Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

WITNESS STATEMENT OF JACK DAVENPORT

I, Jack DAVENPORT of [redacted] in the State of Tasmania, with contact number [redacted], do solemnly and sincerely declare that:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2. I make this statement on the basis that its contents can be made public. I am happy for the Commission to use its contents as evidence or in the final report.

Background

3. I hold the following qualifications;
    a. a MA Social Work (2010)
    b. a BA (Hons.) European and International Studies (2002)
    c. a Masters in Diplomacy and Trade (2019)
4. I am employed as Parliamentary and Policy Advisor for Federal Senator Peter Whish-Wilson. I commenced my current employment in May 2021.
5. [redacted] I am making this statement in a personal capacity, [redacted].
6. Between October 2017 and May 2021, I was employed as a Clinical Practice Consultant and Educator (CPCE) for Child Safety Services (CSS) within the Tasmanian Department of Communities.
7. During the same period of employment, I also undertook roles of (acting) Assistant Manager, (acting) Manager, and (acting) Principal Analyst at different times, all within the Department of Communities. Aside from my role as Principal Analyst, which was based at home during the COVID lockdown, all of my employment was based at the CSS [redacted] Region office in [redacted].
8. Prior to my employment with CSS, my roles included;
    a. between June 2010 and January 2011 I was employed as a Social Worker for Lancashire County Council (UK);

[redacted]

b. between March 2011 and May 2012 I was employed as a Social Worker for the Department of Child Protection in South Australia;
c. I was unemployed between May 2012 and August 2012;
d. between August 2012 and October 2017 I was employed in a number of roles with the Department of Child Protection in Western Australia, including Senior Child Protection Worker, Team Leader, and (acting) Assistant District Director.

9. My primary role as CPCE was to provide consultative support and guidance to Child Safety Officers and other staff, as well as provide mentoring support.
10. Attached to this declaration and marked 'Attachment JD-001 a copy of my 'Statement of Duties' for my role in 2017.
11. While my team was technically a statewide team, I was attached to support the Case Management teams at the Child Safety [redacted] regional office. Most of my consultations related to children in out-of-home-care (OOHC) on various court orders, and occasionally for children being supported on an extended case planning but without an order.
12. I held no formal decision-making authority compared to, say, a Team Leader or Manager.
13. My immediate line manager was the Clinical Support Manager.
14. While I am confident in the validity of my concerns, and the appropriateness of reporting these to the Commission, I wish to acknowledge that the information I relay here may potentially cause concern and distress to former colleagues, and current staff at the Department of Communities.
15. I wish to acknowledge all those who have personal experience of child sexual abuse, both in the past and the present, and the power of their voice and resilience, most particularly in the context of lutruwita/Tasmania.

The Tasmanian Child Safety System

16. My experiences within the Department of Communities in lutruwita/Tasmania have led me to the conclusion that the child safety system is compromised in terms of integrity, ethics, effective risk assessment and providing safety for children.
17. I have concluded from my experiences that the child safety system in lutruwita/Tasmania is characterised by institutional racism, sexism, ableism, and mentalism, operating at various levels from the 'frontline' of child safety teams, to the leadership and management undertaken at the executive level of the Department of Communities.

[redacted]

18. Sound, proficient practice is difficult to find in a systemic sense within CSS. There were good workers within CSS, demonstrating individual examples of positive work with families. However, these were the exceptions, not the norm.
19. Within CSS, there is no effective ethical safeguard or standard of any coherence or consistency.
20. The ability of CSS to undertake effective risks assessments is thoroughly compromised, and the system has effectively imploded in terms of effective delivery.
21. I was subject to acts of bullying and harassment in CSS. I heard significant levels of anecdotal reports that demonstrated to me that this behaviour was consistent, ongoing and invariably permitted to continue within the CSS [redacted] regional office.

Reporting concerns about children and information sharing

22. Given my role, I tended to have little intersection with the referral system in the immediacy of it occurring. My main interaction was indirectly by reviewing the processes, assessments and decision-making that led to a child coming into care.
23. When I started employment at CSS, the referral system was maintained by localised Intake teams, based at each regional office, which processed new concerns as they were reported.
24. My understanding of the switch to a centralised referral system was that this was driven by a principle desire to achieve consistency, and because of arguments made that this system would help drive down numbers of children in care by supporting early intervention.
25. In my experience, the barriers to reporting CSA and HSB were primarily influenced by a misunderstanding of the child safety system, and poor prior experience of the child safety system. This can exist for both professionals and members of the public.
26. In my experience, reluctance by professionals in reporting concerns occurs when faced with excessive waiting times for referrals to be processed and poor responses from CSS, notably a perception of a lack of urgency from CSS in relation to concerns about a child.
27. Excessive waiting times arise from poor resourcing and a lack of effective administration/organisation. It was not unusual for referred matters to go weeks or months without meaningful response by CSS.
28. I heard anecdotally of situations where some agencies ceased referring concerns due to the belief that no action will come of it. I found these reports plausible, because when I worked in rural areas in Western Australia I encountered this phenomenon in practice, arising from similar issues.

[redacted]

29. For members of the public where they were family members of children, the principal barrier to reporting is fear of CSS involvement due to the belief of overly punitive responses. This can happen even when the family is aware of CSA occurring, because the fear of family breakdown arising from CSS intervention (i.e. bringing a child into care) is considered more of a threat than the presence of abuse. This may be due to the belief that the presence of CSA is easier to control or manage and within their power, compared to external intervention from CSS.
30. The Advice and Referral Line Service was widely considered by colleagues to be understaffed and poorly administered. It was not unusual for reports of child safety concerns to take weeks to process. There was a lack of consistency in the time scale for passing on concerns to the local office in [redacted], which was a regular source of frustration for local staff in the local Response team. Information passed on was often superficial and poorly collated.
31. Local initial assessment was undertaken by the Response team, following the Tasmanian Risk Framework (TRF). Annexed to this statement and marked **JD-2** is a publicly available copy of How is Risk of Child Abuse or Neglect Assessed information sheet.
32. Barriers to assessment at Response level included poor organisation and leadership, lack of resources to respond in a prompt manner, and lack of sound judgement in planning responses. There was a consistent failure to prioritise and triage outstanding reports of concern, carrying the misconception that a response to concerns necessitates immediate allocation to a caseworker. If there was insufficient capacity to allocate a child to a worker, then there was simply no meaningful response.
33. It was my observation that in practice, workers sought complete assurance of safety, as opposed to critically assessing and managing risk. Workers were worried that a partial or incomplete measure of risk and safety would put their status in jeopardy, in that if anything happened to the child the worker would be blamed.
34. This created a binary reactionary process of extremes, operating as either inaction and over-reaction in terms of processes, assessments and response to child abuse concerns.
35. Inaction resulted in treating the reported concern as an abstract issue, where the abuse became 'frozen in time' and was only a factor to be considered once the workers began the process of conducting assessment actions such as sighting the child, speaking with parents or other agencies, and collating other information.
36. However, this inaction produced significant complications in that serious situations would deteriorate over time. Furthermore, time delays inevitably rendered the original referral information less reliable, as the situation had changed. Yet, despite this limitation, this

[redacted]

would still be the primary source for developing decisions and assessment outcomes. There appeared to be little self-awareness of the implications of delaying a response on this basis.

