability and Home Care provides evidence that this recommendation was implemented.

Recommendations not determined

The implementation status of one recommendation from the Wood report could not be determined. This was:

> ***Recommendation 21.5*** *The Department of Ageing, Disability and Home Care and DoCS should develop additional models of accommodation and care for children and young persons with a disability who are subject to the parental responsibility of the Minister for Community*

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[103] NSW Government (2018), Implementation of the NSW Government's response to report 46 of the Legislative Council Portfolio Committee No.2 – Health and Community Services – Child Protection, https://www.parliament.nsw.gov.au/lcdocs/other/11623/NSW%20Government%20-%20Progress%20Report%20-%20Child%20Protection%20-%20August%202018.pdf, 6.

[104] Audit Office of NSW (2020), *Their Futures Matter*, 23.

[105] Audit Office of NSW (2015), *Transferring out-of-home care to non-government organisations*, https://www.audit.nsw.gov.au/sites/default/files/pdf-downloads/2015_Sep_Report_Transferring_out-of-home_care_to_non-government_organisations.pdf, 5.

[106] Tune, *Independent Review of OOHC in NSW*, 42,43.

Services, or for those whose disabilities are such that they are unable to continue to reside in their homes. (Wood report)

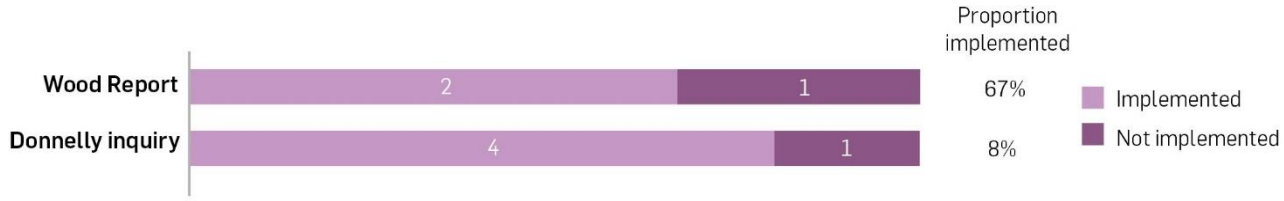
The National Disability Insurance Scheme now funds disability-related supports for children and young people in OOHC.

3.5. COMMUNITIES

This review identified eight recommendations principally concerned with communities, that is how the OOHC system leverages community strengths or addresses gaps.

Figure 9 summarises the implementation of recommendations that relate to communities.

Figure 9 – Implementation status of communities recommendations.



It is worth noting that the low number of community-related recommendations does not accurately reflect the spirit of the reports. There were many recommendations that met the scope of this code but were more relevant to other codes. For example, recommendation 2.6 from the Tune review states:

> ***Recommendation 2.6:*** *Build the evidence base for a range of successful interventions targeted at specific vulnerable cohorts. (Tune review)*

It was determined that this recommendation was more relevant to theory.

Recommendations not implemented

This review found that two recommendations concerned with communities have not been implemented. One calls for the development of a specific strategy to improve opportunities for restoration (Donnelly: 27) and the other recommends that the NSW Government consider targeted measures to address risk factors in Aboriginal communities, such as income management and night patrols (Wood:18.2).

Recommendations implemented

Of the six recommendations under this theme that have been implemented, two are from the Wood report and four are from the Donnelly inquiry.

The recommendations from the Wood report relate to strengthening capacity for Aboriginal organisations (8.5) and families (16.12) to protect and care for Aboriginal children. An outcomes evaluation of the KTS reforms found that the NSW Government had established Protecting Aboriginal Children Together (PACT) to implement recommendation 8.5. PACT is a consultation-based model designed to provide an Aboriginal perspective in child protection.[107] Regarding recommendation 16.12, the NSW Government's position is that Aboriginal children should be cared for by relatives or kin if they cannot be cared for by their parents. There are a range of supports available to help kinship carers care to care for children, including financial support, support groups, information resources and services.[108]

Three of the Donnelly inquiry recommendations that have been implemented focus on improving information and support for parents and carers who come into contact with the child protection system (10, 13, 26). For example, recommendation 26 states:

> ***Recommendation 26*** *That the Department of Family and Community Services publish a plain English policy position on how parents and carers can work towards restoration of their*

[107] UNSW (2014), *Keep Them Safe Outcomes Evaluation*, https://www.cese.nsw.gov.au/evaluation-repository-search/keep-them-safe-outcomes-evaluation-final-report, 60.

