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

WITNESS STATEMENT OF SONYA DEVEREUX ENKELMANN

I, Sonya Devereux Enkelmann of [redacted], do solemnly and sincerely declare that:

1 I make this statement in a personal capacity in respect of my experience as a Project Manager for Out of Home Care Reform within the Department of Communities.

2 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.

BACKGROUND, QUALIFICATIONS AND ROLE

3 I hold the following qualifications:

(a) Social Work Qualifying Master degree, Flinders University, 2021

(b) Graduate Certificate in Management, University of Tasmania, 2001

(c) Honours in Government, University of Queensland, 1995

(d) Bachelor of Arts Degree, University of Queensland 1993

4 I am presently employed as a Therapeutic Specialist at Sexual Assault Support Service (**SASS**). I commenced in this role in May, 2021. Prior to commencing formal employment, I worked with SASS as a student social worker for a period of nine months, from August 2020 to May 2021.

5 In my role at SASS, I provide therapeutic services to young people (aged 16 years and above) and adults who have experienced sexual abuse and sexual harm. This work is governed by the needs of the victim-survivor and may involve brief intervention, long term counselling, or supporting the victim-survivor to make a police statement. I also regularly work as an intake worker. This work involves taking referrals and providing crisis support for victim-survivors or family members. I may also accompany individuals to attend a forensic medical examination or to make a police statement.

6 Prior to my appointment at SASS, my work roles included:

(a) Operations Manager, Save the Children Tasmania (2020-2021)

(b) Project Manager, Out of Home Care Reform - Department of Communities Tasmania (**Department**) (2017 to 2020)

(c) Full time study (Social Work Qualifying Masters Degree (2016-2017)

(d) Manager, Counselling and Community Services South – Relationships Australia (2014 to 2015)

(e) Deputy Regional Director – Tasmanian Government Department of Prime Minister and Cabinet (2013 to 2014)

(f) Team Leader (Account Coordinator and Indigenous Employment) Manager, – Department of Education Employment and Workplace Relations Tasmania (2006 to 2013) and

(g) Deputy State Manager, Tasmania State Office, AusIndustry (2001-2006).

ROLE WITHIN THE DEPARTMENT OF COMMUNITIES

7 I was the Project Manager for Out of Home Care (**OOHC**) reform (known as the *Out of Home Care Foundations project)* for three years, from 2017-2020. I worked across the OOHC sector with people who held different perspectives and levels of understanding. My approach sought to bring together research literature with the lived experience of children and young people and carers, and the practice wisdom of those working within the system. In doing so, I sought to build a common understanding of issues, explore options and solutions and build consensus for a way forward.

8 By virtue of the consultation and co-design processes in which I was involved and implemented during my role, I collaborated and worked directly with children and young people, foster and kinship carers, OOHC workers, service providers and those working in roles such as quality assurance, practice and policy. It afforded me a privileged position to observe and learn from those within the OOHC system.

9 While I worked closely with Child Safety Services (**CSS**) and Children and Youth Services (**CYS**), my role was independent of both organisations. I believe this separation provided for many in the sector a sense of safety in sharing their views. It is from this background that I draw my understanding of the nature and efficacy of the OOHC system as a whole and processes within the system.

10 I feel able to speak to some of the systemic issues which characterised OOHC in Tasmania up until my departure in May 2020. I have not worked for the Department since 2020. However, my professional interest in and interactions with stakeholders and contacts within the OOHC sector suggest that many systemic issues within the OOHC system in Tasmania persist.

11 My comments as outlined in this statement are not directed at individual children and young people, carers and workers for whom I hold the utmost respect and compassion. Many children and young people heal and thrive, due in no small part to their own

extraordinary resilience and determination, and the commitment of those who care for them. This includes staff working in CSS, our service providers, our foster and kinship carers, and those supporting the OOHC system. My comments are instead directed at the OOHC system as a whole. I am making this statement because I feel a responsibility to the children and young people, carers, workers and others who entrusted me with their stories and experiences.

12 My sense is that the OOHC system is at best dysfunctional. It can also be an abusive system, capable of causing harm and trauma in its own right. Situated in the broader Child Safety system, it is perceived by many within the sector as a closed, defensive system, its approach crisis-driven and reactive. It is extremely difficult for those outside of the Department to gain information on how CSS and OOHC operate or even its structure. I found there existed a culture of distrust by many children and young people, carers and its own workers towards the Department.

13 I listened with great sadness to the harm experienced by children and young people in OOHC, but also by carers and workers. People who wanted to care for these children sometimes ended up harmed themselves through burn out, vicarious trauma and overwhelming stress. There are too many good people - capable, hardworking and intelligent workers and carers - who have been harmed by the system in which they work or give their time. This harm continues. While I was prepared for frustration and anger by carers and workers, I was not prepared for the extent of trauma and harm inflicted by a system meant to prevent it. These are people who at least have some voice; too often children and young people in OOHC do not.

