

“...as a good parent would...”

Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care

August 2015



COMMISSION FOR CHILDREN AND YOUNG PEOPLE

Children, Youth and Families Act 2005 – section 174

Secretary's duties in placing child

- (1) In dealing with a child under section 173, the Secretary —
- (a) must have regard to the best interests of the child as the first and paramount consideration; and
 - (b) must make provision for the physical, intellectual, emotional and spiritual development of the child in the same way **as a good parent would¹**; and
 - (c) must have regard to the fact that the child's lack of adequate accommodation is not by itself a sufficient reason for placing the child in a secure welfare service; and
 - (d) must have regard to the treatment needs of the child.

Warning: this report contains explicit material that may cause distress.

Letter to the Legislative Council and the Legislative Assembly



COMMISSION FOR CHILDREN AND YOUNG PEOPLE

Mr Andrew Young
Clerk of the
Legislative Council
Parliament House
Spring Street
East Melbourne 3002

Mr Ray Purdy
Clerk of the
Legislative Assembly
Parliament House
Spring Street
East Melbourne 3002

Dear Sirs

“...as a good parent would...”
Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care (the Inquiry report)

I hereby request that the Inquiry report produced by the Commission for Children and Young People be tabled in accordance with section 50 of the *Commission for Children and Young People Act 2012 (the Act)*.

I would be grateful if you could arrange for the report to be tabled in both the Legislative Council and Legislative Assembly on the next sitting day.

I confirm that the Minister for Families and Children and the Secretary to the Department of Health and Human Services have each been provided with a copy of the Inquiry report in accordance with section 49 of the Act.

Yours sincerely

Bernie Geary, OAM
Principal Commissioner

18 August 2015



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Addressing the issue of sexual abuse and exploitation of children in care is both confronting and challenging. Their highly distressing experiences have been the driving force for this Inquiry.

I am most grateful for the forthright contributions of a number of organisations and individuals during the course of this Inquiry, particularly those who made detailed and considered written submissions or contributed their time generously during the consultation process.

I would like to thank the Victorian Department of Health and Human Services and the Community Service Organisations, which includes the Aboriginal Community Controlled Organisations, who provide residential care services for Victoria's most vulnerable children, for their willingness to support the Inquiry through provision of information, access to records, visits and interviews, in response to my requests.

I would also like to acknowledge the work of the Inquiry team led by Fiona Fyffe for their tireless effort and, more broadly, the Commission staff who all contributed in some way to our first self-initiated Inquiry.



Bernie Geary, OAM
Principal Commissioner

Commissioners' foreword

"...as a good parent would..."

The title of this report is taken from the *Children Youth and Families Act 2005* (Vic), section 174(1)(b), which requires that the state, when placing a child away from their family, must ensure that the child's best interests are paramount by providing for the child's physical, intellectual, emotional and spiritual development.

As Victoria's first Commissioners for Children and Young People and Aboriginal Children and Young People, it is our great privilege and immense responsibility to hold government and the broader community accountable for the care of our most vulnerable children. Our role at the Commission is to perform all our functions with independence and impartiality. We have achieved this in conducting this Inquiry. We initiated this Inquiry because we can no longer watch a well-meaning but desensitised system continue to fail many children in state care.

A child in residential care once told us:

'I don't feel special to anyone'

How could she? She had no stability or permanency. She is away from her family, friends, cultural connections and community and she lives in a place that is at times unsafe.

We must make her and children like her feel special.

It is an indictment on us all that our most damaged children, some as young as seven, are suffering sexual abuse in state-funded residential care. We urgently need immediate action and systemic reform. There must be bipartisan collaboration to commit and refocus resources, radical thinking by our policy makers and a sustained effort to change residential care. We believe it is time to draw a line in the sand and to move forward in a proactive child-focused manner.

In the past 12 months, we have examined reports relating to 166 children (25 of whom were Aboriginal) who have allegedly been sexually abused whilst living in Victorian residential care. Some of these children were subject to multiple reports of sexual abuse in care. Others were reported to be raped or sexually assaulted by other children in their residential care unit. These are places that are meant to offer them safety and sanctuary from the abuse and trauma that led to their placement away from their families.

We interviewed 87 Departmental and CSO staff, visited 21 residential care units throughout Victoria, heard directly from many children, reviewed children's files and received public submissions.

The dedication of those who work so tirelessly in residential care is greatly appreciated, however it is so often distracted by a system that makes it challenging to act **as a good parent would**. This report is about the children.

There are significant flaws in the system. Children who have been sexually abused whilst living in residential care do not always receive the same care and attention as children in families. They are often not connected to culture, and they may not receive adequate professional or specialist support, nurturance and care.

This Inquiry has revealed a poverty of options for the individual care needs of children, and no real solutions to the problem. In its present form, the system creates the opportunity for sexual abuse and sexual exploitation to occur. It is simply intolerable to continue propping up this flawed model of 'care'. Children are channelled through a system that is not equipped to heal them of past abuses, let alone provide them with the most basic physical and emotional protection and care.



Bernie Geary, OAM
Principal Commissioner

It seems both logical and entirely possible that the annual expense of \$200,000–\$1 million per placement – the current cost of Victorian residential care – could be better used to support families, kinship and home-based care. Where these options are not suitable for an individual child, a specialised, targeted and safe alternative is required.



Andrew Jackomos, PSM
Commissioner for Aboriginal
Children and Young People

We are committed to monitoring the implementation of our recommendations. We will continue to ask the hard questions, work with others and hold the system accountable for these vulnerable children.

This report is dedicated to improving the lives of the 500 children who are in residential care tonight.

They are all incredibly special.

A handwritten signature in black ink that reads "B. Geary".

Bernie Geary, OAM
Principal Commissioner

A handwritten signature in black ink that reads "Andrew Jackomos".

Andrew Jackomos, PSM
Commissioner for Aboriginal
Children and Young People

Table of contents

Letter to the Legislative Council and the Legislative Assembly	1	3. Analysis of sexual abuse incident reports	42
Acknowledgements	3	3.1 Client Incident Reports	42
Commissioners' foreword	4	3.2 Sexual abuse: the nature of the problem	48
Abbreviations and acronyms	8	3.3 The voice of children	54
Definitions	9	3.4 Pornography, social media and the internet	56
Executive summary	11	4. Practice issues	58
Findings	14	4.1 Poor record keeping and lack of appropriate action	58
Recommendations	18	4.2 Practice issues identified during site visits	59
1. Introduction	24	4.3 Inadequacies in the CIR process and case recording	59
1.1 Recent Victorian inquiries	24	4.4 Duty to act in the same way 'as a good parent would'	60
1.2 International inquiries	25	4.5 Failure to ensure privacy and confidentiality	61
1.3 Royal Commission into Institutional Responses to Child Sexual Abuse	26	4.6 Insufficient oversight of CSOs by the Department	61
1.4 Residential care in Victoria	26	5. File reviews, staff interviews and sector submissions	62
1.5 Children living in residential care	27	5.1 Sexual abuse by external predators	62
1.6 Current demand for residential care in Victoria	27	Case Example 1: 14-year-old girl alone at a train station	65
1.7 Government funding of residential care	28	Case Example 2: 15-year-old girl reports having a miscarriage	66
1.8 Brief history of residential care in Victoria	29	Case Example 3: Intellectually disabled 14-year-old boy abused by older men	67
2. About the Inquiry	32	Case Example 4: 13-year-old Aboriginal girl with a 24-year-old 'boyfriend'	68
2.1 Role of the Commission for Children and Young People	32	5.2 Child-to-child sexual abuse in residential care	73
2.2 Background	33	Case Example 5: Intellectually disabled 10-year-old boy abused by another boy	74
2.3 Terms of Reference	34	Case Example 6: Intellectually disabled 12-year-old boy abused by two older children	76
2.4 Governance	34	Case Example 7: Eight-year-old boy abused by older boy	77
2.5 Methodology	35	Case Example 8: Eight-year-old girl abused by 14-year-old boy	78

5.3	Staff-to-child sexual abuse in residential care	84	7.10	Establish an independent visitor program to every residential care unit	116
	Case Example 9: 17-year-old Aboriginal girl reports being abused by worker	85	7.11	Establish an independent advocate and complaints body	117
	Case Example 10: Intellectually disabled 15-year-old girl reports being abused by worker	86	7.12	Redress for children who have been abused in care	117
	Case Example 11: 16-year-old girl reports being abused by worker	88	7.13	Provide education about sexual abuse and sexual exploitation	118
			7.14	Improve service provision and implement client based funding	118
6.	Site visits to residential care units	92	8.	Opportunity to respond	120
6.1	Departmental standards for provision of residential care	92	9.	Appendices	122
6.2	Absent children	93	Appendix 1: Charter for children in out-of-home care	122	
6.3	State of disrepair	94	Appendix 2: Guide to making a submission	123	
6.4	Therapeutic residential care units	99	Appendix 3: List of people and organisations who provided a submission	124	
6.5	Surveillance cameras in bedrooms	103	Appendix 4: Departmental categorisation of incident type	125	
6.6	Punitive and restrictive practices	104	Appendix 5: Data tables	126	
6.7	Inappropriate behaviour by staff	108	Appendix 6: Response from the Department	130	
6.8	Safety of children in residential care	108	10.	References	134
7.	Improving the safety and wellbeing of children in residential care	110			
7.1	Improve entry to care	110			
7.2	Improve the referral process	111			
7.3	Professionalise foster care	112			
7.4	Specialist group care	113			
7.5	Improve the skill base and qualifications of residential care staff	114			
7.6	Legal obligation to children	115			
7.7	Discontinue the use of labour-hire agency staff	115			
7.8	CSO specialist practitioner for every residential care unit	115			
7.9	Improve responses to absent children	116			

Abbreviations and acronyms

Aboriginal	The term Aboriginal in this report refers to both Aboriginal and Torres Strait Islander people	Inquiry	The Commission for Children and Young People’s Inquiry into the adequacy of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care
ACCO	Aboriginal Community Controlled Organisation	Inquiry period	1 March 2013 to 28 February 2014
AHCPES	After Hours Child Protection Emergency Service	LAC	Looking After Children
CCYP/Commission	Commission for Children and Young People	QoC	Quality of care
CCYP Act	<i>Commission for Children and Young People Act 2012 (Vic)</i>	Report	<i>“...as a good parent would...” Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care</i>
Charter	<i>Charter of Human Rights and Responsibilities Act 2006 (Vic)</i>	Rights of the Child	United Nations Convention on the Rights of the Child
Children	The term children (or child) in this report refers to children under the age of 18 years	SOS	Streetwork Outreach Service ⁶
CIR	Client Incident Report	TRC	Therapeutic residential care
CRIS	Client Relationship Information System ²	VACCA	Victorian Aboriginal Child Care Agency
CRISSP	Client Relationship Information System for Service Providers ³	VAGO	Victorian Auditor-General’s Office
CSO	Community Service Organisation ⁴	VVCI	Victoria’s Vulnerable Children’s Inquiry
CYFA 2005	<i>Children, Youth and Families Act 2005 (Vic)</i>		
Department/DHHS	Department of Health and Human Services ⁵		

² The Department operates three integrated web-based client and case management systems. CRIS is the client information and case management system used by child protection, youth justice and other Departmental programs. CSOs that have been case contracted to provide a service to a child protection client are provided access to the CRIS file.

³ CRISSP is based on CRIS and uses similar functionality. It is a system provided to CSOs that are funded to provide services in child protection placement and support, disability services, youth justice, early childhood intervention services and family services.

⁴ The term CSO is used throughout this report and is inclusive of ACCOs that also provide residential care services for children.

⁵ On 1 January 2015, the Victorian Government established the DHHS, bringing together the former Department of Health, Department of Human Services and Sport and Recreation Victoria.

⁶ SOS is a program within the child protection branch of the Department. It provides after hours outreach to young people at risk of harm or exploitation in St Kilda and the central business district of Melbourne.

Definitions

Sexual abuse

This includes the sexual assault, rape or alleged rape of, or by, a child or young person.

Sexual exploitation

This is considered a specific form of sexual abuse because children and young people, by virtue of their age and development, are unable to give informed consent. Sexual exploitation of children and young people takes different forms. It can include children and young people being involved in sexually exploitative relationships, receiving money, goods, drugs or favours in exchange for sex with one or more adults, or being exploited in more 'formal' forms of sex work. In all cases, those exploiting the children or young people have power over them by virtue of their age, gender, physical strength, economic or other resources, such as access to drugs.

Out-of-home care

Children who come into out-of-home care are placed in one of the following placement types:⁷

Kinship care

This is the preferred placement type. It involves relatives or members of a child's social network being approved to provide accommodation and care. This placement type is targeted at children aged up to 18 years of age who are subject to intervention by child protection services and assessed as requiring out-of-home care. The placement is supervised and supported according to the child's level of assessed need.

Home-based care

This is the next preferred placement type. Volunteer carers act as foster parents to children. They provide care in their own home and are usually not known to the child before the placement. This placement type is for children up to 18 years of age who are temporarily or permanently unable to live with their family of origin. CSOs are responsible for recruiting, training and supporting caregivers. Home-based care includes foster care, adolescent community placement, shared family care and therapeutic foster care.

Residential care

This is the least-used option in the out-of-home care service system. Care is provided in a 'home-like' residential building by paid staff. It caters for groups of up to six children who are seven years of age and older. Younger children are sometimes placed in residential care with their older siblings.

Lead tenant

This is the provision of semi-independent accommodation and support for young people aged 15 to 18 years of age who are in transition to independent living. A volunteer lead tenant lives in a house with a small group of young people and provides them with support and guidance in developing independent living skills.

⁷ Department of Human Services, Child Protection Practice Manual (online) (2012), www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/child-protection-practice-manual-online, accessed 2 July 2015.

189
REPORTS

OF ALLEGED INCIDENTS
OF SEXUAL ABUSE AND
SEXUAL EXPLOITATION

166
CHILDREN

WERE SUBJECT TO
THE 189 REPORTS
OF ALLEGED ABUSE

42
CHILDREN

WERE SUBJECT TO
MULTIPLE REPORTS

87
STAFF

WITHIN THE DEPARTMENT
AND CSOs WERE INTERVIEWED
FOR THIS INQUIRY

21
**RESIDENTIAL
CARE UNITS**

WERE VISITED BY
THE COMMISSION

Executive summary

The Commission's Inquiry into the adequacy of the provision of residential care services to children and young people who have been subject to reports of alleged sexual abuse or sexual exploitation whilst residing in residential care (the Inquiry) was established by the Principal Commissioner, Mr Bernie Geary, in March 2014, pursuant to section 39 of the *CCYP Act 2012*.

Concerns about the adequacy of the Victorian residential care system are not new. There have been many previous independent inquiries and reports. Despite the awareness of deficits in the system, children continue to be at risk of sexual abuse and sexual exploitation when they are in residential care. Action is urgently needed, particularly because the number of children living in out-of-home care continues to grow and there is vast over-representation of Aboriginal children.

Society is measured by how we treat our most vulnerable members and there are few more vulnerable than children in out-of-home care. These children are particularly vulnerable to a range of human rights violations and, as a corollary, those in charge of their care should be more acutely focused on protecting their human rights. At the most fundamental level, these children have the right to protection and to feel safe - and they have the right to be free from torture and cruel, inhuman or degrading treatment or punishment. In Victoria, through instruments such as the Charter and the Rights of the Child, we have the tools to demand public authorities and those exercising public functions to guard and protect the human rights of these vulnerable children and provide a far higher standard of care.

This Inquiry has called for an urgent redevelopment of residential care services in Victoria and the development of specialised care options for children. Nine key recommendations have been made. The recommendations are interlinked and should not be read in isolation. The recommendations have been formulated through findings from this Inquiry, learnings from other inquiries, contemporary research and sector consultations.

The decision to undertake the Inquiry resulted from our grave concern at the ongoing inadequacies of systemic responses to preventing and responding to the occurrence of sexual abuse and sexual exploitation of children in residential care. We have read and confirmed reports of alleged sexual abuse and sexual exploitation in residential care of children as young as seven.

We sought advice and information from the sector, the broader community and invited people with personal experience to make a submission to the Inquiry.

We analysed the Department's CIRs from 1 March 2013 to 28 February 2014 (the Inquiry period). This involved 189 reports of alleged incidents of sexual abuse and sexual exploitation relating to 166 children in residential care. Forty-two of these children were subject to multiple reports. Of major concern, we discovered this data is flawed.

The true extent of sexual abuse and sexual exploitation of children living in residential care is not yet known. This is due to the Department's inadequate and inconsistent record keeping, which has resulted in poor data availability. The data is unreliable and this is made even worse by current reporting systems. The Commission witnessed inconsistencies in the way that serious allegations of sexual abuse and sexual exploitation in residential care are defined, reported and investigated.

In April 2015, the Department advised the Commission that 402 CIRs relating to incidents occurring between January 2013 to April 2015, therefore falling within the Inquiry period, had not been provided to the Commission due to an 'oversight'. Of these 402 CIRs, 69 related to allegations of sexual abuse or sexual exploitation. These 69 CIRs were unable to be included in this report. We must therefore assume that the data presented in this report significantly underestimates the extent of the problem.

Executive summary

We reviewed the child protection files for all 166 children in the 189 reports made available to us, to understand their backgrounds, experiences and demographics.

We visited 21 residential care units, where many of these children lived. We interviewed 87 dedicated staff within the Department and CSOs, who each had a clear commitment and passion to create better outcomes for children. However, we found that the current system inhibits their ability to realise these outcomes, which often leads to fatigue, discontent and desensitisation.

We found that there are no specialist residential care services for children with particular vulnerabilities and complex needs. There is an absence of choice when placing a child in out-of-home care. This is most noticeable for Aboriginal children as there is a scarcity of residential care units operated by ACCOs, despite the high representation of Aboriginal children in residential care.

We know from experience that placing Aboriginal children away from their family and community further isolates them from cultural and support networks. This leads to greater disconnection, and places them at greater future risk of suicide, mental illness and incarceration. Cultural connectedness is a strong resilience factor and must be preserved for Aboriginal children in the state's care.

When a child is unable to live with family or community, foster care and residential care are currently the only two remaining options. The number of foster care placements is declining rapidly, placing greater demand on residential care placements.

It is encouraging to note the establishment of the Victorian Government's Ministerial Advisory Committee for Children in Out-of-Home Care, which comprises community sector leaders. This committee will recommend strategies to recruit more foster carers and to retain those already working with vulnerable children. Recruitment of foster carers to the current model, however, will be difficult without significant and discernible changes to the model.

We heard strong and persuasive arguments for the introduction of a professionalised foster care model, where qualified people with expertise in working with traumatised children would provide this care. Professional foster carers would need intensive support, supervision and appropriate remuneration.

The Department funds CSOs over \$100 million per year to provide residential care for vulnerable children. However, every year it costs more than this. The demand for placements always exceeds the Department's capacity to provide them. Individual placements for some children with additional needs can cost over \$1 million per year each. In 2014 the Victorian Auditor-General identified a 27 per cent gap between the current ongoing funding of residential care and the actual demand for residential placements. The funding shortfall comes from taking money from other areas, such as family violence and Aboriginal services.⁸

This Inquiry found that the monitoring of residential care, a task that is undertaken by the Department, is based on contractual performance only. There is little to no monitoring of compliance with service standards and virtually no focus on outcomes for children in care; thereby facilitating an environment where abuse can occur.

Funding and accreditation of CSOs must be based on tangible and positive outcomes for children in residential care. These outcomes must – at a minimum – include cultural connectedness for Aboriginal children, regular school attendance and active engagement with the child's family and community of origin, and the environment must be home-like, reparative and free from abuse.

We found that children and young people living in residential care experience multiple placements changes. They are exposed to other young people with high-risk behaviours. They lose contact with family, culture, school and community supports. They are at greater risk of creating lifelong institutionalised behaviours, developing mental health problems, substance abuse, experiencing homelessness and involvement with the youth justice system. They often repeat a pattern of intergenerational abuse and/or state care. Protecting these vulnerable children in residential care is important not only for their individual wellbeing, but also for the community, which ultimately bears the economic and social costs of our failure to effectively protect and heal them.

We found that children are poorly matched to placements and placement decisions are often based on where there is an available bed, rather than on the needs of the child. A key recommendation of this Inquiry is that the decision to place a child in residential care should be made by an expert placement panel. The child should also be consulted, and they should be given the opportunity to express their views to the panel.

8 Victorian Auditor-General, *Residential Care Services for Children* (Melbourne: Victorian Auditor-General's Office, 2014).

Many children in residential care live in appalling physical conditions as evidenced through this report. Despite large financial contributions by government, we found numerous children and young people living in sub-standard conditions.

Although the Secretary's duty when placing a child in out-of-home care is to care for them **as a good parent would**, the present model of residential care does not seem to provide for their physical, intellectual, cultural, emotional and spiritual development and creates an environment where children are at risk of and not protected from sexual abuse.

We found many children are subject to restrictive and intrusive care practices and punitive limit setting. The absence of professionally qualified staff has been highlighted in other inquiries as problematic. This Inquiry recommends the implementation of mandatory minimum-level qualifications for direct-care staff as soon as possible.

The voices of children and young people must be heard. Disturbingly, we found overwhelming evidence that fair and appropriate treatment was not given to many children who had been sexually abused in residential care. This Inquiry recommends the establishment of an independent complaints body for children and the establishment of an independent visitor program to every residential care unit.

The Department's response to children who have experienced sexual abuse in residential care is variable. It often appears to be below the standard required in the Department's own practice standards and inconsistent with the requirements of the CYFA 2005.

Systemic flaws were identified in the Department's QoC system and processes. This Inquiry recommends that these investigations should be delegated to an independent body, which is separate from the funding source and the provider of service delivery. The scope of QoC investigations must be expanded to include child-to-child abuse in residential care.

Our findings show that the residential care system is not compatible with human rights described in the Charter. We are very concerned about apparent breaches of children's rights in some of the individual cases reviewed, including placement decisions and the way the children were treated while they were in care. These potential breaches indicate that some people who work in the sector do not understand

children's rights or their own obligations under the Charter. If the Department and CSOs are to meet their obligations under the Charter, there is a need for guidance by the Department and training of all staff.

We need strategies to prevent sexual abuse and exploitation of children in care. There must be more information sharing between the Department and CSOs, and a better understanding of the existence and issues of sexual exploitation to ensure that responses are effective. Greater community awareness is needed about the sexual exploitation of children, especially vulnerable children in residential care.

It is encouraging that the Victorian Government has recently announced increased funding to the out-of-home care system. However, a far greater commitment is required if we, as a society, are to meet our human rights' obligations to vulnerable children in our care.

It is acknowledged that, for a small number of children, specialist group care may be required for short periods to allow for intensive treatment before transitioning to an appropriate home-based care option with the services following them. This Inquiry recommends the development of a suite of specialised services to cater for the needs of:

- Aboriginal children
- sibling groups
- children with a disability
- children who have been or are at risk of sexual exploitation
- children with identified sexually abusive or problematic behaviours
- pregnant girls and young parents.

We must have fewer children in residential care and a greater capacity for children to be placed in kinship or home-based care. We must reduce the ever-increasing number of Aboriginal children being placed in out-of-home care. The focus should instead be on supporting appropriate and healthy kinship placements with a clearly defined plan for cultural connection.

Our children and young people in residential care cannot wait any longer.

They only have one childhood.

Findings

Finding 1: The current system creates opportunities for the sexual abuse of children and young people

Children living in residential care in Victoria are reporting an alarming level of sexual abuse and sexual exploitation. Outlined below are elements of the system which, when not well-managed reduce the Department and CSOs' ability to keep children safe from harm.

The current residential care system does not always provide for vulnerable children in the same way **as a good parent would**.

Poor placement assessment and inappropriate matching of children

- There is inadequate assessment of the suitability of placements, including the impact and risk to other children when a child is placed in a residential care unit.
- The mix of children in residential care units is sometimes inappropriate. This includes children with disabilities and children as young as five years of age being placed with children with known sexually problematic or abusive behaviours. This creates the opportunity for child-to-child sexual abuse to occur.
- It would seem that the availability of beds, rather than the child's best interests, dictates most decisions about the placement of a child in residential care.
- The behaviour of other children can be a negative influence on a child in residential care. This is also a risk factor for the recruitment of vulnerable children into sexual exploitation.

Staffing

- The low skill base of some direct-care staff – some of whom are unqualified, unsupported and poorly supervised – is completely inadequate for the unique needs of children living in residential care.
- The low staffing ratios in residential care units – particularly overnight, when there is usually only one staff member for up to four children – leads to poor supervision of the children and an inability to respond to children if they are in crisis and away from the unit.
- The high number of rostered staff and the substantial use of labour-hire and casual staff by some CSOs works against providing stability for vulnerable children. Children who do not have stable, consistent care cannot develop strong and trusting relationships with their carers.
- In some situations there is an over-reliance on police being called to attend residential care units to respond to children's behaviours that are not of a criminal nature. Such reliance on police may indicate that some staff are not adequately equipped or supported to respond to trauma related behaviours of vulnerable children.

