NSW GOVERNMENT Family & Community Services

Summary Paper

Managing Critical Incidents in Out of Home Care (OOHC) NGOs

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Thanks and acknowledgement

FACS would like to acknowledge and express our thanks to all the individuals across the OOHC NSW sector that not only contributed to the productive dialogue at the Managing Critical Incidents in OOHC NGOs Forum, but contribute every day to working towards improving the outcomes for children and young people in OOHC in NSW.

EXECUTIVE SUMMARY

The Out of Home Care (OOHC) transition represents the largest reform to the OOHC sector in many decades. It has been three years since the beginning of this significant change and the two day state-wide *Managing Critical Incidents in OOHC NGO* Forum (the forum) was a timely opportunity for OOHC NGOs, peak bodies and government agencies to have a conversation about how the service system is meeting the needs of the children and young people they serve and reflect upon future directions and needs of the service system.

The forum was organised in response to issues raised by stakeholders in relation to gaps in understanding policy, system and procedural responsibilities in managing critical incidents for children and young people in OOHC case managed by NGO providers. These issues included managing disclosures of abuse, reportable conduct and child deaths.

Four consistent themes emerged from both presenters and participants which focus on the importance of:

1. **Cross sector collaboration** in the OOHC sector including senior executives and all levels of practitioners from NGOs and government agencies.
2. **Information sharing** between OOHC NGOs, between various governments and OOHC NGOs and with jurisdictions outside NSW.
3. **Knowledge and learning** that is consistent, regular and targeted for staff at all levels of OOHC NGOs.
4. **Ongoing practice improvement:** review and reflection.

The forum successfully brought together key partners and stakeholders to learn, contribute and identify how we can strengthen the current NSW OOHC NGO system to ensure that its response to critical incidents results in the best possible outcomes for the children and young people in OOHC.

The conversations between OOHC NGOs and key partners at the forum have led to the development of a number of resources to improve the service system and outcomes for children and young people in OOHC NGOs in NSW.

A continued process for ongoing dialogue to foster shared accountability in identifying issues and producing joint solutions and further systems improvements could be met by the establishment of a cross sector senior executive leadership group.

INTRODUCTION

This Summary Paper documents and draws together the key ideas and discussions that emerged from the *Managing Critical Incidents in OOHC NGOs* forum held on 21 and 22 April 2015 at the UTS Arial Function Centre (the forum).

Critical Incidents are an expected reality in an OOHC setting and we need to ensure that the service system can adequately respond and manage these incidents.

For the purposes of the forum and this paper we have considered critical incident management to include:

- Responding to and managing allegations of reportable conduct
- Responding to and managing child abuse allegations in care including those involving the Joint Investigation Response Team (JIRT)
- Responding to and managing a death of a child in OOHC

Working groups were established with our key partners to collaborate on planning and delivering the forum. Working group representatives included:

- FACS (OOHC Transition Program Office, Reportable Conduct Unit, Child Deaths, Helpline, JIRT, OOHC Service Improvement)
- Office of the Ombudsman
- Office of Children's Guardian (OCG)
- Victims Services
- NSW Coroners Court
- Aboriginal Child, Family and Community Care State Secretariat (AbSec)
- Association of Children's Welfare Agencies (ACWA)
- NSW Police (JIRT)
- NSW Health (JIRT)

The aim of the forum was to provide OOHC NGO service providers the opportunity to explore their understanding of the roles and responsibilities of NGOs and their sector partners in managing critical incidents. Specifically, it provided a significant platform for government agencies, peak bodies and OOHC NGO service providers to:

- engage in collaborative discussions to strengthen the sector's understanding of roles and responsibilities in relation to managing critical incidents
- discuss management, policy and practice issues
- identify barriers and opportunities to improve systems and responses to critical incidents to increase the quality of outcomes for children and young people
- reflect on how the service system is currently meeting the needs of the children and young people they serve
- reflect on future directions and needs of the service system.

Please refer to the program agenda at **appendix A.**

WHY DID WE NEED THIS FORUM?

In 2009 the Wood Special Commission of Inquiry into Child Protection Services in NSW made a series of recommendations including the transition of OOHC from the government to the NGO sector. The NSW Government's commitment to this recommendation, through the *Keep Them Safe* Reform 2009-2014, provided the platform to commence the largest reform to the OOHC sector in NSW in decades, the transition of the provision of OOHC from the government to the NGO sector.

The transition has brought about a significant transformation to a relatively small NGO sector in a short timespan. As at 31 March 2015, since the transition began in March 2012, more than 5,577 children and young people have transitioned to NGOs. As at March 2015, 7,268 children and young people were placed in statutory OOHC with NGOs, which equates to 57% of the total number of children and young people in statutory OOHC[1]. Prior to transition there were 1,491 children and young people placed with carers in NGOs. This represents an increase of 450% in three years.

1 OOHC Transition Dashboard for March 2015

The FACS Minister continues to hold a non-delegable duty of care for children and young people that are managed and cared for by OOHC NGOs and therefore continues to have a significant interest and role in these children and young people's lives and the services that support them. In addition FACS has a contracting and funding role with OOHC NGOs, as well as being an OOHC provider. Given these roles, FACS has responsibilities in providing policy and practice guidance and support in OOHC and overall practice and systemic improvements.

During this process of significant expansion and development, stakeholders have identified gaps in understanding policy, system and procedural responsibilities in managing critical incidents for children and young people in OOHC case managed by NGO providers. OOHC NGOs are, in line with their increased service provision, increasingly having to respond to critical incidents. Whilst some NGOs are experiencing the challenges of an increase in the number of critical incidents, other NGOs that are new to the OOHC sector are experiencing the challenges of developing skills and knowledge about their role and responsibilities in this area.

There are a number of partner organisations that work with OOHC NGOs and have different roles and responsibilities in the critical incident space. These government agencies together with the peak organisations and the NGOs have raised concerns about the complexity in managing the breadth of potential issues facing children, carers and staff following a critical incident.

In this context, FACS took on a lead role to drive and coordinate the delivery of a two day state-wide practice forum on *Managing Critical Incidents in OOHC NGOs* to bring the sector together, stimulate sector wide conversations, learning and practice improvements for agencies and the sector and in turn improve outcomes for children and young people in care.

FORUM CONVERSATIONS

Forum participants articulated a strong commitment and a willingness to work collaboratively to improve the management of critical incidents to ensure optimum outcomes for children and young people in OOHC. The active engagement of participants with presentations and discussions in the workshops has provided this paper with invaluable content to assist in the direction of future work.

The Secretary of FACS identified in his opening address at the forum that whilst we need to be relentlessly optimistic about kids not just surviving but thriving, we also need to be brutally realistic about how hard that is to achieve. Another presenter highlighted the need for bravery and a shared sense of responsibility as we reflect as a sector on how we currently serve the children and young people in OOHC NGOs in NSW. The forum provided a platform to have this timely and important discussion.

The presentations by a number of key partners provided information about roles and responsibilities, different perspectives on the current challenges and ideas in managing critical incidents.[2]

The workshops provided an opportunity for forum participants to engage in discussion with their sector partners and key ideas from this discussion were recorded by each workshop group and have contributed to this Summary Paper.[3]

[2] **Appendix E** resource wall chart for OOHC NGOs contains details of how to access transcripts and recordings of the presentations

WHO WAS THERE?

The forum was attended by 41 different OOHC NGOs, peak bodies and relevant government agencies. In total there were 230 executive, cross government and NGO participants (180 delegates, 50 webinar registrations). The forum included presentations and participation from senior representatives from a number of key stakeholders including FACS, Office of the NSW Ombudsman, Office of Children's Guardian, Victims Services, NSW Coroners Court, AbSec, ACWA and JIRT.

Forum evaluation results were overwhelmingly positive, with 92% of responding participants rating the forum content relevant or very relevant.

WHAT WAS THE STRUCTURE OF THE FORUM?

Please refer to the program agenda at **Appendix A** and the workshop reference material and table of discussion outcomes from the workshops at **Appendix B.** The structure of the two day forum included:

- A number of presentations from senior executives from:
  - FACS, including the Secretary and Executive Directors
  - Other statutory bodies, such as the Office of the NSW Ombudsman, Office of Children's Guardian, Victims Services and the Coroners Office
- JIRT Panel presentation about working with OOHC NGOs
- Participant workshops on:
  - responding to reportable conduct matters
  - responding to child death matters
  - media training in response to a critical incident
  - what works now and how we build on works when there is a critical incident
- Key note panel discussion allowing participants to raise questions directly to senior executive representatives from the key partner agencies.

Please refer to the resources at **Appendices E and F** for details about how to access transcripts and recordings of the presentations and **Appendix C** for a transcript of the key note panel discussion.

WHAT WERE THE KEY THEMES WE SPOKE ABOUT?

The forum initiated a sector conversation that identified areas to begin to build on and further explore. The thoughts and ideas that emerged from both presenters and participants have been compiled into four key themes. There is considerable overlap in the practical application of these themes. **Table 1** lists thoughts and ideas from participants grouped under the key themes and **Table 2** lists strategies and suggestions for sector improvement from participants grouped under the key themes. In summary the key themes focused on the importance of:

1. **Cross sector collaboration** in the OOHC sector that includes senior executives and all levels of practitioners from NGOs, peak groups and government agencies.

   As the FACS Secretary identified in his opening address the service system and the children and young people it serves is increasingly relying on everyone to work collaboratively and accept shared responsibilities to ensure the inherent risks in OOHC are mitigated.

[3] **Appendix B** Workshop reference material and table of workshop discussion outcomes

These thoughts were echoed consistently by representatives from key agencies including the Office of the NSW Ombudsman, OCG, FACS, Victims Services, Coroners, Health, Police, AbSec and ACWA. This desire for collaboration was also reflected by participants in the workshop discussions. Whilst there was a general consensus about the importance of collaboration there was uncertainty about the practicalities and nature of this collaboration.

2. **Information sharing** between OOHC NGOs, between various government agencies and OOHC NGOs, and with jurisdictions outside New South Wales.

   Understanding by OOHC NGOs about the use of Chapter 16A of the *(Children and Young Persons) Care and Protection Act* in sharing information between agencies was varied. Whilst there was general consensus about the benefits and need to share information there was uncertainty about how and when to do this. The forum presentation from the OCG outlined that the:

   - current legislation does not allow New South Wales to share information with other states and that most of the other states and territories (with the exception of Western Australia) are also unable to share information. This has been raised at the National Operators Forum, and there is an acknowledgement that it needs to be addressed at a national and legislative level perhaps utilising the National Child Protection Framework.
   - current challenges in exchanging information with other jurisdictions that have different definitions, thresholds and understandings. The Royal Commission process has also identified the difficulties around information exchange.
   - emerging issue that a number of Working With Children Check (WWCC) bars have been lifted following employees appealing a decision with NCAT. Whilst this is not an issue that was raised by OOHC NGOs at the forum, it is an area that will impact on OOHC NGOs in the future; both in bars being lifted on particular employees as well as a longer term impact on practices surrounding reportable conduct findings and outcomes.

3. **Knowledge and learning** that is consistent, regular and targeted for staff at all levels of OOHC NGOs.

   The need for more training and information was a strong and consistent message throughout the forum. Eighty percent of groups in the day two workshop identified training in their discussion response to the question posed ‘how do we build on what works now’. Contact with various organisations including Office of the NSW Ombudsman, Office of the Children’s Guardian, Victims Services, AbSec and ACWA following the forum indicated there is a significant amount of training and information that is already available to the sector that is currently not being accessed by parts of the sector. There was an acknowledgement that the complexity of managing critical incidents requires specific learning and skills development for all levels of OOHC NGO staff and carers.

   Additionally, there were a number of key areas that were not able to be fully explored within the time limitations of the forum that require further discussion, promotion and development by the sector. A summary of these areas can be found at **Appendix D**.

4. **Ongoing practice improvement**: review and reflection.

Ongoing practice improvement was identified by a number of the key speakers and the content of the workshop discussions reflected that this had considerable resonance with many participants. Whilst there was consensus about the need for review, reflection and practice improvement, it was approached from a number of different perspectives. Seventy percent of the workshop groups identified the need for some sort of review or reflection occurring following a critical incident. Many of the comments indicated a collaborative approach to review was needed. FACS Safe Home for Life presentation identified the importance of actively seeking opportunities for critical reflection.

The Office of the Senior Practitioner (OSP) presentation identified that:

- The way we respond as a service system and as individual agencies following critical incidents has consequences for service delivery and ultimately the children and young people we serve. OSP referenced the response by England's child protection system following the death of Victoria Climbe that resulted in a 50% increase in removals and very risk averse practice that was not good for workers or children and young people.
- In ten years and over some 800 child death matters, only one death was linked a workers action or inaction, there are usually multiple points that the system let the child down, not one individual worker.
- Critical events can influence an individual's work with children and families for years and can have an effect on staff retention.

The OCG introduced concepts and areas that OOHC NGOs should consider in working towards making their agency a child safe organisation. These areas included situational prevention, effective risk management and creating and maintaining a child safe culture. This was an area that had considerable resonance with the participants however the scope of the forum did not allow a full consideration of these issues.

As noted in **Table 2,** preventative work was identified as a specific knowledge and learning need for the sector.

Ongoing practice improvement is an area of OOHC NGO development that requires active prioritisation by NGOs and will require significant effort and be driven by a change in organisational culture The sector has communicated that the challenge of balancing current workload demands with capacity and resources may impact the ability of individual organisations and the sector to make review and reflection an area of priority.