14 I was employed by the Department as Project Manager of the *Out of Home Care Foundations Project*. I undertook this project between 2017 until my departure in 2020. I am unaware of the status of this project. As the Project Manager, I was responsible for three key pieces of work:

(a) the development of an Outcomes Framework for OOHC (**OOHC Framework**). The Outcomes Framework identified 11 wellbeing outcomes for children and young people. These wellbeing outcomes were mapped across six domains consistent with the Tasmanian Child and Youth Wellbeing Framework.[1] Co-designed with children and young people with a care experience, the Outcomes Framework was intended to inform and drive development of policy, procedures and practice. While the Outcomes Framework was released by the Minister in 2018, it does not seem available on the Department's website. A

[1] Department of Health & Human Services (2018), 'Tasmanian Child and Youth Wellbeing Framework' (Hobart: Tasmanian Government).

copy of this document, titled "Outcomes Framework for Children and Young People in Out of Home Care Tasmania" and dated October 2018 is annexed to this statement and marked SE-1. A Companion Document to the Outcomes Framework, was also developed to establish indicators, benchmarks and reporting processes to monitor and report on progress against the Outcomes Framework. Over time, reporting on wellbeing outcomes would identify areas working well and those requiring improvement. This work was undertaken with a working group from Children and Youth Services before going out to consultation with the OOHC sector. A fundamental principle underpinning the Companion Document was to establish a base line for reporting while allowing for its ongoing development, most notably to include data which reflected the experience of children and young people in OOHC (such as the approach being developed by the Child Advocate, see paragraph 87). I am unaware of the status of the Companion Document;

(b) the development of a model for Family-Based Care. The phrase family-based care was use to include both foster care and kinship care. This work included developing and releasing a Discussion Paper, itself informed by consultation with children and young people with a care experience, foster and kinship carers, workers, policy officers and service providers. Organisations such as the Create Foundation, the Foster and Kinship Association of Tasmania, service providers and the Department assisted in this process. I also convened two working groups: one a cross-sectoral working group with representatives from CYS and service providers; and the second, a working group comprising Departmental OOHC workers. The release of the Discussion Paper was followed by intensive workshops around Tasmania through the latter part of 2018 and receipt of approximately 15 written submissions. A copy of this document, titled "Discussion Paper Series: A Future Program for Family Based Care Out of Home Care Foundations Project" and dated October 2018 is annexed to this statement and marked **SE-2**. While it was released by the Government it does not seem available on the Department's website. A Summary Paper on the Consultation Process was prepared to summarise feedback from the consultation forums and submissions. It supported extensive work with CYS during 2019 to develop the Model for Family-Based Care. While it was intended for public release, I am unaware of the status of the Summary Paper on Consultation Process. Nor am I aware of the status of the Model for Family-Based Care; and

(c) the drafting of OOHC standards and a draft Quality and Continuous Improvement Framework for OOHC. The Quality and Continuous Improvement Framework sought to identify the standards and processes necessary to deliver a robust, responsive OOHC system that is contemporary and sustainable, and which will underpin quality services. Draft OOHC standards were initially developed with a small working group comprising experienced personnel with a background in policy, quality assurance and child advocacy. These draft OOHC Standards and the draft Quality and Continuous Framework were further developed with CYS in 2019 but neither were approved for release for consultation with the sector. Since then, the OOHC standards have been re-drafted but I am unaware of the current status of those standards. I am also unaware of the status of the Draft Quality and *Continuous Improvement Framework*.

OVERVIEW OF SYSTEMIC ISSUES IN THE OOHC SYSTEM IN TASMANIA

15 Organisations such as Stop It Now and Berry Street note that children who have a history of abuse, who lack trusting and safe relationships with adults, who have low self-worth or feel emotionally isolated are at higher risk for child sexual exploitation and grooming or child sexual abuse.[2]

16 I hold grave concerns about the capacity of the OOHC system in Tasmania to protect children and young people from sexual abuse while in OOHC or to reduce their risk of harm from sexual abuse once they leave care. In short this was because the OOHC system in Tasmania:

(a) too often failed to address the vulnerabilities of children and young people when they entered OOHC, and may have, due to systemic weaknesses within OOHC, exacerbated these vulnerabilities; and

(b) was poorly placed to know how many children experienced child sexual abuse prior to or during their time in OOHC. This was due to a combination of factors including poor oversight of OOHC but also – for some children and young people – a lack of healthy, trusting relationships with adults necessary to notice if children and young people were being groomed or to enable them to disclose sexual abuse.

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[2] Stop It Now, 'Understanding What Makes Kids Vulnerable to Being Sexually Abused' https://www.stopitnow.org/ohc-content/understanding-what-makes-kids-vulnerable-to-being-sexually-abused; Berry Street, 'Grooming and child sexual exploitation', https://www.berrystreet.org.au/learning-and-resources/fact-sheets/grooming-and-child-sexual-exploitation.

17 It is my view that the Department was unlikely to know the full extent of harm, including sexual abuse, experienced by many children or young people when they first entered care. While some children may have come to the attention of CSS because of their history of child sexual abuse (for example through police investigations), there may have been other victim-survivors. Factors such as a child's young age, level of disability, capacity to communicate, the upheaval and uncertainty experienced by a child or young person when they enter OOHC, their sense of shame and self-blame, their worry about what will happen to their family or siblings if they tell anyone and/or fear of the perpetrator could mitigate against disclosure. Research suggests it can take years for victim-survivors to disclose child sexual abuse.[3] We therefore have to be open to the likelihood there are children and young people living in OOHC with an undisclosed history of child sexual abuse.