Systemic factors

- The current systems for preventing, monitoring, reporting and responding to sexual abuse allegations in residential care are inconsistent and often inadequate to keep children safe.
- There are not enough targeted and specialised care options to meet the individual needs of vulnerable children.

Cultural and community connections

- The current residential care system can contribute to the isolation of Aboriginal children from their culture and community. Cultural connectedness is essential for the development of strong resilience and pride, and must be preserved.
- Isolating Aboriginal children from their family and community adds to the cumulative trauma of past actions of government and non-government agencies towards Aboriginal people.
- There needs to be a greater emphasis on the importance of connecting children to their family, friends, community, culture and education.
- Most Aboriginal children in residential care are cared for by non-Aboriginal staff who have limited cultural training.

Physical environment

- In some residential care units, the human rights of children are violated by restrictive and intrusive practices.
- The physical environment of some residential care units visited by the Commission, were deplorable.
- Poor physical environments are not conducive to children remaining at home. Many children were absent, and their whereabouts unknown when the Commission visited. These absences can result in children being at risk of sexual abuse and exploitation by external predators.

Findings

Finding 2: The current system does not prevent sexual abuse or offer consistent responses when it occurs

There are inconsistent approaches to the prevention of sexual abuse. Children who have been sexually abused in residential care are not always given the same response that **a good parent would** provide to a child in a family.

Inadequate responses to reports of sexual abuse

- Some children are not provided with adequate acknowledgement and assistance after they disclose sexual abuse in residential care.
- Some children do not receive counselling after being sexually abused in residential care. Although referrals to counselling are often made, many children are reluctant to discuss such traumatic events with a counsellor that they do not know, and often in an unfamiliar location.
- Responses to reports of sexual abuse are often not tailored specifically to each child.

Poor sexual health education

- In the residential care units visited by the Commission, children received very little education about healthy and safe relationships, sexual health and the safe use of the internet and social media.
- The lack of sexual health education increases the vulnerability of children to sexual abuse and exploitation by other children and predatory adults.
- There was strong evidence that pornography, social media and the internet play a significant role in the lives of children in residential care. Whilst these are issues for the community in general, traumatised and abused children are particularly vulnerable to exploitation.

Systemic factors

- The absence of any independent oversight of investigations into reports of sexual abuse and sexual exploitation in residential care means there is insufficient accountability for the resulting decisions and actions of the Department.
- The absence of formal, consistent procedures for responding to reports of child-to-child sexual abuse results in varied responses.
- The current service response to allegations of sexual abuse and sexual exploitation is not generally child-friendly and often relies on a child being taken to an adult who they may not know and to a location that is unfamiliar.

Children's voices

- There are few opportunities for children to talk to anyone independent about feeling unsafe, having a negative experience in residential care or reporting sexual abuse.
- Children are often not provided with adequate information about outcomes, counselling, redress or their legal rights.

Finding 3: The current system has structural problems, poor data monitoring and insufficient oversight of CSOs

The present Departmental structure does not support the effective monitoring or oversight of residential care services. The Department's incident reporting data systems lack sophistication, therefore, the scale and extent of sexual abuse in residential care cannot be adequately measured or responded to and the effectiveness of response strategies cannot be gauged.

Departmental structure

- The present Departmental structure works against effective planning and placement of children and hinders appropriate monitoring and oversight of residential care services. There are so many people involved in the placement decisions that there is often confusion about who has the ultimate decision making responsibility in relation to the placement; and who has responsibility for ensuring the application of the best interest principles and, where necessary, the Aboriginal child placement principles.
- Role confusion within the Department results in misunderstandings about who is responsible for monitoring and overseeing residential care services and the effective assessment and placement of children.

Data limitations

- The current paper-based CIR system is outdated, inefficient and open to misinterpretation. It is not child-focused and lacks an effective feedback loop.
- Because CIRs are considered allegations only, there are no formal links between the original allegation, the investigation, whether or not the allegation is substantiated, the outcome for the child or the development of strategies to prevent further abuse.
- Many children's health, wellbeing and development records are incomplete and/or poorly maintained. If pertinent information is missing, this compromises the ability for children to be provided with optimal care and to be kept safe from abuse.

Service oversight and operation

- Although the Department has comprehensive guidelines around the delivery of quality residential care services, it does not satisfactorily monitor their implementation or ensure they are followed.
- The present service agreements between the Department and CSOs do not have a strong focus on achieving positive outcomes for children as a key indicator of performance.
- The current carers register allows potential offenders to move between different vulnerable groups without detection, for example, working between aged care, disability and children's sectors.
- The three-yearly accreditation process for CSOs is not sufficiently independent. The CSO finances the review, decides when it will take place and chooses who conducts it, albeit from external auditors approved by the Department.

Recommendations

Recommendation 1: Immediate changes to the residential care model

The government must redevelop the present model of residential care services in Victoria, in order to protect children from sexual abuse.

The number of children in residential care should be significantly reduced, home-based care alternatives should be improved and a suite of specialised residential care options for children with particular vulnerabilities should be developed. The Commission seeks the reduction in numbers of children in residential care from 500 to 300 over the next two years, and will monitor this progress. This is consistent with work being undertaken in many jurisdictions, including California⁹. The Commission acknowledges that there has been progress through the allocation of targeted care packages which commenced in 2015.

Immediately improve the physical environment of residential care units to make them look and feel like homes

Properties must meet basic standards of cleanliness and hygiene, just **as a good parent would** provide for their child. Properties that are in disrepair or that do not provide adequate safety, supervision and care for children must be closed down. Damage to residential care units must be promptly repaired.

The Department must invest in and implement a streamlined capital works program that regularly and promptly improves the physical environment of residential care units. Direct-care staff should not be expected to undertake property maintenance and repairs.

All children must be able to choose personal items to decorate and furnish their bedrooms. The current practice of using the bed of one child, who is temporarily away from care, for the placement of another child must cease.

Immediately cease all punitive, restrictive and deprivation-based practices

All restrictive and punitive practices must stop immediately. This includes disconnecting electricity from children's bedrooms and other areas, locking food away and locking linen cupboards, bathrooms, toilets and games rooms. The practice of observing children in their bedrooms via CCTV must never occur again.

⁹ California Department of Social Services, *Continuum of care reform*. (California, USA, 2015) www.cdss.ca.gov.

Create a panel of experts to assess placement decisions

As a matter of priority, the Department must improve systems and processes for children entering residential care, changing placements and exiting residential care. This should be done by creating an expert panel, with some members independent of funder and provider, to assess all residential care placement decisions.

The panel will assess placement decisions by considering:

- compliance with the Aboriginal child placement principle for Aboriginal children
- the impact on other children in the residential care unit
- the suitability and safety of the placement
- a demonstration that the placement will provide the best outcome for the child
- the adequacy of stability planning and planning for when a child leaves care.

The panel will document and record its decision in the child's file.

As some placements occur at a time of crisis, senior child protection practitioners (this may include the Department's Principal Practitioner) should have the authority to authorise or prohibit a child's placement in residential care until the expert placement panel convenes. This senior child protection practitioner (or Principal Practitioner) would be responsible for ensuring the application of the CYFA 2005 best interest principles and if the child is Aboriginal, the application of the Aboriginal child placement principle.

There must also be provision for independent scrutiny of placement decisions, including the ability of children and workers to seek review of decisions.

The Commission will periodically monitor and review panel decisions.

Improve direct-care staff capability and support

The introduction of a minimum Diploma-level qualification in Child, Youth and Family Intervention for all direct-care staff providing out-of-home care must be implemented immediately. Recruitment of all direct-care staff must include an evaluation of their aptitude for working with traumatised children and their own psychological resilience.

A recruitment strategy for Aboriginal direct-care staff must be developed and implemented as a priority.

All direct-care staff must receive regular, individual and live supervision by an expert practitioner.

Improve consistency of staff

The number of different direct-care staff rotating through a residential care unit must be kept to a minimum. This will give children the opportunity to form trusting relationships with their carers, and contribute to them seeing the unit as a safe place to live.

The use of labour-hire staff must be significantly reduced. They should account for less than 10 per cent of the total staffing complement across the sector.

Recommendations

Recommendation 2: Medium-term changes to the residential care model

Professionalise foster care

There is a strong need for the introduction of professional foster care as an adjunct to the current voluntary foster care model. Professional foster care will be delivered by tertiary-trained, qualified professionals with expertise in areas such as child protection, child development, counselling and trauma-informed practice. This model recognises the importance and value of specialist home-based care and will help to divert children from institutional forms of care. It will require intensive support, supervision and appropriate remuneration.

Current kinship and voluntary foster care models need better support and reimbursement levels that reflect the demands of caring for children who cannot live with their immediate family.

Develop a suite of specialised residential care services

The Department must develop and implement a suite of specialised residential care services to provide for the individual care needs for children with particular vulnerabilities who are not ready to live in home-based-care options. This includes:

- Aboriginal children
- sibling groups
- children with an intellectual or other disabilities
- children who are at risk of sexual exploitation
- children with identified sexually abusive or sexually problematic behaviours
- pregnant girls and young mothers who are subject to a child protection order (young mother or baby).

Expert specialist practitioner for every residential care unit

It is clear that there is a strong need for every residential care unit to have access to a CSO specialist practitioner with expertise in sexual assault and sexually abusive or problematic behaviours.

Such expert practitioners would be involved in responding to and coordinating care and support for a child following an allegation of sexual abuse in care, particularly where children are reluctant to seek external counselling.

The expert practitioner could also provide sexual health education to children and develop preventative strategies with children and staff, to keep children safe from sexual abuse and sexual exploitation.

Recommendation 3: Listen to the voice of the child

Independent oversight and consistent responses to children in residential care is needed. Research from the Royal Commission into Institutional Responses to Child Sexual Abuse has highlighted the importance of ensuring that children who disclose sexual abuse are believed and validated.¹⁰ There must be a rigorous and thorough investigation when a sexual abuse allegation is made, without predetermining the validity of the allegation.

A complaints body, which is independent of the Department (funder) and CSOs (service provider), must be established to hear directly from children. Additionally, QoC investigations should be delegated to such an independent complaints body. The scope of QoC investigations must be expanded to include allegations of child-to-child abuse in residential care.

The independent visitor program should also be established in all Victorian residential care units.

It is also recommended that revised and simplified guidelines be developed to ensure a consistent response to children who make a QoC allegation. This response should include counselling, information about the process of the investigation and its outcomes, and information about the child's legal right to access compensation and redress for substantiated cases.

Improving responses to children who experience sexual abuse in residential care will be achieved by a senior child protection practitioner (such as a Principal Practitioner) and the CSOs' expert practitioner coordinating the investigation, timely completion of CIRs, referral to the complaints body for QoC matters, and immediate support and counselling for the child and, where appropriate, their family.

Recommendation 4: Improve outcomes for children

Funding and accreditation of CSOs that provide out-of-home care services must be linked to demonstrated outcomes for children. Outcomes must include:

- provision of an environment that is healing and free from abuse
- strong cultural connection for Aboriginal children
- demonstrated compliance with the Charter
- regular school attendance and achievement, not simply enrolment
- provision of individual therapy and trauma-informed practice
- active engagement with the child's family and community of origin (except where this would be unsafe for the child)
- provision of standardised sexual health education to all children that, at a minimum, covers reproduction, safe and healthy relationships, consent, safe use of the internet and social media platforms, safe sex practices and gender identity issues
- adherence to record keeping requirements, including requirements of the LAC framework, to ensure up-to-date information about each child's health and wellbeing is accurately documented
- Demonstrated reduction in police attendance to residential care units for behaviour management issues that are not criminal.

¹⁰ Royal Commission into Institutional Responses to Child Sexual Abuse, *Interim Report, Volume 1* (Canberra: Commonwealth of Australia, 2014), pp. 128–151.

Recommendations

Recommendation 5: Establish a national register of carers

The Commission recommends that the Royal Commission into Institutional Responses to Child Sexual Abuse progress an interconnected national register of carers, for staff who work with vulnerable people, such as children, people with a disability and the elderly, to reduce the risk of abuse.

Recommendation 6: Review the Departmental structure

The Department must review the current structure of its divisions in relation to children and out-of-home care. This should include:

- reviewing the responsibilities and expectations of all Departmental roles that intersect with children in residential care, including child protection, youth justice, agency liaison, placement coordination and client outcomes and service improvement roles to ensure there is cohesion, clarity, accountability and consistent practice across multiple program areas within the Department
- focusing on ensuring the application of the best interest principles and the Aboriginal child placement principles
- reviewing the current accreditation process for CSOs providing residential care services to ensure it is independent and reflective of good outcomes for children
- ensuring every child in residential care is allocated a caseworker who visits them in their placement at least once a fortnight
- providing training to all staff about their responsibilities and obligations to children under the Charter.

Recommendation 7: Improve data systems

The Department must improve data collection systems to support a detailed understanding of the nature and extent of the problem and risk of sexual abuse in care and guide the development of effective responses. This can be achieved by:

- ceasing use of the current paper-based CIR system and – as a top priority – upgrading to an integrated electronic CIR system that is recorded on the CRIS and CRISSP databases
- ensuring that all CSOs have access to CRIS and CRISSP
- recording the investigation outcomes of CIRs to improve data reliability and ensuring an effective feedback loop occurs with the CSO and the data
- encouraging the participation of children in the CIR process, either by writing their own account of the incident or having a trusted adult or advocate write it on their behalf
- categorising all client incidents of a sexual nature as Category One to allow higher-level oversight, consistent responses to and analyses of the incidents
- timely management of CIRs and efficient record keeping.

Recommendation 8: Prevent sexual exploitation

Ensure ongoing funding and resources for a state wide preventative sexual exploitation strategy, building on the knowledge and work already done in some Victorian localities such as Shepparton and Dandenong. This can be achieved by:

- continuing the collaborative approach between the Department, Victoria Police, CSOs and child sexual assault experts who have experience working with children as both victims and offenders
- local profiling of the nature and problem of sexual exploitation across Victoria, similar to work being conducted in the UK¹¹
- ensuring the participation of children and young people in developing, implementing and reviewing the strategy
- effective information sharing across all agencies
- providing supervision, support and specialised training for all staff who encounter sexually abused and sexually exploited children
- delivering public awareness education campaigns.¹²

Recommendation 9: Develop child-safe standards

CSOs must develop rigorous and ongoing child-safe practices, rather than simply relying on pre-employment screening to prevent the risk of staff-to-child sexual abuse. The Department must monitor CSO's adherence to child-safe standards.

Particular emphasis should be placed on:

- providing ongoing training to all CSO staff to ensure they are competent in understanding how sexual abuse can occur in an institutional setting, and detecting grooming behaviours and/or possible sexual abuse by trusted adults
- ensuring that guidelines about caring for children are clearly communicated, and include clear rules and expectations about physical boundaries, privacy, language, personal relationships and friendships, contact outside the organisation with the child, discipline, photography, video and the use of social media
- ensuring children understand their legal rights in relation to their care and to whom they can complain if they feel unsafe
- improving structures to provide children with regular opportunities to give feedback on all aspects of their care.

11 Sue Berelowitz et. al., *'If only someone had listened'*; National Crime Agency, Child Exploitation and Online Protection Centre, *Out of Mind, Out of Sight: Breaking down the barriers to understanding child sexual exploitation* (London: Child Exploitation and Online Protection Centre, 2011).

12 This could be similar to the 'Stop Sex With Kids' initiative in Manitoba, Canada (www.stopsexwithkids.ca).

1. Introduction

1. Over the past five years, attention to the sexual abuse and sexual exploitation of children in institutional care has received unprecedented and widespread focus in Australia and internationally. The Commission has been attentive to the progress, findings and recommendations of these inquiries in considering the issue of sexual abuse of children living in residential care units in Victoria.

1.1 Recent Victorian inquiries

2. In Victoria, key recent inquiries include Victoria's Vulnerable Children's Inquiry (VVCI) and the subsequent Victorian Parliamentary inquiry into the handling of child abuse by religious and other non-government organisations. Key findings were that there are major barriers to the disclosure and reporting of institutional abuse and that there have been significant failures of adults and institutions in listening to and protecting children. Some of the recommendations of relevance to this Inquiry include:
 - The development of a comprehensive five-year plan for Victoria's out-of-home care system to improve stability, quality and outcomes for out-of-home care placements, with an overall goal that growth in out-of-home care should be in line with overall population growth of children and young people in the state.¹³
 - Amendments to the CYFA 2005 to include, in its best interests principles, the need to protect the child from the crimes of physical abuse and sexual abuse.
 - Development of clear and transparent client-based funding for the out-of-home care sector.¹⁴
 - Improvements to the regulation and oversight of CSO performance, including comprehensive annual reporting by the Department on the regulation and performance of CSOs against required service standards, information about the registration and disqualification of carers, data regarding the incident reporting and detailed information about abuse in care investigations and outcomes.¹⁵
 - Recommendations that the Victorian Government gives detailed consideration to a professional carer model and requests that the Commonwealth Government addresses associated taxation and industrial relations barriers.¹⁶
 - Reform to legislation to strengthen the potential for the prosecution and punishment of offenders who perpetrate or conceal crimes, notably, the introduction of grooming legislation.¹⁷
 - Recommendations for alternate avenues for justice and improved access to civil avenues of justice.¹⁸
 - Recommendations to improve organisational responses to allegations of criminal child abuse and efforts to improve the prevention of criminal child abuse.¹⁹

¹³ Philip Cummins, Dorothy Scott and Bill Scales, *Report of the Protecting Victoria's Vulnerable Children Inquiry: Volume 1* (Melbourne: Department of Premier and Cabinet, 2012).

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Family and Community Development Committee, *Betrayal of Trust: Inquiry into the Handling of Child Abuse by Religious and Other Non-Government Organisations* (Melbourne: Victorian Government, 2013).

¹⁸ Ibid.

¹⁹ Ibid.

1.2 International inquiries

3. There have been a number of international studies and inquiries into sexual exploitation and institutional sexual abuse of children. Key findings and recommendations are:
 - Ensuring that the views of children and young people are at the heart of developing strategic plans to combat child sexual exploitation. This should be done by seeking their feedback on their experiences of care and protection and by providing opportunities for them to participate in programs to build their resilience.²⁰
 - Building capacity for the development of enduring relationships and support for children and young people who have experienced or are at risk of sexual exploitation, and emphasising the need for long-term specialist youth and universal services specifically for children and young people who have experienced or been exposed to sexual exploitation.²¹
 - Improving data collection, information sharing between agencies, data analysis and problem-profiling. This will lead to a better understanding of the existence and issue of sexual exploitation in order to evaluate the effectiveness of the responses.²²
 - Improving training, supervision and support to all staff to ensure quality practice and compliance with relevant policies. Training must extend to all professionals who work with children and young people who have been sexually exploited.²³
 - Providing relationship and sex education in every educational setting for children as part of a holistic approach to child protection. This should include internet safety, bullying, harassment, receiving and giving consent.²⁴
 - When institutions put their own interests ahead of the interests of the children who engage with them, abusive behaviours are likely to become normalised, potentially leading to sexual abuse.²⁵
 - The culture of an institution has a strong influence on how abuse might occur within it.²⁶
 - The historic nature of many cases reaching media attention, together with developments in safeguarding, might give a false perception that institutional sexual offending can no longer occur. Offenders will continue to exploit systemic vulnerabilities where they exist.²⁷

20 Sue Berelowitz, Jenny Clifton, Carlene Firimin, Dr Sandra Gulyurtlu and Gareth Edwards, *'If only someone had listened': The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups Final Report* (London: Office of the Children's Commissioner, 2013).

21 Ibid.

22 Sue Berelowitz et. al., *'If only someone had listened'; National Crime Agency, Child Exploitation and Online Protection Centre, Out of Mind, Out of Sight: Breaking down the barriers to understanding child sexual exploitation* (London: Child Exploitation and Online Protection Centre, 2011).

23 National Crime Agency, *Out of Mind, Out of Sight*.

24 Sue Berelowitz et. al., *'If only someone had listened'*.

25 National Crime Agency, Child Exploitation and Online Protection Centre, *CEOP Thematic Assessment. The Foundations of Abuse: A thematic assessment of the risk of child sexual abuse by adults in institutions* (London: National Crime Agency, 2013).

26 Ibid.

27 Ibid.

1. Introduction

1.3 Royal Commission into Institutional Responses to Child Sexual Abuse

4. The current Royal Commission into Institutional Child Sexual Abuse has highlighted and exposed historic and contemporary examples of widespread sexual abuse of children in institutional settings, including out-of-home care services. More than 3000 private sessions held by the Royal Commission have allowed individuals to share their stories of abuse in Australian institutions.²⁸
5. Key learnings have been shared with the public during the course of the Royal Commission. These include:²⁹
 - sexual abuse often occurs with other forms of abuse, such as physical and psychological abuse
 - lifelong negative impacts on health are associated with sexual abuse experiences
 - repeated abuse and multiple perpetrators are common.
6. The Royal Commission has reported that all children in institutions and out-of-home care are at risk of sexual abuse. It has highlighted the heightened vulnerabilities of some groups of children based on factors including age, gender, ethnicity, disability and prior experiences of abuse and neglect.³⁰ Given this is the profile of many children in state care, it is therefore unequivocal that children in residential care in Victoria are at significant risk of sexual abuse and sexual exploitation.
7. The Royal Commission found that child sexual abuse in institutions continues to be widely under-reported, despite the legal obligation to do so. Many institutions and individuals have failed to identify or report abuse of children in their care.
8. Current research indicates that victims of institutionalised sexual abuse can take up to 20 years to disclose their experience of abuse in care.³¹ It is therefore highly probable that children who are currently victims of sexual abuse in Victorian residential care have not yet disclosed their experience, and may take decades to do so.
9. The Commission notes that this places even greater responsibility on CSOs and the Department to be vigilant about their responsibilities in caring for children in residential care. The workforce must be educated in how to understand and prevent sexual abuse, and how to develop a safe environment for these vulnerable children that builds their resilience and security.
10. Where allegations of sexual abuse and sexual exploitation are reported in state care, the response must be professional and timely and the best interests and safety of the child must be paramount. The intervention must be child focused. The response must, at a minimum, be what **a good parent would do**. Interventions must be therapeutic and aimed at healing, and must uphold the child's human rights and legal rights including appropriate legal redress and compensation.

1.4 Residential care in Victoria

11. Residential care is out-of-home care provided by employed staff in a residential facility for children. It is used where it has been determined by the Department that living at home is not consistent with the child's best interests, due to the risk or likelihood of abuse and neglect. Children placed in residential care are cared for on a 24-hour basis by staff who work on a roster.
12. Groups of up to six children (usually unrelated and of mixed gender) are accommodated in these placements in Victoria. Children as young as five are placed in residential care facilities in Victoria. As at February 2015, 72 (15 per cent) of the children placed in residential care were aged 12 and under.³²
13. Residential care is usually considered an option for the placement of children where there are no home-based care options available, or where home-based care or familial care arrangements have not been successful.
14. As at June 2015, there were 163 residential care units operating in Victoria, comprising 123 standard models and 38 therapeutic models that are funded at a higher level and two secure welfare services.³³

²⁸ Royal Commission into Institutional Child Sexual Abuse, www.childabuseroyalcommission.gov.au, accessed 22 April 2015.

²⁹ Royal Commission into Institutional Responses to Child Sexual Abuse, *Interim Report*.

³⁰ *Ibid.*

³¹ *Ibid.*

³² Unpublished data provided by the Department to the Commission, 14 April 2015.

³³ Unpublished data provided by the Department to the Commission, 1 June 2015.

15. CSOs are funded by the Department to provide residential care services. CSOs are authorised to provide this care by the Minister for Families and Children.
16. CSOs that provide out-of-home care are subject to accreditation every three years. This process involves being reviewed against the Department's Registration Standards for Community Service Organisations.

1.5 Children living in residential care

17. All children in residential care are there because they are subject to current protective involvement by the Department as a result of abuse, neglect, trauma or relinquishment. These children have often experienced the greatest level of trauma and require the most expert therapeutic care and support.
18. Children are presently required to leave residential care at the expiry of their protective order and move into other arrangements, such as lead tenant (until they are 18), independent living or kinship care.
19. Published research on outcomes for children leaving care is particularly bleak. Young people leaving care are considered one of the most vulnerable and disadvantaged groups. Young people transitioning from out-of-home care have poor emotional, social and financial support³⁴ as they transition to adulthood. Their educational outcomes are poorer compared to their non-care peers.³⁵ They are over-represented in the youth justice system³⁶ and are at higher risk of mental illness,³⁷ homelessness and early parenthood.³⁸

34 Alexandra Osborn and Leah Bromfield, *Young People Leaving Care, Research Brief No. 7* (Melbourne: Australian Institute of Family Studies, 2007).