37. Over-reaction was characterised by over emphasis on care proceedings, with the expectation that the care system alone was the only viable way to generate safety.
38. This type of restrictive response leads to binary extremes - a prolonged period of no action versus highly intensive anxiety-led action. The high intensity action is normally directed towards removal of the children as the primary, sometimes only, means of assuring safety.
39. There was a tendency for workers to undertake initial home visits with the intention of seeking a 'requirement' to be signed by the parents. This was often with little or no interrogation of the facts, and before even the most rudimentary contact with the family had begun.
40. A 'requirement' is a reference to sections 20 and 21 of the Children, Young Person and their Families Act 1997. In practice, 'requirements' were quasi-legal documents in which parent/s sign over temporary custody of their child to CSS.
41. I am concerned that 'requirements' were deeply disempowering for parents and children, were being misused by CSS, and I have significant ethical issues about their use.
42. The process to have the authority to undertake requirements was perfunctory and lacking a rigorous process. To acquire the authority, CSO's would be expected to accompany a colleague on a Priority 1 (that being the most urgent matter), and to submit a written analysis about the experience. There was no obvious criteria by which a written analysis might be judged. This would constitute the process to be a registered officer.
43. Past experience was insufficient to be counted towards being a registered officer. For example, despite me holding a senior position, having a social work degree, and having seven years post-qualifying experience in child protection in a variety of roles, I did not meet the criteria for being a registered officer without undertaking the process outlined above.
44. Despite the legal nature of the requirements, CSO's received no specialised training in their use or guidance about using a legal instrument of this nature. Parent/s never had the opportunity to seek legal advice about this, compelling a decision to be made there and then about whether to accept a requirement.
45. From time to time, I would accompany workers on home visits for Priority 1's. While I cannot recall an example of requirements presented as an explicit ultimatum (for example, a worker stating "sign this or we will get a warrant and take your child into care anyway"), this was implicit in the manner and approach of workers, and the implied institutional power they carry.

[redacted]

46. Other barriers to investigating include a serious deficiency in the knowledge of social and psychology theories, and theories of social work practice; misunderstanding of procedure; outdated procedure and policies; judgemental attitude to families (this increased substantially if the family was Aboriginal); sexism (directed at the mother, even in situations where they were clearly a victim); ableism (disability being held as effective risk concern); mentalism (including perceptions of addiction and drug use).
47. I observed workers using terms relating to social work and psychological theory with only superficial understanding demonstrated. There was virtually no comprehensive understanding of the impact of trauma and its relevance to establishing context around particular actions or behaviours of children and adults.
48. This led to highly derogatory descriptions of children and young people by staff, particularly those in care. Behaviours and actions which could be clearly linked to trauma were typically described as "acting out", with little or no regard to the past experience of the child. The term "risk taking" behaviour was used as a coded reference to victim-blaming, implying that children at high risk of sexual exploitation were actively seeking it out.
49. The fear of undertaking provisional safety planning in the [redacted] region of CSS appeared to be highly influenced by past experiences of child deaths, a number of which had been the subject of extensive reporting in media and criticism from the Coroners Court of Tasmania. Workers were explicitly afraid that anything less than a complete intervention process (that is, bringing a child into care) may lead to the death of a child. Staff at the office appeared to carry a significant level of observable guilt, doubt and shame.
50. I had no reason to question the findings of the Coroners Court, but it was clear that CSS was ill-prepared for release of findings when they occurred, and took a highly passive approach to supporting staff. This usually manifested in recommending accessing the Employee Assistance Program, but no evident action to support workers to do this or to acknowledge the wider impact of coronial reports on staff morale.
51. Workers tended to have an idealised concept of the assessment process, where all pertinent information would be available and unknown factors minimised. Workers felt safer about conducting long term involvement with a family if they had completed relevant checks with other agencies, undertaken a home visit, sighted and/or interviewed the child, and liaised with relevant agencies, and this produced unambiguous data. A lack of certainty in any of these processes compromised their confidence in undertaking effective work with the family, pushing them towards anxiety response and increasing the likelihood of a push towards care proceedings. All assessments carry a level of uncertainty and element of risk –

[redacted]

this is the very character of critical practice. It is not feasible to complete an assessment with absolute certainty, and with all reasonable questions answered. However, it was my observation that workers identified the care system as being the only successful way of mitigating any risk, and were averse to carrying safety where potential unknown factors existed.

52. It is for this reason requirements were so utilised, as they were seen as assuring safety for the child by removing them from any potential threatening situation. This was usually undertaken without critical analysis of the available evidence, or the potential traumatic impact of removing a child from their family (for both child and parents).
53. There was a consistent failure by workers to understand safety planning as an ongoing process. The idea of constructing safety planning with a family appeared to be a totally unknown approach for some workers, including highly experienced ones and those in Team Leader positions.
54. Misunderstandings about the Signs of Safety Assessment Framework (which was supposed to be a primary framework for practice) inhibited using the framework tools as effectively as possible in safety planning, despite this being one of its principal design features.
55. Practice in CSS using Signs of Safety appeared significantly influenced by the (erroneous) perception that the framework explicitly maintained the child's status in the home, regardless of the risk factors. This appeared to stem from a misunderstanding about strengths-based and solution-focused theory.
56. I was aware of a situation in the [redacted] region office, where multiple assessments were closed prematurely, with little regard to the existing risk factors or the recommendation of the workers. Many workers in the Response team would propose care proceedings to protect a child, but this was regularly refused by their Team Leader TL1.
57. TL1 would routinely amend assessments to justify a non-intervention approach. My understanding is that TL1 would also alter the case completion on initial receipt of the case, in order to suppress key performance indicators showing overdue cases. This was a manipulation of the case file, leaving it 'open' but misleading the system to assume the matter was completed, thus meeting time limits.
58. In my experience, this habitual practice of data manipulation is typical in different states, due to the pressures of meeting (often arbitrary) key performance indicators.
59. TL1 often prohibited Child Safety Officers from seeking consultation from their assigned CPCE. This appeared to be widely known. I observed no effort by the Clinical Support Team, not the Manager, to resolve this problem.

[redacted]

60. CSO's on Response frequently took sick leave or sought workers compensation leave as a result of the pressures they were under. Some left the service. At one stage (in 2018 or 2019), for approximately 6 weeks, there were only two CSO's working in the team.
61. The Case Management Team at the [redacted] region office were extremely hesitant to accept transfers from Response if no care order was in place, despite an explicit procedure in place for this. The rationale appeared to be that work with a family would be impossible without a care order to compel cooperation.
62. This led to a systemic impasse, where investigations of serious concerns were either prematurely ceased, or excessive action was undertaken by bringing children into care regardless of potential safety factors. Almost certainly, this suppression of case management affected statistical data about case numbers, and outcomes.
63. At some stage in 2019 (possibly 2020), TL1 was transferred to another team in Case Management. It was rumoured this was due to awareness of cases being closed prematurely, and the rising numbers of cases yet to be allocated.
64. The [redacted] region office created a second Response team to help resolve the outstanding unallocated list, drawing workers from the Case Management team. While achieving some short-term success in reducing the unallocated cases (purely by virtue of them being allocated to the newly created team), the long-term issues were not resolved with fluctuating situations of large number of unallocated matters, which continued up until the period that I left.
65. Eventually the second Response team was ceased, and members either reassigned or remaining in a larger Response team.
66. I am not aware of any effort made to review historic matters that had been potentially ceased prematurely or without effective assessment being undertaken.
67. My main interaction with these previous matters was through the consultation process, where I could see historic involvement that had been ineffective or inconclusive, giving the impression of long-standing issues over time rather that repeated failure to properly assess the concerns.
68. These issues of overzealous practice were relevant to the consideration of CSA and HSB, as the anxiety-driven response generates a 'smoke and mirrors' effect. Workers may be unduly focused on issues that do not require a significant level of intervention, at the expense of other concerns that need much closer assessment and involvement.
69. A significant barrier to government responses is an over-reliance on frameworks of assessment or practice, such as Signs of Safety, or the more recent Wellbeing Assessment

[redacted]

Framework. In particular, frameworks and new processes were introduced as being transformative processes that will, in some way, correct and resolve flawed processes and outcomes.