TABLE 1 - THOUGHTS AND IDEAS FROM THE FORUM PARTICIPANTS

THEME	ISSUE	THOUGHTS
COLLABORATION	Local level collaboration	Participants articulated a desire that collaboration occur at a local level with some formal protocols in place to assist this occurring. There were many positive references in relation to Regional Implementation Groups (RIGs)[4] fulfilling some of this role. There was agreement that the RIGs provided a formal structure that allowed individual relationships to be forged that resulted in improved outcomes for children and young people.
	Aboriginal OOHC NGOs partnerships with government agencies	These relationships need to be pro-actively pursued given their unique history with government agencies generating a level of distrust distinct from the experience of other OOHC NGOs.
	Partnerships and information sharing with government agencies	There was varied and limited understanding about how government departments and OOHC NGOs should be collaborating. Participants appeared cognizant about the need to work collaboratively with FACS, JIRT and the Office of the NSW Ombudsman in relation to reportable conduct and child deaths however there was varying understanding and awareness of the use of Chapter 16A[5] in sharing information and how to work with these agencies on a practical day to day level.
	Enhancing knowledge	Many participants expressed that they were unaware of the specific role and responsibilities of: • Victims Services (and NGO's specific responsibilities under the Charter Of Victims Rights) • the role of Health in JIRT • NGOs, FACS and the Coroner's Office working together following a death of a child or young person in care
INFORMATION EXCHANGE	Understanding when and how to use Chapter 16A to share information	The current inconsistent understanding within the OOHC NGO sector indicates that the explanation about how to use Chapter 16A to share information on the Department of Premier Cabinet's Keep Them Safe (KTS) website is either not being accessed or is not understood.
	Exchange information across jurisdictions	The information on the KTS website does not identify process for information exchange outside NSW jurisdictions. FACS current advice to OOHC NGOs is to make these requests via Child and Family District Units (CFDU) who will then negotiate these requests via the FACS Interstate Liaison Unit.
KNOWLEDGE & LEARNING	Leadership and coordination	There is a need for coordination and leadership in the management of knowledge and learning opportunities within the sector that is currently not being met. There is a need for a stock take of current training and resources.
KNOWLEDGE & LEARNING	Challenges in the provision of knowledge & learning	• Providing consistent information to a varied and changeable workforce across the state • Foster carers access to knowledge and learning given their varied circumstances and limited availability due to providing care for children and young people • Accessing knowledge and delivery of training in rural areas • Maintaining consistency whilst ensuring local engagement occurs in the delivery of training • Providing specific and targeted training delivered by experts • Cross sector training opportunities to increase collaboration and relationships across the sector.
	Specific learning and skills development	Targeted learning and knowledge opportunities to all levels of OOHC NGO staff and carers are required to address the complexity of managing critical incidents
	Increase NGO awareness about key agencies & the services they provide	These agencies include: • JIRT (the health arm in particular) • Victims Services • Office of the NSW Ombudsman • Coroners Office • OCG (becoming a child safe organisation) • FACS role in the management of child deaths
	Managing disclosure of abuse	Appropriate responses to disclosures of abuse, including: • reporting the abuse • recording disclosure • supporting children and young people through the JIRT and the criminal process system
	NGO roles / responsibilities and legislative requirements following a death of a child in care	This includes: • Reporting requirements of S172 of the Children and Young Persons (Care and Protection) Act 1998 • The Coroner's Office identifying next of kin via biological parents, as guardianship reverts back to the biological parents at the time of deaths • responsibilities in funeral arrangements and arrangements for the child's possessions • support of birth parents and siblings • how the OOHC NGO may act to support the Coroners office and the NSW Police Service, securing (rather than preparing) files processes of review following the death of a child.
	OOHC NGO obligations in conducting their own investigations (irrespective of whether FACS or Police are investigating). Appendix D	This is particularly significant given the majority of reportable conduct matters will not include primary investigation by JIRT or police. This includes: • making their own findings and taking necessary action in relation to the employee, carer and child. • ongoing risk assessment and management during and after an investigation • liaison with a variety of agencies throughout the investigation period. This includes managing risk and information in matters where a third party (JIRT, FACS and Police Local Area Commands) is investigating. • management of dual processes of the investigation of reportable conduct allegations and internal misconduct and disciplinary processes with paid employees (not carers). • responsibilities in notifying the OCG (Carer's Register) and after findings of misconduct in relation to

[4] Regional Implementation Groups (RIGs) were established in 2012 as temporary governance structures to support the state wide and regional implementation of the plan to transition OOHC service provision to the non-government sector. This was part of a key commitment to embed shared leadership and collaboration in building the new service system.

[5] *Children and Young People (Care and Protection) Act 1998*

		serious physical assault and sexual misconduct). • managing conflict of interest and maintaining the integrity of investigation • managing reportable allegations outside the workplace
ONGOING PRACTICE IMPROVEMENT	Reviewing critical incidents	Ensuring that our responses to critical incidents contribute to improved practice and do not adversely affect our service delivery to the sector and individual workers.
	Seeking improvement within individual organisations	This included increasing the knowledge and skills of workers, becoming child safe organisations and strengthening policies and procedures.
	Seeking improvement across the OOHC sector	Through increased collaboration with government agencies and support agencies to improve and create systems that will improve outcomes for children and young people.

TABLE 2 – STRATEGIES AND SUGGESTIONS FOR SECTOR IMPROVEMENT FROM THE FORUM PARTICIPANTS

THEME	STRATEGY	SUGGESTIONS
COLLABORATION	Panels	Establishing panels to manage, discuss, make decisions and discuss complex issues
	Formal partnership agreements	Formalising agreements regarding partnerships/interagency collaboration e.g. MOUs. The sector to develop a clear agreement and statement outlining role and responsibilities of FACS and OOHC NGOs in responding to child deaths. Given these events will be infrequent and involve high levels of emotions and stress this information needs to be clear and easily accessible and embedded into existing NGO policy and procedures.
	Local partnerships	Strengthen local initiatives, such as the Regional/District Implementation Groups (RIGS/DIGS) , including: • developing and delivering local based training through local partnerships e.g. RIG/DIG working groups • seek increased involvement of government agencies in RIG and RIG working groups • facilitate community building activities such as foster carer celebrations/fun days
	OOHC Bulletin Board	Establishing and sharing an OOHC Bulletin Board
	Internships	Developing opportunities for cross agency internships
	Proactively seeking advice from other agencies	• sharing and reviewing each others policies • seeking input from government agencies and services (such as JIRT) at pathways meetings and working groups
	Sector engagement	Agencies to prioritise and ensure participation at forums and interagency training opportunities
INFORMATION EXCHANGE	Awareness raising of the use of Chapter 16A	An awareness raising strategy in relation to use of 16A by OOHC NGOs in sharing information with other designated agencies including a sector specific fact sheet directing OOHC NGOs to the KTS website and containing information about how OOHC NGOs can access information outside the jurisdiction of NSW.
	National approach	A national approach to longer term solutions to address current legislative barriers to information exchange outside the NSW jurisdiction.
	Understanding NSW Civil & administrative Tribunal (NCAT) requirements	Further exploration and action by OCG, FACS, NSW Ombudsman and other key agencies of issues emerging from NCAT processes.
KNOWLEDGE & LEARNING	Cross agency training	The sector to identify knowledge and learning opportunities in relation to: • trauma informed practice for clients and workforce • NSW Ombudsman training to OOHC NGOS about how to conduct investigations of reportable conduct • JIRT training / resources for case managers and foster carers on how to respond to a child or young person disclosure of abuse, including issues to consider when interviewing children • OCG deliver training to support NGO develop child safe organisations • Victims Services training for NGOs about the services they provide that are available for children and young people in OOHC and NGO responsibilities under the Charter of Rights
ONGOING PRACTICE IMPROVEMENT: REVIEW & REFLECTION	Embed review processes	The sector develop strategies to encourage a culture of actively seeking feedback and looking for opportunities for learning via the complaints system as well as creative thinking about ways for getting feedback from staff, carers and children and young people. The sector to access resources and support from the Office of the Senior Practitioner to support this process This includes embedding processes of review in OOHC NGOs within their: • policies and procedures • code of conduct • complaint processes • culture and language • responses to critical incidents to include post critical incident review
	Cross sector guidelines	Government partner agencies develop guidelines and/or distribute tools to assist the NGO OOHC sector in reviewing critical incidents that are in alignment with their contractual obligations with FACS, including advice about: • limiting the public nature of the incident • being respectful and transparent in review process • avoiding polarizing frontline and management • early engagement of workers in the review process • communicating with the FACS contract manager
	Establishing preventative strategies	• Inclusion of reportable conduct information within induction processes, codes of conduct and training • Ensuring children and young people have opportunities and relationships to make disclosures • Use the resources and training about become a child safe organisation provided by the OCG.

CONCLUSION & NEXT STEPS

The forum successfully brought together key partners and stakeholders to learn, contribute and identify how we can strengthen the current NSW OOHC system to ensure that its response to critical incidents results in the best possible outcomes for the children and young people in OOHC.

The forum:

- played a significant role in the ongoing dialogue within the OOHC sector successfully bringing together key partners and stakeholders to learn and contribute in the area of critical incidents
- provided an opportunity for the sector to reflect on how it currently meets the needs of the children and young people of NSW in this challenging area
- brought together many key players to identify how we can strengthen the current OOHC NGO system to ensure that its response to critical incidents results in the best possible outcomes for the children and young people it serves
- strengthened relationships between OOHC NGOs and key partners and has led to the development of a number of resources and activities contributing to improve the service system and outcomes for children and young people in NGO OOHC in NSW
- identified a number of key areas that require further work and development and require ongoing collaboration of OOHC NGO sector and its partners to continue to improve the system.

WHAT HAS HAPPENED SINCE THE FORUM?

The conversation has continued as we work towards strengthening our systems to enable joint solutions and foster shared accountability in managing critical incidents in OOHC sector. Our external and internal working groups reconvened to discuss the themes and issues that were raised at the forum and other opportunities in this area.

The conversations between OOHC NGOs and key partners at the forum and beyond have led to the development of a number of resources to improve the service system and outcomes for children and young people in OOHC NGOs in NSW.

The following resources have been developed to assist OOHC NGOs in their management of critical incidents:

- Recordings of the forum webinars (opening session speakers and key note panel discussion) can be found on FACS website. Keynote speaker podcasts and transcripts have been published on NGO Learning Centre website. These include:
  - FACS Secretary opening address
  - What is JIRT
  - The role of AbSec
  - The role of ACWA
  - The role of the NSW Ombudsman
  - The role of the Children's Guardian
- Panel discussion transcript with additional responses to questions not addressed at the forum due time constraints (**Appendix C**)
- Resource wall chart for OOHC NGOs (**Appendix E**)
- Critical Incidents: information and resources for OOHC NGOs (**Appendix F**)

- Information exchange: information and resources for OOHC NGOs (**Appendix G**)
- Working with JIRT: information for NGO caseworkers working with JIRT to support children and young people in OOHC NGOs (**Appendix H**)

In addition to this, resources regarding victim support have also been developed by FACS to assist OOHC NGOs:

- Supporting victims of crime: Information for OOHC NGO caseworkers factsheet
- Supporting victims of crime guidelines

WHAT ELSE NEEDS TO HAPPEN?

The NSW OOHC sector has expressed its commitment to collaboration and service improvement in the area of critical incidents.

The sector needs to ensure that an ongoing dialogue continues that fosters shared accountability in identifying issues and producing joint solutions and further systems improvements to:

- address the four key themes noted in this paper
- develop, promote and facilitate knowledge and learning including:
  - a stock take of knowledge and learning resources to meet the ongoing needs of the NSW OOHC sector
  - develop and deliver targeted knowledge and learning resources to the NSW OOHC NGO sector
  - implement opportunities to distribute key pieces of research and information to the NSW OOHC NGO sector
- progress the improvement of information exchange outside the NSW jurisdiction
- deliver a follow up forum(s) to provide an opportunity to further explore areas of development within the NSW OOHC NGO sector.

FACS is committed to working collaboratively with its partners in the OOHC sector to identify strategies to improve responses to critical incidents, with the aim of achieving the best possible outcomes for children and young people in OOHC in NSW.

Thanks and acknowledgement

FACS would like to acknowledge and express our thanks to all the individuals across the OOHC NSW sector that not only contributed to the productive dialogue at the Managing Critical Incidents in OOHC NGOs Forum, but contribute every day to working towards improving the outcomes for children and young people in OOHC in NSW.

Appendix A Program Agenda

TRANSITION PROGRAM

AGENDA

MANAGING CRITICAL INCIDENTS IN OUT OF HOME CARE (OOHC) NGOs

Aerial UTS Function Centre, UTS Building 10, Level 7, 235 Jones Street, Ultimo 2007

DAY 1 **Monday 20 April 2015** **Wattle/Thomas Room**
9:00 – 5:30pm **Live webinar from 9-11:10am**

*** Presenter podcast will be available on the FACS NGO Learning Centre in the near future**

Purpose: The aim of the forum is to provide OOHC NGO service providers opportunity to increase understanding of their roles and responsibilities in managing critical incidents including: reportable conduct matters; child deaths; working with the Joint Investigation Response Team (JIRT) and; to inform the sector about the new Victims Services. The forum will also provide the platform for government agencies and OOHC NGO service providers the opportunity to discuss, and identify barriers and opportunities to improve systems and responses to critical incidents.