35 Philip Mendes, Dee Mitchell and Jacqueline Wilson, 'Young People Transitioning from Out-of-home Care and Access to Higher Education: A Critical Review of the Literature', *Children Australia*, Volume 39, Issue 4 (2014), pp. 243–252.

36 Philip Mendes, Susan Baidawi and Pamela Snow, 'Young People Transitioning from Out-of-Home Care: A Critical Analysis of Leaving Care Policy, Legislation and Housing Support in the Australian State of Victoria', *Child Abuse Review*, Volume 23, Issue 6 (2014), pp. 402–414.

37 Susan Baidawi, Philip Mendes and Pamela Snow, 'Young People in, and Transitioning from, Out-of-home Care and their Mental Health Issues: A Call for Evidence', *Children Australia*, Volume 39, Number 4 (2014), pp. 200–205.

38 Alexandra Osborn and Leah Bromfield, *Young People Leaving Care, Research Brief No. 7* (Melbourne: Australian Institute of Family Studies, 2007).

1.6 Current demand for residential care in Victoria

20. Unpublished data provided by the Department to the Commission indicates that in 2013–14 the daily average number of residential care placements was 495.9.³⁹
21. In Victoria, as is the case nationally, home-based care is the preferred type of alternate care for children and young people who are unable to live with their family of origin. In Victoria, there are comparatively fewer children in out-of-home care than in other Australian jurisdictions. However, the proportion of children placed in residential care in Victoria is comparatively higher than the national average (in Victoria, 7.6 children per 1000 children in the population compared with 5.5 children per 1000 children in the population nationally).⁴⁰
22. Of particular concern is the over-representation of Aboriginal children in out-of-home care in Victoria. In 2013–14, there were 90 Aboriginal children in residential care.⁴¹
23. The Victorian Auditor-General has reported that in the last decade the number of children in out-of-home care has increased by 60 per cent. The number of children placed in residential care has increased by 10 per cent over the same time period.⁴²
24. Of great concern, the Victorian Auditor-General further reported that, based on the Department's projections, demand for residential care is due to increase by 29 per cent. Demand will rise from just over 500 placements in 2012–13 to just under 650 placements in 2017–18.⁴³
25. The Department reported that in 2013–14 the daily average number of children in all out-of-home care placements (foster care, kinship care, permanent care and residential care) was 7283. This exceeded Departmental forecasting.⁴⁴

39 DHHS, *Performance, Assurance and Compliance Report* (unpublished data), January 2015.

40 Australian Institute of Health and Welfare, *Child Protection Australia 2012–13* (Canberra: Australian Institute of Health and Welfare, 2014).

41 Australian Institute of Health and Welfare, *Child Protection Australia 2012–13* (Canberra: Australian Institute of Health and Welfare, 2014).

42 Victorian Auditor-General, *Residential Care Services for Children*.

43 Ibid.

44 Victorian Department of Human Services, *Annual Report 2013–14*.

1. Introduction

1.7 Government funding of residential care

26. The Victorian Auditor-General reported that in 2012–13 the annual cost of funded residential care was over \$100 million. The total annual cost per child's funded placement ranged from \$162,880 to \$308,028.⁴⁵
27. The same audit reported that the residential care system in Victoria is currently operating well over capacity. There is a 10 per cent shortfall between funded capacity and actual demand for placements, which influences the quality of care that children subsequently receive.⁴⁶
28. The Productivity Commission has reported that in 2013–14 Victoria's expenditure on out-of-home care was the lowest in Australia. For every child in Victoria, the government spent \$315.92 real expenditure on out-of-home care, compared to an average of \$411.24 per child in the population across Australia.⁴⁷
29. The shortfall in funding and availability of residential care has led to a reliance on unfunded placement arrangements (also known as 'contingency' placements).
30. The costs of these unfunded placements are significant. The Victorian Auditor General reported that in 2012–13 the Department purchased additional placements at a cost of \$24 million.⁴⁸
31. Funding for these additional unfunded placements comes at the expense of other important programs, many of which are early intervention and family preservation initiatives. The Victorian-Auditor General highlighted that in 2011–12 funds were shifted by the Department away from key projects including:
 - family violence risk assessment
 - building the capacity of Aboriginal organisations
 - children's health and education assessment initiative
 - a number of key disability service initiatives.⁴⁹
32. In 2014, the previous Victorian Government released its *Out-of-Home Care: A Five Year Plan*. This plan outlined a number of long-term goals for service improvement in order to improve outcomes for children, reduce demand on the system and create the foundation for a sustainable and effective out-of-home care system.⁵⁰
33. Following the release of *Out-of-Home Care: A Five Year Plan*, the government announced its 'long-term vision' that all residential care placements will become therapeutic placements, with supports that appropriately and effectively address the complex needs of the children.
34. Funding of \$70 million over four years was allocated in the 2012–13 Victorian State Budget to increase capacity and improve outcomes for children in state care including additional residential care placements and the expansion of TRC.⁵¹
35. Further funding of \$91 million over four years in the 2013–14 Victorian State Budget was allocated to address the increased demand for out-of-home care, expand therapeutic foster care and improve service capacity for the needs of complex clients.⁵²

45 Victorian Auditor-General, *Residential Care Services for Children*.

46 Ibid.

47 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2014* (Canberra: Productivity Commission, 2014).

48 Victorian Auditor-General, *Residential Care Services for Children*.

49 Ibid.

50 Department of Human Services, *Out-of-Home Care: A Five Year Plan* (Melbourne: Victorian Government, 2014).

51 Department of Treasury and Finance, *Victorian Budget 2012–13 Budget Overview* (Melbourne: Victorian Government, 2012).

52 Department of Treasury and Finance, *Victorian Budget 2013–14 Budget Overview* (Melbourne: Victorian Government, 2013).

36. There was no funding allocated in the 2014–15 Victorian State Budget for children in out-of-home care.⁵³
37. On 7 February 2015, the present government announced a funding increase to out-of-home care, with \$16 million to be directed to residential care to provide:
 - ‘more staff during the day and a staff member who remains awake at night’, a further \$1.5 million to ‘be put towards spot audits of residential care facilities to ensure the highest standards of care managed by non-government agencies’ and investment of \$1.5 million to ‘attract, recruit and retain more foster carers’.⁵⁴
38. In March 2015, the government introduced ‘targeted care packages’ in response to stated policy, to move children out of residential care and into home-based care. Funding of \$43 million was announced to support the initiative, with an emphasis on moving primary school-aged children out of residential care and also focusing on the over-representation of Aboriginal children. The government’s media release commented that home-based care is ‘preferable’ to residential care and noted that:
 - a shortage of home-based care has seen some children placed in residential care as a stopgap measure.⁵⁵
39. The Commission welcomes these initiatives to reduce the number of children residing in residential care and the undertaking of spot audits to ensure compliance with standards.
40. The 2015–16 Victorian State Budget allocated \$39 million to expand out-of-home care placements and a further \$6.3 million to upgrade residential care homes across Victoria.⁵⁶

1.8 Brief history of residential care in Victoria

41. The use of residential care has been well documented in recent Victorian inquiries. Residential care has moved from large-scale, state-run institutional care in 1800–1960s, through smaller, community-based residential care in the early 1970s, to the present system.⁵⁷
42. The history and past actions of government and non-government agencies have impacted negatively on Aboriginal families. Generations of Aboriginal children removed from their family are known as the ‘Stolen Generations’. These children were fostered out to non-Aboriginal families or brought up in institutions. Many Aboriginal people have been affected directly, and many more indirectly, by past policies leading to the Stolen Generations. Between 1835 and 1970 it is estimated that tens of thousands of Aboriginal and Torres Strait Islander children across Australia were removed from families and raised in institutions or with non-Aboriginal families.⁵⁸
43. Historically, residential care in Victoria was provided in the context of a response to children deemed to have been neglected or be involved in juvenile crime.⁵⁹ From the mid-1800s, Victorian children in these situations were sent to either reformatory schools or industrial schools. Physical care was provided through receiving houses and boarding-out arrangements with people willing to take charge of the child’s maintenance and education.
44. Residential care progressed from the use of reception centres in the late 1880s, which had a focus on the child’s ‘reform’ and rescue from ‘moral danger’, to the provision of specific children’s homes and family group homes from the mid-1950s, largely in response to overcrowding at reception centres.⁶⁰

53 Department of Treasury and Finance, *Victorian Budget 2014–15 Budget Overview* (Melbourne: Victorian Government, 2014).

54 Jenny Mikakos, *Better care for our vulnerable kids* [media release], 9 February 2015, Premier of Victoria, www.premier.vic.gov.au/better-care-for-our-vulnerable-kids, accessed 3 July 2015.

55 Jenny Mikakos, *\$43 million to move vulnerable kids out of residential care*, [media release], 16 March 2015, Premier of Victoria, www.premier.vic.gov.au/43-million-to-move-vulnerable-kids-out-of-residential-care, accessed 3 July 2015.

56 Department of Treasury and Finance, *Victorian Budget 2015–16 Budget Overview* (Melbourne: Victorian Government, 2015).

57 Philip Cummins et. al., *Report of the Protecting Victoria’s Vulnerable Children Inquiry*; Family and Community Development Committee, *Betrayal of Trust*.

58 Philip Cummins et. al., *Report of the Protecting Victoria’s Vulnerable Children Inquiry*.

59 Centre for Excellence in Child and Family Welfare, *Submission to the Commission for Children and Young People: Inquiry into the adequacy of the provision of services to children and young people who have been subjected to sexual exploitation or sexual abuse whilst residing in residential care* (Victoria: Centre for Excellence in Child and Family Welfare, 2014). Submissions to the Inquiry can be viewed at www.cryp.vic.gov.au.

60 Australian Government, *Find and Connect: History and information about Australian orphanages, children’s homes and other institutions*, www.findandconnect.gov.au, accessed 5 July 2014.

1. Introduction

45. By the 1970s, there was a greater legislative emphasis on the care and protection needs of the child. Intervention resulted from a guardian's actions or inactions that impacted on the child's physical, mental and emotional development, as opposed to intervention based on the child's behaviour. The 1970s also saw the establishment of Aboriginal Child Care Agencies, reflecting emerging views that, wherever possible, Aboriginal children should be placed within their own community.
46. Additionally, legislation in the late 1970s⁶¹ required that a child could not be admitted to the care of the Department unless all reasonable steps had been taken to provide the necessary services to enable the child to stay with the family.⁶²
47. There was then the phasing down and eventual closure of large orphanages and institutions in Victoria, which were housing up to 100 children in each facility even up until the late 1980s.⁶³
48. A Victorian Auditor-General inquiry in 1996 commented that:
- *History has proven that large institutions did not provide the appropriate environment that was essential for a child's emotional and physical development and in reality, life-long damage was being inflicted on large numbers of children.*⁶⁴
49. By 1996, it was reported by the Victorian-Auditor General that there were 120 family group homes operating in Victoria.⁶⁵ The report detailed that family group homes were community-based properties where caregivers would reside on the premises and care for four to five children on a 24-hour basis. The caregivers, known as 'cottage parents', may have had children of their own and with their partner would provide a family-like setting for the children placed in their care. The intention of these placement arrangements was to provide care for the child until they could either return to their own family, to relatives or to an independent living arrangement.
50. During the 1990s, the Department also operated short-term (placements of up to three months) and medium-term (placements of three to 12 months) community-based residential care units that accommodated four to eight children at a time. Paid staff provided supervision and care of the children in the Departmental residential units on a rostered shift basis. The profile of children placed in these units was described as those who generally had:
- *special needs, displaying challenging behaviours requiring intensive support and supervision.*⁶⁶
51. The Department's policy by the mid-1990s was to progressively close down family group homes in response to a strategy to move towards home-based care as the preferred option of out-of-home care. Simultaneously, service responsibility for residential care units operated by the government was transferred to CSOs.
52. The Department conducted an audit of 387 children and young people in residential care in 2001.⁶⁷ The audit revealed one-third of children in residential care were aged 12 years and under; Aboriginal children were significantly over-represented in the residential care population; 60 per cent of children in residential care were boys; 2.8 per cent of the children had experienced more than 10 residential care placements; and there was an extremely high level (almost 20 per cent) of children with an intellectual disability.
53. The same audit also found that large numbers of children (33) were identified to have engaged in the exchange of sex for money and 62 children were known to have a history of sexual offending. Twenty-seven children were identified as having experienced a sexual assault by another child in their placement and 65 children were known to have been physically assaulted by another child in their placement. The issue of sexual abuse in residential care is not new.

61 *Community Welfare Services Act 1978.*

62 Centre for Excellence in Child and Family Welfare, *Submission to the Commission for Children and Young People. Submissions to the Inquiry* can be viewed at www.ccp.vic.gov.au.

63 Victorian Auditor-General, *Special Report No. 43. Protecting Victoria's Children: The role of the Department of Human Services* (Victorian Government: 1996).

64 *Ibid.*

65 *Ibid.*

66 *Ibid.*

67 Department of Human Services, *Findings of the audit of children and young people in residential care*, (Melbourne: Victorian Government, 2001).

54. Placements in residential care in Victoria have steadily reduced since the mid-1990s, when there were approximately 700 children placed in residential care.⁶⁸ There are presently around 500 children placed in residential care. Yet, as the Victorian-Auditor General has reported, based on the Department's projections, demand for residential care is predicted to increase to just under 650 placements in 2017–18.⁶⁹
55. The VVCI noted the policy move in Victoria towards TRC. The VVCI reported that in response to overwhelming evidence that removal of a child from their family and placing them in alternate care does not lead to improved outcomes or wellbeing, there has been a broader focus on outcomes and the quality and nature of alternate care provided to the child.⁷⁰
56. The conceptual underpinnings of TRC in Victoria are reported to be influenced by the 'sanctuary model', which incorporates:
- *Theory-based, trauma-informed, evidence-supported, whole culture approach that has a clear and structured methodology for creating or changing an organisational culture... theories of attachment, trauma and neurobiology of the brain development underpin practice.*⁷¹
57. An evaluation of TRC pilots⁷² found that TRC leads to improved outcomes for children and young people when core features of the model are observed, including extensive training of staff, additional staff, consistent rostering and a therapeutic specialist embedded in the program that has a trauma and attachment informed approach to the children. Additionally, successful outcomes occur from planned transitions into the TRC placement that involve the child, and consideration of the overall mix of children in the placement. An attractive and homely environment is required and exit planning and post-exit support is crucial.
58. The introduction of TRC was first piloted in Victoria in 2007 and since that time the Department has increased TRC programs to 38 CSO properties and one Departmental operated property, as at May 2015.⁷³
59. The Department provides additional funding to CSOs of \$79,430 per child in a therapeutic placement.⁷⁴
60. This additional funding provides for a therapeutic specialist to be attached to the TRC-funded residential unit to support the direct-care staff in the provision of therapeutic responses to the trauma behaviours of the children. This additional funding also provides for a stand-up staff member overnight.
61. The Department announced in *Out-of-Home Care: A Five Year Plan* the intention to increase the number of therapeutic placements by 60 before the end of 2015, to 140 placements in total.⁷⁵ It is the Department's long-term vision that every residential unit in Victoria will transition to TRC.
62. The Commission visited a number of TRC-funded residential care units during the Inquiry. Some discernible differences were noted in the general physical presentation and operation of these units, however the Commission also observed a number of concerns as detailed in Chapter 6.

68 Australian Institute of Health and Welfare, *Child Protection Australia 2012–13*.

69 Victorian Auditor-General, *Residential Care Services for Children*.

70 Philip Cummins et. al., *Report of the Protecting Victoria's Vulnerable Children Inquiry*.

71 Verso Consulting, *Evaluation of the Therapeutic Residential Care Pilot Programs: Final summary and technical report* (Melbourne: Verso Consulting, 2011).

72 Ibid.

73 Unpublished data provided by the Department to the Commission, May 2015.

74 Unpublished data provided by the Department to the Commission, May 2015.

75 Department of Human Services, *Out-of-Home Care: A Five Year Plan*.

2. About the Inquiry

2.1 Role of the Commission for Children and Young People

63. The *CCYP Act 2012* provides the legislative mandate for the operation of the Commission.
64. The Commission comprises the Principal Commissioner for Children and Young People, Mr Bernie Geary, and the Commissioner for Aboriginal Children and Young People, Mr Andrew Jackomos.
65. The Commission is an independent statutory body. In performing its functions, it must act independently and impartially.
66. The objective of the Commission is to promote continuous improvement and innovation in policies and practices relating to the safety and wellbeing of children and young people generally, with a particular focus on vulnerable children and young people.
67. This mandate includes promoting the highest standards in the provision of out-of-home care services for children and young people. The Commission is also tasked with monitoring youth justice and out-of-home care services, which include residential, home-based and kinship care.
68. The functions of the Commission include the provision of advice to government as well as making specific recommendations to ministers, government departments, health services, human services and school services concerning child-safe policies and practices and the provision of services relating to the safety and wellbeing of vulnerable children and young people.
69. The Commission is also responsible for promoting the interests of vulnerable children and young people as well as promoting child-friendly and child-safe practices within the wider Victorian community.
70. The Commission is empowered to conduct inquiries concerning:
 - the death of child protection clients
 - the provision of services to vulnerable children and young people
 - systemic issues in the provision of services to children and young people.

2.2 Background

71. This Inquiry was established in March 2014 by the Principal Commissioner, Mr Bernie Geary.
72. This Inquiry was established in response to concern at the increasing reports of sexual abuse and sexual exploitation of Victoria's most vulnerable children in residential care; the inadequate systemic response to preventing the abuse; and the lack of confidence that those children who were abused in state care were receiving the therapeutic support and care that was needed to heal.
73. These concerns were highlighted through a number of recent and ongoing inquiries and reports:
 - Ombudsman Victoria, *Own motion investigation into the Department of Human Services Child Protection Program*, November 2009
 - Ombudsman Victoria, *Own motion investigation into Child Protection – out-of-home care*, May 2010
 - *Protecting Victoria's Vulnerable Children Inquiry*, 2012
 - Victorian Parliamentary Inquiry into the handling of child abuse by religious and other organisations, *Betrayal of Trust*, 2013
 - Victorian Auditor-General, *Residential Care Services for Children*, 2014
 - previous inquiries the Commission has conducted at the request of the Minister for Community Services
 - analysis of the Department's Category One CIRs pertaining to allegations of sexual abuse and sexual exploitation of children residing in residential care
 - current Royal Commission into Institutional Responses to Child Sexual Abuse
 - Taskforce 1000⁷⁶
 - recent media reports over the past 12 months about sexual abuse of children in Victorian residential care
 - recent proceedings in the Melbourne Children's Court that have highlighted the serious issue of sexual abuse and sexual exploitation in residential care.

⁷⁶ Taskforce 1000 was established in 2014 in response to the over-representation of Victorian Aboriginal children in out-of-home care. It is focused on improving outcomes for Aboriginal children and young people in care through oversight of their individual plans and consideration of all aspects of their care including education, health and connection to culture. The taskforce is co-chaired by the Secretary DHHS and the Commissioner for Aboriginal Children and Young People, Mr Andrew Jackomos.

2. About the Inquiry

2.3 Terms of Reference

74. The Commission's Terms of Reference for the Inquiry detailed an intention to inquire into the provision of residential care to children and young people in Victoria who are at risk of, or who have experienced, sexual abuse or sexual exploitation while living in residential care.
75. Consideration was given to:
- the adequacy of the response in protecting children or young people from further abuse
 - the appropriate investigation of allegations (to the extent that is appropriate)
 - the supports and services made available to children and young people who have been subject to sexual abuse or sexual exploitation while living in residential care.
76. The Commission, through its Terms of Reference, committed to providing recommendations to government on system reform and improvement, by examining and reporting on:
- the factors that increase the risk and incidence of sexual abuse or sexual exploitation of children and young people in residential care together with effective prevention strategies
 - the adequacy of the present models of residential care being offered to children and young people in Victoria
 - possible changes to the model of residential care being offered to children and young people in Victoria
 - the interaction between the Department, agencies and service providers and how these sectors can work together to better protect children and young people in residential care from sexual abuse or sexual exploitation.

2.4 Governance

77. The Inquiry was conducted by the support of Commission staff:
- | | |
|------------------------|-----------------------------------|
| ■ Ms Fiona Fyffe | Inquiry Project Manager |
| ■ Ms Liz Down | Senior Project Officer |
| ■ Ms Jenny Wing | Senior Project Officer |
| ■ Ms Tina Papadopoulos | Senior Practice Reviewer |
| ■ Mr Todd Sweeney | Data and Information Analyst |
| ■ Ms Madeline Hardess | Project Administration and Review |
78. Oversight of the Inquiry was provided by an internal Commission steering group to guide and assist progress of the phases of the Inquiry. The steering group comprised the following members:
- | | |
|--------------------------|---|
| ■ Mr Bernie Geary | Principal Commissioner |
| ■ Mr David Ali | Chief Executive Officer (until June 2014) |
| ■ Ms Brenda Boland | Chief Executive Officer (from June 2014) |
| ■ Mr Ray Carroll | Manager, Monitoring Programs and Services |
| ■ Ms Mary McAlorum | Manager, Inquiries and Systemic Reform |
| ■ Ms Janette Kennedy | Senior Strategic Adviser to Commissioner for Aboriginal Children and Young People |
| ■ Ms Danielle Woollorton | Legal Counsel (from November 2014) |
| ■ Ms Fiona Fyffe | Inquiry Project Manager |

2.5 Methodology

79. In conducting the Inquiry, a range of approaches were undertaken:
- consideration of the legal framework and standards
 - analysis of Category One CIRs from the Department relating to allegations of sexual abuse, sexual behaviour or sexual exploitation of children placed in residential care
 - reviews were undertaken of the child protection files of 166 children and a detailed analysis was conducted on a sample group of 20 per cent of these files (32 children)
 - comprehensive reviews of these 32 child protection files to consider each child's experience in residential care including, but not limited to, the provision of education, health and culture; evidence of the best interests principles being applied in all decision making; how the incident(s) of child abuse in care occurred; the response provided to the child from the CSO and the Department; the support and treatment that the child received; the strategies put in place to prevent a further occurrence; and any other relevant issues
 - site visits to a sample group of 21 residential units
 - interviews with 87 staff from the Department and CSOs
 - interviews with a number of children who are currently living in residential care
 - interviews with a number of young adults who previously lived in residential care and have since left state care
 - public submissions.

2.5.1 Legal framework and practice standards

80. In considering the sexual abuse and sexual exploitation of children in residential care, the Commission has been cognisant of the state's legal obligations and applicable practice standards, including but not limited to:
- *CCYP Act 2012*
 - *CYFA 2005*
 - *Crimes Amendment (Protection of Children) Act 2014* (Protection of Children Act 2014)
 - *Charter*
 - Rights of the Child
 - National Standards for out-of-home care⁷⁷
 - Charter for children in out-of-home care⁷⁸
 - *Privacy and Data Protection Act 2014* (Privacy Act 2014).
81. The following sections of the CYFA 2005 are of particular relevance for the Inquiry:
- Part 1.2, division 2, section 10 – Best interests principles. Includes the cornerstone principle that the best interests of the child must always be paramount when determining whether a decision or action is in the best interests of a child, the decision making must have regard to a child's need to be protected from harm, protect their rights and to promote their development.
 - Part 1.2, division 3, section 11 – Decision-making principles. Sets out the principles that must guide the Secretary and CSOs when making a decision or taking an action in relation to a child.

77 Department of Families, Housing and Community Services and Indigenous Affairs together with the National Framework Implementation Group, *An outline of National Standards for Out-of-home Care: A priority project under the National Framework for Protecting Australia's Children 2009–2020* (Commonwealth of Australia, 2011).

78 The 'Charter for children in out-of-home care' (2007) was developed by the former Child Safety Commissioner and endorsed by the Department of Human Services Victoria. Refer to Appendix 1.