70. There was little indication of an understanding, even at executive level, that frameworks were reliant on a number of factors in order to be successful, including effective ethical framework, high-level competency of workers, and sufficient skills level. It is also possible that the reason for the emphasis on introducing new frameworks is motivated by perceived difficulty in trying to resolve deeply ingrained structural problems, and thus at an executive level decision-making is focused on making changes that were within their control.
71. My experience of OOHC providers was not positive. While individual workers were well-meaning, caring and in some cases professionally proficient, the systemic issues affecting CSS also applied to external services.
72. Despite the presence of a Special Care Package process for children with extensive needs, external providers were rarely capable of providing these services. This included some providers whose service provision was based on providing Special Care Packages.
73. In my experience, staff with OOHC providers were poorly trained and lack any confidence in working with children with complex needs. I saw no evidence of a viable, safe system for children with complex needs.
74. CSS workers routinely used a local residential unit specifically for trauma related care. This was utilised primarily as an emergency placement option, not a site for supporting children with complex needs. Furthermore, it was apparent that the staff for the centre frequently lacked the skills to provide a safe or therapeutic environment.
75. It was not unusual for children to be placed in the residential unit with other young people that had displayed signs of HSB.
76. Rarely was a children placed at the unit with an effective or detailed long-term case or care plan. Placements were typically reactionary.
77. Children at the residential unit frequently left the centre unsupervised of their own volition. Although notionally a confidential address, it was apparent that the address was widely known. It would be very easy for potential abusers to target vulnerable children at the centre, and I am aware of at least one situation where a child placed there was still potentially exposed to perpetrators of CSA.

Information Sharing

78. Information sharing arrangements were primarily based on procedural letters formally requesting information, and memorandums of understanding. These were poorly

[redacted]

administered, with a significant impact on child safety work and meaningful support for families.

79. Information requests were often made by workers, but were poorly interrogated in terms of assessment and analysis. It appeared workers were fairly efficient at seeking information, possibly because it is an uncomplicated process and fulfils a basic requirement of assessment and investigation (sometimes referred to as 'ticking boxes'). However, workers were highly prone to judgemental attitudes from other professionals with little evidence of critical thinking.
80. In practice this meant workers inherited poor professional perspectives of children, parents, and families. For example, if a child was considered to be untruthful or unreliable by a professional, this was taken at face value with little consideration of any presenting evidence or context, or indeed the appropriateness of forming such an opinion.
81. Furthermore, workers displayed a tendency to inherit negative perceptions from colleagues who held case management previously. This was particularly a problem when a child transferred from Response to Case Management, or from worker to worker within a team. Workers were heavily reliant on the verbal description of the previous caseworker, and it was not clear to what degree case documentation was critically analysed (or what time capacity a new worker had to study this documentation).
82. External organisations have a tendency to 'fire and forget' when it comes to information sharing. This presents in practice as a reluctance to cooperate once information is provided, as though the information provided is the full extent of cooperative working and should be sufficient for CSS to undertake their work. This problem is exacerbated by CSS unwillingness to proactively coordinate work with other agencies.
83. There was a huge expectation that CSS would take a primary and all-encompassing role in managing the safety of a child, even when the child or family needs related to matters beyond CSS control, such as the provision of housing or health. This appeared to be because external agencies did not want to carry the risk for a child. In my experience this is a universal issue across Australia, not simply in lutruwita/Tasmania.
84. I observed a lack of safe service provision at Launceston General Hospital (LGH) for children or young people suffering acute mental health complications. On two separate occasions I was involved with case matters where a young person (teenage years) was admitted to the adult mental health unit for medical attention. It was apparent there was no focused child-friendly/safe mental health provision at LGH, particularly for acute situations.

[redacted]

85. On one of these occasions there was a rumour amongst CSS staff, never confirmed, that one of the adult patients on the mental health unit was a sex offender.
86. The hospital staff appeared to provide specific service provision for safety, including continuous supervision of the child by a staff member.
87. LGH placed a high emphasis on CSS providing solutions to ongoing mental health conditions, and potentially accelerated the discharge process on this basis. LGH staff placed significant emphasis on the lack of suitability of the mental health unit for young people. Although I have no direct evidence, I find it highly likely that concern about something going wrong for the young person while in the ward contributed to LGH attempting to accelerate a discharge.
88. On one occasion a worker from the Child and Adolescent Mental Health Services (CAMHS) asked me who we would approach for specialist advice about managing acute mental illness for young people normally, and appeared surprised when I responded that CAMHS were expected to be that service.
89. I observed a silo effect within CSS. Response and case management operated separately. There would be an initial response by Response, but with the expectation that Case Management teams would unambiguously take carriage of the matter. Due to lack of staffing and over-allocation, this was invariably a fraught process to transfer from one team to the next.
90. This had implications for maintaining consistent and meaningful work for the child and family. Forward planning was limited, especially for children in care, and highly dependent on rigid and arbitrary stage processes for restoration.
91. The silo effect also extended to my role as CPCE. I appeared to be pigeon-holed into the case management space, and Response workers appeared reluctant to approach me for consultation independently. This occurred even if the other CPCE at the office was unavailable (due to illness or leave for example), without explicit consent. Although I initially took this to be a rigid interpretation of distinctive responsibilities, I later held the suspicion that I was being deliberately excluded from decision-making at the Response level of assessment. I need to be clear that I had no explicit evidence of this; it was a view formed from observation of behaviours.
92. There was clearly a view that the Response team undertake any complex investigation work, not Case Management workers. This generated significant delay and inefficiency when concerns for a child in care were raised. Case Management workers appeared to be de-skilled in basic assessment approaches. It was not uncommon for Response workers and

senior workers to openly comment on the disparity between the team functions (creating a 'them and us' scenario). I found this problematic because there was a general dearth of high-standard in assessment, which meant there was an unrealistic perception of the specialism of the Response team.

93. The child advocate within the Department of Communities was a positive presence, but in practice was highly susceptible to negative opinions from workers. The primary issue was that many delays and failures of OOHC were systemic, or viewed as being so, but intervention by the child advocate was taken as a personal slight on ability. While performance issues in CSS need addressing, including poor decision-making and planning for children in OOHC, it was not feasible to expect the advocate to render the necessary change on their own. Workers felt as though they were being badgered into unrealistic actions, or having their professional judgement questioned. On some occasions they would accept recommendations in meetings with the advocate, but revert to continued practice without making substantive change. There was a tendency to accept recommendations from the advocate in meetings, only to comment afterward that the agreed plan would not work.