MC: Jo Sammut, Director, Transition Program, Child Safety & Permanency, FACS

TIME	CONTENT	PRESENTER
8:15am	Arrival & registration	
9:00am	Welcome to Country	Uncle Allen Madden
9:05am	Welcome & opening address	Michael Coutts-Trotter, Secretary, FACS
9:15am	Welcome & introduction to managing the critical incidents service system	Simone Walker, Program Design and Innovation, Programs and Service Design, FACS
9:25am	Definition of a critical incident and lessons learnt by FACS about critical incidents *	Kate Alexander, Acting Deputy Secretary Programs & Service Design, FACS (and Executive Director Office of the Senior Practitioner - Quality & Innovation)
9:55am	**Key Note Speakers** Office of the NSW Ombudsman * Office of the Children's Guardian * Victims Services AbSec * ACWA *	 Steve Kinmond, Deputy NSW Ombudsman Kerryn Boland, Children's Guardian Mahashini Krishna, Commissioner of Victims Services Dana Clarke, Board Chair, AbSec Andrew McCallum, CEO, ACWA
10:55am	Forum overview & housekeeping	Jo Sammut, Director, Transition Program Office, Child Safety & Permanency, FACS
11:00am	Morning tea	
11.30am	**Participants to attend one of the following concurrent workshops:** **WORKSHOP 1 - Jones/ Broadway Room** Media training in response to a critical incident. **OR** **WORKSHOP 2 - Wattle/Thomas Room** Responding to reportable conduct and child death matters in OOHC NGO.	 Kristine Murray and Sonia Zavesky, The Media Training Professionals Julianna Demetrius, Office of NSW Ombudsman Natasha Mewing, Office of NSW Ombudsman Monica Wolfe, Office of NSW Ombudsman Kelly Hetherington, FACS Helpline Susan Mattick, FACS Reportable Conduct Greg Bennett, Operations Manager, AbSec Donna Mapledoram, FACS Child Deaths Jane Gladman, NSW State Coroner, Dept of Police & Justice
1:00pm	Lunch	
2:00 pm	**Workshop 1 & 2 continue**	
3.30pm	Afternoon tea	
3.50pm	**Workshop 1 & 2 continue**	
4.30-5.30pm	**Networking drinks & nibbles**	

TRANSITION PROGRAM

AGENDA

MANAGING CRITICAL INCIDENTS IN OUT OF HOME CARE (OOHC) NGOs

Aerial UTS Function Centre, UTS Building 10, Level 7, 235 Jones Street, Ultimo 2007

DAY 2 **Tuesday 21 April 2015** **Wattle/Thomas Room**
8:45am – 4pm **Live Webinar from 2:30-3:30pm**

*** Presenter podcast will be available on the FACS NGO Learning Centre in the near future**

TIME	CONTENT	PRESENTER
8:45	Arrival	
9:00am	Welcome to Country	Uncle Allen Madden
9:05am	Welcome to Day 2	Jo Sammut, Director, Transition Program Office, Child Safety & Permanency, FACS
9:15-10:30am	Joint Investigation Response Teams (JIRT) working with OOHC NGOs *	Cherie Smith, Assistant Director, JIRT, FACS Peter Yeomans, Detective Inspector, Child Abuse Squad, NSW Police Catharina Webb, JIRT Health Workforce Development Officer, NSW Health Education Centre Against Violence
11:00am	Morning tea	
11:30am	Wandabaa Mari Performance	
11:40am	Child Safe Organisations	Morgan Lander, Child Safe Project Officer, Office of the Children's Guardian
12pm	**Group activity:** What works now when there is a critical incident and how do we build on what works?	Myra Craig, Executive Director Community Services, Statewide Services, FACS
1:30pm	Lunch	
2:30pm	**The Panel Challenge** Panel Challenge (2 minutes) – agency thoughts & directions Forum questions and themes Questions from the floor/webinar	Myra Craig (facilitator) The Panel: Steve Kinmond, Deputy Ombudsman, NSW Ombudsman Louise Coe, Director, Office of the Children's Guardian Mahashini Krishna, Commissioner of Victims Services Andrew McCallum, CEO, ACWA Greg Bennett, Operations Manager, AbSec Simone Walker, Program Design and Innovation, Programs and Service Design, FACS
3:30-4pm	**Wrap up & next steps**	Jo Sammut, Director, Transition Program Office, Child Safety & Permanency, FACS

Appendix B

Day One Group activity checklist: What do I need to do when there is a critical incident?

Participants attending the *Responding to reportable conduct and child death matters in OOHC* workshop were divided into table groups of approximately ten people. Seven groups were given a case study outlining a reportable conduct scenario and six groups were given a case study outlining a child death scenario. Both groups were asked to consider the scenarios and respond to the questions listed with the case scenarios and record their responses on butchers paper within the following domain areas; community, family, staff member, child, agency, carer and other. Each group was given a facilitator to encourage robust discussion and was briefed to only prompt where necessary to answer questions and help the group recognise guidelines that currently exist to guide their practice.

Reportable Conduct Scenario:

Observations (seven groups):

- All groups identified the need for a risk assessment and consideration of supports
- Six groups identified the need for procedural fairness
- All groups mentioned reporting to the Ombudsman and three groups also mentioned contacting the Ombudsman for initial advice or support
- Five groups mentioned contacting or reporting to the FACS Helpline – the other two groups commented about liaising or joint work with FACS
- Five groups mentioned the use of Chapter 16A: two groups did not specify whether this was to request or provide information; one group specified this was to provide and request information; one group specified this was to provide information; and one group specified this was to request information. Of the two groups that did not mention Chapter 16A, one group mentioned the carer's other employer and the other group mentioned 'information to and from with regard to investigation, child and carer'
- Four groups identified the carer's secondary employment as an issue
- Four groups identified John or other household members as an issue
- Four groups referenced policies, procedures or guidelines
- Two groups identified carer history as an issue
- Two groups identified child's history as an issue

It is difficult to know what impact the facilitator or group make up had on the information recorded. It is also difficult to make conclusions about the content of the discussions based on the group's note taking. In addition, the attendees are a particular group within the sector: a group that has already identified managing critical incidents as a topic worthy of attending a forum. However, with the above limitations noted, the following conclusions may be made:

- The understanding of what Chapter 16A can be used for and how it can be used varies
- There is a lack of clarity in NGOs understanding of how they should work with FACS following a reportable allegation
- There is a lack of clarity in NGOs' understanding of risk assessment and risk management (i.e. risk to child, carer, agency or other children and what information should be gathered or considered in this)
- There is a lack of clarity in NGOs' understanding of procedural fairness (i.e. they may know it is an issue may not know what it means in terms of practical tasks)

- There is a lack of clarity in NGOs' understanding of recording and documentation requirements
- There is a lack of clarity about requirements for NGOs to have policies and procedures in place and the quality of policy and procedures
- Only four out of seven groups identified 'John', the carer's partner, as an issue, indicating a lack of clarity about identifying risk or grooming behaviour.

None of the groups explored the scenarios beyond an initial response. This was reasonable given the scenarios, questions asked and time constraints. In relation to reportable conduct, this is a significant 'unexplored area' for future work. In particular:

- NGO's obligations to conduct their own investigations (irrespective of whether FACS or Police are investigating), make their own findings and take necessary action in relation to the employee, carer or child.
- Issues of conflict of interest and integrity of the investigation e.g. in the case scenario it is likely that the carer would want John, the carer's partner, present for the interview and as a possible perpetrator and/or witness this would not be appropriate
- NGO liaison with government agencies throughout the investigation period including: managing risk in a matter where police or FACS are investigating including the management of risk in a matter FACS or police has not given clearance for the NGO to investigate. NGO responsibilities in notifying the OCG
- Police Standard Operating Procedures (SOPS) – are there SOPS for NGOs? I.e. for working with Local Area Commands (LACs)?
- Need for ongoing risk assessment and management
- Reportable allegations in relation to their paid staff (inside and outside the workplace)
- Despite presentation by Kate Alexander that morning not many of the groups identified her key messages about securing the file, involving staff early in the process and arranging external support for the staff member (so they can feel safe), linking future work of the NGO with the way the NGO responds to the critical incident e.g. becoming risk adverse
- The scenario did not lend itself to a discussion of:
    - victims services/compensation(noting presentation on Day 2)
    - preventative practices such as child safe organization; whether the child had an opportunity to speak with the worker without the carer present(case management; inducting or training carers about the process of reportable conduct investigation; and rigorous assessment processes
    - reflective practice following a critical incident

Child Death Scenario:

Observations (six groups)

- Four Groups identified securing or preparing files for review
- All groups identified funeral arrangements as an issue. None of the groups identified who would take the lead role or incur the financial cost of this.
- All groups identified support for carer
- All groups identified support for staff members
- Three Groups identified support for 'family'

- One group identified managing such things as Facebook as an issue
- One Group mentioned S172 (this requires Principal Officers of designated agency who has supervisory responsibility of the child must immediately notify parents, Children's Guardian and Coroner) however I note that all groups identified notifying parents and family (only one group specified by who- jointly FACS), two groups identified notifying Coroner thee groups identified notifying OCG, four groups identified notifying NSW Ombudsman. I note that the case scenario references a P79A report of death to Coroner and that FACS was notified, this may account for some groups not including notifying the Coroner

It is difficult to know what impact the facilitator and group make up had on the information that was recorded. It is also difficult to make conclusions about the content of the discussions based on the group's note taking. In addition, the attendees are a particular group within the sector: a group that has already identified managing critical incidents as a topic worthy of attending a forum. Whilst groups have recorded actions and issues under different headings, there appears to be a fair degree of consensus.

The headings appear to have been good prompts in thinking about different aspects but were interpreted slightly differently by groups. Whilst things like 'Coroners office' were noted, it is not clear whether NGOs understood what this should look like (keeping in mind Jane Goodman's presentation earlier that day)

However, with the above limitations noted, the following conclusions may be made

- There is a lack of clarity in NGOs' understanding of the legislative framework and requirements e.g. S172, unclear if NGOs are aware that following the death of child, guardianship reverts back to the biological parents
- There is a lack of clarity in NGOs' understanding of who takes the lead and financial responsibility in organising the funeral and what is done with child's possessions.
- There is a lack of clarity in NGOs' understanding of who takes responsibility for supporting birth parents and siblings
- No mention of how NGOs may act as an intermediary between Coroners office and police
- NGOs have a general understanding that files will be reviewed – it is not clear whether NGOs understand that files should be 'secured' rather than 'prepared'

Scenario 1: Child Death

Table Number	Child	Agency	Carer	Family	Other	Community	Staff Member
4	Clarify legal status of the child Draw on supports identified in the child' cultural support plan to assist the carer and family following a death	Notify head of agency On call response Report to the helpline Seek advice from FACS Interim action plan Gather information Prepare files for external review	Physical support Incident report Risk assessment Debrief/ counselling	Notify mother in accordance with agreed action plan Notify aunt, siblings and extended family in accordance with agreed action plan Debriefing and counselling Meet with family and define roles/ responsibilities for future arrangements	Ensure police are aware of death	Funeral arrangements negotiated with FACS Manage potential impact on broader community Media release response	Debrief/ counselling Advising other staff of incident
3	Sibling safety Cultural- paying respect	Escalate to services/CS Notify the CEO Ombudsman	Support other children in placement	Mum and siblings of extended family Notification for all family done by CS/FACS jointly	Police report Travel Communication Ombo??	Support i.e. health support clinical Notification of death	Clinical support debriefing
8	Secure file Life story Assisting with funeral arrangements	Review policy Risk assessment Carer training Media management Availability for placement of other children	Support Risk assessment Training Review authorisation	Support Notification Risk assessment Sibling safety ATSI Assisting funeral	Report to the Ombudsman, AAE, Children's Guardian Liaise with police stakeholders	If Aboriginal – consultation with elders etc.	Support Notification to agencies debrief

Table Number	Child	Agency	Carer	Family	Other	Community	Staff Member
		Safe sleeping policy?		arrangements			
9	Section 172 Notification of death to parents	Internal notification Seal files Notifications to Coroner, Police, office of the Children's Guardian Prepared for media Review information and training ROSH report Safety/risk assessment Key NGO contacts	Supporting the carers Extra support of critical times e.g. anniversary	Funeral arrangements Costs Life story work possessions	Siblings NGO	Sibling's school Cultural community	Supporting staff members EAPS Relevant staff members
11	Decisions around coronial and funeral processes Respecting the child's relationships and belongings	Policy – reviews, critical incidents Media communication personnel Consultation – FACS, NGO, Aboriginal Notification to NSW Ombudsman Agency involved in investigation Media policy Information security	Supports and other children (own) – immediate, medium and long term risk Reportable conduct New risk assessment: further placement of children, authorised carer/household members	Notification: who, when, how, siblings(ongoing support) Who has the relationship? FACS/NGO/ CARER Support for the post death process Legal supports	Rapid timely notification: families, between agencies Social media management Remembering the human aspect within the 'process and system'	Carer community School community for siblings Notification of Aboriginal services, elders/kin/community, consultation	Debrief/ counselling Order of notification Make aware of process re investigations Information security