2. About the Inquiry

- Part 1.2, division 4, sections 12–14 – Additional decision-making principles for Aboriginal children. Sets out the additional decision-making principles that must be applied by the Secretary and CSOs in relation to Aboriginal children.
 - Part 3.3 – community services. Provides for the establishment, registration and monitoring of CSOs including performance standards and the responsibility of CSOs and the Secretary.
 - Part 3.4, division 2, sections 76–79 – Approval and employment of out-of-home carers. Details the prescribed matters that a CSO must have regard to when employing out-of-home carers.
 - Part 3.4, division 2, sections 119–120 – Offences relating to out-of-home carers. Sets out the CSOs' obligations when employing out-of-home carers and the subsequent penalty if guilty of an offence.
 - Part 4.3, division 2, sections 172–174 – Responsibility of Secretary as guardian or custodian. Sets out the responsibilities the Secretary has for children whom the court has ordered that the Secretary take over guardianship or custody. The Secretary is required by law to provide for each child's physical, intellectual, emotional and spiritual development in the same way as a good parent would.
 - Part 4.3, division 2, section 179 – Responsibility of Secretary or CSO to provide information to carers. Requires the Secretary to provide all information known to them to the CSO to assist the carer/CSO to make an informed decision as to whether or not to accept the care of the child.
 - Part 6.1, section 493 – Offence to fail to protect child from harm. States that it is an offence for intentional action or inaction that results, or is likely to result, in a child suffering significant harm as a result of physical injury, sexual abuse, significant emotional or psychological harm or significant harm to a child's physical development or health.
82. The following sections of the *Protection of Children Act 2014* are of relevance to the Inquiry:
- Section 3 – Failure by a person in authority to protect a child from a sexual offence.
 - Section 4 – Failure to disclose a sexual offence committed against a child under the age of 16 years.
83. Section 38 of the Charter (Conduct of public authorities) sets out the obligations of public authorities (the Department and CSOs) to act compatibly with the human rights contained in the Charter and to give proper consideration to these rights.
84. The Charter contains a number of rights that are relevant to children in out-of-home care, including:
- Section 8 – Recognition and equality before the law. Every person has the right to enjoy his or her human rights without discrimination. Every person is equal before the law and is entitled to the equal protection of the law, without discrimination. This includes children. For example, a child does not lose his or her right to privacy simply because they are a child. As with adults, interferences must occur for a good reason, although the fact that they are children and it is necessary to protect them may provide that justification.
 - Section 10 – Protection from torture and cruel, inhuman or degrading treatment or punishment. Every person has the right not to be subjected to torture or to be treated or punished in a cruel, inhuman or degrading way. Physical, sexual and emotional abuse falls within this right. In relation to children in state care, there is not only an obligation not to engage in such treatment, but to protect children from such treatment by others, including by other children and persons in the community.
 - Section 13 – Privacy and reputation. Every person has the right not to have their privacy, family, home or correspondence unlawfully or arbitrarily interfered with. This means that there must not only be a good reason for interfering with privacy (for example, to protect a child from harming themselves), but that the interference is proportionate or reasonable in the circumstances. An interference may also be arbitrary if it occurs for good reason but without a fair or transparent process.

- Section 17 – Protection of families and children. Every child has the right, without discrimination, to the protection of their best interests by reason of being a child. Both the Secretary, as guardian, and the CSO, as out-of-home care provider, have positive obligations to protect the best interests of children in their care. This right is informed by the more specific rights set out in the Rights of the Child (see below).
 - Section 19 – Cultural rights. Provides for the cultural rights of a person and, importantly, recognition that Aboriginal persons hold distinct cultural rights to maintain their identity, culture, language and kinship ties. The right to family in section 17 is enjoyed by all children, and includes a right of the child to know their family and cultural heritage and (provided it is in their best interests) to maintain that relationship. Section 19 emphasises the importance of that right for Aboriginal children.
85. The following articles of the Rights of the Child are of relevance for the Inquiry:
- Article 9 – Separation from parents. Children have a right when separated from their parents to stay in contact with both parents unless this is contrary to the child’s best interests.
 - Article 16 – Right to privacy. Children have the right to be protected by the law against an attack or interference of their privacy.
 - Article 19 – Protection from all forms of violence. Children have the right to be protected by government from being hurt or mistreated physically, sexually or mentally. Children have the right to be protected from violence, abuse and neglect.
 - Article 20 – Deprivation of family environment. Children who cannot be cared for by their family of origin have the right to special care and assistance. They must be cared for by people who respect their ethnic group, religion, culture and language.
 - Article 23 – Children with disabilities. Children with any kind of disability have the right to a full and decent life in conditions that ensure dignity, promote self-reliance and facilitate active participation in the community.
 - Article 24 – Children have the right to good quality health care. Children have the right to the highest attainable standard of health, and government must strive to ensure no child is deprived of their right to access health care services.
 - Article 25 – Review of treatment in care. Children in care have the right to have their living arrangements looked at regularly to consider whether they are the most appropriate and are serving their best interests.
 - Article 27 – Adequate standard of living. Children have the right to a standard of living that is adequate for their physical, mental, spiritual, moral and social development.
 - Article 28 – Right to education. Children have the right to accessible education and government must take measures to encourage regular attendance and reduce drop-out rates.
 - Article 33 – Drug abuse. Government should use all means possible to protect children from illicit drug use.
 - Article 34 – Sexual exploitation. Government must protect children from all forms of sexual exploitation and abuse.
86. The following information privacy principle contained in schedule 1 of the *Privacy Act 2014* is of relevance:
- Principle 3 – Data quality. This requires an organisation to take reasonable steps to make sure that the information it collects, uses or discloses is accurate, complete and up-to-date.

2. About the Inquiry

2.5.2 Analysis of alleged sexual abuse Category One CIRs

87. The Commission analysed CIRs that were provided by the Department to the Commission during the 12-month period 1 March 2013 to 28 February 2014. This time frame was selected as it marked the first year of the Commission's operation as an independent statutory body. The CIRs reviewed by the Commission were for alleged instances of sexual abuse, sexual behaviour and sexual exploitation of children placed in residential care.
88. Of the reports supplied to the Commission by the Department, 189 related to sexual abuse. Between them, the reports named 281 children, 42 of whom were subject to multiple reports. In total, there were 166 individual children subject to the reports, with some children being subject to more than 10 reports of sexual abuse in the 12-month period.

2.5.3 Child protection file reviews

89. The Commission reviewed the Department's child protection files of all 166 children who were subject to CIRs alleging incidents of sexual abuse or sexual exploitation in residential care during the Inquiry period. One additional child's case was brought to the attention of the Commission through the public submissions process.
90. A broad examination was undertaken of the 166 files relating to the children, their backgrounds and experience of the child protection and service systems.
91. A representative sample of 32 files (20 per cent) was selected from the 166 files. This sample group represented children living in metropolitan and rural Victoria, from each of the Department's four divisions. The children lived in units managed by eight of the 22 CSOs. A comprehensive file review was conducted on each of the 32 children, looking at their history in care, the circumstances leading to the incident of reported sexual abuse in residential care and the service system's response.
92. Of the 32 children:
 - 10 were Aboriginal
 - 21 were girls
 - 11 were boys.

2.5.4 Site visits to residential care units

93. The Commission visited 21 residential care units, representing almost 13 per cent of the total number of residential care units operating in Victoria.
94. The units visited were the ones in which the children who were subject to alleged sexual abuse CIRs were living at the time the report was made.
95. The profile of the residential care units visited was as follows:
 - 21 units were operated by eight different CSOs
 - 11 units were in metropolitan Melbourne; 10 were in rural Victoria
 - six units were funded as therapeutic units, designed with four beds per unit (therapeutic units receive the highest level of funding)
 - 12 units were funded as standard model units, designed with four beds per unit
 - three units were unfunded units (known as contingency placements), each providing care for one child only (contingency placements are the most expensive type of residential care; the funding comes from the relevant division's general operating costs and is not budgeted for or accounted for)
 - 13 units were purpose-built properties for residential care; the remaining eight units were not purpose built.
96. All 21 residential care units used rostered staffing models, with generally two staff members on day shifts and one staff member on overnight. An overnight sleepover model was the general practice, but a small number of the units operated a stand-up (non-sleeping) model. During the course of the Inquiry, additional funding was announced by the government to allow all residential care units to operate a stand-up model of staffing.
97. Most of the residential care units employed a combination of staff such as:
 - permanent direct-care residential workers
 - regular casual direct-care residential workers employed directly by the CSO
 - direct-care residential workers engaged by the CSO through a labour-hire (i.e. casual employment agency). Labour-hire agency staff are potentially unknown to the children and the CSO, and they may also work shifts for a number of other different CSOs and sectors including disability and the elderly.
98. An exception to the above point was one metropolitan CSO that has developed a model using permanent staff and a consistent pool of casual staff employed directly by the CSO. This CSO does not employ staff through a labour-hire agency as they believe this is a less desirable staffing model.

2. About the Inquiry

2.5.5 Interviews with staff

99. The Commission interviewed 87 staff from the Department and CSOs who had roles in program management, operations, direct-care and service oversight.
- 34 people came from a cross-section of the Department, including staff from the four divisions of rural Victoria, metropolitan Melbourne, AHCPEs and SOS. These people had a variety of roles including child protection practitioners, client outcomes and service improvement, placement coordination, Principal Practitioners and staff with oversight of CSOs.
 - 21 people were senior staff from eight of the 22 CSOs that operate across Victoria. These people were senior staff at residential care program manager level and above.
 - 32 people were direct-care residential workers.

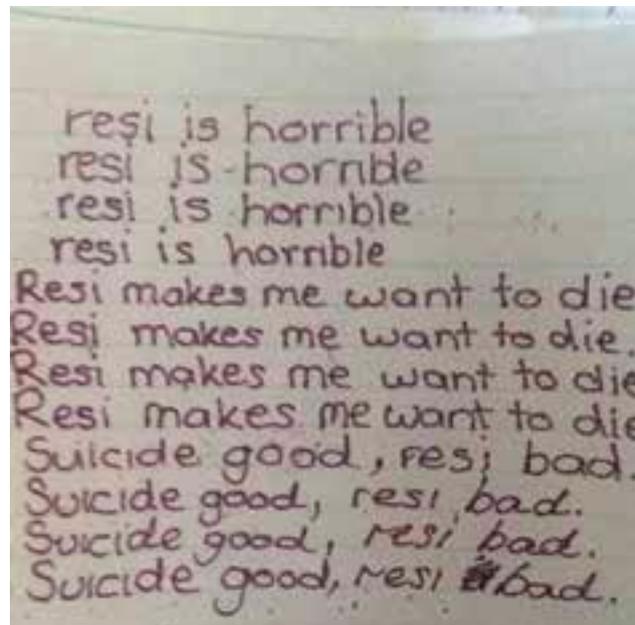
'Children in out-of-home care need the best care that society can provide regardless of whether it is provided by a family member, volunteer or paid staff. Children in out-of-home care are likely to have already suffered abuse or neglect. If they are subjected to further abuse while in out-of-home care, the harm they have already suffered will be further compounded. Rather than experiencing out-of-home care as a safe and protective environment, they will lose further trust in adults and the effect of the abuse will be aggravated.'

Source: DHHS, Practice Advice # 1466 'Abuse in Care'.

2.5.6 Children's voices

100. The voice of the child is fundamental to the work of the Commission. The Inquiry sought feedback from children and young people currently living in residential care. Feedback was also given by young people who have primarily lived in residential care units.
101. In order to hear from young people, the Commission engaged with Create Foundation and St Kilda Gatehouse to support and facilitate young people's participation with the Inquiry.
102. The Commission was fortunate to speak personally with young adults with prior residential care experiences who shared their experiences candidly. The Commission also spoke with a parent of a child who experienced abuse in residential care. These contributions are vital.

Photograph 1: Note written by a young person, found in the living area of a residential care unit during the Commission's visits to residential care units



Source: Photograph taken by the Commission, March 2015.

2.5.7 Submissions

103. The Commission sought advice and information from the broader community and, in particular, from any person with direct experience about how the residential system in Victoria responds to children and young people who have experienced sexual abuse or sexual exploitation whilst living in residential care.
104. Key stakeholders were invited to make a submission to the Inquiry. In June 2014, print advertisements were placed in *The Age*, the *Herald-Sun*, the *Indigenous Times*, the *Koori Mail* and a print article appeared in *Actual* magazine.
105. The submission process was accessible to the public via the Commission's website, with a specific 'Guide to Making a Submission' section that included questions relating to the Terms of Reference and allowed for electronic lodgement of the submission.⁷⁹
106. The Inquiry received 16 submissions⁸⁰ and, where consent has been provided, they are available on the Commission's website.⁸¹

2.5.8 Literature review: sexual abuse and sexual exploitation of children in residential care

107. The Commission engaged the peak body for child and family welfare in Victoria, the Centre for Excellence in Child and Family Welfare, to conduct a literature review of past and current responses to the continually growing problem of sexual exploitation of children in residential care in Victoria, and to inform the Inquiry on four key themes:⁸²
 - a narrative that describes the changing nature of the Victorian legislation relating to vulnerable children
 - a description of the development of policy and operational responses to vulnerable children in residential care
 - a summary of contemporary themes and issues relating to the sexual abuse and sexual exploitation of children in residential care, including responses from other jurisdictions
 - a description of current approaches to TRC models.

79 Refer to Appendix 2: Guide to making a submission.

80 Refer to Appendix 3: List of individuals and organisations that provided a submission.

81 www.ccpv.vic.gov.au.

82 Centre for Excellence in Child and Family Welfare, *Responses to the sexual abuse and sexual exploitation of children in residential care in Victoria* (2014), www.cfecfw.asn.au/policy-advocacy-sector-development/inquiries/responses-sexual-abuse-and-sexual-exploitation-children available at ccpv.vic.gov.au.

2.5.9 System improvements

108. In response to overwhelming recommendations from sector consultations, and through many of the written submissions received, the Commission sought to explore costings related to the feasibility of a professionalised foster care model.
109. The Commission engaged Professor Brett Inder, Department of Econometrics and Business Statistics, Monash University, to undertake exploration of the potential costings of such a model of care. A compelling high-level model was costed, suggesting the viability of professionalised foster care as an initiative that could be implemented in Victoria.
110. The Commission also sought to research alternate specialist models of group care in other jurisdictions and other sectors. A residential and educational care facility for children and families in Jasper, Oregon, USA, was visited by the Commission's CEO in May 2015.
111. A number of practice improvements are suggested on the basis of submissions to the Inquiry, data analysis, file reviews, interviews with professionals and children and visits to residential care units.

'We are all traumatised maintaining a system that's broken.'

Source: DHHS Child Protection Operations Manager, March 2015.

'There is not one staff member who doesn't know that the system is contributing to making the situation worse.'

Source: Manager, Residential Care, CSO, March 2015.

3. Analysis of sexual abuse incident reports

3.1 Client Incident Reports

3.1.1 What are Client Incident Reports?

112. The Department requires all funded service providers, such as CSOs, to comply with its client incident management and reporting processes, known as CIRs. A CIR is required for all critical incidents involving or impacting upon clients that occur at the service or during service delivery.

113. The Department advises that:

- *A key reason for reporting incidents is to learn from them and, if possible, prevent the future occurrence of similar incidents. Most incidents initially reported under a CIR are considered allegations as, at the time of reporting, they are yet to be proven.*⁸³

114. The Department manages its CIR system through the classification of reportable incidents into two categories. Incidents are classified using a set of Departmental resources and instructions. These rely on the 'professional judgement of senior staff'⁸⁴ to determine whether the incident is Category One or Category Two.

115. Category One CIRs are defined by the Department as those that relate to a serious outcome such as a client death or severe trauma. Category Two incidents are those that involve events that threaten the health, safety and/or wellbeing of clients or staff.⁸⁵

116. Incidents relating to the sexual abuse of children are categorised by the Department as either a 'behaviour' or an 'assault'. There are two subsets in each category, either 'behaviour sexual' or 'behaviour sexual exploitation'. Assault is either 'sexual assault indecent' or 'sexual assault rape'. These subsets are defined by the Department as follows:⁸⁶

- **Behaviour:**

- **Sexual** – Behaviour of a sexual nature by a child that places the child's safety and wellbeing at risk
- **Sexual exploitation** – Sex work by a child under the age of 18 years.

- **Sexual assault:**

- **Rape** – Alleged rape (penetration or attempted penetration) of or by a client. Exchanging sex with predatory adults for money, goods, substance or favours.
- **Indecent** – Any indecent act in front of or by a client that is reportable to the police. Exchanging sexual acts with predatory adults for money, goods, substance or favours. Production/possession of child pornography.

117. Discretion is presently provided by the Department to review the classification of certain sexual abuse incidents as Category One or Category Two. This discretion applies to incidents relating to 'behaviour sexual' and 'sexual assault indecent'.

83 Department of Human Services, *Critical client incident management instruction: Technical update 2014* (2014), www.dhs.vic.gov.au/funded-agency-channel/about-service-agreements/incident-reporting/human-services, accessed 3 July 2015.

84 Department of Human Services, *Critical client incident management summary guide and categorisation table 2011: Updated December 2012* (2012), www.dhs.vic.gov.au/funded-agency-channel/about-service-agreements/incident-reporting/human-services, accessed 3 July 2015.

85 Department of Human Services, *Critical client incident management instruction*.

86 Department of Human Services, *Incident Type Categorisation Table 2011*, updated December 2012 (see Appendix 4).

3.1.2 Process of reporting CIRs

118. CIRs are a paper-based reporting system. There is currently no mechanism for electronic completion or submission of CIRs. The report is completed by the most senior staff member who has either directly witnessed the incident or is the first to be advised of the incident. It is then checked and signed by a manager in the CSO. Individual reports contain the details of one or more children subject to the incident.
119. If the report is generated by the CSO, the report is then submitted to the Department. Departmental standards stipulate that Category One reports must be submitted within one working day of the incident or within one working day of first being told of the incident.⁸⁷
120. CSOs must submit the CIRs to the Department by facsimile to a central number within the Department. The CIRs are then disseminated to the relevant Departmental offices throughout Victoria.
121. The CIR may trigger the Department's QoC processes if the concerns identified indicate issues about the care given to the child by an adult carer. The present QoC framework does not, however, provide for responses when the child is harmed by another child in the same placement.⁸⁸
122. Senior Departmental staff must escalate Category One reports that relate to 'behaviour sexual', 'behaviour sexual exploitation', 'sexual assault indecent' and 'sexual assault rape', using a VIP email alert to the Departmental Secretary and the Minister for Families and Children.⁸⁹

123. The purpose of the VIP email alert is to:

- ensure timely and effective information to ministers, the Secretary and deputy secretaries on specific Category One incident types
 - report on immediate actions taken for the client and planned responses to their experience of a critical incident
 - report that due diligence and responsibilities of the Department to clients have occurred.⁹⁰
124. In 2013–14, the Department's unpublished statistical data revealed that there were 939 Category One CIRs relating to all serious reportable matters for children living in residential care.⁹¹

87 Ibid.

88 DHHS (2009) *Guidelines for responding to quality of care concerns in out-of-home care*.

89 DHHS, *Guide for submission of VIP email alerts and information updates for Category One incident* (2015).

90 Ibid.

91 Department of Health and Human Services, *Performance, Assurance and Compliance report* (unpublished data), January 2015.

3. Analysis of sexual abuse incident reports

3.1.3 Quality of care

125. Since 2005, the Department has had internal procedures and staffing structures to receive and investigate reports relating to the quality of care for children placed in out-of-home care. This is separate from the Department's CIR system.⁹²
126. The remit of the Department's QoC guidelines extends to foster carers, lead tenants, residential carers, kinship carers and all members of the carer's household or family who have contact with the child in their placement.
127. The Department has, in each division, a QoC coordinator who manages the investigation of QoC concerns, oversees care reviews and ensures the implementation of recommendations.
128. Unlike practices in New South Wales,⁹³ there is presently no routine independent investigation of the QoC process. The Department can, if it chooses, contract an independent investigator to investigate and report on serious physical or sexual abuse allegations against a registered carer.
129. The QoC guidelines specify expectations that children and young people will be listened to and heard. The guidelines state that children must be:
- supported in a child-friendly manner to tell their story and express any concerns
 - provided with ongoing support during and after any investigation or formal care review process
 - provided with information in a child-friendly and age appropriate manner about their rights, the support available to them and the procedures and processes of the investigation or formal care review
 - informed of the outcome of an investigation or formal care review process in a child-friendly and age appropriate manner.
130. The Suitability Panel was established under the CYFA 2005 and provides a process for deciding if an out-of-home carer should be disqualified from being on the register of carers or whether a carer's disqualification should be revoked.
131. The Suitability Panel is made up of a legal practitioner chairperson and other members with relevant qualifications. All panel members are appointed by the Governor-in-Council under the CYFA 2005. The chairperson and two other members must sit on each panel hearing. At a hearing, the panel must decide whether or not the allegation that the person has physically or sexually abused the child is proved on the balance of probabilities, through hearing evidence by the Secretary to the Department, evidence from any of the parties and any other matters considered relevant by the panel.⁹⁴
132. If the panel finds that the abuse has occurred, a finding of misconduct is made and the panel is then required to decide if the person poses an unacceptable risk of harm to children.
133. Following a QoC process the Department can, at its discretion, refer the matter to the Suitability Panel for determination about the ongoing registration of the carer.
134. The Commission is provided with summary data about the Department's QoC investigations. The Department advised the Commission that from 1 March 2013 until 31 March 2015, there were 25 QoC investigations concerning alleged staff-to-child sexual abuse in residential care. Eleven matters were substantiated and six of these were referred by the Department to the Suitability Panel.

3.1.4 Limitations of QoC

135. The scope of the Department's QoC guidelines does not extend to child-to-child abuse in placement. Therefore, Departmental data about the quantity and outcomes of QoC allegations and investigations is not a full depiction of the extent of sexual abuse in care.
136. The Commission found little evidence in the files reviewed of the progress or status of an investigation and significant delays in the QoC outcomes being recorded. In a number of cases, the QoC investigation was not recorded on the child's file at all, despite an investigation having occurred.
137. In one divisional office of the Department, the Commission heard that staff were confused about who had responsibility for entering the QoC reports into the relevant child's file. Senior staff mistakenly believed that the responsibility lay with another branch. This led to a backlog as 12 months' worth of QoC reports had to be entered into the children's files.

92 Department of Health and Human Services, *Guidelines for responding to quality of care concerns in out-of-home care: Technical update 2014* (2014), www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/Guidelines-for-responding-to-quality-of-care-concerns-in-out-of-home-care, accessed 3 July 2015.

93 In New South Wales, allegations of sexual abuse are 'reportable conduct' and must be reported to the Ombudsman, who oversees the designated agency's investigation and may conduct its own investigation. Such information must also be provided to the Children's Guardian. A reportable conduct scheme was recommended by the Victorian Parliamentary Inquiry Betrayal of Trust (2012), but is yet to be implemented.

94 www.suitabilitypanel.vic.gov.au.

3.1.5 Commission's analysis of CIRs

138. The Department has provided the Commission with copies of Category One CIRs for children and young people living in out-of-home care in order to aid the Commission's objectives and functions under sections 7 and 8 of the CCYP Act.
139. The Commission's analysis has revealed that there are significantly more incident reports for children placed in residential care than there are for children in other forms of out-of-home care, such as foster care or kinship care. This is very concerning, especially given the comparatively small proportion of children (seven per cent) who are placed in residential care.⁹⁵
140. Additionally, the Commission is very concerned about the escalation of reports relating to sexual assault, abuse and sexual exploitation for children placed in residential care.

3.1.6 CIRs – limitations to data

141. The true extent of the incidence of sexual abuse and sexual exploitation in out-of-home care in Victoria is difficult to gauge, due to poor data availability and the limitations of the Department's present model of record keeping and reporting of critical incidents.
142. The Department's current model of reporting sexual abuse and sexual exploitation is through the CIR. The technical instruction provided to Departmental staff and CSO staff about how to complete a CIR states that such incidents are allegations only. At the time the incident is recorded, the abuse is deemed not yet proven.
143. The current CIR system has no mechanism for recording the outcome of the allegation contained in the CIR. It is often a stand-alone document. There are no direct links between the original CIR allegation, the investigation, whether the allegation is substantiated, the outcome for the child victim (and/or victim perpetrator), whether the supports in place for the child are effective, or any analysis of how to prevent future abuse or incidents occurring in the residential care unit.
144. The Commission relies on the administration practices within the Department to provide all Category One CIRs relating to children in out-of-home care. This is problematic. Presently there are nine different contact points within the Department that provide CIRs to the Commission. The Commission notes that there have been many occasions where there have been delays or omissions in the provision of the reports, thus leading to poor data reliability and integrity.
145. In April 2015, the Department advised the Commission that 402 Category One CIRs, of which 69 were incidents of alleged sexual abuse or sexual exploitation had not been provided to the Commission from January 2013 to April 2015 due to an 'oversight'. These 69 incident reports were unable to be included in this report. Therefore the data presented in this report is significantly less than the true extent of the problem.
146. The classification of an incident is a subjective process. It relies on the 'professional judgement of senior staff',⁹⁶ which therefore leads to potential inconsistencies in the categorisation of an incident. Currently, it is possible to deem some sexual behaviour as a Category Two incident. The Commission has observed that this is problematic. It creates confusion for staff completing incident reports and results in inconsistent practices.
147. The Commission observed differential practices in the categorisation of similar incidents. For example, the use of 'behaviour dangerous', 'poor quality of care', 'behaviour sexual' and 'community concern' were each used in different instances to report similar events. If the Department is serious about its stated reason for reporting CIRs – to learn from them and prevent the future occurrence of similar incidents – there is an obvious need to reform the CIR system to ensure accurate reporting and data collection.
148. Additionally, the current incident reporting system allows nomination of only one incident type per report. The Department instructions are to choose the most serious incident. If there are multiple concerns in the notified incident, such as 'behaviour dangerous', 'poor quality of care', 'self-harm', 'absent/missing persons' and 'sexual assault', there is no way to record each of these separately. It is therefore possible that crucial risk issues may not be adequately recorded, measured or responded to.