CSS process

94. Record keeping policies in CSS were poorly described and there is insufficient auditing. I frequently saw notes and documents that were incomplete, inaccurate, or filled with irrelevant information.
95. Some case notes lacked even the most rudimentary useful information. It was not uncommon for home visits or other substantive interactions to be summarised in only two or three lines. At other times I read extensively worded case notes that provide little meaningful detail, but provided significant levels of superfluous description (such as describing the weather).
96. Where environmental conditions in a home were noted to be unsafe or unhygienic, it was rare for workers to collect photographic evidence. When asked to describe their concerns, CSO's would generally keep to broad descriptions rather than specifics. It was also rare for workers to evidence that they tried to resolve the concern there and then with the family.
97. Few casenotes reflected a 'product' from the interaction. For example, a case note might describe a prolonged discussion with a family about the child safety concerns, but with no safety plan or agreed next steps arising. Similarly in one-to-one conversations with a child in OOHC, there would be a lack of follow-up activities. It was not uncommon to find casenotes

[redacted]

of interactions that lacked rationale for occurring (that is, why the interaction was occurring in the first place).

98. Case notes documenting home visits or other conversations with family invariably demonstrated a failure to resolve concerns there and then. A common feature of practice in CSS appeared to be treating the family as an abstract issue in a wider assessment. For example, after speaking with parents about concerns, it was not unusual for a worker to comment that they would go away to complete the assessment, as though the assessment needed to be completed before safety issues could be resolved (and effectively dehumanising the family in the process).

99. Case and care planning documents were usually poorly described, with only limited information about the child included. Workers were highly reliant on external agencies to update them on a child's progress, and rarely evidenced seeking out or using the child's perspective.

100. The language and terminology used was jargonistic, and rarely conformed to the type of conversations or language ordinarily used to describe children. There were some set templates available, but this narrowed involvement to rigid interaction and invariability reinforced use of jargon.

101. While I have never come across an example of an outright lie in an affidavit, I have sighted a number of affidavits that provided only partial contextual detail, omitting critical information, which may have given rise to erroneous conclusions and interpretations by the court.

102. There were often discrepancies between the information presented in affidavits and the information recorded on casefiles. These discrepancies were usually where information was contained in an affidavit that appeared to elaborate on a decision or action taken described in casenotes (for example, adding extra reasons or rationale for taking a particular course of action).

103. Workers inconsistently scanned handwritten notes of interactions onto the casefile, even though these would be more contemporaneous than notes written up afterward. There did not appear to be a practice of making this a common action following any interaction with child, family or other stakeholder.

104. Despite low literacy rates in Tasmania, there was an over-reliance on written material provided to families. There was rarely follow-up or confirmation sought with parents about their reading ability. Even when reading ability is known to be low, there was

a tendency by CSS to continue to rely on written documents. Parents were often held responsible for failing to follow written requests, without consideration of writing ability.

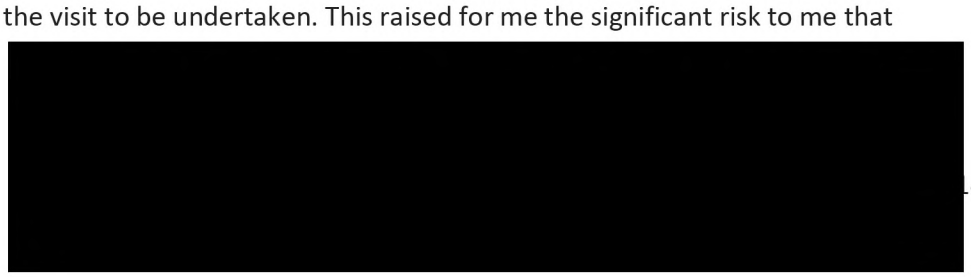
105. Case noting in CSS was very poor in general, with many decisions and actions not recorded, and naming of notes non-descriptive and essentially useless. Case files were difficult to navigate, contain misleading or erroneous information, and typically overstating superfluous detail without analysis. I struggled to trust in the case notes due to the frequent absences of meaningful data. If information was contained that referenced a dangerous individual or risk to a child, it is likely such information would be difficult to find, if documented at all.

106. I have noted that a number of CSO's have reflected on the limited ability to perform meaningful tasks, such as visiting children, due to the burden of paperwork and administrative tasks. However, on reviewing casefiles I found multiple examples of inadequate recording. In some cases an average of only one case file being entered per week or even per month. Many of these case notes were external documents such as school or health reports, taking only a minute of time to enter onto the record. It was thus unclear what work was being undertaken by some workers that limited their ability to undertake direct work with children and families. I saw little evidence of oversight of their work efficiency by team leaders or senior management.

107. Much of the administration appeared to take place on email, which was used extensively for communication, information sharing, and decision-making. However, these emails were often not recorded, or poorly described in casefiles.

108. There was an extreme over-reliance on email chains for making decisions. This is likely influenced by the need to document all steps of a process. However, this could lead to significant delay with even rudimentary decisions taking days or weeks, as the chain continued. There was resistance to holding short, simplified meetings to make and record decisions.

109. In many cases there was no chain of decision-making evident. On some occasions I saw files where significant decisions were made - such as taking a child into care or ceasing a placement - with no documentation to explain how that action came about. A notable trend was for weeks of inaction on a casefile followed by an apparently urgent home visit without any context. To the casual observer this would suggest that workers had spontaneously decided to visit a family, when what would be likely is that a series of events occurred leading to the visit to be undertaken. This raised for me the significant risk to me that



decisions about children were being made with no opportunity for oversight, and led to significant confusion in tracking the actions of CSS in relation to any one child.

110. There appeared to be confusion about who had responsibility for recording documentation of meetings or consultations, particularly if they were unplanned. There appeared to be a general reluctance of team leaders to record notes of decisions they had made, but little action evident on their part to ensure that the decision was recorded.

111. There was little specialised training offered to workers in relation to children who make disclosures of CSA and HSB.

112. It was my experience that the internal training on offer improved over my time at CSS. Training courses became more detailed and analytical, and the standard for some courses was exceptional.

113. I understood that some workers undertook a training course in 2015 called Interviewing Vulnerable Witness Training, offered by the police. The training was designed to aid staff in understanding the process of working alongside the police when forensic interviews were needed. The training was not designed to train staff to undertake the interviews themselves. However, some workers interpreted this training as being appropriately trained to undertake forensic interviews.

114. Following a number of criticisms of CSS in relation to child deaths, a series of compulsory risk assessment training courses were held for all staff. While functional, well-informed and appropriate in themselves, I found it implausible that these short courses would somehow compensate for the significant systemic failings of CSS, or the individual deficiencies of many workers. These appeared to be kneejerk responses to public criticism, and lacked integration into a wider improvement scheme for practice.

115. CSS staff lacked the expertise to manage highly complex matters. Many did not have more than a rudimentary professional education background and internal training was insufficient to meet their needs. Training systems were largely inadequate. Frequently courses were cancelled due to lack of take-up, with workers often pulling out at late notice citing workload pressures. It was uncommon for senior management to motivate or even compel workers to attend training. From time to time, there have been some excellent training courses available, but this is still inhibited by low take up and limited exposure for staff.

116. Specialist advice documentation was also dated, in some cases by decades.

[redacted]

117. Attached to this declaration and marked 'Attachment JD-002' is a copy of a Department of Health and Human Services document titled 'How is Risk of Child Abuse or Neglect Assessed?'

118. Attached to this declaration and marked 'Attachment JD-003' is a copy of CSS specialist advice documentation.

119. There were significant challenges in the way that CSS and the police worked together. In terms of CSA, they were two separate entities with inconsistent levels of communication.

120. If there was a criminal investigation there was a tendency for CSS work to become delayed or cease outright in terms of effective action, with no sound rationale.

121. There was a fear among workers that they would be required to give evidence if the child said anything to them so they did not engage in more meaningful dialogue with children.