18 Child abuse, including child sexual abuse, is a form of interpersonal violence. By necessity, it involves a betrayal of trust by an adult towards a child. A lack of resources and capacity within OOHC system however meant children did not routinely and consistently receive therapeutic support to help them form healthy attachments with their carer and heal from trauma. While working in OOHC, workers and carers both voiced to me their frustration about the difficulty of accessing therapeutic support services. The Australian Childhood Foundation (**ACF**) was contracted by the Department to provide these services. From what I saw, deliberations about funding were undertaken in isolation from an assessment or understanding of need. It meant support was often restricted to children with the most extreme behaviours or highest level of need. Such an approach did not take account of children's different responses to trauma, and it carried an implicit assumption that children who were 'well behaved' or 'compliant' did not require therapeutic support. Failing to address children's needs for relational safety and attachment early may result in escalating behaviours later, for example, as children approach puberty. I was told by workers on multiple occasions how many carers, able to care for young children, found it increasingly difficult when these same children hit 10-13 years of age. I wonder how often this was because these children did not get the help they needed when they entered care to form healthy, trusting attachments with their caregiver and to address their trauma.

19 When children are removed from their birth families, the state assumes legal (if not moral) responsibility for their care. A lack of resources and capacity severely undermined the capacity of OOHC to meet the needs of children and young people – from physical health (including specialist medical services), to learning needs, to their

[3] Townsend, C (2016),' Child sexual abuse disclosure: What practitioners need to know', retrieved from https://www.d2l.org/wp-content/uploads/2016/10/ChildSexualAbuseDisclosurePaper_20160217_v.1.pdf.

ability to participate in society like their peers. This was a consistent area of feedback by children and young people, exasperated and desperate carers and workers. For example, Anglicare Tasmania's report (2016) *Fostering Education: supporting foster carers to help children and young people to learn* drew on interviews with 113 foster care households to illustrate the experiences of children and young people in education.[4] Data suggested children in OOHC were often behind their peers in education. This may have been because they missed significant amounts of schooling or because of learning difficulties for example. Despite this, some children were on long waiting lists for an education assessment, let alone for assistance to help them catch up, or for support with their emotional regulation in the classroom. Education is a basic right for children and young people, but it can provide social support as well. By failing to meet the wellbeing needs of children and young people, the OOHC system may deny them opportunities to connect with social supports available to children in the broader community and potentially increase their sense of isolation.

20 Children and young people in OOHC may not have had a safe, trusted adult in their lives to a) provide the healthy relationships they need to heal and b) to notice and act if they see warning signs of children experiencing grooming behaviour, child sexual exploitation or sexual abuse. While many children and young people were fortunate to live with carers where they felt safe, this experience was not universal. High caseloads, administrative burden, and high rates of staff turnover significantly constrained case managers from meeting this need. OOHC workers, who oversaw foster and kinship carers, may potentially have provided a safe pair of eyes on children. However, my observation of the demands placed upon Departmental OOHC workers meant this was often unrealistic. The upshot was that some children and young people in OOHC may not have had a safe adult in their life that they trusted, and who was able to watch over them. It begs the question still: for those children and young people who do not have the benefit of safe relationships with their carers (including residential care workers), who has eyes on them? Who is looking out for them? How do we know they are safe?

21 In summary, many children and young people thrived in OOHC and benefited from the care they receive. Some safely returned home to their birth family or lived with their carers. There were others however, already made vulnerable to harm by their past experiences, whose needs would not be met, or vulnerabilities addressed. For some, these vulnerabilities may have been exacerbated as a result of their care experience, if for example, there was a breakdown in their home or if they were geographically

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[4] See Hinton, T (2016), 'Fostering Education: supporting foster carers to help children and young people to learn' (Anglicare Tasmania: Hobart), retrieved from https://www.anglicare-tas.org.au/research/fostering-education-supporting-foster-carers-to-help-children-and-young-people-to-learn/.

separated from protective factors (such as schools, friends, siblings). Without healthy, trusting relationships with safe adults to watch out for them, children and young people in OOHC may have a higher risk for sexual abuse from carers or others in the extended care network, other adults with regular access to the child (teachers for example) or others in the community. They may also be at higher risk for experiencing harmful sexual behaviours from other children in the home or community and/or use harmful sexual behaviours themselves.

OVERVIEW OF THE OUT OF HOME CARE SYSTEM IN TASMANIA[5]

22 The number of children and young people living in OOHC in Tasmania remains a concern. At the end of 2017, there were 1207 children and young people in OOHC; in 2019-20, this number had reduced to 1112.[6] Monthly data available from the Human Services Dashboard suggests an upward trend again for 2021-22, with 1275 children in OOHC at the end of February 2022.[7]

23 At the time I worked in OOHC reform, the organisational structure for OOHC included:

(a) Children and Youth Services (**CYS**) – now known as Children Youth and Families (**CYF**), an operational division within the Department. It "develops and delivers state-wide policy, programs and services to support and enhance the safety and wellbeing of Tasmanian children, young people, families, carers and our staff" (Department of Communities Tasmania website). Child Safety Services sits within CYS/CYF.

(b) Child Safety Services (**CSS**) – the role of CSS is to protect children and young people at risk of abuse or neglect as laid down in the Children, Young People and their Families Act 1997. OOHC sits within CSS.

24 I understand work to restructure CSS which started as part of *Strong Families, Safe Kids* continues. I also note the Government's intention to move CYF and CSS to the Department of Education later this year. Questions concerning the scope and organisational structure of CSS are best directed to the Department.

25 Tasmania utilises a hybrid OOHC model. By "hybrid", I mean some OOHC services are delivered by the Department (as system owner and provider), and some OOHC services are delivered by non-government agencies referred to as service providers. When I worked for the Department, CSS provided case management services for

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5 I refer to the report prepared by the Commissioner for Children and Young People Tasmania titled 'Monitoring Report no.1 the Tasmania out of home care system and 'Being Healthy' out of home care monitoring programme 2018-2019.' It provides some information on the basis structure and operation of OOHC.