⁹⁵ Victorian Department of Health and Human Services, *Annual Report 2013–14*.

⁹⁶ Department of Human Services, *Critical client incident management summary guide and categorisation table 2011*.

3. Analysis of sexual abuse incident reports

3.1.7 Number of children subject to sexual abuse allegations

149. A total of 189 CIR reports that named 281 children were reviewed by the Commission. These reports related to 166 individual children, 42 of whom were subject to multiple sexual abuse CIR reports during the Inquiry period.

150. Broad demographic and background data was obtained about these children from the incident reports and supplemented by their Departmental child protection file. This analysis revealed the details outlined below.

3.1.8 Gender

151. There were 109 girls (66 per cent) and 57 boys (34 per cent) in the CIRs.

3.1.9 Aboriginal children

152. The Commission has seen many inconsistent practices by the Department and CSOs in accurately checking and recording a child's Aboriginality. Accurate reporting about the Aboriginal status of the child relies on:

- the person completing the report taking the initiative to ascertain if the child is Aboriginal
- this information then being recorded on the CIR form.

153. There were 25 children (16 per cent) identified as Aboriginal in the CIRs; however, this number is likely to be much higher, given the inconsistent practices identified above and the 69 CIRs (relating to allegations of sexual abuse or sexual exploitation) that were not provided to the Commission and therefore not included in this Inquiry.

3.1.10 Child protection history

154. The children subject to reports of sexual abuse in residential care had between one and 31 prior child protection reports.⁹⁷

155. The average number of child protection reports per child was 8.4.

3.1.11 Placement changes

156. Data from the file reviews of 166 individual children subject to reports of sexual abuse in residential care revealed that:

- the average number of residential care placement changes per child was 4.5
- the average number of secure welfare admissions per child was 1.3
- the average number of home-based care placement changes per child was 10
- the average number of total out-of-home care placement changes per child was 16
- one child experienced more than 100 placement changes
- 85 children (52 per cent) experienced more than 11 placement changes.

⁹⁷ A report can be made to the DHHS's child protection program by any person who believes on reasonable grounds that a child is in need of protection. Some professionals, such as doctors, nurses, police and school teachers, are mandated to report suspected child abuse.

3.1.12 Looking After Children (LAC) framework

157. The LAC is a framework that identifies both the needs of children and young people in care and an action plan to meet those needs. Seven developmental domains are considered including a child's health, emotional and behavioural development, education, family and social relationships, identity, social presentation and self-care skills. The Department's child protection manual states:⁹⁸

- *At a simple level, the LAC framework attempts to strengthen communication and collaboration between carers, DHS staff, CSO staff, other professionals, clients and their families. It prompts all members of the child's out-of-home care team to consider the things any good parent would⁹⁹ naturally consider when caring for their own children.*

158. The Department requires that within two weeks of a placement commencing, the CSO must start recording important factual pieces of information about the child in the LAC Essential Information Record, such as who can give authority for medical treatment, Medicare information and important health information. Additionally, CSOs are required to also begin a LAC Care and Placement Plan for children aged under 14 and a LAC Care and Transition Plan for children aged 15 and above.

159. The Commission has reviewed the templates for these key LAC documents and considers them vitally important in the provision of care for children. Accurate recording and sharing of information about the child's health and development needs are basic requirements and fundamental to the child's wellbeing.

160. In conducting 166 file reviews, the Commission observed a widespread practice of CSOs failing to use the LAC framework. The Department failed to ensure that this practice was complied with, although it is part of the CSOs' performance management and adherence to service delivery and client care requirements.¹⁰⁰

161. Specifically, a lack of compliance with LAC was observed in the children's CRIS files as follows:

- 64 per cent did not have a Health Card number recorded
- 77 per cent did not have a GP's details recorded
- 92 per cent did not record known childhood illnesses or medical conditions
- 93 per cent did not have a record of any hospitalisations
- 99 per cent did not record information about current health alerts
- 80 per cent did not record the child's dental health assessment
- 89 per cent did not record information about the child's immunisations
- 90 per cent did not record information about the child's illegal drug use
- there was no record of a Leaving Care plan having been commenced for any of the children aged 15 or over.

⁹⁸ Department of Health and Human Services, *Child Protection Practice Manual* (online).

⁹⁹ Emphasis added.

¹⁰⁰ Department of Health and Human Services, *Program requirements for residential care services in Victoria* (2015), www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/programs/children,-youth-and-family-services/program-requirements-for-residential-care-services-in-victoria, accessed 3 July 2015.

3. Analysis of sexual abuse incident reports

3.2 Sexual abuse: the nature of the problem

162. There are a number of different forms of sexual abuse and sexual exploitation that children and young people residing in residential care experience. This Inquiry has examined three forms of identified sexual abuse:

- abuse perpetrated by external predators
- abuse perpetrated by other children (child-to-child)
- abuse perpetrated by staff on children (staff-to-child).

163. While there are common issues with each form of abuse, there are also unique practice responses and preventative issues that require individual attention.

164. The Commission reviewed the sexual abuse Category One CIRs received during the Inquiry period that related to 281 children living in residential care. The reports related to allegations of sexual behaviour, sexual abuse and sexual exploitation.

165. The children named in these reports are primarily victims of assault and can also include perpetrators and witnesses. The Commission views all these children as affected by the incident because of their development and vulnerability.

Table 1: Sexual abuse CIRs received by the Commission, 1 March 2013 – 28 February 2014

NUMBER OF REPORTS SUPPLIED BY THE DEPARTMENT	189
NUMBER OF CHILDREN SUBJECT TO THE REPORTS	281
NUMBER OF INDIVIDUAL CHILDREN SUBJECT TO THE REPORTS (A CHILD CAN BE NAMED IN MORE THAN ONE REPORT)	166

Table 2: Children subject to CIRs reports, 1 March 2013 – 28 February 2014

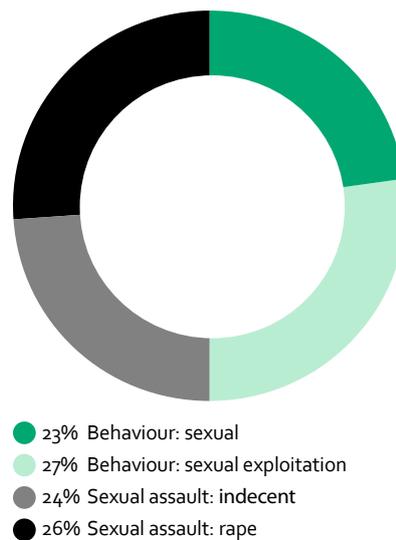
NUMBER OF REPORTS PER CHILD	NUMBER OF CHILDREN
1	124
2-4	33
5-10	7
11-13	2
Total	166

166. Table 2 indicates that 42 children were subject to multiple reports of sexual abuse. Two children were subject to more than 10 reports of alleged sexual abuse and behaviour causing trauma in residential care during the Inquiry period. This is around one incident every month.

3.2.1 Type of alleged sexual abuse reported

167. Figure 1 provides a breakdown of the types of sexual abuse allegations reported in the CIRs during the 12-month Inquiry period.

Figure 1: Type of sexual abuse reported, 1 March 2013 – 28 February 2014



n = 281 children subject to sexual abuse CIRs during the Inquiry period. Source: Appendix 5, Table 3.

168. Figure 1 shows that 140 children (50 per cent) were subject to incident reports classified as 'sexual assault'. Just over half (72) of these children were subject to reports of alleged 'sexual assault rape' and the remainder (68) were subject to reports of alleged 'sexual assault indecent'.

169. Figure 1 shows that 141 children (50 per cent) were subject to reports classified as 'behaviour'. More than one in four (77) children were subject to reports classified as 'behaviour sexual exploitation'.

170. The Commission observed that incidents classified as 'behaviour sexual exploitation' included circumstances where children are pursued by predators for potential sexual exploitation through online platforms such as social networking websites, dating websites and applications (apps) on mobile phones.

171. Figure 1 shows that 64 children (23 per cent) were subject to reports classified as 'behaviour sexual'. The Department's definition of this category type is:

- *behaviour of a sexual nature by a client that places a client's safety and wellbeing at risk.*¹⁰¹

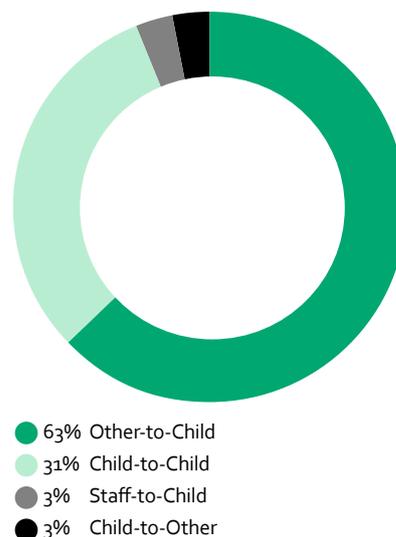
172. Despite this definition, the Commission noted that incidents such as allegations of rape, indecent assault and sexual exploitation are often incorrectly classified as 'behaviour sexual'. The rationale for this misclassification is unclear. This can significantly impact how the child is supported through this trauma and, importantly, how the Department and CSOs uphold the child's human and legal rights.

3.2.2 Identified source of harm (alleged perpetrator)

173. The CIR has the capacity to identify the source of harm (the alleged perpetrator) for incidents involving assault. The options available are 'client to client', 'client to staff/carer', 'client to other', 'staff/carer to client' and 'other to client'. For the purposes of this analysis, 'client' means 'child'.

174. Figure 2 provides a breakdown of the source of harm, as selected by the person who completed the CIR, identified in the CIRs during the 12-month Inquiry period.

Figure 2: Source of harm reported, 1 March 2013 – 28 February 2014



n = 281 children subject to sexual abuse CIRs during the Inquiry period.

Source: Appendix 5, Table 3.

175. Figure 2 shows that external predators to the residential care unit account for 63 per cent of all identified perpetrators.

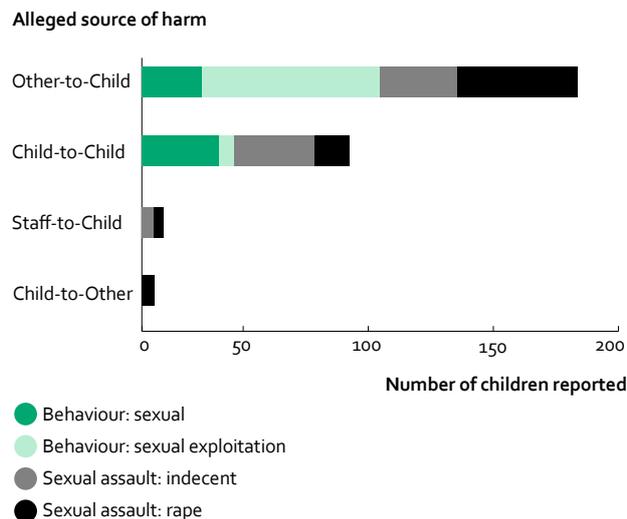
176. Of equal significance and concern to the Commission was the high rate (31 per cent) of child-to-child sexual abuse occurring within the residential care unit.

¹⁰¹ Department of Health and Human Services, Victoria, Incident Type Categorisation Table 2011.

3. Analysis of sexual abuse incident reports

177. This rate of child-to-child sexual abuse raises a number of concerns, including:
- the way in which decisions to place certain children together are made
 - the adequacy of the staffing model
 - the skill, education, training and experience of staff
 - the need for specialist therapy to be available for all children in residential care
 - the understanding of the trauma and emotional damage that children in state care are likely to have experienced in their formative years and behavioural management.
178. Figure 2 shows that nine children (three per cent) were subject to allegations of staff-to-child sexual assault (indecent and rape).
179. Given the inadequate record keeping, problematic categorisation of CIRs, lack of reliable data and under-reporting of abuse, the actual incidence of each of the three abuse types is therefore likely to be much higher.
180. Upon examination, six of the seven 'client-to-other' reports appear to have been incorrectly classified by the CSOs and/or the Department. The information recorded in these CIRs suggests that these reports should have been classified as 'other to client' (external predator).
181. Figure 3 provides an analysis of the type of reported sexual abuse by alleged perpetrator type in the CIRs during the 12-month Inquiry period.

Figure 3: Type of reported sexual abuse by source of harm, 1 March 2013 – 28 February 2014



n = 281 children subject to sexual abuse CIRs during the Inquiry period.
Source: Appendix 5, Table 5.

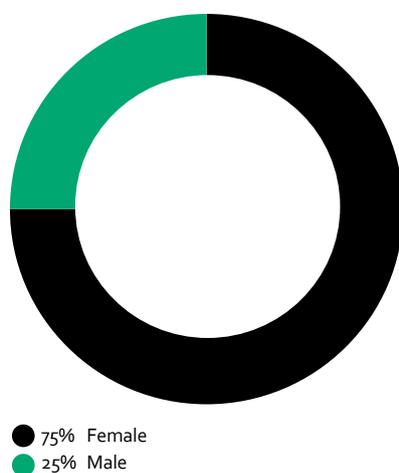
182. External predators posed the greatest risk to children as they were identified as the source of harm for:
- 48 children who were subject to reports of alleged rape
 - 31 children who were subject to reports of alleged indecent assault
 - 71 children who were subject to reports of sexual exploitation
 - 28 children who were subject to reports of behaviour sexual, where the child's safety and wellbeing is considered at risk.
183. Of significant concern was the alleged sexual abuse between peers (child-to-child abuse). This accounted for:
- 14 children who were subject to reports of alleged rape
 - 32 children who were subject to reports of alleged indecent assault
 - six children who were subject to reports of sexual exploitation
 - 35 children who were subject to reports of behaviour sexual, where the child's safety and wellbeing was considered at risk.

184. Nine children were subject to reports of staff-to-child sexual abuse. This included four children who were subject to reports of alleged rape and five children who were subject to reports of alleged indecent assault.

3.2.3 Gender and sexual abuse

185. Overall, girls were subject to significantly higher rates of reporting of sexual abuse in residential care than boys.

Figure 4: Gender of children subject to sexual abuse incident reports, 1 March 2013 – 28 February 2014



n = 281 children subject to sexual abuse CIRs during the Inquiry period.
Source: Appendix 5, Table 3.

186. Figure 4 shows that 75 per cent of the children subject to CIRs of sexual abuse in residential care were girls.

187. There are fewer girls than boys placed in residential care. Data from the Department indicated that as at April 2014, boys accounted for 54 per cent of the residential care population.¹⁰²

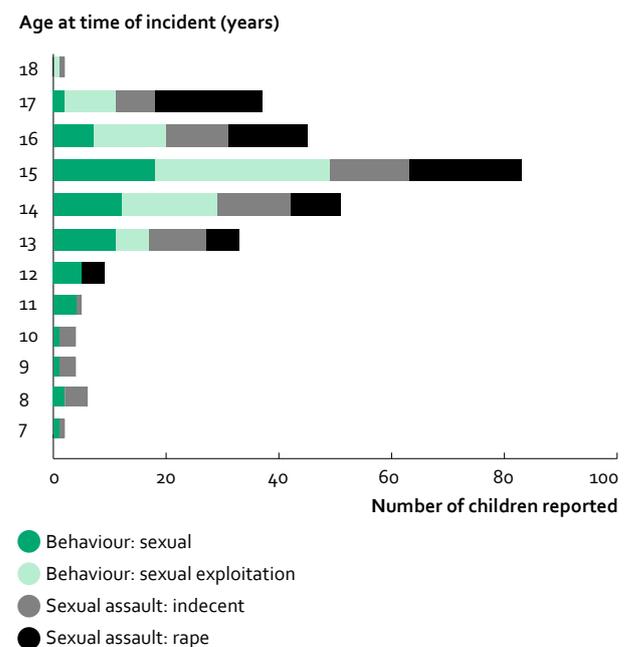
188. The higher rate of girls being subject to sexual abuse in residential care highlights the issue of gender. However, further examination is needed about potential barriers that may exist that prevent boys from disclosing sexual abuse. This also highlights the need for professionals working with children in care to be mindful of these issues and to be skilled in detecting and recognising potential sexual abuse for both girls and boys.

3.2.4 Age of children at the time of the reported incident

189. Children as young as seven were allegedly sexually abused in residential care. Reports for younger children related to 'behaviour sexual' and 'sexual assault indecent'. Older children were subject to reports across all categories, including alleged 'sexual assault rape' and 'behaviour sexual exploitation'.

190. Figure 5 provides an analysis of the ages (at the time of the incident) and type of abuse of children who were subject to reports of alleged sexual abuse CIRs.

Figure 5: Age and type of sexual harm of children subject to sexual abuse incident reports, 1 March 2013 – 28 February 2014



n = 281 children subject to sexual abuse CIRs during the Inquiry period.
Source: Appendix 5, Table 4.

¹⁰² Unpublished data provided by the Department to the Commission, April 2014.

3. Analysis of sexual abuse incident reports

191. Children aged between 14 and 16 were subject to greater numbers of sexual abuse CIRs. This age group represented almost 64 per cent (179 children) of all children subject to sexual abuse CIRs in residential care.

192. Over 10 per cent of the children subject to the sexual abuse CIRs (30 children) were aged between seven and 12.

193. Children as young as 12 were subject to reports of alleged rape, while children as young as seven were subject to reports of indecent sexual assault.

194. There were 72 children (26 per cent) between the ages of 12 and 17 subject to reports of 'sexual assault rape', including:

- four children aged 12
- 16 children aged 14
- 20 children aged 15
- 19 children aged 17.

195. One quarter of the children (68) were subject to reports of 'sexual assault indecent' including:

- one child aged seven
- four children aged eight
- three children aged nine
- three children aged 10
- one child aged 11
- 10 children aged 13
- 13 children aged 14
- 14 children aged 15
- 11 children aged 16
- seven children aged 17
- one child aged 18.

196. There were 77 children subject to reports of 'behaviour sexual exploitation'. These children ranged in ages from 13 to 18.

197. Reports for children aged 15 were greatest for 'behaviour sexual exploitation', with 31 children (11 per cent) in this age group being subject to these reports.

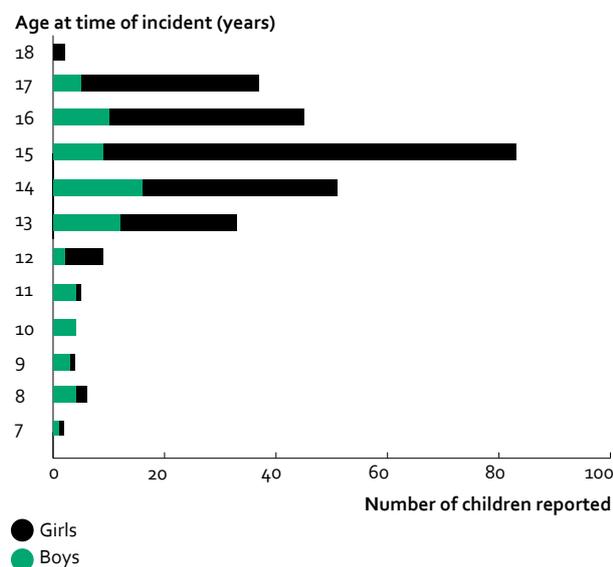
198. There were 64 children aged between seven and 17 who were subject to reports of 'behaviour sexual'.

199. Children aged 16 and over are subject to fewer sexual abuse CIRs. This is attributed to the likelihood of them leaving residential care.

200. Reporting rates of sexual abuse CIRs for girls in residential care was substantially higher from the onset of adolescence (13 and older). For younger children, reporting rates were slightly higher for boys than for girls.

201. Figure 6 provides an analysis of the ages (at the time of the incident) and gender of children who were subject to reports of alleged sexual abuse CIRs.

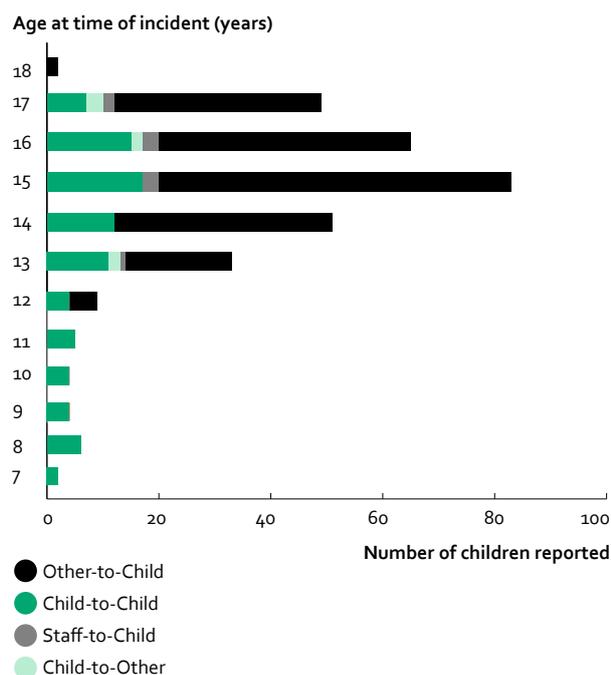
Figure 6: Age and gender of children subject to sexual abuse incident reports, 1 March 2013 – 28 February 2014



n = 281 children subject to sexual abuse CIRs during the Inquiry period.
Source: Appendix 5, Table 6.

202. Figure 7 provides an analysis of the ages (at the time of the incident) and the source of harm reported in the CIRs.

Figure 7: Age and source of reported in sexual abuse incident reports, 1 March 2013 – 28 February 2014



n = 281 children subject to sexual abuse CIRs during the Inquiry period.
Source: Appendix 5, Table 5.

203. It is a great concern that children aged 11 and younger were solely identified as victims of child-to-child abuse. This observation clearly highlights the vulnerability of younger children in the residential care environment to peer abuse.

204. The youngest child subject to a report of alleged sexual abuse by another child in the same residential care placement was seven years old.

205. There were 25 children (nine per cent) aged seven to 12 who were subject to alleged sexual abuse CIRs by other children in the residential care placement.

206. Children aged 15 were subject to a greater number of sexual abuse CIR reports in which external predators were identified as the source of harm than other identified perpetrators. There were 63 children (22 per cent) aged 15 who were subject to alleged sexual abuse by an external predator.

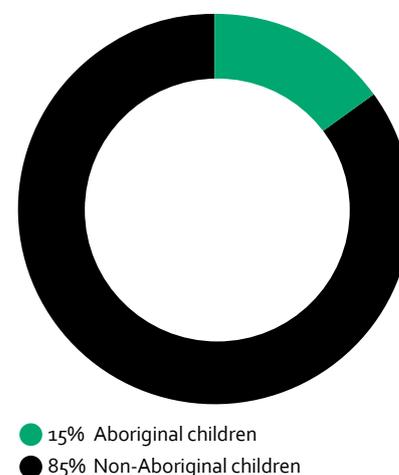
207. Nine children aged between 13 and 17 were subject to reports of alleged staff-to-child sexual abuse.

3.2.5 Aboriginal children and sexual abuse

208. As at 30 June 2014, there were 90 Aboriginal children placed in residential care in Victoria. This represents 17 per cent of the total number of children in residential care.¹⁰³

209. Figure 8 shows the total number of Aboriginal children reported in the CIRs.

Figure 8: Sexual harm reports for Aboriginal and non-Aboriginal children in residential care, 1 March 2013 – 28 February 2014



n = 281 children subject to sexual abuse CIRs during the Inquiry period.
Source: Appendix 5, Table 3.