[108] DCJ (2020), *Foster, relative and kinship care*, https://www.facs.nsw.gov.au/families/carers

children, including a clear internal review process for parents and carers who have been denied restoration. (Donnelly inquiry)

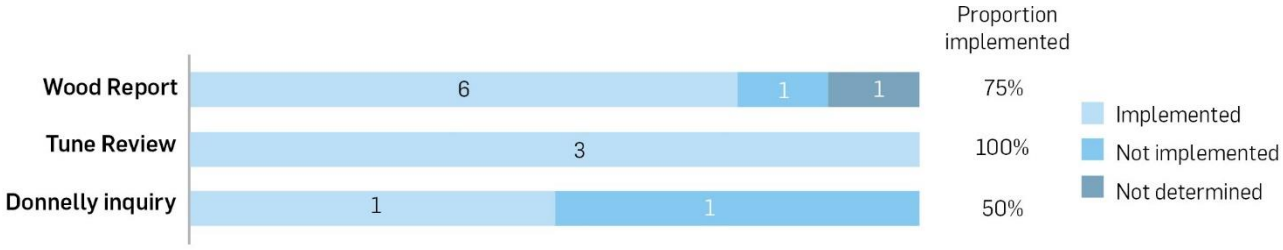
This recommendation has been implemented and this information is available on the DCJ website on the page 'Information for parents with kids in OOHC'.[109]

The remaining recommendation relates to providing a greater degree of Aboriginal self-determination in decision making (28). The NSW Government's response to the Donnelly inquiry outlined several initiatives that address this recommendation including the development of the Aboriginal Cultural Inclusion Framework and the Aboriginal Co-design and Evidence project.[110] The formal response to Family is Culture, while not comprehensive, provides some indication of the Government's intention to further embed self-determination in the system by establishing an Aboriginal Outcomes Taskforce and an Aboriginal Knowledge Circle.[111]

3.6. THEORY

These recommendations are principally concerned with strengthening evidence-informed practice and processes within the NSW child protection system. This review found that 13 recommendations relate to this theme. Figure 10 summarises the implementation of these recommendations.

Figure 10 – Implementation status of theory recommendations



the evidence base for a range of interventions to improve outcomes for vulnerable families (Tune 2.5, 2.6).

Recommendations not implemented

This review found two recommendations under this theme have not been implemented, one from the Wood report and one from the Donnelly inquiry. Both of these are very specific, for example, recommendation 5 from the Donnelly report states:

> ***Recommendation 5:*** *That the NSW Government benchmark funding levels for men's behaviour change programs in other state and territory jurisdictions, to ensure an adequate level of funding is allocated to these programs in New South Wales. (Donnelly inquiry)*

While the Government indicated that it supported this recommendation, this review found no evidence of implementation. A 2018 progress report did not provide any indication that benchmarking was planned or underway.

Recommendations implemented

Six recommendations from the Wood report have been implemented including two relating to procedures in the Children's Court (13.1, 13.2), one relating to DoCS' practices (23.2) and one relating to expanding the remit of the Drug and Alcohol Expertise Unit (9.8).

Another recommendation implemented, made in both the Tune review and the Donnelly inquiry, advocated for the development of a framework focusing on improving outcomes for vulnerable young people and families (Tune 2.2 Donnelly: 6). The NSW Government developed a Shared Outcomes Framework at the end of 2019 as part of the TFM reforms.[112]

[109] NSW Government (2020), *Information for parents with kids in OOHC*, https://www.facs.nsw.gov.au/families/out-of-home-care/parents-with-kids-in-oohc

[110] NSW Government, Implementation of the NSW Government's response, 17.

[111] NSW Government, *NSW Government response to Family is Culture Review Report*, 3, 4.

[112] Audit Office of NSW, *Their Futures Matter*, 31.

The remaining recommendations relate to a general need to define outcomes, evaluate services and build the evidence base for a range of interventions to improve outcomes for vulnerable families (Tune 2.5, 2.6).