6 Productivity Commission (2021) *Report on Government Services,* see Table 16A.3 'Children in Care by Indigenous Status'.

7 See https://www.communities.tas.gov.au/human_services_dashboard.

children and young people in OOHC and oversaw all kinship care and some foster care. Service providers were contracted by the Department to deliver services related to foster care, residential care, specialised therapeutic residential care (also known as special care packages), and therapeutic services.

26 I do not know how many service providers are contracted by the Department for OOHC services. I believe in 2020 there were five service providers contracted to provide foster care services. Catholic Care was contracted to provide residential care and there were numerous other agencies delivering special care packages. Questions about these agencies are best directed to the Department.

27 The Child Advocate and Commissioner for Children and Young People sit independently of CYS/CYF and CSS and form important external safeguards. Please refer to paragraphs 81-92.

28 When I worked for the Department, the Department's OOHC teams were responsible for arranging a placement for a child or young person when they entered OOHC. Placement types included:

(a) kinship care;

(b) foster care;

(c) sibling group care;

(d) residential care; and

(e) special care packages.

29 While the intention was to find a good fit between the needs and wishes of the child or young person and the home, this was often constrained by insufficient numbers of carers and compressed timeframes. Not having enough carers put enormous pressure onto our OOHC workers and existing carers. Some Departmental foster carers spoke about their sense of responsibility to provide a home even though they were already caring for relatively large numbers of children (for example four or more children), including multiple sibling groups. I saw firsthand the pressure on an OOHC team leader trying to find a home for a child entering OOHC or as a result of a breakdown in their home (care placement). It is extremely difficult.

30 The lack of placements does not suggest children were placed into unsafe homes but – if there had been other options – a child may not have been placed there. Sometimes children were moved hours away from their community and support networks, isolating them from their school, friends and social networks. Sometimes children were placed on special care packages - living on their own with worker(s) rostered around the clock -

because there was nowhere else for them to live. This was well known by CYS management and there was significant investment of time and effort by specialist practitioners to find these children homes with foster carers. I have heard anecdotally that special care packages may still be used because of a lack of other options. Questions about how many children continue to access special care package arrangements and the reasons for these special care packages (for example, level of disability, number of placement breakdowns (complex needs), no other care options available) are best directed to the Department.

CASE MANAGERS IN OOHC

31 It is important to preface the discussion of the case manager's role by acknowledging children and young people may have complex needs and exhibit trauma-based behaviours as a result of their experience of child abuse and/or neglect and associated developmental trauma.

32 Case managers were employed by CSS to provide case management and case work services to children and young people to ensure their safety, stability, and developmental needs are met. CSS, with input from case managers, were responsible for a child's overall case direction – for example, if a child was intended to return home or remain in care. While they worked with others in a care team, the case manager was the primary person responsible for managing the child or young person's care plan.

33 Case managers were required to see children in accordance with the child visit policy. My memory is that the frequency varied between monthly and three monthly, in accordance with the child's age, type of care placement and level of assessed risk. This however would need to be verified with the Department.

34 From the feedback I received, high caseloads and administrative burden made it extremely difficult for case managers to fulfil their responsibilities. Turnover of case managers was also extremely high despite what felt like constant recruitment. This is demanding and challenging work and the shortfall in case managers and appropriate supports for case managers had significant implications for both children and young people, and for the case managers themselves.

Implications for OOHC

35 Children and young people with a care experience consistently expressed a desire to have a meaningful relationship with their case manager. They wanted a "safe person" independent of their home environment with whom they could spend time and talk with.

36 When case managers were overloaded and under-resourced, children would go long periods of time without seeing a case manager, having care team meetings or updating their care plans. If a case manager left, children were often 'held' by the Team Leader until they could be allocated another case manager. These issues were constantly raised by children and young people and carers as a source of frustration.

37 If case managers cannot devote the time necessary to develop meaningful and trusted relationships with children, then these children may not feel able to communicate their worries or disclose incidences of harm. These issues may not surface until a child or young person's behaviours escalate, become violent and/or destructive – such as through alcohol and substance misuse, self-harm, killing a family pet, destroying or setting fire to property. For others, these issues may not come out at all.

38 While a lack of trained and resourced case managers impacts on the quality of care received by children and young people, it also means there is one less person to watch over a child or young person in OOHC. For some it might mean there was no safe adult in their life at all.

Examples from the consultation process: Case managers and children and young people in OOHC

One young person (16) told me she regarded her case manager as a mentor. She spoke about how the case manager had helped her navigate significant life decisions, including her return to education.

A child (10), spoke with real affection and happiness about a case manager who had taken her and a sibling out for a day. It was an important memory for her.

Another young person's (13) case manager had been on leave for months. They did not have another case manager and had not been able to ask anyone about seeing their sibling for their birthday. When I asked how far away their birthday was, they replied it was 3 months. Their sibling lived within 30 minutes of their home.

A child living with their kinship carer had 13 case managers over a period of 15 years.

39 The level of turnover, vicarious trauma and stress was a live issue for case managers when I worked in OOHC reform. Recruiting more case managers is unlikely to improve the situation unless there is also action to address the reasons for staff leaving and to improve staff retention. This has been a known issue for many years and questions about staff wellbeing, whether reviews have been undertaken and the findings of such reviews should be directed to the Department.