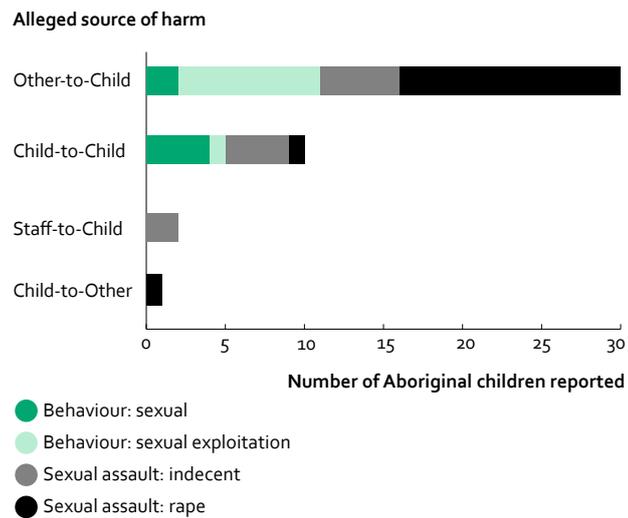
210. There were 25 individual Aboriginal children subject to 43 reports of sexual abuse in residential care during the Inquiry period. This means that more than one-quarter (27 per cent) of the Aboriginal children in residential care have been subject to a sexual abuse CIR. However, this figure is likely to be higher given that the identified practice issue of not accurately ascertaining a child's Aboriginality.

211. Figure 9 provides an analysis of the type of sexual abuse reported by alleged perpetrator for all reports relating to Aboriginal children.

¹⁰³ Steering Committee for the Review of Government Service Provision, *Report on Government Services 2014*, Table 15A.19.

3. Analysis of sexual abuse incident reports

Figure 9: Type of reported sexual abuse by source of harm for Aboriginal children in residential care, 1 March 2013 – 28 February 2014



n = 43 total Aboriginal children subject to sexual abuse CIRs during the Inquiry period.

Source: Appendix 5, Table 3.

212. Most reports received for Aboriginal children (14 children) related to 'sexual assault rape' where the identified source of harm was an external predator.
213. Almost one-quarter (23 per cent) of sexual abuse reports for Aboriginal children identified co-residents as the source of harm.
214. When analysing the CIRs, serious concerns were raised about the ability of the Department and CSOs to uphold and protect the human rights of children in their care, and the treatment of children when these rights appear to have been breached. These concerns were also evident from the file reviews, hearing directly from the children, site visits and interviews with staff from the Department and CSOs. These are discussed in more detail in the following chapters.

3.3 The voice of children

'... young people in out-of-home care are treated like second-class citizens when all they've done is basically become an orphan.'

'Having your life story laid out in front of people you don't know... is totally humiliating.'

Source: Youth Movement Initiative, *Spaghetti Bolognese on a Tuesday Night: Reflections on the DHS Child Protection Best Interest Plan Process*.

215. The Commission was privileged to speak with a number of children and young people who have previously lived in residential care units about their experiences.
216. The children and young people who spoke with the Commission reported many unfavourable experiences:
- multiple placement changes that happened with little notice and explanation
 - being cared for by staff who spent long periods in the staff office, not engaging with the children
 - large numbers of different rostered staff
 - often having unfamiliar carers rostered to work at the unit
 - their residential unit didn't feel like a home
 - being embarrassed about the physical state of the residential care unit
 - not being allowed to have friends visit the residential care unit
 - being unhappy with the 'prison-like' atmosphere – having to ask permission for toilets to be unlocked, for cupboards to be unlocked so they can get a towel for a shower and food being locked away in cupboards and fridges
 - witnessing physical assaults and violence between children
 - feeling frightened and unsafe at the unit because of the other children, or unfamiliarity with the rostered staff
 - having to call Kids Helpline as a support to cope with living in residential care.

217. The feedback shared with the Commission by young adults who used to live in residential care reflected the experience of other young people. The St Luke's project, 'Leaving Care Service', recounted similar lived experiences by children in residential care. The key issues and themes identified were the sense of isolation, not only in residential care but as part of the overall 'care system':¹⁰⁴

- high turnover of caseworkers
- children feeling a lack of trust and being invisible
- feeling worthless in meetings because of how they are run
- having no voice
- being out numbered in meetings by adults who they don't know but who are making important decisions about their future
- moving placements too often, with no planning and no understanding of why the move was happening.

218. Throughout the Inquiry, the Commission noted a common theme of the lack of involvement of children. Children's views and opinions about their experiences in the residential care system are rarely heard. The involvement of children was missing and where it did occur, it was not given sufficient prominence in the decision making. This lack of participation and failing to hear the child's voice was evident in the file reviews and interviews with Departmental and CSO staff.

219. The review undertaken of the sample group of 32 files revealed many examples where children's disclosures of sexual abuse were readily discounted or not investigated adequately. Where allegations were investigated, there seemed to be a lack of attention to making sure that the child received information about the outcomes, reassurance that they would be kept safe, counselling or support.

220. Even in circumstances when allegations were proven, there was no record that the children were given the ability to pursue their legal rights (either by way of compensation or redress for their experience).

'What do I do? I want to go home but a couple of the workers that is in the note I gave you is on and I don't want to see them or be near them. Please help.'

Source: Text message sent by young person living in residential care to their caseworker, as noted on their Department file records, February 2014.

221. These practice deficits have led the Commission to consider a number of improvements that will ensure children's voices are heard. The establishment of an independent complaints body where children can raise concerns and provide feedback about their experiences in care is essential.

222. If the decision-making principles that are enshrined in the CYFA 2005 are to be applied to children in out-of-home care, the incident reporting system must be improved. It must allow the child to participate in the process by either writing their own account of the incident or having an advocate write it on their behalf. This would ensure the child's perspective is heard and would validate the experience of the child in the process.

223. The Commission commenced a pilot independent visitor program in a number of residential care units in the South Division in 2014. Through this forum, children are able to raise concerns with trained volunteer visitors who are overseen by Commission staff. Issues are taken up with CSOs and the Department for a response and action.

224. The extension of the Commission's independent visitor program to all residential care units would give children and young people the opportunity to be heard regularly. It would provide a forum for them to talk about their experiences of care, with a particular focus on the promotion and protection of their rights, interests and opportunities.

'No kid should have to ask for cereal, or to have a towel or to ask for fruit.'

Source: Young person who has lived in residential care units and had over 80 different placements in eight years.

104. Youth Movement Initiative, *Spaghetti Bolognese on a Tuesday Night: Reflections on the DHS Child Protection Best Interest Plan Process*, (St Lukes, 2014).

3. Analysis of sexual abuse incident reports

3.4 Pornography, social media and the internet

225. Recent national research¹⁰⁵ has indicated that young people are prolific users of social media and technology, with 93 per cent using social networking sites at least once a week. Significant numbers of young people receive or send sexually explicit photographs. The research found that sexually active young people engaged in the practice of sending sexually explicit videos of themselves.
226. Pornography is now the most prominent sexuality educator for many young people. Recent research has found that most young people discover pornography well before they encounter sex, with more than 90 per cent of boys and 60 per cent of girls having seen pornography on the internet.¹⁰⁶
227. Accessibility to pornography has grown significantly since the advent of smart phones and tablet devices.
- 'Violent pornography is now the most prominent sexuality educator for many young people.'**
228. Statistics cited by the Reality & Risk project indicate that 30 per cent of all internet traffic is pornography related and 88 per cent of the scenes of the most popular pornography include physical aggression.¹⁰⁷ Such aggressive sexual acts include: physical aggression, verbal aggression, gagging, choking and slapping.
229. Additionally, the Reality & Risk project highlights the perceived normalisation of sexual acts including: ejaculation on faces and bodies, oral sex to induce gagging and vomiting and heterosexual anal sex.
230. Exposure to such explicit and violent sexual acts has a profound negative impact on children's healthy development of attitudes towards sex and relationships.
231. In the absence of proactive education efforts, pornography offers young people a false sense of credibility in normalising the images and violent acts. This is a significant contemporary dilemma for policy makers and professionals charged with the day-to-day care of vulnerable children.
232. It was evident during this Inquiry that there is very little consistent education provided to children and young people in residential care about healthy and safe relationships, sexual health and the safe use of the internet and social media. Based on the information provided during the Inquiry, it would seem that there is presently no education provided to children and young people in residential care that confronts and dispels the influence of pornography.
233. The phenomena of social media and instant connectivity through the internet was raised in a number of submissions to the Inquiry as being a facilitator of potential sexual abuse, particularly in connecting children and young people to people outside their residential care unit. Many young people are adept and active consumers of social networking and as most mobile phones have internet capability, the task of monitoring and supervision of children's safe internet use is exceedingly difficult.

105 Anne Mitchell, Kent Patrick, Wendy Heywood, Pamela Blackman and Marian Pitts, *5th National Survey of Australian Secondary Students and Sexual Health 2013* (Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University, 2014).

106 Michel Fleming, Shane Greentree, Dayana Cocotti-Muller, Kristy Elias and Sarah Morrison, 'Safety in cyberspace: Adolescents' safety and exposure online', *Youth and Society*, Volume 38, Number 2 (2006), pp. 135–154, cited by Maree Crabbe and David Corlett, *Reality & Risk: Pornography, young people and sexuality*, www.itstimewetalked.com, accessed 4 July 2015.

107 Ana Bridges, Robert Wosnitzer, Erica Scharrer, Chyng Sun and Rachael Liberman, R, 'Aggression and sexual behaviour in best-selling pornography videos: a content analysis update', *Violence Against Women*, Volume 16, Number 10 (2010), pp. 1065–1085, cited by Maree Crabbe and David Corlett, *Reality & Risk*.

234. It was evident when conducting file reviews, analysing the CIRs and conducting site visits that social media and the internet play a significant role in enabling the sexual abuse and sexual exploitation of children in residential care. Illustrative examples include:

- a nine-year-old girl taking naked photographs of herself on her mobile phone
- a 13-year-old girl posting a sexually explicit video of herself on YouTube
- a 14-year-old boy joining an adult dating site and connecting with older men who were reported to have raped him
- a 14-year-old boy meeting older men in the community through Facebook and exchanging sex for alcohol and drugs
- a 16-year-old girl with a diagnosed intellectual disability accessing an adult dating site and exchanging sex for money, alcohol and drugs.

235. The Inquiry saw evidence that pornography, social media and the internet play a significant role in the lives of vulnerable children and young people in residential care. The challenge for the Victorian Government and the entire service system is how to prevent and manage the inevitable and ongoing risk that social media poses to our children in care who, prior to entering into care, have experienced significant trauma, psychological damage and abuse.

236. The absence of any proactive, specialised education in the area of sexual health and safe relationships for children in residential care places our most vulnerable children and young people at an even greater disadvantage and heightened risk of further sexual exploitation and sexual abuse. The challenge is how to educate and build self-respect, resilience and awareness in these children.

237. Such education for children in residential care should include, at a minimum, information about sexual health, positive relationships, reproduction, issues related to consent, safe use of the internet and social media platforms, safe sex practices and protective behaviours.

238. These vulnerable children need to be fully equipped with the highest standard of sex education and support. The Department of Education and Training states in its sexuality education program, *Catching on Early*¹⁰⁸ that the most valuable learning about sexuality comes from the home. This is where children learn their values and attitudes towards sexuality. For children in residential care, who often come with traumatised backgrounds, this learning could help build resilience and understanding. It should be provided by educators with the highest level of competency.

¹⁰⁸ Department of Education and Early Childhood Development, *Catching on Early: Sexuality Education for Victorian Primary Schools* (Melbourne: Department of Education and Early Childhood Development, 2011).

4. Practice issues

239. Significant practice issues were identified during the course of the Inquiry that the Commission considers contribute to the occurrences of sexual abuse and exploitation.

240. Whilst undertaking the Inquiry, the Commission became aware of a number of cases whereby particular children appeared to be at continued and serious risk of abuse. In such cases, the Commission immediately brought these issues to the attention of the Department for review and appropriate action.

4.1 Poor record keeping and lack of appropriate action

241. While undertaking file reviews and analysing the CIRs, the Commission was concerned to note a consistent lack of appropriate and professional case recording of information relating to the children in residential care.

242. Case recording is a key task in statutory child protection. The information recorded forms part of the Department and CSO's assessment of risk when dealing with all children in care. Some of the consistent issues identified included:

- failure to acknowledge a child's disclosure of alleged sexual abuse or sexual exploitation, which resulted in a failure to provide a response and a failure to adequately investigate the allegation
- failure to complete a CIR
- significant delays by both CSOs and the Department in the processing of CIRs
- significant delays by the Department in entering CIRs in child protection files

- risk assessment routinely not recorded in case notes
- poor communication between the Department and CSO after a CIR has been sent to the Department for action
- delays by the Department in completing and recording outcomes for QoC investigations
- practices that appeared to be contrary to the legal and practice requirements of confidentiality and privacy relating to a child.

243. Poor quality case recording was observed in most of the CRIS files reviewed by the Commission. Absence of adequate risk assessment was noted as a common feature in the files reviewed. The quality of case notes rarely met the Department's own practice standards.

244. The impact of poor case recording may compromise the capacity of the Department and CSOs to form accurate risk assessment. Additionally, an absence of analysing risk and patterns of harm inhibits the consideration of preventative strategies.

245. An exception to this observation was the case recording of the Department's AHCPEs staff. The quality of their case recording, risk assessment and action plans was considered comprehensive and thorough.

246. The Commission believes the Department should benchmark minimum standards for case recording, using the AHCPEs case notes as a basis for good practice.

4.2 Practice issues identified during site visits

247. Practice issues also became evident during site visits to residential care units. The Commission had serious concerns about the physical environment of many properties where restrictive, intrusive and punitive practices towards many of the children were observed.¹⁰⁹ The Commission immediately advised the Department of these examples during the course of the Inquiry and sought immediate remedy.

4.3 Inadequacies in the CIR process and case recording

248. As noted earlier, the Department manages its critical incidents through completion of CIRs. The Department guidelines state that the aims of incident reporting are to:¹¹⁰

- ensure that timely and effective responses are taken to address immediate client safety and wellbeing
- be accountable to clients for actions taken immediately and planned in response to their experience of a critical incident
- ensure that due diligence and responsibilities to clients are met
- support the provision of high-quality services to clients through the full and frank reporting of adverse events
- assure and enhance the quality of services and support to clients through monitoring and acting on individual incidents as well as trends identified through the analysis of incident reports
- support organisational consistency

- ensure that identified deficits in services and support are addressed
- inform the appropriate ministers, the Secretary and executive officers in a timely and accurate manner of significant incidents affecting clients.

249. In reviewing the CIRs that related to allegations of sexual abuse and sexual exploitation and in conducting the file reviews, the Commission found this practice instruction was not adequately followed.

250. There was minimal evidence from the child protection files that there is a process of formally investigating the allegations contained in the CIRs. The CIR form does not provide for an outcome to be recorded about the substantiation of the allegation.

251. In reviewing the children's files, it was evident that detailed analysis of trends and patterns of harm reported in the CIRs does not occur to assist in future learning or improve service delivery.

252. During the Inquiry, many Departmental staff advised the Commission of significant backlogs in processing CIRs due to the sheer volume of reports generated on a daily basis. The Commission observed delays of up to 12 months in entering CIRs in many children's files.

253. All CSO staff interviewed during the Inquiry advised that after the CIR is faxed, there is no confirmation from the Department that the report has been received. CSO staff advised that there is rarely any feedback provided by the Department about the incident or actions arising. The lack of an effective feedback loop to CSOs and the resulting poor communication can result in ongoing risks to the children and young people concerned.

254. The Commission was advised by most CSOs that if feedback is provided by the Department, it usually only relates to an error in completing the CIR.

109 For detailed examples refer to Chapter 5 and 6 of this report.

110 DHHS incident reporting system, 15 January 2013, advice number 1046.

4. Practice issues

255. Timely entry of CIRs is crucial for all professionals working with the child in order to have a thorough understanding of their circumstances and inform accurate assessment of risk. This is particularly the case with vulnerable young children in residential care who, when in crisis, often come into contact with the AHCPEs or SOS, which operate outside of usual business hours. These services are reliant on accurate and updated risk assessments and current file records detailing CIRs in order to provide an appropriate response to the child. Incomplete and inaccurate records contribute to systemic failures to protect children.
256. The Department has comprehensive guidelines for Department and CSO staff to ensure appropriate and timely responses to critical incidents relating to vulnerable children in care. It is imperative that the barriers to adhering to these guidelines be overcome by the Department as a priority.
257. The issue of accurate and complete case note recording in a child's CRIS file in accordance with the Department's practice standards has been noted and commented on by the Commission on numerous occasions when the Commission has conducted other inquiries in relation to vulnerable children involved in child protection services.
258. The current CIR process appears outdated, cumbersome and inefficient. It is a labour-intensive and fraught process whereby significant delays are encountered. In its current form, the CIR system does not support analytic capacity, as it has no ability to measure themes and issues in real time.
259. When undertaking the file reviews, the Commission found, in a number of cases, serious incidents of sexual abuse being described in the child's file notes, however, a CIR was not completed by staff and there was no due process recorded. There was often no evidence of a risk assessment or investigation being undertaken by child protection or the CSO in relation to the allegations.
260. In such circumstances, it is unclear how the Department and CSOs meet their obligations under the Charter and the Rights of the Child in relation to the protection of the child from all forms of violence and the child's right to access health care services.

4.4 Duty to act in the same way 'as a good parent would'

261. The cornerstone of the best interest principles as detailed in the CYFA 2005¹¹¹ states that the best interests of a child must always be paramount. When the Secretary has been given the custodial and guardianship responsibility of a child through the Children's Court, the Secretary has a duty to provide for that child's development in the same way **as a good parent would**.¹¹²
262. If a child in the general community experiences sexual assault, usual practice may include a forensic medical examination, specialist sexual assault counselling, medical treatment and police investigation. These standards do not appear to be uniformly applied to vulnerable children and young people in residential care when they have experienced sexual assault. This suggests that the standard of care for children in state care is lower than the care provided to children outside child protection, even though the Secretary's legal duty is to provide for a child in care **as a good parent would**.
263. Some of the most concerning examples that the Commission found where the file notes showed inadequate action by the Department and/or CSO included:
- A 12-year-old boy with an intellectual disability was absent from his placement and known to be with an older boy from the same residential unit. The two boys were believed to be visiting a 50-year-old man who was alleged to be a paedophile.
 - A 13-year-old girl who disclosed she had sex with a 32-year-old man was observed to have bruising on her chest and stated that her breasts were hurting.
 - A 13-year-old girl attempted suicide and disclosed she had met an older male through Facebook and had sex with him.
 - A 17-year-old girl disclosed to a residential care worker that she noticed that a staff member in her residential care unit had an erection and he made her feel uncomfortable.

111 CYFA 2005, Section 10.

112 Section 174 of the CYFA 2005 states the Secretary's duties in placing a child. The Secretary is required to have regard to the best interests of the child as the first and paramount consideration and must make provision for the child's physical, intellectual, emotional and spiritual development of the child in the same way as a good parent would.

264. Not only must the Department act **as a good parent would**, but it and the CSOs have an obligation under the Charter to ensure that every child has the right, without discrimination, to such protection that is in their best interest by reason of being a child.

4.5 Failure to ensure privacy and confidentiality

265. Issues pertaining to the privacy of children's information were also noted as a widespread practice issue across the file reviews conducted. The Commission is concerned about the failure to apply the privacy principles outlined in the *Privacy and Data Protection Act 2014*, as shown by:

- it was noted there were occasions where CIRs were incorrectly added to the wrong child's file, detailing highly personal information
- CIRs that identified and listed the names and dates of birth of other children and then saved onto multiple children's files
- file notes that provided personal and confidential details of the situations of other children.

4.6 Insufficient oversight of CSOs by the Department

266. The Commission has found that a greater level of scrutiny and independent oversight is required of CSOs delivering residential care services, and an urgent review of the current processes regarding the oversight and accreditation of CSOs is required. Despite prescriptive and detailed guidelines designed to ensure the delivery of quality residential care services, the Commission found that there is role confusion within the Department and corresponding lack of ownership to ensure guidelines are implemented.

267. It is of grave concern that these conclusions have been reached in previous inquiries and have not been acted on. The Victorian Auditor-General found in 2005 and again in 2014 that performance monitoring of CSOs is inadequate and that quality assurance mechanisms are lacking.¹¹³

268. The Department conducts sporadic spot visits to residential care units. In the past the focus has been on 'fabric assessment' of the facility, rather than assessing the wellbeing of the children residing there. The Commission welcomes the initiative in 2015 to undertake spot audits of residential care units to ensure the highest standards of care.

269. Site visits during this Inquiry have revealed substandard care is presently being provided to many children in residential care. Many examples were evident that appear to be contrary to the Secretary's responsibilities as specified in the CYFA 2005, the Charter and the Rights of the Child.

¹¹³ Victorian Auditor-General, *Our Children are our Future: Improving outcomes for children and young people in Out-of-Home Care* (Melbourne: Victorian Auditor-General's Office, 2005); Victorian Auditor-General, *Residential Care Services for Children*.

5. File reviews, staff interviews and sector submissions

270. The Commission conducted detailed file reviews for 32 of the 166 individual children subject to CIRs during the Inquiry period and one additional case example that was brought to the attention of the Commission during the submissions process. The focus of the file reviews was on the children's experience of the care system, the events leading to the alleged incident of sexual abuse and the response to the incident to assist in examining the systemic factors that impact on the problem.
271. The case examples are contemporary and relate to incidents that are recorded in children's CRIS files over the past 12–18 months.
272. Material in this chapter has been organised into three identified areas of sources of harm to children in residential care:
- sexual abuse of children in residential care by external predators
 - sexual abuse in residential care between children (child-to-child abuse)
 - sexual abuse in residential care by staff to children (staff-to-child abuse).
273. Interviews with staff and sector submissions are also referenced in this chapter, where relevant, under each section of identified sources of harm.

5.1 Sexual abuse by external predators

274. The scale and of risk of sexual exploitation and sexual abuse by external predators to vulnerable children and young people in residential care is alarming. This is a problem that is evident in Australia and internationally.
275. Research has demonstrated that problematic drug use plays a central role in young people's entry and continued participation in street sex work, as well as their limited engagement with relevant support services. Additionally, research has highlighted a strong correlation between living in out-of-home care, particularly residential care, and subsequent involvement in commercial sexual exploitation.¹¹⁴
276. Absence from placement is a key risk factor for sexual abuse and sexual exploitation. As at January 2015, the Department advised the Commission that there had been 108 CIRs over the previous six-month period, relating to children and young people being absent from their residential care placement. This is an increase of 50 per cent on the same time period the previous year.¹¹⁵

¹¹⁴ Gaye Mitchell, *From exclusion to community and connectedness: A difficult, tenuous but possible path: A research report on the work of the Women's Team of Sacred Heart Mission St Kilda* (Sacred Heart Mission St Kilda, 2000); Rhiannon Bruce and Philip Mendes, 'Young people, prostitution and state out-of-home care: the views of a group of child welfare professionals in Victoria', *Children Australia*, Volume 33, Number 4 (2008), pp. 31–37; Ben Durant, 'Survival stripped bare: Young people participating in street sex work in Dandenong', Honours Research Project (Australian Catholic University, 2010).

¹¹⁵ DHHS, *Performance, Assurance and Compliance report* (unpublished data, January 2015).

277. The environmental and systemic factors within residential care that have been found by researchers to contribute to commercial sexual exploitation included:¹¹⁶

- peer influence
- older males grooming young people
- drug use
- staffing factors such as staff turnover, inconsistency, low skill base and the inability to fill a substitute parent role
- poor provision of sex and relationship education
- poor placement decisions
- social isolation.

278. Most CIRs that the Commission received during the Inquiry period related to sexual abuse allegedly caused by predators external to the residential care unit. The incidents of reported abuse included rape, indecent sexual assault and sexual exploitation.

279. The Department and some CSOs have been working with Victoria Police for a number of years in response to the problem of external predators. This work has involved collaborative efforts and creative responses including joint training, provision of practice instructions, co-location of staff, the use of high-risk youth schedules and care team

meetings, application of a tiered risk assessment to identify children at acute and high risk of harm, development of a sexual exploitation template and the linking and mapping of at-risk children and persons of interest/known offenders.¹¹⁷

280. In Victoria, there have been commendable efforts by the Department, Victoria Police and many CSOs in response to external predators targeting children in care, particularly residential care. In the following section on file reviews, Case Example 3 highlights collaborative work in responding to a 14-year-old boy's vulnerability to predatory behaviour by older men in the community.

281. The Department has compiled a series of indicators to guide child protection practitioners and CSO staff to identify children and young people who are at risk of sexual exploitation.¹¹⁸ These indicators include:

- absconding from their placement or time spent at placement being irregular
- being picked up from residential care units in cars by unknown adults
- associating with other young people who are involved with older men, or are known to be sexually exploited
- associating with young people who are highly sexualised, accessing or being fixated with online pornography, having open and indiscriminate sexualised friendships or being preoccupied with sexual matters

¹¹⁶ Rhiannon Bruce and Philip Mendes, 'Young people, prostitution and state out-of-home care'.

¹¹⁷ DHHS, *Sexual exploitation: overview of DHHS practice and systems to prevent and respond to risk* (unpublished document, 2014).