122. I observed instances of children not being told why they were in care if the criminal investigation was ongoing. If there were ongoing concerns about a parent still being investigated (for example, where it was unclear if they had abused a child or not), there appeared to be no mechanism to adequately explain why there would be limitations on having contact.

123. CSS workers remained concerned about notifying the perpetrator of any criminal investigation. However, this created problems if the perpetrator was a parent or family member. Children and families could be left in a state of limbo where restoration had not progressed, but they were not told the reason for the lack of progress. There was no coordination, and criminal investigations could take weeks or months with little or no information being shared. While I understood that sensitivity to criminal investigation was important, I have never encountered a system so prone to procedural paralysis.

124. Although a Memorandum of Understanding existed between CSS and police, it was routinely ignored in principle, as criminal matters always took precedence regardless of the issues of safety. Often, the criminal matters were immaterial to the long-term safety of the children.

125. Through past experience, I am aware that in Western Australia there is a joint unit where police and child protection work together, called ChildFirst. It is a specialised unit that shares the burden of complex investigations relating to CSA. They also have specialist knowledge when it comes to child sexual abuse and provide support to the local child

[redacted]

protection teams. While this system had some limitations, it provided significant strengths in managing complex assessments, particularly where CSA was involved.

Placement decisions

126. There were two basic types of placement; kinship (generally family) and non-kinship (extra familial, general foster care and external agency). Placement decisions were primarily decided on the basis of availability. Family was usually considered preferable, but families with extensive involvement with CSS posed greater challenges for safe assessment and could sometimes be dismissed out of hand.

127. There was a reluctance to make in depth enquiry about a parent if they had been separated from the child for a significant period. It was not uncommon for workers to comment on the lack of availability of the parent, or described them as being 'out of the picture', when it became apparent through further questioning that the parent's location was known. It was my experience that many opportunities to find safe parents and facilitate an effective restoration of the child to a safe parent was missed, due to the reluctance to rescind a care and protection order.

128. Decisions about placement were in theory made in a consultative process between the allocated team and the OOHC team. However, in practice the limitations on placement options placed significant pressures on the relationship between these teams. Furthermore, there appeared to be a high expectation that the OOHC team was primarily an extension for the Response and/or Case Management teams to undertake work, rather than a service provision for carers.

129. The principle problem with OOHC placements was that children were placed with providers who struggled to manage children with significant trauma and behaviour issues on a day-to-day basis. Many children going into care came from significant trauma backgrounds. The range of behaviours they exhibited required special care package applications since their needs were too great for conventional foster caring and/or kinship care. Unfortunately, the special care package options were routinely limited, with many providers incapable of providing this care.

130. Placement options for children in OOHC were often limited. There was often only one placement option available to a child and this would be given as a 'take it or leave it' option. There was a clear working assumption that the option provided by the state was is safe, but this was not always the case. There may have been unresolved risks relating to the carer or other children at the placement, and the child would be rarely asked what concerns

they might have about any placement offered. When only one option was given, the child then had a choice to go to that place where they may not feel safe or do something that was within their choice and control.

131. This situation presented the phenomenon of 'self-selection'. Self-selection is a term used widely in child protection to describe a child that has refused any placement option, and instead sought alternative place of residence of their own volition. In my experience it is typically used as a form of victim-blaming, exonerating child protection from responsibility for finding safe placements for children under their care. Even children without stable or safe accommodation (essentially homeless in many respects) are described as self-selecting, even though the burden of providing safe accommodation lies with child protection.

132. It is difficult to quantify how often self-selection occurs because it is not used in a formal description, but it is not a rare occurrence.

133. When I worked at CSS a summary of children in care details was sent monthly that provided details of every young person in care, including their placement type. This information was very useful, but I did not see evidence that there was successful interrogation of this data for managing practice issues or monitoring trends in each regions.

134. I am not aware of an instance where siblings have been kept together in a placement at any cost. However, I am equally unaware of any specific process or procedure that might be applicable to preventing this. Placement availability is the likely decider, with an emphasis on safety planning to manage any risks.

135. The primary concern in these situations is the lack of contact with a child in OOHC to properly ascertain their safety or transition into the care system. It is not uncommon for CSO's to visit carers, sight the child, but not engage with the child during the visit. Case notes, when completed to any meaningful degree, consistently record conversations about the child taking place in front of them, but without proper engagement or inclusion.

136. My interaction with staff at Ashley Youth Detention Centre (AYDC) was limited. This was partly due to a colleague being the principle consultant between CSS and Youth Justice. However, I also felt that my limited role was due to a poor perception that a child incarcerated in AYDC was not the primary responsibility of CSS, even when under care and protection orders.

137. There was no doubt in my mind that AYDC was often seen by CSS staff as a de-facto placement option. It was felt that incarceration often solved problems once a child was in AYDC. This was principally on the basis that children couldn't leave AYDC and there were other people responsible for them (rather than CSS). Because of this, workers were happy

[redacted]

for children to go to AYDC. This attitude was partly driven by workload, but primarily by the sense that the responsibility of carrying risk for the child was relinquished.

Workforce issues

138. Child Safety Officers were employed through an online recruitment process via the Tasmanian Government Jobs website. This usually involves a process of application, interview and background checks (including references).

139. The essential requirements included a Bachelor of Social Work or a Diploma of Community Welfare Work or other tertiary qualifications at Diploma or above level which includes units of case management/casework practice and supervised practical work placements in relevant fields.

140. Attached to this declaration and marked 'Attachment JD-004' is a copy of the Department of Communities Statement of Duties for generic Child Safety Officer.

141. I have met Child Safety Officers who do not appear to hold these qualifications, or it has not been clear what qualifications they hold.

142. The trade unions play little role in directly resolving or preventing CSA and HSB. However, I have observed that union representatives were easily manipulated by a small cohort of workers, whose personal perspectives (and questionable professional practices) directed union understanding of matters. This was particularly the case for HACSU, the primary representation in the [redacted]. They seemed more focused on protecting problematic workers (who were also workplace representatives) than supporting workers/members subject to unprofessional behaviour.

143. I have never been able to discern a working system for reporting misconduct or concern about staff behaviour. There was a policy, but the means of effective enforcement was not evident. Most generally, when faced with concerns, I reported to the relevant staff members' senior manager. I rarely approached a team leader, since I perceived them to be disempowered, or ineffectual, when it came to managing staff on their teams.

144. Human resources would be routinely involved for serious matters, but my perception was that their responses was that they were slow to address serious issues (such as those I record further below). Fear of union involvement was a significant factor, inhibiting the ability of senior figures to properly address poor performance or highly risky behaviour.

[redacted]

145. Anecdotal information I received reported that in meetings involving external union representatives where concerns about staff were being discussed, the union representatives would engage in aggressive behaviour.

146. While this structure exists for reporting staff misconduct, my personal experience of reporting concerning staff behaviour has not been positive. I have provided some specific examples of this later in my statement.

Cultural issues

147. There were significant issues around the treatment of Aboriginal and Torres Strait Islander (First Nation) children, who were over represented in custody and in OOHC. There seemed to be less institutional awareness of issues for First Nation families and numerous comments, interactions and decisions demonstrated to me that the child protection system in lutruwita/Tasmania is institutionally racist.

148. Children in OOHC previously did not always have their First Nation status identified. After I raised this concern there was significant improvement in the completion of records. However, I was perplexed how court proceedings could progress without the cultural status of the child being identified. It was quite evident that workers would deliberately avoid confirming First Nation status.