40 I believe more case managers are needed to support children and young people in OOHC. Investing in more case managers so staff have manageable workloads would greatly strengthen care for children and young people. Building healthy relationships with children and young people would also build safety into the system as case

managers become a safe adult to identify and/or respond to risks associated with grooming behaviours, or disclosures of child sexual abuse.

OOHC WORKERS AND FOSTER AND KINSHIP CARE

41 OOHC workers manage the recruitment, training, support and oversight of kinship and foster carers. Kinship or foster carers provide daily care for a child or young person within a family environment and receive an allowance from the government.

42 Foster and kinship carers were both vital to OOHC. In 2020, foster and kinship care covered approximately 93 per cent of children in OOHC.[8] Over time the proportion of kinship carers has increased within OOHC in Tasmania. This increase was in part due to increasing recognition of the benefits of children being cared for within extended family or community networks. It was also driven by a net loss of foster carers in OOHC over the long term.

43 Kinship care is where care is provided by a relative or someone closely connected to the family or the child or young person's cultural community. Research from the UK suggests that approximately one-third of kinship carers are siblings of the child or young person and approximately half are grandparents.

44 In Tasmania, Departmental OOHC workers held sole responsibility for the recruitment, support and oversight of kinship carers. Approximately 41 per cent of children in OOHC in 2019-2020 were living with kinship carers.

45 Foster care was delivered by the Department or service providers contracted by the Department. In Tasmania, foster care included sibling group care and respite care. My comments are directed to foster care as a whole.

Recruitment and onboarding of carers

46 Departmental OOHC teams and service providers were responsible for recruiting and assessing carers. This included conducting safety checks. Please refer to paragraph 96 for comments in relation to safety checks.

Training and support for carers

47 There was no specific requirement for carers to receive training on how to respond to disclosures of sexual abuse while I worked with the Department. While training on the impact of trauma delivered by ACF would likely cover child sexual abuse, I believe carers would benefit from specific training in this area.

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[8] Productivity Commission (2021), *Report on Government Services – Child Protection* (Australian Government: Canberra), see table 16A:20.

48 When I worked with the Department, kinship carers were not required to undertake training. This sat at odds with most states in Australia with either training requirements already in place or being introduced. Some believed training wasn't required because kinship carers already knew the children. Knowing a child does not mean that person understands how trauma has impacted the child or young person, or how to meet their needs. This can have real consequences for children and young people and their carers. I remember speaking with a kinship carer who shared he had not understood his grandson's extreme fear to having a bandaid applied was rooted in his early childhood experiences. He felt grief and guilt he hadn't met his grandson's needs in that moment.

49 Departmental foster carers received pre-service training consistent with that provided by service providers. During my time on the OOHC reform project, the Department introduced training on trauma-informed care for foster carers and this was a positive development.

50 Service providers tended to provide significantly more training for their carers than the Department. They had been providing ACF training on trauma-informed care for some time as it was a contractual requirement; others provided advanced training and most agencies also offered agency specific training.

51 Training provides a foundation for learning but embedding this learning requires support, reflection and modelling from OOHC workers. Like children and young people, carers consistently spoke of their desire to have a relationship with an OOHC worker. While caring for children with complex needs and trauma behaviours can be deeply rewarding it can also be challenging and exhausting. Carers spoke about needing their own safe person with whom they can debrief and to talk things out. One agency which I spent time with explained it best: *"Carers hold the pain of the child, and we need to hold the pain of the carers"*. This can help them reflect, regather and try again.

52 For most service providers, carers seemed well supported by their workers. Carers had had regular visits/check ins. I understand that the frequency of home visits tended to be monthly and could be more frequent if the carer needed support. This would be best confirmed with the OOHC service providers.

53 Service providers conducted annual reviews of carers which provided an opportunity to review how things were going for the carer, identify concerns regarding the quality of care and identify a plan to address them.

54 The capacity of Departmental OOHC workers to build relationships with kinship and foster carers was severely constrained when I worked for the Department. I would describe the level of support typically provided to foster carers and kinship carers as woefully inadequate. This situation was a **direct consequence** of caseloads which in

my view were untenable and ridiculous. In one OOHC team, caseloads sat between 80 and 100 carers per worker; in other teams, I believe caseloads were closer to about 45-70 carers per worker. Questions relating to current caseloads for Departmental OOHC workers are best directed to the Department.

55 Kinship carers may have additional support needs to foster carers. Many are often older and may have health concerns. They may be negotiating changed familial roles, caring for children or grandchildren and navigating what may be a traumatic or broken relationships with their own children[9]. As noted in the Discussion Paper in 2018:

> *"A number of kinship carers spoke about taking on kinship care because of love and a sense of obligation. It wasn't a choice. It also often involved dealing with grief associated with the circumstances requiring a child or young person to be removed from the biological parent(s), who in many cases is the child of the kinship carer (carer feedback, Devonport)".*

56 The strain on Departmental OOHC workers meant annual reviews on foster and kinship carers often didn't occur. These visits are a poor replacement for regular in-home visits, but they were better than nothing. I do not know if annual reviews are still required or being conducted by the Department and/or service providers. Such a question is best directed to Department.

Implications for carers and children and young people in OOHC

57 I held significant concerns regarding the capacity of OOHC workers – most especially Departmental OOHC workers - to effectively support kinship or foster carers given the weight of their caseloads and the lack of resourcing within OOHC. While service providers were better resourced to support carers, they were also under pressure.

58 The constraints on Departmental OOHC workers meant work with carers was often focused on crisis management, that is, responding when the carer was at breaking point or finding a new home for a child when their existing home broke down.