¹¹⁸ *Ibid.*

5. File reviews, staff interviews and sector submissions

- receiving or sending sexually explicit messages and images via text or internet-based social media sites
 - believing they are in a loving romantic relationship with an adult
 - having experienced significant childhood trauma, including sexual abuse
 - disengaging from supports
 - significant drug and alcohol misuse or mixing with people involved in these activities
 - having mental health concerns and/or experiencing deterioration in their mental health after being missing from their residential care unit.
282. Like any practice standard or framework, the challenge is to ensure compliance and application. Despite the strong framework developed by the Department to identify young people at risk of sexual exploitation, the Commission noted a number of examples of inconsistent responses and an apparent failure by many CSOs and the Department to apply the framework or monitor compliance.
283. In the following section on file reviews, Case Example 1 highlights the case of a 14-year-old girl who asked the residential staff member to pick her up from a train station late at night. The request was refused, resulting in her being out late at a train station by herself. She later reported to a Departmental worker that she was raped by a stranger. The file notes provided no evidence of a medical response for the girl or any follow-up support, counselling or report to the police. A QoC investigation by the Department was mentioned in the file, but the outcome was not recorded on her file. In this instance the Department (and the CSO) did not appear to adequately comply with practice guidelines.
284. Case Example 2 highlights the lack of an appropriate response by both the CSO and the Department to a 15-year-old intellectually disabled girl. It was known that the girl was regularly sexually exploited by older men in the community. The girl reported to staff at the residential unit that she was having pain and unexpected bleeding from her vagina. There are no file records to show that she received medical treatment or appropriate support for the reported miscarriage. **A good parent would** undertake such action. Delays in processing the CIR meant that the Department did not review her circumstances until three months after the incident.
285. Case Example 4 reveals a series of concerning practices around failing to act **as a good parent would**.¹¹⁹ A 13-year-old girl was often missing from her residential care unit for several days at a time. The file notes indicated that the girl had serious health issues that did not appear to receive treatment or monitoring. **A good parent would** make sure that a child with chronic illness received specialist care and treatment.
286. The Rights of the Child (Articles 19, 24 and 34) requires governments to ensure children are protected from being hurt or mistreated, have access to health services and are protected from all forms of sexual abuse and sexual exploitation. It is imperative that vulnerable children living in residential care are afforded these rights and that the Department and the CSOs who have custodial responsibility take all measures to protect and uphold these human rights. The Commission found evidence that in many cases these rights did not appear to be upheld for some vulnerable children.

¹¹⁹ *Children Youth and Families Act 2005, Secretary's duties in placing a child, S. 174 1 (b).*

14YR OLD GIRL ALONE AT A TRAIN STATION

5.1.1 File reviews: examples of sexual abuse of children in residential care by external predators

CASE EXAMPLE 1:

14-YEAR-OLD GIRL ALONE AT A TRAIN STATION

A 14-year-old girl was placed in residential care by voluntary arrangement¹²⁰ because her parents were unable to care for her. It was not documented in the file why home-based care was not considered for this girl. At the residential unit she was regularly absent for long periods (sometimes days at a time). The file notes indicate that the staff held concerns for her emotional wellbeing as she was often reported to be self-harming (for example, inflicting injury to herself by cutting).

The girl told a Departmental worker that one night, after she had been away from the unit, she had called staff at midnight from a train station and asked them to pick her up. Staff refused her request. The girl later disclosed that she was raped by a man at the train station that night. The girl said that after the rape happened, she again called the staff at the residential unit. They told her to make her own way back to the unit. It is unclear from the girl's file if, after making the disclosure about the rape, she received any counselling or medical support.

The Department commenced a QoC investigation. The focus of the QoC was the response or lack thereof to the girl in relation to her request to be picked up at night, her disclosure of alleged rape and the responsibilities and duties to children in their care. The response by the staff at the residential unit was that they could not leave the unit at night to pick her up. The staff member in question was the only worker at the unit on duty that night.

There was no record on the girl's file of the outcome of the Department's QoC investigation. It was not clear from the file that the Department followed its own QoC guidelines. It was not clear whether the girl was supported, provided with information during the process or informed of the outcome.

¹²⁰ Voluntary out-of-home care is where there is no court order requiring a child to reside out of parental care. The parent makes a voluntary arrangement with a service provider by consent for the care and placement of their child in out-of-home care. The voluntary nature of the arrangement ensures the retention of parental legal rights. Parents have the power to end the placement at any time and have the child returned to their care.

5. File reviews, staff interviews and sector submissions

15 YR OLD GIRL REPORTS HAVING A MISCARRIAGE

CASE EXAMPLE 2:

15-YEAR-OLD GIRL REPORTS HAVING A MISCARRIAGE

A 15-year-old girl who was on a Guardianship to the Secretary Order was placed in residential care. Her behaviour was known to be high risk and it was known that she was sexually exploited by older males outside her residential care unit. She was known to use drugs and alcohol and often returned to her residential unit intoxicated, making statements that she had been raped by older men she had met through internet sites and social media.

She disclosed to staff at her residential care unit that she was bleeding from her vagina the previous night and remained in pain. She said she had taken a pregnancy test in the days preceding and it was positive. She was offered Panadol by staff and was asked if she wanted to see a doctor. The girl declined the offer that night. No other action appeared taken that night.

Staff at the residential unit completed a CIR and classified the incident as Category Two, 'behaviour disruptive'. They noted in the CIR that the girl had disclosed she might have been having a miscarriage.

The CSO faxed the CIR to the Department within three days of the incident occurring.

The Department did not review the CIR until three months after the apparent miscarriage. A manager at the Department responded to the CIR by writing the following proposed action on the report: 'young person to be supported to attend a medical appointment'.

The CIR was not entered on the girl's child protection file for nine months after the incident.

It is unclear from the girl's file if she ever received any timely or appropriate medical follow-up or counselling from her experience of an apparent miscarriage.

INTELLECTUALLY DISABLED 14YR OLD BOY ABUSED BY OLDER MEN

CASE EXAMPLE 3: INTELLECTUALLY DISABLED 14-YEAR-OLD BOY ABUSED BY OLDER MEN

A 14-year-old boy who was on a Custody to the Secretary Order was placed in residential care. He had a diagnosed intellectual disability. It was known by Departmental staff and residential care staff that he would regularly meet older males in the community and that these men would allegedly anally and orally rape him. He advised his caseworkers that he was provided with alcohol and marijuana by the older men. Staff knew he was friends with young people who lived in other residential care units and that he was influenced by this peer group to meet these older men.

File notes also indicated that he was connecting with these older males outside the residential care unit through social networking sites and adult dating websites.

The file noted strong collaborative work between the CSO and the Department. Arrangements were made to 'disrupt' the pattern of behaviour by temporarily taking him out of the community where he was at risk for a short holiday break. The care team also liaised regularly with Victoria Police, who took an active role in investigating the reported sexual assaults.

Regular care team meetings occurred to make plans for the boy's safety. Consultation and information sharing occurred centrally through the Department's office of professional practice. Efforts were also made by the caseworker to involve and work with the boy's family as a way of connecting him to a safe adult.

The interventions noted in the boy's file showed a good understanding of the risks to the young boy and a well coordinated and planned approach to managing and minimising the risks and protecting him from further abuse. The boy was at the centre of the decision making and planning so that decisions could be made to keep him safe.

5. File reviews, staff interviews and sector submissions

13 YR OLD ABORIGINAL GIRL WITH A 24YR OLD BOYFRIEND

CASE EXAMPLE 4:

13-YEAR-OLD ABORIGINAL GIRL WITH A 24-YEAR-OLD 'BOYFRIEND'

A 13-year-old Aboriginal girl was placed in residential care on a Guardianship to the Secretary Order. She had had a long history of child protection involvement and had experienced multiple placements. File notes state that prior to her entering residential care she was a talented student with musical ability. She disclosed being sexually abused from a young age by many older males, including familial, a former residential care worker and older males in the community.

The Department's case file indicated that at the age of 13, she was described as having a 'relationship' with a 24-year-old male. Residential care staff involved with her case appeared to accept the status of the older male as a 'boyfriend' rather than viewing his behaviour as exploitative and illegal.

The girl was often missing from her residential care unit and was believed to be in the company of numerous older males, including the 24-year-old 'boyfriend'. As a result of sustaining physical injuries from an assault by one of the older men, the girl was admitted to Secure Welfare Services, where she disclosed to staff that the man had beaten her. There were no records on her file to indicate if this physical assault was reported to police, if there was a criminal investigation or if the man faced criminal proceedings from the assault.

The child protection file indicated that consultations took place with a Principal Practitioner¹²¹ from the Department; however, the nature of the specialist advice and consultation was not recorded on her file.

Although the girl was only 13 years old, missing person's reports were not filed when she was absent from placement, often for extended periods (days at a time).

The girl had serious health issues that were not addressed.

¹²¹ A Principal Practitioner is a specialist practitioner role within the Department. The practitioner provides expert consultancy and case reviews for high-risk and complex matters.

Her father expressed his concern that not enough was being done to protect his daughter from the 24-year-old 'boyfriend' and other older men. The 'boyfriend' was flagged on her file as being a potential danger to workers due to his high levels of aggression.

Police interviewed the girl in relation to a residential care worker who had sexually assaulted her. She stated that the abuse happened over a three-year period, from when she was eight years old. She identified another child who was also sexually assaulted by the same residential care worker. File notes do not indicate if she was offered support or counselling following this interview. It is unclear what investigation or outcomes occurred in relation to the residential care worker, including whether or not this person continues to work in the residential care sector within Victoria.

There was no evidence on file whether the state, as her legal guardian, arranged for her to obtain legal advice in order for her to explore legal avenues of redress, such as victims of crime assistance.

The girl strongly identifies with her Aboriginal heritage and wants to live in a placement that supports her cultural identity. Despite this, a culturally appropriate placement was not provided for her. She was placed in a residential unit that was not managed by an Aboriginal organisation and she was not cared for by Aboriginal carers.

At the age of 14, the girl continued to experience sexual abuse and sexual exploitation by numerous men, some of whom were as old as 50 and known child sex offenders.

The girl was listed on the Department's central Sexual Exploitation Register¹²² as being a tier 1, acute risk. She was reported to be using heroin on a daily basis and was regularly missing from her residential care placement. On one occasion, at the age of 14, she was missing for three weeks. Despite her high-risk status, a missing person's report was not made with police. There was no information on the child's file to suggest that the Department had considered obtaining permission from the Secretary (or the Children's Court) to allow the media to publish information that the girl was missing. It is not clear why these options were not explored.

Around this time, it was discovered the young girl was pregnant. She gave birth to the baby in hospital and one of the violent men she was associating with visited the hospital.

In conducting the review, the Commission was concerned at the ongoing sexual and physical abuses this girl suffered as a young child in state-funded residential care. The significant deterioration in her wellbeing following her entry to residential care was sadly evident. She was a girl for whom the state was her legal guardian and obliged to act **as a good parent would**.

It was noted that there were many staff involved in this girl's life but there were poor outcomes for her.

122 The Sexual Exploitation Register is centrally maintained by the Department of Health and Human Services' Office of Professional Practice. The register records information about the risk level of children where analysis is undertaken to determine if statewide links to other young people and persons of interest exist.

5. File reviews, staff interviews and sector submissions

5.1.2 Submissions: sexual abuse by external predators

287. Many submissions noted the inherent vulnerability and increased threat of sexual abuse and sexual exploitation for children placed in residential care. Many of these children have experienced a number of previous placement changes and breakdowns, have a lack of connection to a primary caregiver, are isolated and may have a history of prior sexual abuse that results in the child normalising abusive behaviours and not recognising that the exploitation they are enduring is an act of abuse.
288. Victoria Police identified in its submission to the Inquiry that the sexual exploitation of children in their experience is:¹²³
- *...often characterised by power and control dynamics in which children are conditioned into a relationship of trust, dependence and reward. This occurs both online and in person and generally involves the gradual development of a relationship with the child for the ultimate purposes of sexual activity.*
289. Victoria Police advised that in their experience, organised networks of males use social media to actively seek out and groom children by offering money and other incentives for sexual favours. The Commission noted during the Inquiry children's prolific use of social networking that facilitates connection with sexually predatory persons.
290. MacKillop Family Services cautioned in its submission:¹²⁴
- *...children and young people in residential care will continue to be targets for sexual exploitation as they are perceived as highly vulnerable, powerless and voiceless.*
291. The inability for children to form attachments with caregivers and significant others within the present model of residential care was noted in the submission received from the Lighthouse Institute:¹²⁵
- *A lack of understanding of attachment and trauma, and its application in practice in the out-of-home care system, has a harmful effect on the developing self of the child in care and their ability to place trust in relationships. The out-of-home care system as it stands today does not promote attachment, and in some ways actually promotes detachment from relationships.*
292. Many submissions called for improvements to the qualifications and skill sets of direct-care staff to better equip carers to respond to children at risk of sexual exploitation.
293. Berry Street Victoria made a clear link in its submission between the expertise of the staff caring for the children and the ability to identify and respond to children at risk of sexual exploitation.¹²⁶
294. The resounding message in the submissions received was that reform is desperately required to improve the quality of care that children and young people receive in order to provide an environment that can be reparative from their trauma backgrounds.
295. Most submissions that the Commission received acknowledged the difficulties in supervising internet access of children and young people. There is a clear need for targeted cyber safety education programs for all children in residential care from a young age, combined with sex and relationships education as an ongoing practice. Practices such as installation of filters on computers within the residential care units is not enough to combat predators targeting children online, particularly given the plethora of devices with internet capability that are available to children.

123 Victoria Police submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccpv.vic.gov.au.

124 MacKillop Family Services submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccpv.vic.gov.au.

125 Lighthouse Institute submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccpv.vic.gov.au.

126 Berry Street Victoria submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccpv.vic.gov.au.

5.1.3 Interviews with staff: sexual abuse by external predators

296. The Commission heard from many professionals, both within the CSO sector and from the Department, of the often negative peer influence of children being recruited into sexual exploitation by other children in the placement.
297. Direct-care staff spoke about the challenges of keeping the children in their care safe. Other children in the same residential unit may persuade or coerce each other into engaging in high-risk activity off site. Many staff spoke of 'contamination', where a younger child is placed with older children who are engaging in high-risk behaviours.
298. One CSO manager provided an example of a girl in her early teens, whereby prior to entering residential care she had been attending school and was a generally healthy girl who had not used drugs. Within weeks of entering residential care, the girl had experimented with the drug ice (a methamphetamine), stopped attending school, was regularly absent from the placement and in the company of an older peer group and was exchanging sex for money, drugs and alcohol. The CSO manager commented that the girl's physical appearance had dramatically deteriorated. She had lost weight, was pale and had a 'blank look' on her face.
299. The public is already aware of the dangers and risk of the drug ice in the community through regular mainstream media. Vulnerable, traumatised and powerless young children who are in residential care are easy prey to the dangers of this drug abuse and sexual exploitation.
300. Many CSO and Departmental staff provided favourable feedback about the joint operations with Victoria Police in tackling sexual exploitation; however, some felt that the emphasis had eased off and noted that it requires ongoing committed resources.
301. Many professionals cited the need for regular training as an urgent need in the sector. Training to educate children about relationships, sexuality and safety was frequently raised with the Commission. Additionally, professionals stated that they would benefit from regular training that would equip staff to detect grooming behaviours and identify children who are at risk of sexual abuse and sexual exploitation by external predators.

5.1.4 Findings: sexual abuse by external predators

302. The state's most vulnerable children and young people are experiencing sexual abuse from external predators, often in the guise of a 'relationship'. There is an urgent need to target the reasons why young people are making connections with older predatory males.
303. There have been inconsistent responses to this significant problem. Positive collaborative efforts have been noted by the Department, with some CSOs and Victoria Police working together to disrupt the predatory behaviour of sexual exploitation. However, despite the existence of Departmental practice instructions and guidelines, these appear to have been inconsistently applied, as indicated in the file reviews conducted during the Inquiry.
304. File reviews disturbingly revealed a sharp decline in the physical and emotional presentation of many children upon their entry to residential care. CSO and Departmental staff interviewed by the Commission confirmed these observations. Examples were noted where after a child entered into residential care they began using drugs, disengaged from school and commenced risk-taking behaviours where they were exposed to or experienced sexual abuse and exploitation by external predators.
305. Additionally, the high volume of rostered staff rotating through each residential care unit impedes the ability to form caring and nurturing relationships with children. The use of casual direct-care staff sourced through a labour-hire agency and/or reliance on casual staff to fill shifts in the residential care units works against the provision of a consistent, stable, nurturing home environment.
306. The Commission observed through site visits, that the physical environment in some residential care units visited was substandard, hostile and stark. Many did not represent a 'home', providing little incentive for the children to remain there. Some notable exceptions were evident and are discussed in subsequent sections of the report.

5. File reviews, staff interviews and sector submissions

307. These environmental and systemic issues are considered major factors in the isolation of the children being cared for in the residential units. There is a lack of incentive for children to be connected to or see their residential placement as 'home'. Coupled with the child's trauma history and other vulnerabilities, the susceptibility to influence from a sexual predator is high.
308. Of concern to the Commission was the lack of consistency about responding to young people when they leave their residential care unit. Practices vary in relation to when (or if) the child is reported as missing and also what attempts are made to locate the child. It appears accepted that a young person who leaves the residential unit without permission is at risk of sexual exploitation, yet there is sometimes little effort to locate the young person. This was evident from case reviews and reinforced from interviews with direct-care staff. Additionally, the Commission noted there is a lack of uniform response when the child returns to the unit.
309. The Commission considers a standard practice of conducting assertive and engaging return interviews with children who have been missing from care must be considered. Such interviews should record the reasons the child left the placement, provide a forum for ongoing discussion about the child's personal safety and offer an opportunity for future safety planning with the child.
310. Recommendations have been made in response to the desperate need for immediate action in ceasing practices that contribute to children's isolation and risk of experiencing sexual abuse by predators. Concurrently efforts should be made to redevelop the current residential care model and develop specialist models of care. These models should be attuned to the individual needs of children and provide the opportunity for attachment, engagement and meaningful caregiving relationships to occur.
311. The Inquiry has also recommended focused attention on improving data about the extent of sexual exploitation by undertaking problem mapping. Findings and recommendations in the UK Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups¹²⁷ speaks of the need for quality problem-profiling to map, monitor and plan strategic interventions. Notable work is occurring in Victoria, but it requires sustained resourcing and greater emphasis on shared learnings.

127 Sue Berelowitz et. al., *'If only someone had listened'*.

5.2 Child-to-child sexual abuse in residential care

312. Peer sexual abuse in residential care accounted for the second largest proportion of CIRs analysed by the Commission during the Inquiry period. These reports of child-to-child sexual abuse were mostly for acts categorised as indecent sexual assault, rape or sexual behaviour.
313. The Commission identified a number of systemic deficiencies during the review of cases for children who had experienced child-to-child sexual abuse.
314. An absence of formalised assessment on the impact to all children affected by a proposed placement was apparent in each of the cases reviewed. Children with particular vulnerabilities were placed together without adequate attention to their individual needs. This was especially noted for very young children, a number of children with identified intellectual disabilities and children with sexually problematic behaviours.
315. There was an absence of documented and planned placements that were comprehensively assessed in a holistic manner and took into account the individual needs of each child in the unit. Most placements of a child (or children) into a residential care unit appeared to be made because there was no other option available. This is evident in Case Examples 5, 7 and 8.
316. Of particular concern in one instance, the Commission observed expert assessment being ignored (see Case Example 5). Senior Principal Practitioners and child protection managers within the Department raised concerns about the risk of child-to-child abuse in placing two particular children together. Bed availability and budgetary considerations appeared to take a greater priority and the placement proceeded, resulting in numerous incident reports of one child being bullied, physically threatened, seriously assaulted and sexually abused by the other child.
317. During site visits and sector consultations, the Commission was concerned that there appeared to be many inappropriate placements of children in residential care. This highlights both the paucity of specialist placement options for children as well as poor risk assessment about the suitability of the placement. Examples included:
- An eight-year-old boy placed with an unrelated 16-year-old girl because his foster carers could not care for him due to personal reasons.
 - Two siblings under the age of seven placed with other unrelated children, some of whom were known to have sexually abusive behaviours.
 - A 13-year-old Aboriginal girl placed with three unrelated children, one of whom was reported to be violent and threatening to the girl. This resulted in her being absent from her placement for long periods.
318. The risk of child-to-child sexual abuse is heightened by such inadequate placement decisions. Vulnerable children are placed in high-risk situations and the CSOs appear to have little capacity to manage or protect the individual needs of children in the units. Staff from the Department and CSOs constantly raised this issue with the Commission at interview.
319. In situations where children have disclosed child-to-child sexual abuse, there is no framework to support a consistent and transparent response to such matters. The QoC investigative framework exists for carer abuse and neglect but does not include child-to-child abuse. This is a flaw in the systemic process, as children are not given the opportunity for an investigation of the matters, review of the suitability of their placement, consideration of their need for counselling and support, or any redress and compensation.

5. File reviews, staff interviews and sector submissions

INTELLECTUALLY DISABLED 10YR OLD BOY ABUSED BY ANOTHER BOY

5.2.1 File reviews: examples of child-to-child sexual abuse of children in residential care

CASE EXAMPLE 5:

INTELLECTUALLY DISABLED 10-YEAR-OLD BOY ABUSED BY ANOTHER BOY

The Commission reviewed the child protection file of a 10-year-old boy with an intellectual disability who had been subjected to serious neglect and physical and sexual abuse prior to being placed in care. He experienced 12 home-based care placements changes before being placed in residential care. He was on a Custody to the Secretary Order at the age of six.

The child was placed in a one-to-one, costly, unfunded residential care placement because it was assessed that he could not be with other children. File notes describe his distress when faced with change, particularly when different and unfamiliar staff were rostered to care for him. Caseworkers reported that the boy had difficult and challenging behaviours because of the early abuse he suffered.

Due to the one-on-one placement, the Department's placement not being a long term option coordination unit¹²⁸ sought an alternate arrangement and suggested he could be placed with another child of similar age in a residential care unit. From the outset, a number of senior Departmental child protection staff expressed concern about the proposed pairing of these children. They had assessed that the then eight-year-old boy would 'be at risk of physical assault' by the other child, given the other child's known behaviours.¹²⁹

The CSO residential care manager also expressed reservations to the Department about the suitability of the proposed placement match and deferred a decision to accept the referral of the boy.

¹²⁸ Placement coordination staff within the Department of Human Services receives a written referral for placement from the child protection worker and is then responsible for locating and arranging a suitable placement for the child, usually through a CSO.

¹²⁹ Documented on the child's Department of Health and Human Services CRIS child protection record.

It appears that there were disparate views within the Department about the placement. An email from the placement coordination staff acknowledged the apprehension by CSO staff and key Departmental specialist staff about the proposed placement. In the email, the placement coordination staff member suggested an internal Departmental meeting to discuss the match and 'how we can possibly make this work in order to present a consistent message to our CSO colleagues re our consultation'.

The internal meeting occurred and a record of the meeting states there were 'no other placement options available at this point of time for [the boy] and he is no longer able to stay in [his placement]... and he needs to move into the identified option'.

Despite the concerns raised by a number of professionals, three weeks after the internal meeting, the boy was moved to the new placement with the other child.

Four days after the placement was made, the boy received a punch to the head by the other child. Over the following weeks the boy suffered a series of serious physical assaults by the other child, including being kicked, punched to the face, having his glasses broken, being verbally threatened and bullied. Additional staff were engaged through a labour-hire agency in response to the difficulties in the co-placement of the children. This in turn led to increasingly distressed behaviours in the boy because of the presence of unfamiliar staff in the residential care unit.

Three months after the placement occurred, the boy disclosed to a direct-care residential worker that the other child rubbed his penis on him and kissed him on the mouth. He disclosed that the incident happened in his bedroom the previous night, that he had been crying and could not wake the staff up to help him. He repeated his disclosure one hour later.

The CSO completed an incident report detailing the disclosures and forwarded it to the Department. The boy's parents were advised of his disclosures and an additional 'stand-up' staff member was put on to provide extra overnight supervision.

It is not apparent from the boy's CRIS file if Departmental staff interviewed him about his disclosures of sexual abuse in care by the other child or if reassurance and support or counselling were offered to him. The children continued to remain in the placement together for several months.

5. File reviews, staff interviews and sector submissions

INTELLECTUALLY DISABLED 12YR OLD BOY ABUSED BY TWO OLDER CHILDREN

CASE EXAMPLE 6:

INTELLECTUALLY DISABLED 12-YEAR-OLD BOY ABUSED BY TWO OLDER CHILDREN

A 12-year-old boy had a number of challenging behaviours resulting from his intellectual disability. His family were struggling to meet his needs.