Table Number	Child	Agency	Carer	Family	Other	Community	Staff Member
		Media policy: delegated person, contact FACS/NGO Advise process for RC					
13	Coroner Funeral arrangements When the child is to buried and who plans e.g. parent Childs belongings	Refer to NGO policy Advise FACS, police Ombo, OCG, Coroner advise parents After hours support and processes for carer/response Debrief and support for staff Communication with police/FACS/Ombo Info sent up/returned at the end of investigation	Immediate support Risk assessment of carer situation and children if any living in the home – may need to be moved Review of situation Was safe sleeping training done	Advise family Support and assistance to family Other siblings? Funeral arrangements Child's belongings? Liaise with police re family discussion if suspicious	Media response with FACS if required Do we manage things such as Facebook? Internal review and practice considerations Police investigation	Who needs to know? E.g. significant people in Aboriginal community Other people involved in the child's life e.g. pediatrician/Dr/preschool?	Make sure all staff are aware Debrief and support Files and information is ready to go Immediate tasks Ongoing tasks e.g. support and counselling

Scenario 2: Reportable Conduct

Table number	Child	Agency	Carer	Family	Other	Community	Staff Member
1	Safety and ongoing supports Safety concerns (DV/removal/current partner)	About meeting obligations and improving systems A policy around assessing carers?	About supports and procedural fairness Probity checks: John? Carer?	Adam – casework-know about him, safety concern? To and from? Biological family –	About information to and from with regard to-investigation, child and carer	School liaison re role of NGO and action will be taken	About timely and appropriate casework practice/ investigation NGO caseworker

Table number	Child	Agency	Carer	Family	Other	Community	Staff Member
	Voice of child in home visits? Direct relationship/contact between caseworker and child (separate from carer opportunity to disclose) Supports- loss, life story Behavior plans for H and F? relevant to allegations as well History of children Greif and loss addressed?	Guidelines for caseworker Information from prior agency	Carer expectations – advice initially and refresher Counseling and grief History of reportable conduct and own agency What reviews/training/ support has been/is in place for Sarah Changing level of support	right to know? When to tell	FACS liaison: transition and transfer information Health? NSW Ombo: advice from and notify Education: relevant as she works there OCG Police victim		supports? Knowledge and training of policy and procedures including information sharing with carers Relationship building with carers Supervision of caseworker Job description Concerns about frequency of visits Why is school advising of info Handover information about case – read to < fully across information to with kids Specific training needs: trauma, BMP and restrictive actions etc.
2	Risk assessment Safety of placement Respite	Restrictive practice – computer (Behaviour Management Plan) Reportable	Interview by person other than caseworker Support	Placement change non-ROSH – no report substantiated ROSH report- informed	Probity checks 16A Carers register	Supports for foster carer while grieving	Supervision re carer support policy

Table number	Child	Agency	Carer	Family	Other	Community	Staff Member
	Joint interview	Conduct: neglect, smacking, tickling, locking in room Grief counseling – death in family WWCC Foster carer supervision Staff supervision Checks Senior management input	Training Annual review 12 month authorisation	after investigation finalised	Notify Ombudsman- reportable conduct Consult with health, therapeutic support Education plan Notify FACS Adam		
5	Conduct risk assessment Interview child/ren Checks re John, assess role and living arrangements Report to Helpline (Review MRG)	Talk to manager Risk assessment Part A notify to Ombudsman Contact Ombudsman for clarification Investigation Follow policies and procedures	Risk assessment Notify carer of investigation Keep informed Procedural fairness	Inform any significant changes/critical event	Education (child's school) Ombudsman Legal advice as an agency where needed ?Sarah's employer ?Health ?OCG	Community expectation to keep children safe	Conducts investigation *This group attached plain butcher papers with the following: Stakeholders: children/young people, carers, birth parents- children, Ombudsman, OCG, the agency, CEO/PPO, FACS, JIRT/police/coroner Siblings (birth and foster) Issues: 'John' – background? Who knows him? Is he staying there?= case management and R Sarah – hit with a

Table number	Child	Agency	Carer	Family	Other	Community	Staff Member
							wooden spoon x2 – injury (could not sit)=RC & R Leaving children at home=RC & R Lock Hayden in the bedroom all weekend=RC &R Sarah's change-disengagement = case management & R John – tickling in bath = R (risk issue?) Kids – escalating behaviours= case management John – taking a role in alone with children, taking the to events, isolating carer from agency Carer's partner recent death Sarah's employment in childcare Felicity reserved with older boys
7	Risk Assessment Determine safety of children in her care: foster/biological/ daycare Collecting information about children Medical assessment	Aboriginal consultation Placement matching Assessing others connected with household Information sharing	Advising of allegations Reviewing file Assessment of carer and others in household Advise of rights Process of allegation	Speak with grandmother and any others with contact Investigate other family members/re-engage History of reports made by family	Helpline Ombudsman-16A to Education Police Health Referring to JIRT	Position within the community Work roles with children	Review of practice Manager reporting Case file reviews Liaising with CSC Risk Assessment Interviewing children

Table number	Child	Agency	Carer	Family	Other	Community	Staff Member
	Interviewing children Moving placement Eligibility for victims compensation Support networks (family/school/friends) Education/school counselling	with other agencies Cultural support being provided Reinforcing expectations around supervision	review and their rights and support Carer family history Training Foster care support Advise of complaints process	members History of biological children Trauma services for Grandma	16A release of information for childcare Interstate info release Liaising with local CSC 16A release about John to the Guardian		
10	Immediate Safety Interview child Linking to support services Full child case review Procedural fairness/natural justice Childs right to know Victims of crime Removal of children Consideration of kinship placement	ROSH report Risk assessment Ombo's notification Internal Process Internal Investigation Plan Safety Plan New risk assessment Agency recommendations and outcomes Part B- Ombo	Contact carer both verbally and in writing Offer counseling/support Interview within 3 days Undertake relevant checks for people residing in household Procedural fairness/natural justice Appeals process	Consider best means of notification Support back to family	S16A to relevant agencies, education Consideration of notifying carer's employer Start process over again Helpline, police, ombudsman	Media management strategy Robust reportable conduct system	Caseworker follows NGO policy Agency supports CW confidentiality
14	Hayden 8 years/Felicity 6 years: teacher reassure Adam 16 years Visit (informal) by case	Document Report via internal procedure Organise respite(?)	Carer advised in conjunction with C/S if allegation needs to be investigated	Advise biological family 'soon' when it is known that allegation is to be investigated	ACAP if alternative placement Ombudsman	Assess ROSH: home visit, Adam, her work Advise NGO (C/S 16A on	Document Teacher – report helpline and NGO

Table number	Child	Agency	Carer	Family	Other	Community	Staff Member
	manager- care when questioning	after initial assessment Call Ombo for early advice Start Part A within 10 days Initial liaise with CSC – visit kids, talk to carer, decide first and next steps Risk assess	Also advise in writing and OCG checklist Offer support etc.	formally Including paternal grandmother		John or agency) Allegation of reportable conduct	
15	Safety assessment and risk assessment Gather information Ensure safety and well being Provide support re interviews	16A: health, NSW Police, education, childcare service (employer of Carer)? Liaise with police/LAC during investigation Commence agency protocol re reportable conduct Secure relevant evidence – identify witnesses	Notify carer Provide general information and appropriate details re allegations Procedural fairness Offer supports Carer review Carer suitability/John Possible carer de-authorisation	Aboriginality Kinship groups maternal/paternal Aboriginal community carer options Advise of allegations- consider which family need to know details Manage relationship with family	NSW Ombo (immediately) FACS helpline OCG Liaise with school re ongoing monitoring Possible media interest Carer register	Possible media interest Maintain confidentiality Consideration needs to be given to current employer of Sarah	Review case management so far: case history, practices part of investigation Providing support

Case study – child death

Circumstances of death

Jasmine (b. 2/09/14) died at the age of seven months on 19 April 2015. She was found lying face down on a sofa bed by her NGO authorised carer, Ms Alanah Brown.

The P79A Report of Death to the Coroner states that Jasmine was placed to sleep on the sofa bed in the lounge room at 4pm on 19 April. She was placed on her back with two rolled up towels on either side of her body. Ms Brown checked on her at 5:40 pm and found her lying face down, cold and not breathing. Ms Brown performed CPR and contacted emergency services. Jasmine was taken to Nepean Hospital but was pronounced dead on arrival.

Family and Community Services (FACS) was notified of Jasmine's death on 20 April 2015. FACS has requested copies of forensic medical records from the State Coroner. To date, no further advice or information has been received. The final cause of death has not yet been determined.

Family structure

Jasmine was the third child of Samantha Phillips (b. 12/11/90) and Craig Stuart (b. 23/5/85, d. 19/12/14). Jasmine had two siblings, Aidan Stuart (b. 13/04/07) and Lisa Stuart (b. 10/03/2011). Both Aidan and Lisa were removed from their parents' care and now reside with their maternal aunt who has parental responsibility for them until they are 18 years old.

Court orders and legal status of child

Jasmine was removed from her mother's care shortly after her birth. Unfortunately Jasmine's aunt who cares for Aidan and Lisa advised she was unable to care for Jasmine as well. Consequently Jasmine was placed with Ms Brown (NGO carer) five days after her birth.

Final orders were made in the Children's Court on 8 March 2015 placing Jasmine under the parental responsibility of the Minister until she is 18 years old. It was proposed that she remain with Ms Brown long term with frequent contact between Jasmine and her siblings. Case management was transferred from FACS to the NGO shortly after final orders were made.

Child protection history

Parents

Ms Phillips was known to FACS as a child. She experienced chronic sexual, physical and emotional abuse and neglect in the care of her mother and her mother's partners. Ms Phillips was removed from her mother's care when she was eight years old, but restored two years later. She was then removed again at the age of 12 years, with final orders being made for Ms Phillips to remain in long term out of home care. Ms Phillips had numerous placements and experienced sexual abuse in care. She has a significant history of drug misuse and mental health problems including self harm and suicide attempts. Since leaving care, Ms Phillips was transient, homeless and involved in extensive criminal activity.

Mr Stuart died late last year from cancer. He did not have a child protection history.

Aidan and Lisa

Aidan and Lisa have been reported to be at risk of significant harm while in the care of their parents. Concerns were raised about the hazardous and unhygienic state of the family home and Ms Phillips and Mr Stuart leaving the children home alone and unsupervised for several days while they used drugs with friends. Over a period of three years, Aidan and Lisa were removed and unsuccessfully restored to their parents care on two occasions.

Jasmine

Jasmine was the subject of several prenatal reports prior to her birth. Most of these reports were about Ms Phillips' drug misuse and mental health. Ms Phillips had disclosed daily use of methamphetamines, was aggressive, refusing medical treatment and denying she was pregnant (despite being in the last trimester of her pregnancy).

Following Jasmine's birth, FACS conducted a safety and risk assessment which determined that she was unsafe and at high risk if left in the care of her mother. Jasmine was assumed into care and remained in hospital until a placement with a NGO carer (Ms Brown) was secured.

Questions

1. You have just been told that Jasmine has died. What do you need to do now? (List the actions/activities)

2. What else would you need to do if the circumstances were different?

What if:

- The carer had other children placed in her care?

- Jasmine's family identify as Aboriginal?

- The post mortem report reveals Jasmine suffered non-accidental injuries just prior to her death. Jasmine had a bi-lateral subdural haematoma (bleeding that is usually caused by a head injury), four fractured ribs and two recently healed fractures to her right arm.

- Police advise they are of the view that Jasmine's death is suspicious and there is a current police investigation into the circumstances of Jasmine's death?

- Media has contacted your organisation and is asking questions about the death?

Case study – reportable conduct

Hayden (8 years) and Felicity (6 years) entered out of home care in 2011 when they were removed from their parents due neglect and domestic violence. They are in the parental care of the Minister until they are 18 years old.

Sarah is the authorised foster carer of Hayden and Felicity and was assessed by Family and Community Services (FACS) as being suitable as their long term carer. Sarah has cared for a number of foster children over the past 14 years including when she resided in Queensland. Sarah has cared for Hayden and Felicity for four years, the last two as sole carer for the children after her partner died as the result of a work place accident. Living in the home also is Sarah's biological son, Adam, who is 16 years old.

Case management was transferred to your agency six months ago. Sarah commented recently that FACS had '*left her to do what she needed to do with the kids'* and that her new NGO caseworker '*does not give her five minutes peace.*'

Sarah identified concerns about Hayden's behaviour when he was initially placed with her in relation to him not following direction, being very active, swearing, hitting and pinching Felicity (sometimes leaving bruises). More recently Hayden has been getting into trouble at school. He will call the teacher names and will often ignore her. He has difficulty with his peers. Hayden will often complain about other children bullying him, but he is often seen to bully other children. Sarah and Hayden's caseworker have tried to work with the school to address some of Hayden's issues and there has been a slight improvement in his behaviour this year. School staff advised the caseworker that recently Sarah had seemed a bit distant from the children and it has been noticed when Sarah has come to collect the children, she is reluctant to control their behavior and on numerous occasions has let Hayden and Felicity fight and not intervene.

Hayden's caseworker advises that Sarah has recently commenced a relationship with John, who is very supportive and helpful in the day to day care of the children and as a result the caseworker has decreased the frequency of her visits to the home.
Felicity started school this year and her teacher commented that she has settled in quite well and has a number of friends in her class however is very reserved around older children, particularly older boys.