149. There was a view that identifying a family as First Nation required excessive amounts of paperwork. Being recognised as a First Nation person was considered a problem as it created extra work and responsibilities.

150. For some workers it was easier to not ask the question about First Nation status or rely solely on the Tasmanian Aboriginal Centre (TAC). If the TAC did not recognise the family, this was treated as the end of the matter, even though it was known that there were competing opinions about the sole use of the TAC to make these determinations.

151. It was a widely held view that there were significant disputes between the TAC for [redacted] region and [redacted] region, to the point that they did not cooperate. This had the knock-on impact of undermining CSO trust in the TAC to operate sufficiently. However, this dispute was purely anecdotal, and it was unclear whether a historic issue had become an attitude of convenience by CSS to justify a lack of consultation.

152. It is also an issue that the system has a base assumption that a child and/or adult is white, and proof is needed to be considered First Nation. First Nation families are required to submit to a process of recognition, meeting a defined criterion to be acknowledged as First Nation. While I am not familiar with the history behind this process, it has become

[redacted]

evident to me that CSS routinely use this process as a way to avoid recognising First Nation cultural identity.

153. First Nation identity was frequently treated as a problem in itself, coded in terms such as 'intergenerational trauma'. This had the convenience of being unresolvable, thus justifying excessive intervention or, conversely, lack of confirmation of cultural identity (reinforcing the binary over-reaction versus inaction).

154. The placement principle was treated as an inconvenience, rather than a critical necessity or positive opportunity to engage with families and communities.

155. There was poor cultural competency within CSS, and I never felt it to be a safe organisation for First Nation families.

156. I am not aware of a specific instance of First Nation children being placed with family purely on the basis of cultural appropriateness, even if CSA was suspected or present in the home. In my experience, using culture as rationale for maintaining an unsafe placement is applied after the fact. The primary cause of children being left in unsafe placements is poor risk assessment and decision-making. Using culture as an explanation is used to justify poor decisions. This is indicative of the institutional racism in child protection, and arguably a form of victim-blaming, holding First Nation families responsible for any harm caused on account of their culture, rather than the faulty assessment processes of the child protection system.

Unprofessional conduct by CSS staff

157. I was concerned about the unprofessional conduct of a small but influential group of child protection practitioners. One of these practitioners is Kirk [redacted] who is employed as a Child Safety Officer (CSO) in [redacted] Tasmania.

158. Kirk [redacted] had a reputation of aggression and intimidation. He was well known for accessing unrelated casefiles and criticising colleagues, usually through the medium of lengthy emails.

159. I was subject to these emails. They were characterised by extensive criticism, often going into many paragraphs. It was clear he had examined the casefile of particular families in detail, even though they were not allocated to him.

160. As Acting Assistant Manager of CSS in 2019, I issued a direction about drug testing. The direction was that staff would have to evidence justification for requesting a drug test from a parent. [redacted]

161. I issued this direction because there was an excessive over use of the drug-testing process, but with little applicability to child safety. It appeared to be used primarily to reinforce negative perceptions about parents, rather than safely manage issues of addiction and any impact on the safety of the child.

162. This was widely interpreted by staff as an instruction that no drug testing should occur.

163. Kirk had a strong reaction and sent me a lengthy email criticising the instruction.

164. I asked to have a meeting with him to discuss my decision, which was also attended by his Team Leader. I refused to acknowledge the specifics of the email, since I did not wish to justify the email being sent in the manner that it had been. However, I invited Kirk Kirk to explain his concerns, even though I found his arguments unpersuasive. In the course of the discussion, Kirk was unwilling to accept the instruction and became agitated. He stood with fists clenched and made a noise that I can only describe as a snarl or growl, before pausing temporarily and then leaving the room. I believe that the pause was a calculation on his part of whether to progress with further violence or not, indicative to me of deliberate intent.

165. I felt physically threatened. This was the first time I had felt this threatened by a colleague in my professional career.

166. His Team Leader confirmed that this was typical of his behaviour.

167. I reported his behaviour but was not aware of any follow-up or repercussions for Kirk It became quite apparent to me that, for staff at the region office, this type of behaviour was normalised.

168. Suitable repercussions would have been potentially suspension or at the very least performance management. Neither of these things occurred.

169. I do note that Kirk sent an email after the incident apologising. I found the apology to be unconvincing, because while being unprompted, it conveyed a sense of 'both sides' argument, and failed to account for the violence implications of his behaviour (including for both me and the Team Leader as potential victims).

170. On one occasion Kirk distributed copies of an assessment guide that he had authored to colleagues. The guide was lengthy, and appeared to represent his views on how to undertake an effective assessment and investigation. My professional view of the document was that it contained little in the way of functional analysis, was highly subjective, and was contrary to established practice and procedure.

171. I raised concerns about the guide being distributed, as I believed it would send confusing signals to staff, and also undermine the role of senior positions including Team Leaders, Managers and CPCE's.

172. After raising concerns the senior management issued an instruction to staff that had received a copy to hand back the copy. However, no instruction was given to [redacted] to cease distributing the book. I felt certain that the lack of action against [redacted] was due to a fear of retaliation or conflict arising, and that it was considered easier to target staff rather than risk conflict with him.

173. I am also aware of significant boundary breaches involving [redacted] In late 2020, I was asked to consult on a matter for a group of four siblings. I would prefer not to name these children in my statement so will refer to them collectively as CH1. CH1 included [redacted] The children were all victims of sexual abuse and the family were what I would describe as 'high profile' in the department, with an extensive history of involvement. It was my understanding that the children had previously disclosed CSA but been left to reside with the perpetrator of the abuse, leading to further CSA.

174. [redacted] had previously been the allocated worker for CH1 prior to my involvement.

175. During my consult and involvement, I became aware that [redacted] had separately taken two of the CH1 girls to his home. It was referenced in their case files and occurred in 2020. The case files stated that [redacted] took the children to his home unaccompanied, however there was no substantive details of the time they spent there. [redacted] justification for taking the children to his home was that people were looking at them in a public place and to show the children his dogs.

176. I could see no evidence that this action had been approved, or that his actions were acknowledged by senior management. There was nothing on the case file to show that the children had been spoken to independently about the visit to his home.

177. It was also reported to me by other staff that [redacted] had an evening meal with a relative of CH1 who had travelled from another state, with his spouse present. This occurred after he was no longer the allocated worker for CH1. To my knowledge, there was no prior relationship between [redacted] and the family beyond his professional involvement. There was no record of permission being given or the meeting being in the context of supporting the children. There is no professional standard that I am aware of that would permit such action to take place.

[redacted]

178. I reported my concerns to my supervising manager. They informed me that there was ongoing work being undertaken by human resources and senior management in respect of Kirk and that I should not "assume that things aren't happening". However, I was unclear on whether this applied to my specific concerns or other issues. I did not persist with my concerns due partly to my belief that progressing concerns would not lead to anything, and also because of the Commission of Inquiry.

179. My understanding is that the manager of the region had full awareness that this had occurred. I am not sure if it was passed on to the Director of the Department. I am aware that Kirk received a letter expressing concerns about his conduct, but I am not aware of specifically what aspects of conduct, and whether there was any other departmental response.

180. I reflected on how this might be perceived in the abstract, if I had received a report that a lone male worker was inviting victims of CSA back to his home to see his dog, or taking them unsupervised , and furthermore having meals with family members outside of any working arrangement. In any normal circumstance this would raised serious concerns - 'red flags' - requiring further investigation.