> ***Example: Impact of high caseloads of OOHC workers- carers and children and young people***
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> *I remember visiting the OOHC team one day in the south. I ran into a worker returning from reception: a foster carer who had cared for a child for 6-7 years had 'cracked' and brought the child into CSS. The sense of frustration and despair was palpable on the part of the worker. They spoke about knowing this carer, knowing their dedication, and the worker's sense that had they been able to spend time with the carer before events*

[9] See Breman, R, MacRae, A (2017), '"It's been an absolute nightmare": Family violence in kinship care' (Victoria: Baptcare)

had escalated, this situation could have been avoided. I could sense the harm done – to the child, to the carer and to the worker.

59 The research literature identifies the importance of continuity, stability and relational safety for achieving positive outcomes for children and young people in OOHC; it also notes the corrosive effects of breakdowns in a child's home. For example, Kelly and Salmon (2015 cited in CFP, 2015, p 3)[10] found "children who have two or more behaviour-related placement disruptions have only a 5 per cent chance of achieving placement stability 2 years later". Please refer to Appendix Three of the Discussion Paper (attachment SE-2) for a summary of key messages from research literature, reviews and reports about the importance of placement stability for children and young people.

60 In my view, placement breakdowns were a stark indicator of a system failing children. These are not 'bad' children but children whose needs were consistently failed. For some children, breakdown(s) in the home and escalating trauma behaviours made it increasingly difficult for these children to live within existing foster or kinship care.

61 A breakdown in a child's home had broader repercussions as well – carers open their homes and their hearts to care for children. A decision they can no longer care for a child was not made lightly. Service providers and carers spoke of the heartache and sense of failure carers experienced if they were no longer able to care for a child. Despite asking for help, many carers would persevere in extremely difficult circumstances and with little support until it reached the point of crisis. Some left the care system as a result.

62 If OOHC workers were unable to spend time in the home observing and working with the carer, then the system lost another opportunity for a safe adult to check on the safety and wellbeing of children and young people. If Departmental OOHC workers are still unable to conduct regular home visits and/or annual reviews, how does the Department know the child is being adequately supported and cared for? How do we know the child is safe? Given the constraints facing many case managers and Departmental OOHC workers, there is a possibility some children and young people in foster and kinship care have no oversight by CSS to ensure they are safe and well.

63 These problems are not insurmountable but require a willingness to invest in staff and our carers. In my view it also requires broadening the continuum of care to include

[10] Child and Family Practice (2015), 'Support Needs and placement matching in out-of-home care: A Literature Review' (Queensland: Queensland Government).

intensive foster care as a legitimate option within foster care (and where possible kinship care).

64 There are examples of such intensive foster care programs. While undertaking the OOHC project, I travelled to Victoria with a practice specialist to meet with the ACF and Anglicare Victoria about the TrACK program. This intensive foster care provided a step down for children and young people in residential care into foster care or an alternative form of care for children and young people who had experienced serious abuse and harm. This model is firmly grounded in principles of trauma-informed care and contained the following elements:

(a) A care approach which sought to provide long term stable care for the child or young person necessary for healing;

(b) Higher levels of training and assessment for carers, and with it, higher rates of payment which recognised carers were often unable to work due to the level of support required by a child;

(c) Intensive support for carers by workers in the home, with these workers holding small caseloads; and

(d) Regular work/consultation between the carer and worker with a therapeutic specialist to consider the specific care needs of the child or young person.[11]

65 A program evaluation by McPherson, Gatwiri and Cameron (2018) found the TrACK produced "tangible and lasting results" for children and young people and that, with effective training and support, children and young people with complex needs and behaviours were able to live within family-based care.[12]

66 I understand there are other intensive foster care programs available locally which share in common with TrACK a focus on therapeutic care and intensive support. To be effective these programs need to be implemented proactively and not as an option of last resort. Questions regarding what the Department is doing in relation to these kinds of programs is best directed to the Department.

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[11] See Appendix Six of the Discussion Paper, Attachment SE-2 to this statement.

[12] McPherson, L, K Gatwiri and N Cameron (2018), 'Evaluation of the Treatment and Care for Kids Program' (Southern Cross University and Australian Childhood Foundation), retrieved from https://researchportal.scu.edu.au/esploro/outputs/report/Evaluation-of-the-Treatment-and-Care-for-Kids-Program-TrACK/991012822197402368.

RESIDENTIAL CARE

67 Residential care in Tasmania was delivered under contract by service providers. The Department retained overall responsibility for the oversight and care of these children and young people

68 There were two 'kinds' of residential care in operation in Tasmania:

(a) 'traditional' residential care in which children and young people lived in small homes of up to four children and young people with residential care workers responsible for their daily care; and

(b) specialised residential care arrangements, commonly known as special care packages, where children and young people lived alone or with a sibling(s) with workers rostered around the clock.

69 Some young people told me they preferred to live in residential care and those choices need to be respected. While residential care could be used as part of a step-down model, pressure on foster and kinship care meant that this was not necessarily an option.

70 Most states had restrictions on the age of children allowed to live in residential care. I believe in Tasmania the policy was that children under the age of 10 should not be placed into residential care except in exceptional circumstances. Anecdotally I am aware children aged 10 and younger are and have lived in residential care (either the 'traditional' form or under special care packages) but questions on this need to be directed to the Department.