Last week Hayden had a difficult day at school and his disruptive behaviour continued until there was an incident at lunch time when he got into a fight with a younger child. Hayden hit the child in the face when the child said that Hayden could not play a game with him. Hayden received a short suspension from school.

Yesterday, Felicity told her teacher that Sarah was really upset over the weekend. Felicity said that Sarah got really angry that Hayden was suspended and Sarah smacked Hayden with a wooden spoon. Felicity also said that Hayden was locked in his room all weekend. Last week Felicity told her teacher that there had been times when Sarah had left the house and the children did not know where to find her.

Felicity also stated that John was very upset about Hayden's suspension from school and has '*put him on a computer ban for two weeks'*. Felicity stated that it is much better now that John is around as this time Hayden could sit down after Sarah hit him with the wooden spoon, not like another time when Sarah wouldn't let Hayden go to school because he could not sit on a chair properly. John has told Felicity that now that he is around they don't need their caseworker bothering them anymore.

Further discussion with Felicity indicates that John is spending a considerable amount of time in the home and takes Hayden to football training and cooks dinner on Monday nights. Felicity also disclosed that John plays a tickling game with her in the bath that she does not really like and that Sarah does not know about the tickling game.

Sarah works as a child care assistant in a long day care centre two days a week.

Questions

1. Your agency has just become aware of the above reportable allegations. What do you need to do now? (List the actions/activities)

2. What else would you need to do if the circumstances were different?

What if:

- A medical assessment of Hayden was undertaken and extensive bruising, some of which was faded, was found?

- Sarah's partner (now deceased) identified as Aboriginal however Sarah does not identify as Aboriginal? Both Hayden and Felicity identify as Aboriginal.

- Hayden and Felicity have regular contact with their paternal grandmother who has been vocal in expressing her dissatisfaction about the care the children receive from Sarah and has been to her local member in relation to the children's general care and that the children are not with an Aboriginal foster carer?

- There have been previous concerns in relation to Sarah's biological children who are now adults. Concerns include domestic violence, the children not attending school and absconding for significant periods?

- Contact with police indicates that Sarah's boyfriend John has a police history involving domestic violence and drug abuse?

Critical Incidents Forum

Day Two Brainstorm Activity

Groups were asked to consider what is currently working at agency, local and statewide levels and how we can build on what works now. Each group was given a facilitator to encourage robust discussion and was briefed to only prompt where necessary to answer questions and help the group recognise guidelines that currently exist to guide their practice.

Observations (10 groups):

- Many of things that were identified as 'working now' were also identified in 'how do we build on what works now' e.g. training
- Collaboration, training and sharing resources were common themes across groups
- In response to 'how do we build on what works now';
  - seven groups identified some sort of reflective practice/ reviewing policies/procedures/practice
  - six groups mentioned becoming child safe organisations (part of that resonance may be due to speaker before the group activity)
  - eight groups identified training ; three groups identified training as an interagency activity and three groups identified forums and conferences as part of training comments
  - three groups identified Increased involvement /and links to JIRTS/police

Ideas for action (as identified in tables):

- Induction of young people including charter of rights, photo book of who to go to, information posters including external services
- Community building activities e.g. foster carer fun days
- Training in investigative practice including interviewing
- ACWA and AbSec providing more regional and local training
- Training to Police with NGO OOHC
- OOHC Bulletin Board (input from OCG, Ombudsman, FACS)
- A role (within agency) that is responsible for critical incident management
- Cross internships
- Shared roster for training developed by interagency groups
- FACS has RCU worker, develop one for NGOs
- AbSec to developed resource package to share with ACWA to then distribute
- Code of conducts to include clear examples of appropriate/inappropriate conduct
- Standardised procedures
- Review policies and procedures and understanding by agency
- Review training
- Establish consistency in the exchange of information
- Carer and staff training in relation to reportable conduct
- Attend conferences and forums
- Sharing information from forums and conferences

- Seek advice from other services: proactive communication
- Provide feedback to agencies on their processes etc.
- RIGS as an opportunity to learn from other agencies experiences
- Provide robust responses to 16A requests
- Clear escalation/after hours procedures: sharing of contact numbers and identifying who is responsible
- JIRT attendance at Pathways meetings
- JIRT representative on working groups
- More JIRT resources
- Generic training package for frontline staff and carers about critical incidents
- Regional based training and supports (e.g. CREATE, foster care training)
- Develop opportunities to proactively seek feedback/complaints/strengths form children and young people
- Publishing information on website
- Independent care reviews
- Use JIRT and others expertise in training
- Trauma informed practice
- Panels to manage, discuss, make decisions and discuss complex issues
- Formal agreements re partnerships/interagency collaboration
- JIRT training
- OCG training: child safe organisations
- Special training for Aboriginal carers
- State-wide consistency in training and messages -Carer training from child safety
- Clear guidelines for sharing information about core messages/training and what/where is the scope for individualised approach/customise
- Centralised information - JIRT
- Training stocktake
- Identify coordinating role (? For training)
- More time to be strategic as opposed to operational
- Minimum level of entry and training for all staff

Brainstorm Activity

Question/ Table number	Agency	Local	State-wide
What works now? Table 2	Training Embedded healthy culture of child protection Awareness and empowerment of children and young people Good communication- instant response Record keeping and reporting systems Internal compliance checking Written policy and procedures Operation manuals and carer handbooks Relationships with children and young people- trust Induction of young people including charter of rights, photo book of who to go to, information posters including external services Providing professional confidence – follow through, honest, confidential, professional, integrity, congruence, leadership	Local partnerships with health, education and other stakeholders such as counsellors, health professionals Police if there is a major critical incident PCYC Ambulance Aboriginal perspective – significant people in the community (e.g. carers, elders, young people leaders Support groups for carers e.g. Kim Hawken CC [sic] Local CSCs if relationship with children and young people Other local agencies	Peaks Other colleagues in professional field Ombudsman Helpline sometimes; if there is a critical incident OCG legislation
How do we build on what works now? Table 2	Shared interagency training Sharing best practice models Community Building activities within agencies e.g. foster carer fun days Sharing skill sets on specialised issues Reflective practice opportunities Reviewing critical incidents Reviewing policies Training in investigative practice including interviewing A role that is responsible for critical incident management Adequate documentation to provide evidence Acknowledging success for outcomes Counselling and support for wellbeing of staff during after handling incident	Peer supervision Strengthening interagency relationships through areas MOUs Shared resources including staff specifically in relation to specialised skills Educating/liaising positively with police and emergency services Police contacts – pathways with police to foster consistent processes and responses More regional/local training	OCG and Ombudsman ACWA and AbSec providing more regional/local training Training to police with NGO OOHC OOHC bulletin board from OCG, Ombudsman, FACS, [?]agencies
What works now? Table 3	Have a good understanding of procedures when a critical incident occurs Agencies manage conflict of interest by getting	Good working relationships between involved agencies Well developed interagency partnership	Mandatory reporting legislation Regulatory systems well established and comprehensive

Question/ Table number	Agency	Local	State-wide
	other teams outside the district to do this. Cross internships	Work in partnership by modelling, shadowing, advising etc. Cross internships	When there is an incident there is a responsive system to support, advise and assist Building capacity and collaboration across
How do we build on what works now Table 3	Cross internships External investigators or another division investigating Building a child safe organisation – good practical tips Shared roster for training etc. worked at interagency groups	Working in partnership by modelling, managing and advising. Cross internships	RCU worker for FACS, develop one for NGOs AbSec developed resource package share with ACWA for distribution to all agencies
What works now? Table 4	Good relationships with external agencies i.e. Ombudsman, OCG, JIRT FACS etc. 24 hour on call Policies and procedures Good communication between agencies with all parties and stakeholders Regular review/update process and policies Exposure to new ideas through training Reflective Practices Documentation and record keeping Incident Reports Reviewing of case notes	Police Response Open communication and transparency Panel discussions Discussions RIG meetings: issues and risk log Good relationships/partnerships	ACWA and Ombudsman training: reportable conduct Resources available to all through websites
How do we build on what works now Table 4	Child Death Policy: accessible and in place Review of policy/training/understanding within agency of policy and procedures Roles and Responsibilities Clear transparent induction process Code of conduct: clear examples of appropriate/inappropriate conduct	Exchange of information Good transition meetings Communication Interagency collaborations and meetings Standardised Procedures Consistent training	Consistency in the exchange of information Good communication
What works now? Table 5	Incident Report Policy Investigation of reportable conduct Make ROSH Report to FACS Notify other agencies: Ombo and OCG Assess risk: take action to ensure safety	Relationship Building In constant contact with other services to build partnerships Interagency meetings RIG meetings	Attend forums/conferences Action recommendations and ideas from meetings/forums and conferences Being across ?ding/new legislation/new research

Question/ Table number	Agency	Local	State-wide
	Provide supports (carers, child and staff) Immediate concerns: notify police Build relationships with partner agencies i.e. school, police, FACS Media processes Being compliant Carer assessment processes WWCC's Retaining experienced staff	Regular FACS meetings	Attend training
How do we build on what works now? Table 5	Review policy, procedures and practice Suggest changes Sharing information learnt at conferences and forums Carer and staff training on Reportable Conduct Expanding child safe culture Continue up-skilling Don't underestimate NGO role and skills	Proactive communication Getting feedback from RIGS Promote child focus work Seek advice and assistance from other services	Communication Attend relevant conferences and seminars Network and build partnerships Be clear about what we want from another agency Remain child focused Seek advice from other services Provide feedback to agencies on their processes etc.
What works now? Table 6	Critical Incident Protocols – ISOPRO Agreement to meet in [sic] Media Policies/protocols Mandated reporting Reportable Conduct – investigations department Guidelines for consultation FACS specific policies i.e. sibling safety, critical incident, allegations against employees	FACS/NGO response to critical incidents/reportable conduct Policies and procedures Terms of reference Networking/relationships – across over all 3 spheres	Legislative responsibilities Responsibilities of agencies to ensure people are trained to respond WWCC 16A Criminal record checks
How do we build on what works now? Table 6	Learning form other agencies experiences i.e. child deaths via the RIGs and practice forums Networking and relationships	Robust responses to 16A need to be provided Learning from Critical Incidents: reflective exercises, de-briefing and reviews Escalation/after hours procedures need to be clear – sharing of contact numbers/details for the escalation of matters particularly after hours and establishing where it sits and who is responsible for it. Networking and relationships	Carer registry is rolling out but beneficial for national approach Best Practice Unit – learn from the model being developed. Networking and relationships

Question/ Table number	Agency	Local	State-wide
What works now? Table 7	Policy/guidelines Complaints management Sharing of skill set to manage situations	Communication Support Partnership Networking via relationships established Sharing knowledge Interagency governance Sharing of skillset to manage situations Strong representation at RIG	Clear procedures and processes Complaints management Oversight bodies: ombudsman, guardian Legislative provisions Support of a peak body and training advice
How do we build on what works now Table 7	Putting policy into practice – training and induction Carer induction training Areas that can be improved/building child safe organisations	Clarification with respect to JIRT criteria Partnership/share understanding with JIRT Possible attendance at pathways meetings/RIG meetings Forum for carers Improved information sharing process JIRT rep on working groups	Helpline contacts via service provider Mandatory reporting tool – identify authorised carer or child with parental responsibility to Minister More JIRT resources JIRT representative on RIGS Carers register Improved information sharing process JIRT rep on working groups
What works now? Table 10	Policy and Procedures: code of conduct, recruitment, HR, carer recruitment/authorising, training, case management and review WWCC – systems approach: compliance Establishment of investigation units Debriefing processes for staff/carers Consistent level of support for carers and children and young people	Partnership with FACS Networking/working groups Improved cross agency collaboration – not consistent	Information exchange e.g. S16 A Combined training NGO/government e.g. this conference OCG accreditation
How do we build on what works now? Table 10	Carer recruitment and training to include child safe organisation examples Training – ongoing – for agency staff and carers Specific examples of conduct expected in Code of Conduct Recruitment of staff in general is difficult to train and retain staff. OOHC requires specialised Working with Unis and TAFE re seminars/presentations	Improve opportunities for cross NGO collaboration	Generic training package for frontline staff and carers about critical incidents Regional based training and supports (e.g. CREATE, foster care training) Developing opportunities to proactively seek feedback/complaints/strengths from children and young people Focussing on ‘prevention’ and not just managing critical incidents.
What works now? Table 12	Policies and procedures: child protection, incident reporting management Staff training	Agency collaboration Child protection panels CRC	Legislation Court ACWA/CCWT

Question/ Table number	Agency	Local	State-wide
	Risk assessment Professional conduct Code of conduct Code of ethics Complaints chart/process for carers and workers Report and document Protective behaviour programs for kids Up-line to senior management Peer supervision and ongoing supervision Charter of rights Case reviews Work/health procedures Fact sheets/critical incidents WWCC Legal critical records Training and assessment S16A use H/V policy Case practice Case management Critical incident register RC register On call feedback (am) and 24 hour on call Panels: matching placement – carer assessment, multiple and related placements, high risk needs Case planning/visuals (for young person)	RIGs (working groups, share information between agencies) Connecting carers Local relationships with government (police DEC, health) Knowing services – referral i.e. FRS	AbSec training Mentor Sharing resources SHFL training/legislative Connecting carers NSW Ombudsman Victims Services OCG WWCC Service monitored by OCG/NDIS
How do we build on what works now?	Publishing information on website Independent care review Regular reflective practice Ongoing carer Training use JIRT input/others expertise Trauma informed practice Special training for Aboriginal carers Governance – child safety from the top down Aware of research local and national and overseas Panels; manage/discuss/decisions/complex issues	Joint training RIG calendar Working closely with other agencies Sharing info/resources Research Conferences Formal agreements re partnerships/interagency collaboration	JIRT training State-wide consistent messages and training - Carer training from Child Safety OCG training: child safe organisations Clear guidelines for sharing information about core messages/training and what/where is the scope for individualised approach/customise Centralised information – JIRT Stocktake training AbSec – Local Area Commander meeting/forum/Aboriginal services/NSW Ombudsman