181. I have been told by other staff that Kirk has previously had sole contact with children he is involved with, taking them to the cinema unaccompanied. This type of behaviour is commonly spoken about amongst staff.

182. While it is important to note that workers frequently have sole contact with children, especially those in care, this is undertaken with a level of oversight and in keeping with agreed case decisions through processes such as supervision.

183. There is no doubt that Kirk feels like he has permission to do these things. He obtains tacit permission without providing the full facts. It is my belief that staff, including managers, were intimidated by him. My understanding is that this partly arose out of historic behaviours, where senior staff used to work on the same team as him, and had been exposed to aggression for a consistent period.

184. I believe this to be emblematic of the permissive nature of the Department, particularly CSS, in that staff make egregious and serious breaches of any ethical standard, but receive no effective consequences. Furthermore, there is a failure to uphold standards in general. I suspect many workers would not comprehend the concerns arising from such behaviour, or feel empowered to act on any concerns.

185. In my opinion Kirk [redacted] needs to be performance managed but I never saw any effective sign that this process was used. There needs to be a system that holds him accountable, a professional board that he can be reported to.

186. I observed a significant problem with alcohol use by CSS staff in the [redacted] region, extending to a culture of drinking and workers consuming alcohol during working hours. This problem was exacerbated by a faulty and permissive policy on alcohol (which, at time of resignation, was in draft form only). It was not unusual for groups of workers to attend local pubs during working hours, sometimes for hours at a time, consuming alcohol. They would return to work and resume their duties. I observed workers operating clearly under the influence of alcohol. There were frequent references to some workers being at work smelling of alcohol, which I too experienced. There was no clear action taking place to monitor if these workers were undertaking visits in government vehicles, contacting children or even transporting children. There was no recognition of the implications of workers potentially making critical decisions about children under the influence of alcohol (which is known to affect cognitive functioning).

187. I did report concerns to senior management about individuals consuming alcohol during working hours. On one occasion in 2017 or 2018, I reported concerns that a particular CSO was regularly visiting a local pub for lunch, consuming alcohol and returning to work. Rather than be admonished, the CSO was asked to approach me about my concerns. This led to a highly challenging confrontation in my office, where the CSO repeatedly highlighted policy as not simply allowing him to drink, but also actively promoting it.

188. I was concerned that rather than face operational-level consideration through supervision processes and performance management, the CSO was instead allowed to challenge me as the person raising the concern. Furthermore, this was encouraged by senior management at the region office. The implication is that in raising concerns staff will be confronted by the person they were concerned about, and subject to bullying and harassment as a result.

189. Drug use was also an issue, with two CSS staff openly using cannabis in a laneway outside the rear of the [redacted] office building. The drug use was linked to significant personal issues the staff members were facing. While those issues were regrettable, this behaviour was consistent and in the open, clearly known by senior management. My experience when reporting the CSO describe above for drinking reduced my willingness to report concerns about this drug use.

[redacted]

[redacted]

190. Mental health was a significant problem at the CSS [redacted] office. I observed clear signs of mental illness and trauma, including workers being in tears about mistreatment by those in senior positions or colleagues, workers self-harming, and prolonged absence from work.

191. On one occasion, during work hours, a worker indicated they might suicide. The concern from colleagues was significant enough to respond immediately; the worker was not in the office at the time, but close by and this was during the working day.

192. Staff were regularly exposed to emotional abuse by various adults/clients, usually verbally. Some were threatened, sometimes with physical harm and use of weapons (including firearms). One staff member had to change address due to a plausible threat to their safety. The general response of CSS was that this sort of behaviour should be anticipated and expected as being part of the job, a scenario I completely refused to accept.

193. There was generally a passive use of the Employee Assistance Program as a means of helping staff (that is, offering the service, but with little proactive support). Managing vicarious trauma was generally left to individual staff members.

194. I was informed anecdotally of an incident where a worker, identified as suffering from significant mental health challenges, had a serious episode resulting in them climbing under their desk and remaining there for a number of hours. There was no indication of external support being sought (such as calling an ambulance). I found the story plausible and believable.

195. Social work, and by extension child protection, is widely considered as one of the most stressful occupations in the world. The presence of mental health issues in this profession, such as anxiety, depression, and addiction, is not unique to lutruwita/Tasmania. The inference I make is that not all situations described here, or experienced by under-resourced and over-worked staff, should be judged through the prism of what is considered appropriate or inappropriate conduct. I report these concerns to draw attention to the passive and generally unresponsive position of CSS and the wider Department of Communities, being unable to sort behaviours arising from genuine mental health concerns and vicarious trauma, from unprofessional conduct, and furthermore being unwilling to engage more effectively to support staff.

Risk Assessment and Child Sexual Exploitation

196. Risk assessment processes in CSS are very poor and of a low standard. [redacted]

197. There was an observable lack of specialism or proficiency in risk assessments. Workers most proficient in assessment process and ethical practice tended to be the most minimised in terms of effectiveness, while highly problematic workers had the most sway and, most worryingly, were seen as role-models for effective practice. The Team Leader/worker relationship was very poor, with poor leadership, motivational and decision-making processes actively inhibiting effective practice.

198. Typically, risk assessment focused on a simplification of concerns, rather than a specific context. For example, workers might talk to parents about concerns relating to neglect, but not specify what the neglect looks like or the impact on the child. This also had ramifications for outcomes. For example, where CSA occurred, there was lack of emphasis on the specific dimensions of the abuse, focusing rather on the fact that CSA had occurred (thus diminishing the individual experience of the child).

199. Furthermore, there was a lack of critical assessment in understanding the factors affecting a family circumstance. For example, a family might be considered to be at risk on account of limited access to food and difficulties paying rent, but no consideration of the limited access to payments and allowances through agencies such as Centrelink. The expectation of a family on a low income to be self-sufficient was equal to a family on a much higher income.

200. I observed risk assessment being prone to significant bias and what I would interpret as a moralising judgement. They lacked an evidentiary format, being subject to significant assumptions, or failure to clarify critical details. There was a general inability to critically analyse data.

201. There was clearly a derogatory attitude towards non-offending parents when they were female. This was particularly the case for family domestic violence. There was considerable focus on the mother of children 'doing the right thing', without consideration of the risks associated with seeking to escape violence (such as escalation of violence).

202. Risk assessment tended to cease when a perceived perpetrator was incarcerated. Workers had a belief that no work could be undertaken to manage safety when the perpetrator was not present in the home. This led to recommendations to undertake no work, or cease involvement with the family and await re-referral on release of the suspected perpetrator.

203. While this behaviour is most notable for family domestic violence, I saw nothing that would satisfy me that this would not occur for incidences of CSA. There was a simplistic belief that non-offending parents (usually the mother of the child) must take appropriate

[redacted]

action, as though these considerations were independent of other influences (such as violence or grooming). There was an unwillingness to engage in prolonged, patient work with non-abusing parents, to help them overcome barriers to providing a more secure, safe environment for their children.

204. There was a definite aversion to working with safe parents to enhance or strengthen safety in families. This aversion increased for domestic violence, parents with disabilities, and for First Nation families.

205. Many interactions with families were characterised by significant history of involvement but without effective long term stability being established. This led to serious situations developing into major crises, increasing pressure on workers, and the likelihood of requiring care orders.

206. One example relates to a teenage girl who I shall refer to as TG1. I had concerns about the rationale for her coming into care. TG1 had exhibited significant behavioural difficulties, including acts of violence against family members. TG1's [redacted] had been repeatedly asking for help by CSS but this was ignored, culminating in a crisis situation which led to no other meaningful option except to initiate care proceedings. TG1 situation in care went from one extreme to another and she started exhibiting concerning behaviours.