71 There may be additional levels of risk for children and young people living in residential care as it was often used as the placement option for children and young people with more complex needs and behaviours. This may arise, for example, when a child or young person had experienced a previous breakdown(s) in the home (care placement). As stated before, placement breakdowns can exacerbate and make more complex a child or young person's needs and behaviours. If the child or young person didn't have healthy ways to meet their needs or address their trauma, then they could have a higher risk for child sexual exploitation/child sexual abuse. This risk may stem from others in the residential care home or from others in the community.

72 When young people can build trusted relationships with workers, they are more likely to disclose worries or instances of harm. This can and does happen. I understand however that residential care workers may not have sufficient direction or guidance by CSS on how to a) manage these disclosures and b) support the young person after this

disclosure. I need to note however I am not personally familiar enough with residential care to comment further and questions are best directed to the Department.

73 In my experience, special care packages were intended to provide specialised, residential care delivered to children and young people deemed to require exceptionally high levels of care. Sometimes this is because a child's level of disability and care needs or because the child had experienced multiple breakdowns in the home.

74 Under a special care package, a child would be placed into a residential property on their own, or with a sibling(s) with workers rostered over a 24 hour period. I do not know if there are specific requirements for the workers who care for these children and this is a question best directed to the Department.

75 I heard concerns from the sector, including Departmental workers, about young children being placed into special care packages. Given the relative isolation of these children, I would note their potential vulnerability to harm by workers, for example. This level of risk is likely to increase for young children and for children with disability. Questions about the numbers of children on special care packages, their age and/or level of disability need to be directed to Department. If young children (under the age of 10) are to continue accessing special care package arrangements then I would ask whether we require additional safeguard for these young children.

MONITORING AND OVERSIGHT WITHIN THE OUT OF HOME CARE SYSTEM

76 When the state decides to remove children from their birth family, it effectively becomes the parent. It is therefore incumbent upon the state to ensure the child or young person is safe, well and has their wellbeing needs met.

77 In the three years I worked with the Department, its limited capacity to oversee service provision and to ensure children and young people were receiving quality care was deeply concerning. Reports by the Auditor-General into OOHC in 2011 and 2018 – the latter of which refers to Safe Pathways and special care packages - are illustrative in this regard.[13] The 2018 report refers to an internal review by then Department of Health and Human Services into Safe Pathways, a provider of special care packages. Safe Pathways' contract was terminated in 2017 for matters of administrative non-compliance, which included (among others):

(a) failing to obtain valid working with vulnerable people registration for all staff

[13] Auditor-General (2018), 'Special Care Packages for Children in Out of Home Care', retrieved from: https://www.parliament.tas.gov.au/ctee/joint/Reports/Tasmanian%20Audit%20Office%20-%20Special%20Care%20Packages%20for%20Children%20in%20Out%20of%20Home%20Care%20-%20January%202018.pdf

(b) poor staff recruitment and induction practices

(c) inadequate staff training and support

78 The internal review identified a need for the Department to improve how it monitored providers and received complaints, as well as its governance over funding agreements. The Auditor-General's report noted these issues were known by the Department and it had put in place a plan to address recommendations made across numerous reviews. I would contend that **substantively** the Department has not addressed the issues around monitoring providers or governance over funding agreements.

79 In my view, the Department was – and remains - chronically under-resourced to oversee and manage service provision. Service providers were unable to access Departmental policies and procedures in real time – such as through an online portal. When they received policies, they were often outdated or not adhered to by the Department. Not all service providers were on contracts. When I raised my concerns with one of key personnel in CYS about some providers of special care packages not having funding agreements, I was told there was no point in putting them on contracts because they would not be monitored anyway. I found this concerning given the significant amounts of funding associated with special care packages.

80 The Care Concern process formed one of the Department's key internal mechanisms to respond to concerns about a child or young person's care. The Department is best placed to explain the Care Concern process but in short, complaints about a child or young person's care could be made by a child or young person, worker, or another person. This complaint was then reviewed and investigated as appropriate, I am aware this process has identified harm or abuse of children and young people in OOHC. I am concerned however that the efficacy of the Care Concern process is undermined by:

(a) Its reliance upon someone to come forward with a complaint – for example, a case manager or OOHC worker, a carer, or the child/young person. If a child or young person does not have a safe person to tell, if they are worried about whether they will be believed, if they don't feel safe, then the chances of them making a complaint is reduced.

(b) Its reliance upon case managers, carers and out of home care workers being sufficiently connected to children to notice behavioural changes and potential red flags, for example for grooming behaviours for child sexual exploitation;

(c) Poor communication about the process and progress of the complaint's investigation. When I worked with the Department, investigations could take

between 3 months and up to 12-18 months, causing upheaval and disruption for not just the child or young person, but also the carer;

(d) The focus of the care concern process residing in the investigation of the complaint rather than identifying and prioritising therapeutic support around the child or young person; and

(e) A lack of follow up to ensure a child or young person is safe should they 'self-select'[14] to return to a birth parent.

EXTERNAL MONITORING OF OOHC IN TASMANIA AND THE NEED FOR REFORM

81 The Child Advocate and Office of the Commissioner for Children and Young People Tasmania provide important safeguards for children and young people in OOHC.

82 The Child Advocate role, created in July 2018, advocates for and on behalf of children and young people in foster, kinship and residential care in Tasmania. The Child Advocate reports to the Secretary of the Department.

83 The current Child Advocate is Ms Sonya Pringle-Jones and in my experience, she is an impressive and dedicated advocate. I note that the Child Advocate also spearheaded the development of a reporting process to track wellbeing outcomes from the perspective of children and young people.