Recommendations not determined

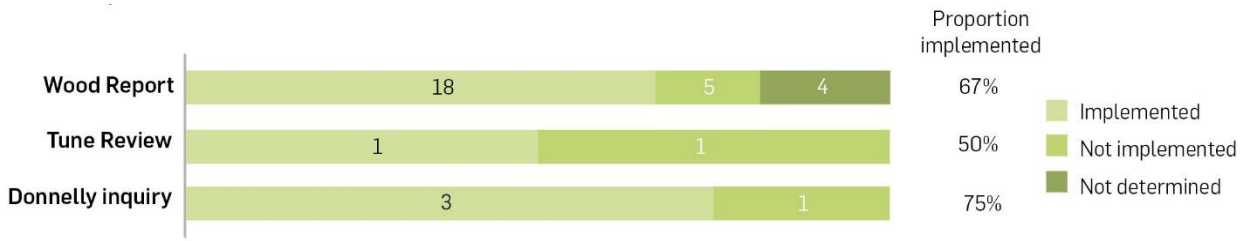
The recommendation status of one recommendation from the Wood report could not be determined. It states:

> ***Recommendation 13.5:*** *The Children's Court should revise its practices in relation to changing hearing dates and moving proceedings between courts, as well as its listing practices for callovers and mentions.*

3.7. WORKFORCE

Thirty-three recommendations are concerned with the child protection workforce. Most of these (n=27) are from the Wood report. Figure 11 summarises the implementation of recommendations that relate to the workforce.

Figure 11 – Implementation status of workforce recommendations



Recommendations not implemented

Around one quarter (n=8) of workforce-related recommendations have not been implemented. Of these, three reference the challenging nature of child protection work and advocate for improved training and development for caseworkers (Donnelly 23) and the introduction of caseload targets (Wood 16.14, Donnelly 19). Caseworker targets are not supported by the Government.

Other recommendations that have not been implemented include three relating to establishing new positions, roles or teams (Wood 2.5, 10.10 Tune 1.3) and two which endorse the appointment of additional Children's Magistrates (Wood 13.10, Donnelly 11). While the Government has indicated that it supports the objective of this recommendation – to ensure all child protection matters in the state are presided over by specialist Children's Magistrates – it does not support the appointment of additional Magistrates.

Recommendations implemented

The review found evidence that 20 workforce recommendations been implemented. Focus areas of these recommendations include implementing formal models of professional development and support (Wood: 9.5, 9.6, Donnelly: 20), reducing caseworkers' administrative burden (Wood: 3.2, 3.3), improving collaborative practice and/or training (Wood: 13.6, 16.5, 17.3, 21.3) and building capacity in the NGO sector (Wood: 10.6, 10.8, 10.10, 10.11 Tune: 1.7). The remaining recommendations relate to specific positions, including:

> ***Recommendation 16.4*** *NSW Health should appoint an OOHC coordinator in each Area Health Service and at The Children's Hospital at Westmead. (Wood)*

> ***Recommendation 16.5*** *The Department of Education and Training should appoint an OOHC coordinator in each Region. (Wood)*

Both of these positions were funded under KTS.

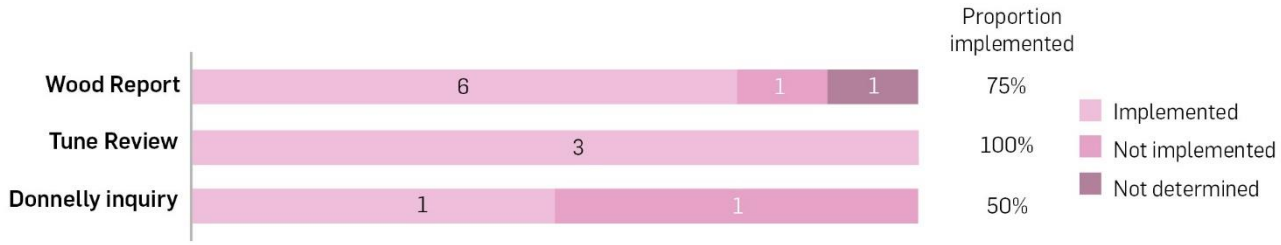
Recommendations not determined

The recommendation status of five workforce recommendations from the Wood report could not be determined. Three of these highlight the need for interagency collaboration (24.2, 24.3, 24.5), one advocates for the appointment of specialist caseworkers to each DoCS region (20.1) and one supports the development of models of professional support for novice caseworkers similar to those in medicine (9.7).

3.8. TOOLS

Across the three reports, 16 recommendations relate to tools. Figure 12 summarises the implementation of these recommendations.

Figure 12 – Implementation status of tools recommendations



Recommendations not implemented

This review found that two recommendations of this type have not been implemented. Both relate to the need for assessment tools to be enhanced to enable better triaging and responses for vulnerable children and families. These are:

> ***Recommendation 1.6*** *Introduce a common risk and need assessment tool. The assessment tool should be informed by actuarial information and data analytics. (Tune review)*
>
> ***Recommendation 4*** *That the NSW Government commission an independent review of the Department of Family and Community Services' screening and assessment tools and processes, to identify how they can be improved to enhance objectivity within child protection assessments. (Donnelly inquiry)*

The NSW Government's response to the Donnelly inquiry indicated that the redesign of the system navigation architecture (System Transformation) addressed the intent of this recommendation.[113] However, as outlined in Section 4.3, System Transformation has not yet been implemented.