207. In examining TG1's background history I found compelling evidence suggesting she may have been sexually harmed before coming into care. This evidence included reports of her being gone from home for long hours, frequenting an area with adult males and having clothes bought for her by unknown adults. I advised that further investigation should be made about the potential for sexual harm having occurred, but no action was taken.

208. It was viewed that TG1 was the problem in terms of her behaviours, not a potential victim. This was further exacerbated by an unsatisfactory placement process, in which she was placed in an intensive care placement, requiring 2-1 supervision at all times. Staff from the placement agency appeared to be untrained in managing traumatised behaviours and lacked the ability to confidently look after the child. At one point, various staff members from CSS, including executive officers, were undertaking placement duties to care for the child, which resulted in police call outs. There was no coherent safety management plan for TG1.

209. CSS demonstrated a limited ability to manage complex networks of offenders, notably sexual offenders targeting children. There was no mechanism to manage social media being used to target children, including those in care. The police had little involvement if no criminal activity explicitly took place.

[redacted]

210. There was no capacity for undertaking complex assessments for CSA where there were multiple abusers.

211. The principle decision-making body for making decisions about whether to seek or renew orders was called the Court Application Advisory Group (CAAG). This group was expansive, consisting of the Manager, Assistant Manager, CPCE's, Team Leaders and other associated officer positions.

212. The CAAG was designed to discuss potential applications for court orders. It was further developed to include wider consideration of matters that were complex or high risk for court proceedings if nothing changed.

213. Workers were often worried about attending the CAAG to make a recommendation.

214. It was my observation that the CAAG poorly organised in terms of critical practice discussion. Attendees were highly reliant on the veracity of the attending worker and their team leader. There was practically no opportunity to significantly interrogate case files.

215. The CAAG was subject to inherited bias, in that some senior workers had historic involvement with families and took on their experiences as being contemporary fact, rather than historical context.

216. The CAAG was also subject to a form of groupthink, in which recommendations were frequently considered with little critical perspective. I found it difficult to provide alternative perspective, particularly in questioning whether alternatives existed to seeking care orders. The size of the group inhibited effective discussion, with too many participants.

217. As previously identified, decision-making tended to swing between extremes of inaction and over-reaction. I saw no evidence of a high threshold for the removal of children (e.g. rape of a child). I saw many instances where potential avenues for building safety were ignored, in favour of bringing children into care. Conversely, I saw many instances where gaps in safety were ignored, and assessment ceased to progress.

What could be improved?

218. There is a widespread failure to understand the very real risks to children posed by the systemic failures of the child safety system. CSO's operating in this space were occupied by risk-aversion, seeking the swiftest way to insulate themselves from blame. This leads to polarisation of outcomes. Children were either processed through the care system too swiftly, and uncritically, or were left ignored for months at a time. While there were micro-

[redacted]

organisational issues, particularly around time-keeping and basic day-to-day organisation, these issues were primarily systemic.

219. I believe that CSS has failed as an operational part of the child safety system, and that it should be broken up and decentralised. Primary focus can be embedded in communities, with smaller teams of workers operating out of community, health and family centres. This includes in more remote clusters of small population areas, to maximise consistent presence, and minimise the arm's length approach that currently characterises CSS involvement.

220. These smaller community teams could be more focused on broad-based support for families, and completing early intervention work. They could also undertake more localised work with children in care and carers.

221. For more remote communities, there are similar systems in larger states such as Western Australia, that use Community Child Protection Workers directly embedded in remote communities. While lutruwita/Tasmania does not have the same geographic size, there is sufficient presence of smaller communities to warrant a localised service.

222. There needs to be a fragmentation of the assessment process, where criminal or complex child safety matters exist. In these instances, a specialised multi-agency team should be used to conduct the investigation. This would leave broader based child safety issues, and opportunities for non-intensive investigation, to be undertaken by localised teams. I look to examples such as Western Australia, which utilises the ChildFirst approach to serious investigations.

223. Separate legal processes teams could be formed to manage matters progressing through the court process. This would free up workers from extended and time consuming court processes, allowing them to prioritise working with families. I believe that Queensland has such a system.

224. The issue of a lack of professionalism and ethics go hand in hand. Many good workers were employed by Children, Youth and Families (CYF), and some operate at a high-level of aptitude despite having minimal qualification. However, CYF lacks the consistency of standard to provide a satisfactory service to keep children safe, and support families. Cost may be factor in inhibiting professionalisation, but I would argue that restraints on spending have led to this very problem, and that the outcome (rising children in care for example) adds further long term costs that effectively obliterate any short term saving made. It is, in other words, better to spend money to save money in the long run.

[redacted]

225. The basic standard of CSO's should be raised to require a Social Work degree, granting eligibility to join the AASW. While some states (such as WA) operate a 'Specified Calling' system, I believe that only a professional standard of social work would be sufficient to resolve the dearth of expertise in the child safety system. This debate is an extensive one in different states, and subject to some professional controversy, but everything in my experience has led me to the conclusion that there needs to be a cementing of professional standard and social work qualification is the best means to deliver this.

226. There may be shortages of social worker availability. This could be mitigated by supporting a bursary system for students, promoting uptake of social work degrees by paying for fees and providing bursary/grant support to encourage take-up. This has been undertaken in the UK.

227. All social workers should become members of the AASW, with the associations' code of practice as the professional standard for CSS. At the very least, a fully defined Code of Practice should be created for operational staff within CSS, and preferably the wider Children and Youth Services.

228. Delivery of child safety should be localised, with teams delegated more to outlying regional areas rather than centralising their presence. This would allow for building stronger community relationships. CSO's could be appointed to family centres directly, working with other family support services in communities (including more urban ones), helping to bridge gaps of understanding and miscommunication.

229. There needs to be an assertive effort to employ Aboriginal officers and examine with Aboriginal communities (beyond organisations) ways to develop service delivery that is culturally sensitive and appropriate.

230. I believe that CSS requires a cultural audit to be undertaken to establish necessary courses of action to resolve the institutional racism within the child safety system. Such an audit was completed in Western Australia in 2019.

231. Everything I have seen in my practice has told me that there is no way to rationalise legislation principally developed by white people that is clearly implemented against Aboriginal people. I would recommend nothing less than a separate process for managing child safety issues where Aboriginality is identified, possibly including a separate service. This may be beyond the scope of this inquiry, but I see no other recourse to manage the systemic issues and what is institutional racism.

232. The policies and procedures of CSS need significant updating and improvement. There is limited capacity within the policy sphere for updated and relevant expert research

to be used to inform practice standards. I would recommend an independent panel of experts to review research on a regular basis, and make recommendations for updating procedures.

233. There needs to be a massive review of OOHC provisions, particularly the standards of 'specialised' services. Placements into institutional care needs to be subject to an independent review process.

234. The use of alcohol in working hours should be banned for workers that have direct involvement with children.

235. On-hand therapeutic support should be available for all workers in CSS. One such model to use would be Mental Health First Aid. Furthermore, a review of safety measures for staff to protect against vicarious trauma needs to be undertaken.

I make this solemn declaration under the *Oaths Act 2001* (Tas).

Declared at [redacted] in the State of Tasmania

On 3 June 2022

[redacted]

Jack DAVENPORT

Before me:

[redacted]

[Full name of Justice, Commissioner for Declarations or Authorised Person]