84 I am concerned however that with over 1,200 children and young people in OOHC, the Child Advocate cannot feasibly be the "safe person" for every child in OOHC, even with another Child Advocate appointed for the North and North-West. The Child Advocate role has a lot to offer in terms of individual and system advocacy, but the lack of capacity within the system for case managers and OOHC workers to 'have eyes' on children and work with children and young people could potentially undermine the sustainability of the Child Advocate role.

85 The Office for the Commissioner for Children and Young People Tasmania (CCYP) is an important system advocate for children and young people in OOHC. Since 2018 the CCYP role has also included system monitoring of OOHC, with monitoring reports released on wellbeing outcomes of Being Healthy and more recently, a monitoring plan, Being Loved and Safe. My observation would be that this is a valuable role as the CCYP brings transparency to a system which can often appear opaque.

86 While the office of the CCYP has been and continues to be a fierce advocate for children and young people in OOHC, I cannot imagine how frustrating it must be to

[14] The term 'self-select' is one commonly used within the Department to describe children and young people as having left their care arrangement and returned to their birth parent.

continually revisit recommendations long accepted by Government, but which remain to be implemented.

87 There seems to be a long tradition of undertaking reviews into Child Protection/Child Safety and OOHC which then quietly drop from sight. Understanding what sustains this systemic inertia is difficult and I will leave that to others – but a history of chronic underfunding in the Department to build its capacity and infrastructure cannot be overlooked. I am not referring to services (although they are too often underfunded) so much as capacity – having the right people and sufficient number of people in the right jobs to manage and implement change over the long term. A system in crisis is not well placed to manage change.

88 These shortcomings within the OOHC system brings us back to ask: if we don't have appropriate oversight of OOHC, if we don't have clear standards by which to assess the care received by children and young people, if our children and young people do not have safe and trusting relationships with the adults in their lives, if we don't have OOHC workers able to support and oversee carers, then how can the Department assure itself that it is meeting the needs of children? How can we know whether children have experienced harm, including sexual harm, since they have entered OOHC?

89 It is my view that affecting meaningful change will require political will and bipartisan support over the long term. I believe it requires establishing oversight mechanisms independent of Government and invested with sufficient power through legislation to fulfil its role. This includes the establishment of an independent accreditation body to accredit and monitor OOHC government and non-government providers of OOHC services.

90 The system of oversight for OOHC in New South Wales (NSW) provides an interesting point of comparison to Tasmania. NSW has in place the *New South Wales Child Safe Standards for Permanent Care* (2015) (**NSW Standards**). The Office of the Children's Guardian is an independent statutory authority in NSW which accredits agencies to provide statutory OOHC or adoption services in NSW. The Office of the Children's Guardian works with government and non-government agencies who provide OOHC services to ensure they meet the requirements contained in the NSW Standards. It has the power to accredit, provisionally accredit, impose conditions of accreditation, suspend or cancel an organisation's accreditation. In this way, NSW has implemented an independent system oversight for the OOHC system.

91 I believe there is an opportunity as the Tasmanian Government implements the recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse to learn from other state's experiences. I would refer you to the CCYP in

Tasmania and to the NSW Office of the Children's Guardian for further information on options for independent oversight of OOHC but also for safeguarding children.

92 Another issue about which I remain concerned is how we ensure our carers and workers are fit and proper people to care for children and young people in the first place. A Carer's Register and Reportable Conduct Scheme form part of the solution, but I also believe we need to focus attention on safety checks and what these checks constitute. While I have been out of the sector for too long to comment on their adequacy, I would ask: will our safety checks – whether they are Working with Vulnerable People Checks or National Police Checks or checks conducted by Child Safety – identify patterns of behaviour which suggest a person may not be safe? Will these checks for example, identify the existence of formal police statements or information reports relating to sexual assault? Will they identify whether a person has been the subject of a family violence order? Will these safety checks pick up complaints of inappropriate conduct made against an individual to their employer? If so, over what period of time? I think it important to test our processes against known systemic failures beyond the horizon of OOHC.

93 Finally, I consider a robust external system of oversight for OOHC as necessary but insufficient to improve the safety and wellbeing of children and young people in OOHC and that safe OOHC system must be able to:

(a) Meet the needs of children and young people when they need it, including to form healthy attachment relationships

(b) Train and support foster and kinship carers in the home so they can provide the care children and young people need and deserve and, importantly, to provide stability and safety in all its forms – relational, physical and psychological and

(c) Enable workers – through realistic caseloads and resourcing - to work collaboratively and respectfully with others in the care team to meet the needs of children and young people and carers.

94 Overall, I remain hopeful of change. There are so many people who care deeply and dedicate themselves to improve the wellbeing of children and young people in OOHC. I was struck by willingness of those within the OOHC system to work together to achieve meaningful change. From what I understand this appetite to work together continues and it underlines the opportunity we have in front of us to make a real difference to the lives of children and young people in OOHC.

95 Children and young people offer the keenest insights about what they need, able to state in the simplest terms what adults so often complicate, so I'd like leave the last words to them.

Feedback from children and young people on what it meant to be loved and safe in OOHC

Love… it's about feeling valued and loved, being listened to, and being happy. Group feedback, Hobart

You need to make sure carers and their families are safe and look after kids properly. Group feedback, Devonport

"[Carers] don't need to be professional people, they just need to love you for who you are", 11 year old, Launceston.

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

Declared at [redacted] Tasmania

on 26/04/2022 .....[redacted]

Sonya Devereux Enkelmann

Before me [redacted]

.Commissioner for Declarations