Question/ Table number	Agency	Local	State-wide
			Calendar ? Coordinating role?
What works now? Table 14	Critical Incident Plan Everyone knows their role Ownership and responsibility Detailed plan	Support from local agencies Strong relationships Relationship with external agencies e.g. clinical support, victims support, health, Aboriginal agencies Training Collaborative work FACS support Cross agency relationships	Support from Ombudsman Reference/information Advice/guidelines JIRT valuable
How do we build on what works now? Table 14	More training Knowledge building Documenting Sharing knowledge and resources Leadership Reflection – what worked/what could we do better More time to be strategic as opposed to operational	Build networks Knowledge Relationships Youth advisory group Better technical support and resources (computer, iPad, phone, remote access) for caseworkers to make their jobs easier	More funding More support Clear guidelines Communication about who the key government agencies are and what they do Streamline paperwork Easier operational processes
What works now? Table 15	Reportable Conduct Process Complaints policy 24 hour/after hours support Connections to carers and children and young people Solid casework Employee training	Networking and Relationships: CSC, CFDU, other agencies, police, health, education, Aboriginal Community Organisations 16 A's Local sector network meeting	WWCC Fit2 Work TPO Forum ACWA CREATE OCG accreditation
How do we build on what works now? Table 15	Carer/staff training and up-skilling Develop child safe organisations Robust policy and procedures- constant improvement Obligations to staff/partnering agencies	CSC- transitioned carers and children Build relationships Maintain networks to be responsive to need	Consistent guidelines and practice Carers register Minimum level of entry and training for all staff

Appendix C Panel questions and answers

TRANSITION PROGRAM

MANAGING CRITICAL INCIDENTS IN OUT OF HOME CARE (OOHC) NGOs

Aerial UTS Function Centre, UTS Building 10, Level 7, 235 Jones Street, Ultimo 2007

DAY 2 - QUESTIONS TO THE PANEL

Panel facilitator: Myra Craig, Executive Director Community Services, State-wide Services, FACS
The Panel:
Steve Kinmond, Deputy Ombudsman, NSW Ombudsman
Louise Coe, Director, Office of the Children's Guardian
Mahashini Krishna, Commissioner of Victims Rights, Victims Services
Andrew McCallum, CEO, ACWA
Greg Bennett, Operations Manager, AbSec
Simone Walker, Program Design and Innovation, Programs and Service Design, FACS

TWO MINUTE CHALLENGE

Panel members were asked to encapsulate their thoughts about what has been discussed over the last two days, future directions and how their agencies can contribute to our discussions going forward.

Steve Kinmond, Deputy Ombudsman, Office of the NSW Ombudsman: It is timely to consider a stocktake of what is happening in the sector. Are we confident that what is being reported is currently what should be being reported? Not to be comfortable with existing collaborative relationships but to build on existing collaborative relationships e.g. how do we make sure we have the necessary connections with LACS, how do we make sure that we have a good understanding of initial and early response, and if we don't have that understanding, who do we go to for support?

The number of critical incidents in the non-government sector is going to rise with the movement of out of home care from the government to the non government sector. Do we have a clear practice framework? What is the ongoing role of FACS? What is reasonable for FACS to expect non-government agencies to respond to? Who should non-government agencies be communicating with other than FACS? What are the roles and responsibilities of the various parties?

Simone Walker, Executive Director, Programs and Service Design Safe Home for Life Reform, FACS: I would like to reiterate a couple of things Kate Alexander said yesterday morning. Firstly we need to try to keep our responses to critical incidents in the response category rather than the reactive category. We know if we get knee jerk reactions to big circumstances this will have an effect on practice that is not good for us working well with children and families. We are going to keep that focus and we have spoken to the new minister about the real need to take a considered approach to critical incidents whether inside FACS or NGOs.

Secondly, the development of the social benefit bond (SBB). Some of you may be aware of the Newpin SBB with Unitingcare Burnside which is about restoration. We got to a point in the negotiations as part of the development of the SBB that we were sitting around a table with the NGO, Treasury and about twelve lawyers. It became abundantly clear that no-one was able to remove themselves from the risk of the situation and that there are inherent risks in restoration and that we needed to recognise that. What has made the SBB incredibly successful is not the stack of documents but the incredibly good relationship between FACS and Burnside. You can write as much documentation as you want but If the relationships are not strong then you don't have a foundation to work from. So we are going to keep the importance of relationships and having a considered response to critical incidents in the front of our minds.

Louise Coe, Director, Office of the Children's Guardian: What I am taking away from the forum is thinking about how we can cooperate with and better serve the NGO OOHC sector. I recognise that this is a difficult area and I think, as the regulator, there are things we can do to make it clearer for agencies about what needs to be done and some of this can be done as part of the accreditation process and the minimum standards. We need to look at whether agencies have an organizational approach to ensure that people are living and breathing the policies and procedures, we need to be driving home the child focus message and providing more resources to

help you do what you need to do. We gather a lot of information as we look at what agencies are doing in regards to reportable conduct, Working with Children Checks and soon the carers register and I think we can give some of that information back to the sector about when it is working well and when it isn't.

Andrew McCallum, CEO ACWA: There are currently varying levels of sophistication in the sector and this needs to be evened out and the bar raised. There is some work for peak bodies in this space around what our training should look like in the future and how we can focus on specific training needs. We also need to think about how we get to those who don't know they need it. At a forum that I attended recently about future proofing, a comment from O'Leary was, 'I don't see the people in the room who need to be in the room.' We need to think about how we proactively outreach to the organisations that need it as they are the ones that will be become unstuck. Whatever training we might provide is not much good if agencies don't know that they need it. Regulation is a very blunt instrument it has to go along with a whole range of sophisticated understandings within agencies. Agencies need to understand that they can't regulate themselves out of this; they need internal practices and cultures that meet these things.

Greg Bennett, Operations Manager AbSec: Training has been a common theme of the forum. Training needs to be at the grass root level and regular. We need to support agencies to have a culture of ongoing and regular training. We need to further develop training packages and ensure that these are being accessed regularly. It is particularly important for small Aboriginal organisations to have regular training as the frequency of critical incidents will be lower and if it has been some time since the last incident, the regular training will assist them in feeling confident and skilled to respond to critical incidents.

Mahashini Krishna, Commissioner of Victims Rights, Victims Services: What I have taken away from this forum is the importance of disseminating information about Victims Services. The forum has shown me that a lot of organisations were not aware of our services. We need to think about how we can better disseminate this information amongst the NGO sector and how we can support you in this. I have already spoken to Jo Sammut about attending more meetings and working groups. We need to make the information more appropriate and specific to your needs. We recognise that this is a very small part of what you do, so we need organise the information in a format that is easy to understand and readily accessible when agencies need to use it.

PANEL QUESTIONS AND RESPONSES

The following material includes panel questions and responses that were part of the panel discussion on day two of the forum as well as questions and responses that were not able to be addressed within the time constraints of the forum. **NOTE:** * indicates additional responses to questions not addressed at the forum, due time constraints.

The panel discussion was originally broadcast as a webinar. An audio recording of this webinar can be accessed through a link in the Out of Home Care Transition section on the FACS website or can accessed directly via the following link:
http://youtu.be/Laxamqmq1DI

1) CARER'S REGISTER

1.1 Carer's Register: Will this be available to agencies providing voluntary OOHC under a respite banner? (author: Disability Macarthur)

Louise Coe: The carers register is a centralised database of persons who are authorised, or who apply for authorisation, to provide statutory or supported out-of-home care in NSW. It is not part of the Voluntary Out of Home Care (VOOHC) register. This register tracks children in voluntary out of home care. We will still be maintaining VOOHC register. The Carers Register will capture authorised carers and those who are going through the process of authorisation. For more information about the carers register including a presentation about the carers register: http://www.kidsguardian.nsw.gov.au/out-of-home-care/nsw-carers-register

2) VICTIMS SERVICES AND LEAVING CARE

2.1 What thoughts have you had regarding how young people (after 18 years old) when they leave care, can manage the victims services payment compensation? (author: unknown)

Mahashini Krishna: The current legislation ensures that up until the child or young person turns 18 years of age, any monies they are awarded goes into trust. Once the young person has turned 18 years old, unless there is a financial management order in place, we cannot withhold payment from the young person. What we have been able to do if there are circumstances where, in discussions with FACS, a person is unable to manage their monies due to disability or cognitive impairment, then a guardianship order or a financial management order has been

taken out. In other circumstances where there is some uncertainty about how the young person will manage a large sum of money, we have, in consultation with FACS, asked the person to undertake financial counselling. This has been facilitated by various caseworkers in FACS who retain some sort of an oversight role as part of their leaving care plan. As I mentioned we cannot withhold the money as the legislation is quite clear we can only hold it up until they are 18 years old.

Simone Walker: I think that Andrew will probably have an opinion on this as well because I know leaving care is his absolute passion at this point in time. We need conversations about victim's compensation to happen in a much more integral way in the work we do inside FACS. Leaving care, I think it would be fair to say, has been given short shrift over a number years inside the department, so we really need to reconsider how we do that work. I think we would want to recast (not the legislative component), but how we ensure young people use the dollars that are available for them, and considering developmental and age stages to get them the best outcomes. Taking a much broader view, we need to think about the work in leaving care as the best early intervention that we can possibly do for them and future generations. Rather than thinking about leaving care, we really want to start thinking about the transition to independence or adulthood. I think we can do this much better and I think we will be doing this much better with our NGO partners.

Andrew McCallum: In the context of the national framework, the proposal I put up is that I think we need to be prioritising financial and other supports for young people who leave care that are maturationally appropriate for them. The TILA payment at the moment is a flat fee that goes to kids when they leave care, and if the young person is aware of it, it seems to do a lot of good for the white goods industry but not much for anything else. I think we need to look at something (like the trustees) where young people can be independently case managed well into the future. This should take the young person's development and maturation into consideration. For example, we need ensure that if a young person at twenty eight years of age decides they want to go into tertiary education that there is something available for them to do that. I think we need to recognize that saying eighteen years old is the time that things happens, is arbitrary and does not actually reflect the reality. We need someone to say that you are not getting that money; we are going to watch you and keep an eye on you. I think we need to be far more sophisticated around the way we look at leaving care in a way that actually prioritises these people for a long, long time.

3) ROYAL COMMISSION / STRENGTHENING THE SYSTEM

3.1 Royal Commission: The system is reasonably strong, what do we do to make it stronger? (author: Steve Kinmond)

Andrew McCallum: I was never out in front as a great supporter of the Royal Commission because I think they can tend to be a bit retrospective. Also if I had half a billion dollars would I spend it on a Royal Commission if we are looking to actually improve the system? That is one of the sort of lens from which I work. I have been happy that they have been positively trying to look to the future. Their brief was always about dealing with historical abuse and that is always going to be a problem in itself, but I think there are a number of Commissioners that are mindful about what it means for the future of the sector, how we can evolve through this process and identifying areas of learning to take forward.

I think that in NSW we are well placed but I still think there is more of shakedown to happen in terms of the sector configuration. I don't think we have it quite right yet. We must make sure that when we talk about the community services sector in NSW we are not just talking in terms of out of home care but we are talking about a whole range of things. It is necessary for agencies that are going to be operating in this space to be mindful that you cannot just provide out of home care unless you are a sophisticated boutique organisation. We need to make sure that we know where the kids have come from and where they are going to, we need to look at leaving care, prevention, diversion and working in a holistic way with families. We still have a way to go to get to that holistic notion about what we are doing in this particular space but we are well placed to do it and that the collaboration and goodwill is there to do it.

Steve Kinmond: I had the opportunity to speak to Bernie Geary, the Children's Commissioner from Victoria last week. He indicated to me that he expects that this year he will be rolling out Victoria's reportable conduct scheme. One of the things that we can be quietly pleased about, is that here in NSW we do work together. We can be confident that as a result of us working together, the system is now stronger than it was a few years ago and that it will be stronger in a few more years time.

This is a national Royal Commission and it is my particular view that we have national responsibilities. So, if our colleagues in Victoria are heading in the same direction it is a great opportunity to be getting alongside our Victorian colleagues. We need the non-government's leadership in this area just as we need the leadership from FACS, Police and other entities to sit down with Victoria and have a look at benchmarking each others practices. Ideally, a Royal Commission comes along and creates a momentum for change and it's all done and dusted and

it's wonderful. But that is not the way it is happening, there is a lot of pushback that is taking place and there is a lot denial that is still in place nationally about what needs to be done.