Recommendations implemented

The review found that less that more than half (n=10) of recommendations concerned with tools have been implemented. These are all from the Wood report and mostly relate to developing guidelines, procedures and tools to assist caseworkers and mandatory reporters in decision making. Two key recommendations advocate for the use of Structured Decision Making (SDM) tools to improve the assessment process (9.1, 9.2). SDM tools are now used to support mandatory reporters to determine whether to make a report to the Helpline and to identify alternative supports for vulnerable children and families.[114]

Some of the guidelines, procedures and tools referenced in the recommendations are no longer being used. For example, recommendation 2.1 states:

> ***Recommendation 2.1****: The KiDS Core Redesign Project should be funded and implemented.*

A 2014 report by the NSW Ombudsman found that FACS redesigned and upgraded the KiDS system with key enhancements including removing the initial assessment field to enable more efficient recording of ROSH reports at the Helpline.[115] The Department transitioned from KiDS to ChildStory in 2018.

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[113] Audit Office of NSW, *Their Futures Matter*, 17.

[114] NSW Government (2019), *Structured Decision Making*, https://www.facs.nsw.gov.au/providers/children-families/child-protection-services/making-decisions

[115] NSW Ombudsman (2014), *Review of the NSW child protection system: Are things improving?*, https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0004/15691/Review-of-the-NSW-child-protection-system-Are-things-improving-SRP-April-2014.pdf, 3.

Recommendations not determined

The implementation status of four tool-related recommendations from the Wood report was not able to be determined. All of these relate to updating guidelines and policies that appear to have been superseded. For example, recommendation 11.4 states:

> ***Recommendation 11.4*** *DoCS should review its Casework Practice Policy, Taking Action in the Children's Court, to ensure it is consistent with the Children and Young Persons (Care and Protection) Act 1998, in particular, the principles set out in ss.9, 10 and 36.*

This review could not find any information relating to this policy.

3.9. DATA

Across the three reports, there were 10 recommendations concerned with data. More than half (n=6) of these are from the Wood report, with two each from the Tune review and the Donnelly inquiry. Figure 13 summarises the implementation of recommendations that relate to data.

Figure 13 – Implementation status of data recommendations

Recommendations not implemented

One data-related recommendation has not been implemented. It is from the Wood report and states:

> ***Recommendation 8.3*** *Pending amendment of the privacy laws as recommended in Chapter 24, a Privacy Direction should be issued in relation to the JIRT process so as to facilitate the free exchange of information between the NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and DoCS.*

This recommendation was intended as a temporary measure but was not required as the Government introduced legislation to implement recommendation 24.6.

Recommendations implemented

This review found evidence that most (n=9) recommendations under this theme have been implemented. One of the most significant of these, from the Wood report, states:

> ***Recommendation 24.6*** *The Children and Young Persons (Care and Protection) Act 1998 should be amended to permit the exchange of information between human services and justice agencies, and between such agencies and the non-government sector, where that exchange is for the purpose of making a decision, assessment, plan or investigation relating to the safety, welfare and wellbeing of a child or young person.*

This recommendation was implemented through the Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009 as part of the KTS reforms.

Another key recommendation, from the Tune review, advocated for the establishment of a cross-agency dataset (2.3). This recommendation was implemented in 2018 as part of the TFM reforms. The TFM Human Services Data Set links de-identified data from 11 government agencies spanning

child protection, housing, justice, health, education, mental health, alcohol and other drugs, parental risk indicators and commonwealth services.[116]

Other recommendations implemented relate to conducting data analysis (Tune 2.4), improving information sharing across jurisdictions (Donnelly 24) and enhancing data collection, storage and availability (Wood 6.3, 6.4, 11.3, 21.1).

3.10. INFRASTRUCTURE

Infrastructure is the least common theme across the reports. The Tune review and the Donnelly inquiry made no recommendations in this area, while Wood made four, all of which relate to improving technology. Figure 14 summarises the implementation of recommendations that relate to infrastructure.