It is great that our Victorian colleagues are going to be stepping up; but it is essential that we work with them. I have talked with Bernie about getting a firm called Orima to do some joint database development work with the goal of operating from a common database platform. The relationship with police is critical and the relationship between the non government sector and various arms of the government sector is absolutely critical. We have a responsibility in this area given that it has taken us years to get this system both up and running and operating as it should. We have a responsibility to support Victoria because if we can get things moving in the eastern states then the potential is for this to catch fire and spread elsewhere. WA has already had discussions with me about their desire to explore certain child protection issues from within the education sector. So can we make that commitment that we work together in terms of giving this some national momentum? I think that is important.

Related to this issue of developing a national system is information exchange: in particular, cross border information exchange. The current system is causing a lot of frustration. At the moment there is no guarantee that you will get information about someone who has previously engaged in inappropriate behavior in another state or territory. We need to work on a strong push to the federal government to establish a consistent information regime to enable the exchange of information across borders when there is significant safety welfare and well being issues associated with certain children or a class of children. As Andrew mentioned yesterday, we do have a national strategy in place in terms of children. I think that this issue should be part of the national strategy. We need to use the strengths of the NSW system to support each other but, much more importantly; we need to support each other to move in the same direction.

Simone Walker: There are over 500 kids in OOHC in other states and territories and I think about two in Kenya that we found throughout some the WWCC process. The current system only considers their experiences in NSW. The reality is that people move and potential carers such as grandparents may not be residing in NSW. If we are going to be thinking about the best permanency outcome for kids then we need to think much more broadly about cross jurisdictional issues. The Royal Commission is teaching us a lot of lessons and there some opportunities for work in this area; however I am cautious about thinking about a bigger system. I do not think we should be looking to a bigger out of home care system but should be looking at permanency principles and the best permanency outcomes for kids.

Mahashini Krishna: I would like to confirm what everyone else has said and note that the Royal Commission process is also making us identify what we are doing well. NSW is the stand out for a lot of issues but it has also given us the opportunity to look at what other states doing and learn from their practices to hopefully improve what we are doing. From a Victims Services perspective, the Royal Commission has given a voice to the victims. The Royal Commission has allowed victims who may never have actually discussed this at all to come out and take up the opportunity to discuss what has happened. Hopefully their voices will be a lesson for everyone in government and non-government agencies to make sure we have systems in place that ensures what used to happen does not happen again. I also note the important lessons highlighted in Victoria's Betrayal of Trust Report.

4) INFORMATION EXCHANGE

4.1 What processes are available for NGOs to request information about carers from other states and territories? (author: unknown)

Louise Coe: We have experienced a lot of problems in exchanging information with other states. This has been in relation to Working with Children Checks (WWCC), assessments they may have done and outcomes that we have. This issue has been discussed at National Operators Forum (involving all the states that conduct working with children checks). Our current legislation in NSW does not allow us to share information with other states. WA can share information but most of the other states cannot share information. There is work to be done in that space. Whilst it is really important to properly investigate and manage reportable conduct matters, the next step is getting judicial bodies to recognize them. A few of the people the OCG has placed bars on have lodged appeals to NCAT however NCAT does not seem to take reportable conduct matters as seriously when there has not been charges or convictions. We need to establish an understanding that the workplace records of reportable conduct matters are extremely important because these show how people behave in the workplace.

Myra Craig: As several speakers have identified the system for sharing information across the various states and territories is not simple or uniform. The pathway for NGO organisations is through your FACS Child and Family District Unit (CFDU) and they can then request the information from another state on your behalf. As previously identified, there are current difficulties with the present system and a better system of sharing information across states would be really useful to put on the agenda coming out of the Royal Commission.

4.2 What are the rights of NGOs for information exchange from DEC and Health etc.? (author: unknown)

***Myra Craig:** Reducing risk of harm to children and young people is matter of paramount importance. Child protection remains a key objective of the NSW Government, FACS, NSW Health and the Department of Education and Communities. Non-government organisations clearly play a vital role in ensuring children and young people are safe. Contemporary strategy recognises effective child protection is a collective responsibility of both the government and the community.

The collective child protection responsibility relies heavily on the ability to share information between relevant government and non-government agencies.

Chapter 16A of the NSW *Children and Young Person (Care and Protection) Act 1998* outlines a comprehensive scheme which facilitates the exchange of information between prescribed bodies for the purposes of child protection related issues. Prescribed bodies include both government and non-government bodies. Through the operation of both the Act and associated Regulations a wide range of children's related services are covered.

The four key principles of Chapter 16A [section 245A(2)] are as follows:

- Organisations which have responsibilities for children or young people should be able to provide and receive information which promotes the safety, welfare or wellbeing of children and young people
- Organisations should work collaboratively and respect each other's functions and expertise
- Organisations should be able to communicate with each other to facilitate the provision of services to children and young people and their families

Details regarding sharing information with DEC and Health can be found at:
http://www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm

4.3 What rights do parties have to information in relation to ROSH, reportable conduct and placement change? (author: unknown)

http://www.community.nsw.gov.au/kts/guidelines/info_exchange/provide_request.htm

* **Myra Craig:** The individual answer to what information relating to ROSH, reportable conduct and placement change will depend on the nature and scope of the 16A application. The capacity to exchange information under Chapter 16A is dependent on the provider of the information reasonably believing the information will assist the recipient to:

- Make a decision, assessment or plan to initiate or conduct any investigation, or to provide any service, relating to the safety, welfare or well-being of the child or young person or class of children or young people
- Manage any risk to the child or young person (or class of children or young people) that might arise in the recipient's capacity as an employer or designated agency.

In relation to reportable conduct type matters:

The Carers Register administered by the Office of the Children's Guardian, flags the existence of current reportable allegations when a reportable allegation is currently being investigated by an agency, or when the Ombudsman's office has provided a direction to the agency that the allegation should not be finalised on the Register.
In addition, a permanent record of reportable allegations will be maintained where a designated agency determines that there may be ongoing risks that relate to the safety, welfare or wellbeing of a child in out-of-home care.
The Carers Register will record the date and status of the allegation date – not the details. However, information relating to finalised reportable allegations (and some current reportable allegations), may be shared with other agencies as part of the 'Other designated agency check' (see fact sheet: Probity and suitability checks for carers and household members) on the OCG website.

All allegations against authorised carers or adult household members that are:

- reportable allegations within the meaning of section 25A of the Ombudsman Act 1974, or
- allegations of conduct of a class or kind exemption from being reportable conduct under section 25CA of that Act must be recorded on the carers Register.

When a record shows 'Current Reportable Allegation' or 'Finalised reportable allegation – contact agency', relevant information can be exchanged when conducting 'Other designated agency checks' or a 'Community Services check'.
In cases where 'Contact the NSW Ombudsman's Office', is recorded, the designated agency must seek advice from the NSW Ombudsman about how to proceed before taking any other action: this includes not discussing the allegation with any other person or agency, including the person the subject of the allegation, and not continuing with any probity checks related to the individual or their adult household members. Refer to the Carers Register User Guide for further instructions. **http://www.kidsguardian.nsw.gov.au/out-of-home-care/nsw-carers-register/carers-register-user-guide**

***Reportable Conduct and Serious Case Review (formerly Child Deaths and Critical Reports Unit):** The NSW Ombudsman provides guidance about the nature of information that could be shared and when in the process of an investigation it may be appropriate to share information with parties who are involved in an investigation. *https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0007/3886/Reporting-Progress-and-results-Investigation-Feb-12.pdf*

***Out of Home Care Reform:** Under the OOHC Case Management Policy, NGOs are responsible for supervising the placement and giving directions to the authorised carer relating to any incidents in the care environment or any change in household membership. The investigation and assessment of reportable conduct allegation is the responsibility of the NGO who authorised the carer. NGOs must notify the NSW Ombudsman within 30 days of any reportable conduct allegation or reportable conviction against an employee that the NGO becomes aware of. The NGO must also conduct an investigation into the allegations, make findings and provide these findings and all supporting records to the NSW Ombudsman in a timely manner. The NSW Ombudsman is responsible for monitoring NGO systems for preventing and responding to reportable conduct allegations. Any reportable conduct allegations or critical incidents which meet the risk of significant harm threshold must be reported to the Child Protection Helpline. FACS is required to investigate any reportable conduct allegations that meet the risk of significant harm threshold. FACS will advise the NGO of the risk of significant harm report outcome, including where the case is closed or unallocated.

5) REPORTABLE CONDUCT

5.1 Should more matters be exempted from notification to the Ombudsman? (author: Steve Kinmond)

Steve Kinmond: Yes more matters should be exempted from notification to the Ombudsman as the stronger the system becomes, there should be an increase in matters that will not need oversight from the Ombudsman. Ombudsman oversight is necessary for some reportable conduct matters but not necessary for many matters. This, to some extent, should be seen as one of the benchmarks to measure the strength of the system. So when we are sitting here in two years time, as the system strengthens, there should be more matters that do not require notification to the Ombudsman.

5.2 If the foster carer's partner is involved in a reportable conduct offence, is the offence reportable to the Ombudsman? (author: unknown)

Steve Kinmond: If the foster carer's partner is deemed to be engaged to provide services to children, then the conduct is reportable. Some agencies have taken the view that the foster carer's partner is not actually engaged, that they just happen to be living with the foster carer. We have taken a dim view of this as out of home care is within our jurisdiction for the purpose of providing safe family environments for these kids. Given this purpose, it does not make any sense to have a system whereby the approved foster carer is under the watch of the scheme but any adult that they may choose to live with isn't. We take the view that if those adults are not engaged then they ought to be engaged. We have not taken a fixed view in terms of whether they have to be fully authorised foster carers, but that is different from them being prepared to acknowledge that they have certain responsibilities in relation to any children living in the same household. If the foster carer's partner is saying that they have no responsibilities whatsoever in relation to the child or young person and are not prepared in any way shape or form to be engaged to provide any supports or services to that child or young person, that is anomalous to what we are seeking to achieve in terms of foster care. So the short answer is they should be engaged and if they are engaged they come under our jurisdiction.

5.3 How do we ensure that we are providing a strong response in relation to reportable conduct/sexual misconduct/sexual assault allegations? (author: Steve Kinmond)

***Steve Kinmond:** Collaboration between key agencies is essential to ensuring the most robust response to reportable allegations possible, particularly those meeting the criminal threshold. The best outcomes are achieved when each agency with a role to play does their part in a timely and effective manner and keeps communication channels open with other relevant agencies. Introspective or insular responses by individual agencies fail children. The Ombudsman, FACS, Police, employers, the OCG – each has a role to play and each role is enhanced or complemented by others. By 'roles' I mean not only what each agency is *required* to do, but what each agency is *able* to do – and there's a wide gap in between. When agencies do the bare minimum, they fail children. In our oversight role, we see contrasting cultures within various agencies and the effect that has on how well or otherwise the agency contributes to the protection of children in NSW. Agencies should health-check their organisational culture. Is the agency's starting point: 'How can I justify not taking any action in response to this information?' Or, is it: 'What is within my authority to do to ensure the best response to this information?'

5.4 How confident are we that what should be reported to the Ombudsman is being reported? (author: Steve Kinmond)

***Steve Kinmond;** I'm confident that the majority of agencies in our employment related child protection jurisdiction act in good faith and endeavour to comply with their legislative obligations to notify reportable allegations to the Ombudsman. However a number of other factors impact on compliance – the strength of internal reporting systems, policies and procedures; knowledge and awareness among employees and volunteers (including foster carers); complaint-handling systems; record-keeping practices; resources. The Ombudsman has a role in scrutinising agencies' systems for preventing and responding to reportable allegations, and we fulfill this function in a number of ways. With the growth in the non government out of home care sector, we have directed a significant proportion of our resources to scrutinising and capacity-building within the sector. The numbers do tell us that there may be underreporting from the sector, and we've identified a number of agencies to focus on in the coming year. We're committed to working with and supporting these (and all) agencies as they grow and strengthen their systems, understanding and compliance. We encourage all agencies to make contact with us to talk through any questions they have about their reporting obligations – whether it's about an individual case or about systems.

***Greg Bennett:** I am very confident that our agencies are aware of what they should be reporting to the Ombudsman and comply with their reporting obligations because our agencies are provided with significant support and specialised training such as the following;

- Ongoing staff training – I attend our agencies and deliver a half days training on what is reportable conduct and what as OOHC workers do they need to report and who in their agencies they must report it to and how it reported (agencies working documents and relevant policies & procedures)
- Carer training on reportable conduct and managing disclosure of harm – I provide 2 hours training session to our agencies carers as well as providing a fact sheet which is also provided in the agencies carer inductions packages
- AbSec strongly advocates that senior staff in OOHC especially staff conducting reportable conduct investigations have completed the NSW Ombudsman's reportable conduct training
- Ongoing support (phone and in person) to CEOs and senior manager regarding the identification and management of reportable conduct matters
- Specialised resources (work documents and dummy file) developed to assist agencies in managing reportable conduct matters
- Deliver specialised training created by AbSec to staff in relation to how to interview children.

6) COLLABORATIVE RELATIONSHIPS

6.1 How do we continue to build collaborative relationships in this area? (For example, building an effective relationship with JIRT/Police/Health?) (author: Steve Kinmond)

Greg Bennett: We need to continue to have conversations and regular meetings with the key players including NSW Police, NSW Ombudsman and other peak groups. We need to work together on training to ensure that it is appropriate and consistent. We had a positive recent experience at Coffs Harbour with Aboriginal agencies having those conversations with other agencies and reaching a place where the child is at the center of that conversation and everyone is open and willing and questioning how we can do things better? There has been a level of distrust by Aboriginal agencies towards certain government bodies in the past but there is a real willingness by Aboriginal agencies to work more closely with Police, JIRT, the Ombudsman and others to ensure the outcomes for our kids are good. In summary I think it is about starting that conversation and continuing those conversations through regular meetings.

Andrew McCallum: In the past there was a Keeping Them Safe senior officers group that used to meet. This was quite beneficial as it got many of the not-so-usual suspects together in a room with the NGO peaks. I think what AbSec ran with the police at Coffs Harbour at the end of last year was a very good example that there is more scope for us to think more laterally when we are having some of these sessions. We tend to get a bit myopic about whom we get in the room and sometimes it's the ones that are not in the room that we need to talk to.

7) RESPONDING TO CHILD DEATHS

7.1 How can foster families best be supported by the Coronial system when a child dies in their care? (author: NSW Coroners Court)

Andrew McCallum: I am not overly familiar with the system as it currently stands, but given the increasing number of children and young people being cared for by the NGO sector experiencing a child dying in care is becoming an increasingly more likely scenario for NGO organisations. The onus is on the organisation to have internal processes in place including supports for the foster carer and the natural family. A well operating organisation

would already have processes in place not only for this particular circumstance but would already have processes in place for when other critical deaths occur. This would include supports in place for all those involved including staff, caregivers, all levels in the organisation and the natural family. A good organisation would have policies that would already actually address most of those situations.

Simone Walker: Regardless of whether a child's death ends up in the Coronial system agencies need to have policies and procedures in place to care for the foster carers and the birth parents. I know from my previous experience (I was a paediatric intensive care social worker) that the Coroners Court have role about the nature of that support certainly in the early stages of a Coronial inquest but I assume that is done with close concert with the NGO or with the Department because it is actually about the needs of the family rather who can take up that space.

7.2 How does the NGO response to Child Deaths fit within the existing FACS network? (author: NSW Coroners Court)

***Reportable Conduct and Serious Case Review (formerly Child Deaths and Critical Reports Unit):** When a child dies who was placed with an NGO, the NGO is responsible for undertaking their own internal child death review that looks at their policy and practice. FACS' Office of the Senior Practitioner liaises closely with the NGO to guide and provide assistance with reviews and to share findings from FACS and NGO child death reviews with interested parties such as the Minister for Family and Community Services, NSW Ombudsman and NSW Coroner's Court.

7.3 Will Coroners continue to liaise with FACS directors in relevant cases or will NGO Directors be appointed with this responsibility? (author: NSW Coroners Court)

***Reportable Conduct and Serious Case Review (formerly Child Deaths and Critical Reports Unit):** Coroners will continue to liaise with FACS when a child has died. The central point of contact within FACS is the Serious Case Review unit (formally Child Deaths and Critical Reports). The exception to this would be if a Coroner requires specific information from or about an NGO.

7.4 How should NGOs be involved in any Coronial liaison with foster families/biological parents? (author: NSW Coroners Court)

***Reportable Conduct and Serious Case Review (formerly Child Deaths and Critical Reports Unit):** Generally, if a child dies in an NGO foster placement, the NGO is the agency that has a relationship with the foster family and they would be responsible for contact and support with the foster family and involvement in liaison with the Coroner's Court. Involvement in coronial liaison with biological parents would depend on whether the NGO has an established relationship with the parents. This would differ from case to case.

8) OTHER SYSTEM ISSUES AND / OR SUGGESTION RE MANAGING CRITICAL INCIDENTS

8.1 Is there any thought to creating a Child Wellbeing Unit (CWU) for the NGO sector? This would be helpful to assist and manage critical incidents, reviews and escalations. (author: unknown)

Simone Walker: After the Wood Royal Commission in 2008 and the establishment of Child Wellbeing Units there was certainly a lot of talk about creating a Child Well Being Centre for the NGO sector. That was not pursued and there isn't any progress in that space at the moment. What is underway at this point of time is looking at the future of KTS noting that current KTS funding goes through to June 2016. There is currently work being done with treasury and the agencies who receive KTS funding about what the future of KTS looks like. They are looking at how to reduce the number of entries to care as well as looking at the non-ROSH space. There has been strong engagement with CWUs in relation to this. My view is that critical incidents, reviews and escalations should continue to be notified to the Helpline. We do not want to create any confusion about the pathway for the reporting of those incidents.

8.2 Are there any stats about the cultural make up of kids in OOHC? E.g. ATSI, CALD, Caucasian (author: unknown)

Simone Walker: Yes there are. The 'dashboard' located on FACS website has a breakdown of the percentages of the kids in care, the progress of transition as well as some statistical information about Aboriginal children and young people in out of home care:
http://www.community.nsw.gov.au/docs_menu/parents_carers_and_families/out_of_home_care_transition/about_the_transition/ongoing_transition_achievements.html

As of Feb 2015, 57 % of children and young people who were in statutory care were with the NGO sector. And 48% of Aboriginal kids in out of home care were with NGO sector. The dashboard also contains information about

new entries to care and whether they are going directly to the NGOs or not. The dashboard is a really useful tool to track where the transition process is up to. The other part of the question was whether we have statistics about CALD kids in out of home care? As far as I know there is nothing on the website that has that specifically breaks this down. My understanding is that the numbers of CALD children and young people in out of home care are at a very different level comparative to the over representation of Aboriginal kids in care.

8.3 What are some of the common themes/obstacles that you find Aboriginal agencies have when dealing with reportable conduct matters?

Greg Bennett: One of the challenges for Aboriginal agencies is developing that relationship with the local FACS office particularly around incident management and reportable conduct. They need to have really clear agreements and processes about who does what so there is no overlap of ROSH into the investigation of the reportable conduct or alternatively that they are both addressed in a timely manner but without one process compromising the other. They also need clear communication channels and agreements with Community Services.
Some agencies are managing this better than other agencies that are taking longer to develop these relationships and understandings.

8.4 How will critical incidents be affected with the role out of the NDIS for children with a disability and the disbanding of Aging Disability and Home Care? (author: Disability Macarthur)

***Steve Kinmond:** We have been working with ADHC and other key stakeholders in following up the concept of a reportable incident scheme covering parts of the disability service system. We hope that by the time of the rollout of the NDIS, a scheme of this type will be in place. In this regard, the reportable disability incident scheme has already commenced in NSW on 3 December 2014.

8.5: Could a follow up session be organised to allow participants to report back on what has been implemented at their agency and local level, and include a discussion on what has been achieved and/or a willingness to share lessons learnt?

***Andrew McCallum:** The two day forum was an opportunity with a range of stakeholders in the room to explore the whole of sector responses to risk management and strong governance. The Royal Commission has drawn out the importance of not only having the right mechanisms in place but also the cultures in the workplace and in the sector. Sessions like these where agencies can share lessons learnt at a statewide or local level assist the sector in developing an understanding of best practice at these critical times. ACWA recently hosted a forum with Dr Helen Buckley presenting on 'Making recommendations from child abuse inquiries in a changing child protection environment'. This forum emphasised the need to share key learnings from reviews and inquiries from her experience on the National Child Death Review Panel in Ireland. ACWA will continue to seek opportunities to bring the sector together around these issues and work towards joint solutions to preventing and managing critical incidents.

9) INFORMATION AND TRAINING IN RELATION TO MANAGING CRITICAL INCIDENTS

9.1 How can we be sure that there is consistent training about critical incidents (and other training) across the sector for all carers? (author: unknown)

Andrew McCallum: ACWA has given some considerable concentration to this since the transfer as we are aware that some of our member organisations do not quite understand what critical incidents need to be reported.
I have spoken with the NSW Ombudsman's office about who is on their radar in relation to under reporting. They are able to identify possible issues by looking at how many notifications they have had over a period of time by particular agencies and look at what the law of averages say about approximate expected notifications by agencies over a time period. We then need to consider possible reasons for this under reporting has the agency just been lucky or have they been misguided or lacking in understanding about what is needed. We run member and regional forums on a regular basis. We try to be proactive with agencies and approach them directly rather than waiting for them to say something to us. We then, through CCWT, develop customised training, and offer the training to agencies. We engage the Office of the NSW Ombudsman and Children's Guardian. Providing training is the collective responsibility of the sector. We do not know the level of non-compliance of organisations however we are aware that some organisations have come from different jurisdictions and have not worked with the Ombudsman and Children's Guardian. It has been a steep learning curve for some of our more sophisticated organisations. We need to continue to be vigilant to under reporting within the sector and identifying the needs of the sector.

***Reportable Conduct and Serious Case Review (formerly Child Deaths and Critical Reports Unit):** This workshop is an important first step in looking at what is available now so that we can start to develop a shared

approach to some issues, like carer training. Connecting Carers has very clear information about carers' training needs so their involvement in the planning process is critical.

Currently, Connecting Carers conduct training and information sessions for all carers (and FACS and OOHC service provider staff). Staff from the Office of the Senior Practitioner regularly present information about the response to critical events at Connecting Carers' training days.

***Steve Kinmond:** These are important issues that warrant further consideration - and joint work – between FACS, ACWA, AbSec and Ombo.

9.2 With the changes in NGO staff and management over time how can we have a consistent package of information and training available for the sector? (author: unknown)

***Steve Kinmond:** These are important issues that warrant further consideration - and joint work – between FACS, ACWA, AbSec and Ombo.

***Andrew McCallum:** CCWT provides Calendar Training from the NSW Ombudsman on responding to reportable conduct allegations, the Office of the Children's Guardian on Child Safe Organsiations as well as a range of other training topics in the Child Protection stream. ACWA is also developing an online resource bank providing key information for NGOs as well as presentations and videos from our range of forums.

***Reportable Conduct and Serious Case Review (formerly Child Deaths and Critical Reports Unit):** Agree with ACWA's identification of some of the issues confronting the sector (outlined by Andrew above). Again, this workshop is an important first step in looking at what is available now so that we can build greater linkages across the sector to support consistency.

Appendix D Areas requiring further exploration

Appendix D

Areas requiring further exploration by the sector

Important discussions were initiated during the forum however the time and the scope of the forum did not allow a full exploration of some of these areas. The forum process has identified some significant unexplored areas for future OOHC NGO sector development. The complexity of managing critical incidents requires specific areas of learning and skills development for all levels of OOHC NGO staff and carers. Specifically:

- OOHC NGO's obligations in conducting their own investigations[6] (irrespective of whether FACS or Police are investigating), making their own findings and taking necessary action in relation to the employee, carer and child. This is particularly cogent given the majority of reportable conduct matters will not include primary investigation by JIRT or police.
- OOHC NGO's management of conflict of interest and maintaining the integrity of investigation e.g. carers often want their partner present for their interview (for support); however as a possible perpetrator or witness this would not be appropriate.
- OOHC NGO's ongoing risk assessment and management during and after an investigation.
- OOHC NGO's liaison with a variety of agencies throughout the investigation period. This includes managing risk and information in matters where a third party (JIRT, FACS and Police Local Area Commands) is investigating. In some matters, the employee subject to the allegations may not be aware of the third party investigation and the third party may not have given the OOHC NGO clearance to act or advise the employee. AbSec identified in the panel discussion that one of the biggest challenges they see for Aboriginal OOHC NGOs is incident management: ensuring that ROSH and reportable conduct are dealt with in a timely manner without one process compromising the other.
- OOHC NGO's management of reportable allegations that occur outside the workplace.
- OOHC NGO's responsibilities in notifying the OCG (Carer's Register and findings of misconduct in relation to serious physical assault and sexual misconduct).
- OOHC NGO's management of dual processes of the investigation of reportable conduct allegations and internal misconduct and disciplinary processes with paid employees (not carers).
- Prevention work in relation to reportable conduct matters including the inclusion of reportable conduct information in induction processes and training, being clear about expectations of behaviour and codes of conduct and ensuring children and young people have opportunities and relationships to make a disclosures.
- Building on the learning gained through the JIRT presentation in relation to OOHC NGO's and JIRT working together to improve outcomes for children and young people particularly in the areas of responding to disclosures of abuse, reporting the abuse and supporting children and young people through the JIRT and criminal process system.
- The day one workshop discussions around the child death scenario indicated that NGOs could identify issues and actions that should be considered in responding to a death of a child in OOHC,

[6] The Office of the NSW Ombudsman previously produced comprehensive guidelines *Child Protection in the Workplace: Responding to allegations against employees June 2004* to assist designated agencies conduct reportable conduct investigations. This publication is no longer available.

however there was a distinct level of uncertainty and detail surrounding responsibilities for particular actions. Specifically:

- NGO's understanding of legislative framework and requirements including the reporting requirements of S172 of the Children and Young Persons (Care and Protection) Act 1998,
- guardianship reverting back to the biological parents at the time of death and the subsequent consequences for the Coroner's Office identifying next of kin,
- responsibilities for funeral arrangements and child's possessions,
- support of birth parents and siblings,
- how the OOHC NGO may act to support the Coroners office and the NSW Police Service, securing (rather than preparing) files, and processes of review following the death of a child.

- Trauma informed practice: training about the understanding of and responsiveness to the impact of trauma.

Appendix E **Resource wall chart for OOHC NGOs**

Appendix F **Critical Incidents: information and resources for OOHC NGOs**

Appendix G **Information Exchange: information and resources for OOHC NGOs**

Appendix H **Working with JIRT: information for NGO caseworkers working with JIRT to support children and young people in OOHC NGOs**