Figure 14 – Implementation status of infrastructure recommendations

Recommendations implemented

This review found evidence that all infrastructure-related recommendations have been implemented. For example, recommendation 2.2 states:

> ***Recommendation 2.2*** *DoCS Information Management and Technology Strategic Plan should be funded and implemented. (Wood report)*

The Information Management and Technology Strategic Plan was updated in the first half of 2009 and outlined key initiatives including a Caseworker Mobility Trial, expanding the trial of partner agency e-reporting and upgrading the KiDS system.[117]

Closely related to this, recommendation 6.6 states:

> ***Recommendation 6.6*** *The trial of e-reporting should be extended to NSW Health, each Area Health Service, The Children's Hospital at Westmead, the Department of Juvenile Justice and the NSW Police Force. (Wood report)*

A 2014 report by the NSW Ombudsman confirms that the e-reporting trial was expanded as outlined in the Information Management and Technology Strategic Plan.[118]

Remaining recommendations relate to the introduction of centralised electronic health records (16.7) and transitioning to electronic record keeping (9.3).

[116] NSW Government (2020), *TFM Human Services Data Set*, https://www.theirfuturesmatter.nsw.gov.au/investment-approach/tfm-human-services-data-set

[117] NSW Ombudsman, *Are things improving?*, 3.

[118] Ibid, 3.

4. SUMMARY OF RESEARCH FINDINGS

This section provides a concluding analysis of the research question and the implications for Fams in preparing for the 2020 inquiry.

Findings of the inquiries

The four reports reviewed provided a critical examination of the significant failures of the NSW child protection system to adequately protect vulnerable children and families, despite decades of reform.

Overall, the reports reached broadly consistent findings in relation to the most urgent challenges facing the system, including:

- Oversight of child protection services and practices are inadequate.
- The volume of ROH/ROSH reports is unmanageable.
- Many children who are the subject of a suspected ROH/ROSH report do not receive an appropriate response.
- Support for young care leavers must be sufficient to ensure they are able to transition to independence.
- Inadequate funding for early intervention and prevention services means that it is difficult to reorient the crisis driven system.
- There is a clear need to address the overrepresentation of Aboriginal children and families in the child protection system. Current approaches do not appear to be working.
- Interventions and investments must be evidence-based.
- Child protection work is difficult work. Workforce capacity needs to be strengthened and caseworkers need to be adequately supported to do their job.

Implementation of recommendations

While it is not necessarily the case that every recommendation should be supported and addressed, it is stark how many recommendations have been unsupported by NSW Government since 2008 despite the consistency of findings of successive reviews.

Of the 161 recommendations assessed, 100 have been mostly or fully implemented. More than three quarters (76%) of the Wood report recommendations have been implemented, while just over a third (36%) of the Tune review recommendations and less than a third (28%) of the Donnelly inquiry recommendations have been addressed. Recommendations that have been implemented tend to be more tactical and specific such as legislative amendments and those focused on procedures and processes. Those that haven't been implemented tend to be those that involve large and immediate budget implications and involve substantial systemic change. Recurring themes in these recommendations that remain not implemented include boosting funding for early intervention, improving screening and assessment and strengthening independent oversight of the system.

Considerations for Fams

The policy impact of the Wood report and the Tune review were significant. Investments made in response to their findings collectively added up to almost $1 billion in reforms. Despite this major investment, reforms have failed to drive the kind of systemic change that successive reviews have outlined as critically important in order to significantly improve the outcomes for vulnerable children and families in NSW. It is notable that the two more recent reports, the Donnelly inquiry and Family is Culture, have so far resulted in far less evidence of action by NSW Government (although noting the recency of Family is Culture, published in 2019). Our review found that less than one third of recommendations of the Donnelly inquiry have been implemented (with less than half being supported), while the NSW Government is yet to provide a detailed response to Family is Culture.

It is possible that reforms have failed to achieve the desired impacts because they haven't been implemented as intended. While it was beyond the scope of this review to assess this, many of the recommendations were intended to be implemented in conjunction with others. In deciding to address some recommendations and not others, the intended impact may be limited.

The high degree of consistency of key findings across the reports suggests the problems in the system are well understood. In light of the upcoming inquiry, questions remain as to why previous inquiries have not delivered improvements in the areas that have been identified as in need of significant change time and time again. Possible explanations for this lack of implementation (which have not been examined within this review) include a lack of capacity; an inappropriate support and authorising environment; and, a lack of commitment among senior leaders to drive systemic change.

Questions also remain as to why so many recommendations, some of them consistent across multiple reports, are yet to be addressed by NSW Government. The immediate resourcing implications of tackling key areas like governance and early intervention may be a factor. However, as outlined in all four reports, early intervention should be seen as a long-term investment to reduce entries into OOHC and ultimately reduce Government spending.

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