The Department placed the boy in a residential care unit on an Interim Protection Order with two older, unrelated children. One of the children was known to have abusive behaviours. In reviewing the placement referral information, the Commission could not ascertain if an assessment was made about the appropriateness of the match of children together or if home-based care was considered.

Shortly after being placed in the residential care unit, the 12-year-old boy started running away. Police were called to find him.

In care team meetings, staff discussed the fact that the 12-year-old boy was being groomed by another older boy within the residential care unit and that the two were engaging in sexual 'play'. They also suspected that the 12-year-old boy was leaving the residential care unit with the older boy to visit a man in his 50s who was believed to be a paedophile. No CIR was completed despite these concerns being noted in the meeting.

The 12-year-old boy also told his child protection worker that he had been hanging around with some other boys at a railway station where an older man gave them free soft drinks.

Direct-care staff in the unit completed an incident report after observing the 12-year-old boy being led around the house with a belt around his neck by a 17-year-old boy in the unit. The description of the incident is one of dangerous play and is categorised as a Category Two CIR.

After a three-month placement in the residential care unit, the 12-year-old boy returned to the care of his family. Upon his return home, he made a detailed disclosure of being victim to an attempted rape by a 17-year-old boy in the residential care unit. He describes how the other child made him behave like a dog by leading him around with a belt tied around his neck. He stated that his pants were pulled down by the older boy, who then tried to insert his penis in his bottom.

File notes indicate that the boy's family alleged there had been a cover-up of the allegations by the CSO and that the Department did not respond to these allegations in a thorough manner.

In reviewing the file, the Commission was concerned to note an absence of a documented CIR regarding the alleged attempted rape and a poor QoC response that did not thoroughly investigate the concerns of information allegedly being covered up. The Commission referred the case for review to senior Departmental practitioners. This resulted in the original CIR being rewritten and upgraded to Category One six months after the incident occurred.

8YR OLD BOY ABUSED BY OLDER BOY

CASE EXAMPLE 7: EIGHT-YEAR-OLD BOY ABUSED BY OLDER BOY

An eight-year-old boy experienced more than 10 different placements prior to entering his residential care unit placement on a Custody to the Secretary Order. He had been exposed to parental mental health difficulties and serious family violence before entering care. He was noted to require an integration aide at school as he has ADHD.

Due to his carer's ill health, the boy was moved into a residential care unit as no other suitable options could be found. Two days after he was placed in the residential care unit, the carer found him outside with an older boy from the unit. The staff member observed the older boy forcing the eight-year-old boy to perform oral sex.

The boy did not receive specialist sexual assault counselling for six weeks after the rape. It would be expected that the Department, acting **as a good parent would**, would have ensured he received timely counselling.

Shortly after, at a meeting where both the CSO and Departmental staff were present, it was openly discussed that cameras had been installed by the CSO in the eight-year-old boy's bedroom to observe him and it was noted in his file that staff had seen him masturbate.

This practice was of significant concern to the Commission. These issues were raised with the Department in particular for it to consider and liaise with the Victoria Police to determine whether this practice infringed upon this child's right to privacy and in consideration of the legislative requirements of the *Crimes Act 1958* and the *Privacy and Data Protection Act 2014*.¹³⁰

There is relatively little documentation on the boy's file relating to the follow-up responses by both his child protection worker and CSO residential care staff following the rape. It is not recorded if conversations occurred with the child about the incident, how he reacted or whether he had been reassured and given an opportunity to talk about his safety.

A decision was made to move the boy to another residential care unit two months after he was raped. File notes record that the boy thought it was unfair that he had to move. It is not clear how the placement change was conveyed to him or that there was adequate transition planning. Shortly after he arrived at his new residential care placement, he was exposed to the violent and sexualised behaviours of a 15-year-old boy. The eight-year-old child was frightened and distressed by the older boy's behaviours.

It is not apparent that an assessment occurred about the suitability of the new placement. The Commission was most concerned about the significant delays in the child receiving counselling, the poor follow-up to the incident and the inadequate assessment for the new placement, where he continued to be exposed to violent and sexually abusive behaviours.

¹³⁰ At the time of writing this report, the Commission had not received a formal response from the Department in relation to these issues.

5. File reviews, staff interviews and sector submissions

8YR OLD GIRL ABUSED BY 14 YR OLD BOY

CASE EXAMPLE 8: EIGHT-YEAR-OLD GIRL ABUSED BY 14-YEAR-OLD BOY

An eight-year-old girl had a long history of child protection involvement due to significant parental neglect. She and her brother were placed in out-of-home care for the first time when she was six years old. File notes indicate there were no suitable placement options. She was placed in emergency placements, sometimes for just one night. The two siblings were not able to be kept together. File notes describe a paucity of foster care placement options for the children across the state. On several occasions, the eight-year-old girl's placements ended at short notice due to the needs of the foster family.

She went on to experience 11 home-based care placements before being placed in a residential care funded for TRC at the age of eight. She was subject to an Interim Accommodation Order.

In the early evening of her first night in TRC, the girl was sexually assaulted by a 14-year-old boy with known problematic sexual behaviours. The boy was seen by residential staff standing over the girl with an erect penis. It is unclear from the file what support was provided to the girl. There is no record of immediate follow-up by her caseworker or that any counselling occurred. It was decided that the girl and the 14-year-old boy should remain in the residential care unit together. There was no QoC investigation, as child-to-child sexual abuse does not fall within the scope of such an investigation.

Very few care team meetings occurred and there is no evidence on the girl's file that there were any consultations with the Department's Principal Practitioner. Recording of key events, including CIRs, was rarely completed, despite reference to significant incidents noted in court reports.

The girl's behaviour deteriorated. She was absent from school and ran away from her residential care placement. She reported to her caseworker that the 14-year-old boy was rough with her. The children continued to live together until, several months later, the 14-year-old boy again engaged in sexual behaviour towards the girl. File notes state that the girl's bedroom door was to be kept locked at night. The 14-year-old boy was moved from the placement several days later. A CIR about the second instance of sexual behaviour was not entered on the girl's file until three months after the incident occurred.

The girl later attempted to harm herself and was admitted to a psychiatric unit for evaluation. She remained in the same placement and it was apparent that the arrival of another child caused her distress as she was not given any explanation or preparation for the new child's arrival. She was eventually moved by herself into an unfunded contingency placement with rostered staff.

Two other children later made disclosures that they witnessed another older boy in the former residential care placement orally rape the girl and place his penis on her vagina. It is unclear from the girl's file what the response was. The girl was referred to an agency for therapeutic services.

The Department commissioned an independent review of the case that found that despite being funded for TRC, staff at the residential care unit were not adequately equipped to manage the complex behaviours of the mixed age range of children in their care. They lacked the support and leadership to work in a therapeutic manner with the children and appeared demoralised and exhausted.

Following a request by the Commission, the Department provided the Commission with a copy of the independent case review report.

This young girl's distressing experience of residential care highlights the critical need for careful placement matching for children in group care settings, rather than placement decisions being influenced by bed availability.

A good parent would act in the best interests of the child. It was difficult to reconcile the experiences of this child with the legal responsibilities of state care.

5.2.3 Submissions: child-to-child sexual abuse

320. Submissions to the Inquiry spoke of the paucity of out-of-home care options for children requiring placement, resulting in admission to residential care where they are vulnerable to sexual abuse and exploitation. The grouping of numerous unrelated children who each have complex needs and histories of abuse and trauma is a diabolical combination. This is confirmed by Case Examples 5, 6, 7 and 8.
321. The Salvation Army noted in its submission that 'the use of any system as the "option of last resort", inevitably leads to a devaluing of that system and poor outcomes for those using the system'.¹³¹
322. The VACCA commented in its submission that 'sadly, by the time a young person is placed in residential care, they can feel worthless and so let down by the system that is supposed to protect them... this can lead them to be easily exploited by both other young people and sexual predators'.¹³²
323. A large number of submissions received by the Commission spoke keenly about the need for urgent progression of quality, alternate home-based care that is well resourced and supported. The introduction of professionalised foster care was repeatedly called for within the sector. This is an initiative that the Commission agrees is needed.
324. MacKillop Family Services highlighted inadequate funding as a key issue that has, in its view, made it difficult for the operation of residential care that is safe for children. MacKillop Family Services cited inadequate staffing numbers, combined with the significant resourcing impost on training and backfilling staff as a key systemic issue that contributes to the effectiveness of the system to keep children safe from sexual harm.
325. The Victorian Equal Opportunity and Human Rights Commission emphasised the over-representation of children with a disability in the out-of-home care system in Victoria, particularly the elevated representation (23 per cent) of children with a disability in residential care.¹³³ Further, the greater vulnerability and higher rates of sexual abuse amongst children with disabilities was highlighted. These observations were confirmed during the file reviews undertaken by the Commission and highlighted the need for specialist responses and care options for children with disabilities.

326. The need for specialist services to cater for children with sexually abusive or problematic behaviours was captured in the Children's Protection Society's (CPS) submission. The CPS has worked with some CSOs over the last three years to deliver support and training to staff to improve consistency of care to children with sexually abusive behaviours.
327. Berry Street Victoria acknowledged in its submission the need for guidelines to be developed for preventing and responding to child-to-child abuse in residential care. It also called for improved placement matching and development of alternate placement options for children to minimise the risk of child-to-child abuse in residential care.¹³⁴

5.2.4 Interviews with staff: child-to-child sexual abuse

328. Inappropriate placement matching of children was considered a major risk factor by professionals in contributing to the prevalence of child-to-child sexual abuse in residential care. This was a resounding message from those working in the CSO sector and within the Department.
329. The majority of CSOs advised the Commission that there are major deficits in the quality and detail of information provided during a placement referral to allow an informed decision about the appropriateness of a placement. Referrals are often crisis driven and require fast decisions.
330. The Commission was shown a number of placement referrals by CSOs and agreed that the level of information provided, often for a child who had been in the out-of-home care system for many years, was lacking sufficient detail to be able to understand the particular needs of the child concerned.
331. Section 179 of CYFA 2005 requires that when a child is placed in the care of a person other than their parent, that the Secretary, or an out-of-home care service:
- *must provide the carer with all information that is known to the Secretary or the service... that is reasonably necessary to assist the carer to make an informed decision as to whether or not to accept the care of the child.*

131 Salvation Army submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccpv.vic.gov.au.

132 Victorian Aboriginal Child Care Agency submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccpv.vic.gov.au.

133 Victorian Equal Opportunity and Human Rights Commission submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccpv.vic.gov.au.

134 Berry Street Victoria submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccpv.vic.gov.au.

5. File reviews, staff interviews and sector submissions

332. Disturbingly, the Commission was advised by a number of CSOs of instances when they believe that information about a child was deliberately not provided by the Department. Examples included:

- a child with known fire-lighting behaviours
- a child with a significant intellectual disability
- a child who was known by the Department to have experienced significant sexual abuse in a previous foster care placement
- a child who had sexually abusive behaviours.

'Placements are financial decisions, not about what is best for a child.'

Source: Child Protection Operations Manager.

'It's about bums in beds.'

Source: CSO Residential Care Manager.

'Kids are moved with little notice, there is scant regard for appropriate matching.'

Source: CSO Residential Care Manager.

'We end up doing internal shuffling. There aren't enough beds, it's an absolute debacle. We are constantly being pushed. If a kid is in secure welfare, we'll be asked to use their bed for another kid.'

Source: CSO Residential Care Manager, March 2015.

333. All CSOs discussed the great pressure they experience on a daily basis from the Department to accept a placement referral. Some CSOs advised that they have been 'forced' to accept a child, even when they have had concerns about the suitability of the placement mix of children in a particular residential care unit. The Commission was advised that there is a lot of pressured discussion, with conversations regularly being escalated to a senior manager/CEO level between the CSO and the Department.

334. A number of experienced CSO staff also voiced their concerns about the risk of child-to-child sexual abuse occurring as a result of vulnerable groups of children being placed together in residential care, particularly very young children and children with intellectual disabilities or learning difficulties.

335. Some CSOs advised that, if another child in the residential care unit was absent from the placement for an extended period (for example, being placed in a secure welfare service), it was expected that they would use that child's bed for another child. This was confirmed by some Departmental staff who acknowledged such practices exist regularly.

'Often beds are closed within 24 hours of [the child] being absent from it. Often they are coming out of secure welfare with no suitable placement identified.'

Source: Senior Manager, DHHS.

336. CSOs spoke of pressure being exerted by the Department to 'meet targets' or face the threat of budget cuts if a placement was not accepted. These situations resulted in a child being accepted on the proviso of additional funding from the Department for a temporary additional staff member or access to specialist support services.

337. A senior Departmental staff member advised the Commission that often when funding is provided for the provision of an additional staff member to the CSO, those resources are taken away from funds allocated for the child's clothing, dental or optical requirements.

338. A CSO advised the Commission that they have recently developed their own additional process at placement referral. They have devised a referral document that the Department must complete before the CSO will consider the placement referral. Senior staff from the CSO advised the Commission that they have instigated this additional step to gather the information they require to make an assessment about the level of risk in accepting the referral and also as a protective mechanism for the organisation for the future if the child comes back to the organisation and questions why they were placed in a potentially abusive or unsafe situation.

339. The Commission consulted staff in the sector about the failure to utilise the LAC record for children. There was widespread acknowledgement that LAC is not adequately maintained or used. CSOs spoke of role confusion around updating the record and Departmental staff agreed it was an area that is not monitored or enforced.

340. The disparity in the skill set of staff about the complex needs of children, many of whom have sexually abusive or problematic behaviours, was a common area of concern for professionals in the sector. Many Departmental staff were critical of the ability of the unqualified, poorly trained and unsupported group of direct-care staff to provide specialist care for this cohort of children. Similarly, CSO staff spoke of frustrations in being able to access specialist training for their direct-care staff to meet the needs of children with complex behaviours. There was a strong call for improved minimum qualifications for direct-care staff.
341. The ratio of staff to children in the residential care unit was another key issue that many staff felt contributed to the prevalence of child-to-child sexual abuse. Most professionals from both CSOs and the Department favoured a model of group care that does not exceed two children, with the exception of sibling placements. Additionally, the Commission was repeatedly told of the difficulties in having only one staff member rostered overnight in being able to adequately supervise four children, each of whom have their own complex needs. This staffing inadequacy was highlighted in the file reviews and site visits.
342. The lack of any consistent framework to respond to child-to-child sexual abuse was an issue that clearly frustrated many staff interviewed by the Commission. A Departmental senior staff member working in a role within service improvement advised that child-to-child abuse was:
- *not our space... we see enough of it and realise it's an issue, we need to strengthen this area. It should be a quality of care issue and we need a framework with consistent principles.*
343. Responses to incidents of child-to-child sexual abuse varied. Some CSO and Departmental staff who were interviewed spoke of practices whereby the child who behaved in a sexually abusive manner would be moved to another placement. Others advised that the child who had been victimised might be moved, while others conceded that sometimes the children would remain in placement together. What is clear to the Commission is that the children were unsafe and the current system is unsustainable.

5.2.5 Findings: child-to-child sexual abuse

344. Recent research from the Royal Commission¹³⁵ indicates a number of key practices that prevent the risk of child-to-child sexual abuse in out-of-home care:
- Provision of adequate information to caregivers at the time of placement regarding the relevant history and needs of sexually abused and/or sexually abusive children.
 - Strong consideration of the appropriateness of specific placements prior to placement.
 - The need for plans to maintain the safety of other children in the out-of-home care institution.
 - Specifically articulated and well-executed procedures for the supervision of sexually abusive and sexually 'acting out' children.
 - Formal, effective therapeutic treatment for children that addresses their sexually abusive and/or sexually 'acting out' behaviour.
345. The Commission did not find evidence that such preventative strategies are consistently practiced in residential care in Victoria.
346. In each of the cases of child-to-child sexual abuse that the Commission reviewed closely, common themes were evident with regard to the systemic failures in both preventing and responding to incidents of this form of sexual abuse.
347. The Commission noted that incident reports were received for children as young as seven, highlighting the need for comprehensive, expert sexual health and relationships education for children in residential care at an early age.
348. It was evident from the broader data alone that the frequency of child-to-child sexual harm in residential care is occurring at an alarming rate. In 12 months, the Commission was provided with reports pertaining to 87 children being subject to child-to-child sexual abuse in residential care. As can be seen from Case Examples 5, 6, 7 and 8, the sexual abuse that occurred in each of these cases is extremely serious and relates to very young, vulnerable and often already traumatised children.

¹³⁵ Sandra South, Aron Shlonsky and Robyn Mildon, *Scoping Review: Evaluations of out-of-home care practice elements that aim to prevent child sexual abuse* (Sydney: Royal Commission into Institutional Responses to Child Sexual Abuse, 2015).

5. File reviews, staff interviews and sector submissions

349. The file reviews also revealed that children with a disability were strongly represented in the group of children who experienced child-to-child sexual abuse in residential care. There is a dearth of adequate placement options for this group of children.

350. Contributing factors to the occurrence of child-to-child sexual abuse appeared to be:

- Poor decision-making practices in placing certain children together.
 - Failure by CSOs and the Department to comply with the LAC framework requirements. Most children's client files were missing significant information about their health, wellbeing and care requirements. Reliable and accurate information about children's individual needs is required to provide for their basic care and protection.
 - Poor quality of information at the placement referral stage. Many placement referrals contained scant and limited information. Most CSOs advised the Commission that placement referral information lacks the level of detail they needed to make an informed decision about the suitability of a referral and how best they could meet the needs of a child coming into a new placement. Some CSOs advised the Commission that significant information relating to a child's background and behaviours was omitted from the referral, even though later it became evident that the department had knowledge of that information at the time of the referral.
 - Failure by decision makers to heed the advice and assessment of risk by child protection staff. This was observed in a number of cases where the likelihood of sexual abuse and emotional harm had been predicted and then occurred.
 - Lack of independent oversight and legislative provisions to guide and support the decision making process for placing children.
 - The heightened vulnerability of certain cohorts of children, particularly the very young and those children with intellectual disabilities.
- The lack of formalised assessment of placement impact on all of the children affected by the placement decision.
 - The lack of any suitable alternate options for placement and the practice of prioritising bed availability over the safety and protection of the child.
 - Inadequate supervision of the children in the residential unit by direct-care staff.
 - The physical layout of the residential care units. Many are not purpose built to facilitate close supervision of the children while still maintaining a home-like environment.
 - The disempowerment of children residing in residential care. This is a result of the abject living conditions and the absence of opportunity for their voices to be heard through any consistent feedback system, independent oversight or independent complaints body.
 - The apparent low skill base and lack of qualifications of many direct-care staff. This leads to an inability to identify and respond in a therapeutic manner to children who exhibit problematic sexual behaviours. This was especially evident during interviews, with a number of CSO staff using derogative language such as describing some children as 'perps'.
 - Inadequate staff to child ratios. All the residential care units visited by the Commission had only one staff member rostered on overnight.
 - The absence of a specialist practitioner within each residential care unit to work closely with children exhibiting problematic sexual behaviours.

351. It was clearly evident that there are inadequate frameworks and systems in place to respond to child-to-child sexual abuse in residential care.

352. The Department's present QoC system precludes child-to-child sexual abuse occurrences as within scope. Clearly this is a major deficit in the service system response and one that was acknowledged by most of the professionals interviewed as requiring reform.

353. The Commission was most concerned to find a number of children are not given adequate care and support following their experience of sexual abuse in state care. There is a lack of recognition of the incident itself, poor follow through with counselling support for the children involved and an absence of redress and compensation for the affected child.
354. In many cases, it was apparent that the child was too traumatised to accept a referral for counselling immediately following the incident.
355. There did not appear to be robust attention to following up with counselling at a later date, nor did there appear to be creative or flexible approaches to engaging the child with counselling.
356. The urgent need for this review is apparent given the numerous examples of poor placement matching of children and the large number of children who are reported to experience child-to-child sexual abuse in residential care.
357. Recommendations have therefore been made to redevelop the current system of residential care as the present model creates an environment where child-to-child sexual abuse appears to be dangerous and persistent.
358. The need to improve the skill level and qualifications of direct-care staff has been recommended in previous Victorian inquiries. This continues to be an issue that remains unaddressed by government. This Inquiry recommends minimum qualifications for residential care staff with the necessary skills and capabilities to care for traumatised children.
359. It is imperative that QoC investigations be expanded to include child-to-child abuse. This Inquiry also recommends independent investigation of abuse in care. Numerous examples before the Commission indicate that the children's best interests have not been served by the current system and that the Department's own guidelines have not been followed.
360. Specialist models of care must be developed to cater for the individual needs of children. The Commission considers that there is a great need for specialist home-based care options that are adequately resourced and supported to avoid the need for children to be placed in group care. Investment in a professionalised model of foster care is long overdue.
361. It is acknowledged that, for a small number of children, specialist group care may be required for short periods to allow for intensive treatment with specific time-limited care plans. Once stabilised these children can then be transitioned into an appropriate home-based care option with the services following them. This Inquiry recommends the development of a suite of specialised services to cater for the needs of:
- Aboriginal children
 - sibling groups
 - children with a disability
 - children who have been or are at risk of sexual exploitation
 - children with identified sexually abusive or problematic behaviours
 - pregnant girls and young parents.
362. The Commission considers that residential care of children should not exceed two children per placement, except in the case of sibling groups, where it is safe to do so.

5. File reviews, staff interviews and sector submissions

5.3 Staff-to-child sexual abuse in residential care

363. CIRs where staff-to-child sexual abuse was identified were fewer in number than reports received for child-to-child sexual abuse or sexual abuse by an external predator. Nine reports were received by the Commission, representing three per cent of all of the reports of sexual abuse in residential care.
364. The CIRs of sexual abuse by staff were serious in nature and related to alleged indecent sexual assault and rape.¹³⁶ These nine reports related to children residing in residential care units managed by five different CSOs.
365. The Commission has not relied on this data as an indication of the extent of the problem of staff-to-child sexual abuse due to known limitations in the quality and integrity of the data, inconsistency in reporting, the known research on delays of disclosure and inability of institutions and individuals to identify abused children.
366. Nonetheless, these reports have provided the Commission with valuable insight into the way in which the systems responded to children when they have had the courage to disclose sexual abuse by a staff member.

5.3.1 File reviews: examples of staff-to-child sexual abuse of children in residential care

367. The Commission noted varying practices in completion of QoC reviews. The Department requires completion of a QoC review within 21 days. This was not observed in the examples the Commission reviewed. Additionally, there were delays in many investigations being entered onto the child's CRIS file after the alleged incident, sometimes of several months.
368. In the course of undertaking detailed file reviews of 32 children, the Commission was disturbed to discover three examples of poor practice relating to staff-to-child sexual abuse.
369. In the first example, an instance of staff-to-child sexual abuse did not appear to have been investigated by the Department, nor did it appear that the CSO took any further action other than advising the Department of the child's disclosure.¹³⁷
370. In the second example, the Commission noted a poor and inadequate response to a young person who disclosed abuse by her direct-care workers in her residential care unit.¹³⁸
371. In the third example, where a QoC investigation was substantiated, the young person received inadequate support and care following her experience of being sexually abused by a direct-care residential worker and the subsequent QoC process.¹³⁹

¹³⁶ See Figure 3.

¹³⁷ Refer to Case Example 9.

¹³⁸ Refer to Case Example 10.

¹³⁹ Refer to Case Example 11.

17 YR OLD ABORIGINAL GIRL REPORTS BEING ABUSED BY WORKER

CASE EXAMPLE 9:

17-YEAR-OLD ABORIGINAL GIRL REPORTS BEING ABUSED BY WORKER

A 17-year-old Aboriginal girl had been a child protection client since infancy and was noted to have experienced 19 different placements: 10 home-based, three secure welfare admissions and six different residential care placements. The girl's case was contracted to a CSO to provide intensive case management due to her high-risk behaviours, including multiple drug use, alcohol use and high risk of sexual exploitation. She was subject to a Guardianship to the Secretary Order.

The girl was absent from her residential care placement on frequent occasions, often later returning significantly affected by drugs and alcohol. Used condoms were found in her bathroom and she was noted by residential staff to leave the unit with a bottle of perfume and revealing clothing in her bag. The girl made disclosures to residential care staff that men she met external to the residential unit had raped her numerous times. She also disclosed to the residential care staff that she exchanged sex for money and alcohol.

A case note on the girl's file indicates that she made a disclosure to her caseworker. The case note observes that a male worker at her residential care unit 'made her feel uncomfortable' and she disclosed that she had observed this worker to have an erection on an occasion when she was alone with him in her residential care unit.¹⁴⁰

The child protection file indicated that two days after the disclosure the CSO manager telephoned the senior Department caseworker to advise of the girls' disclosure about the male worker. Other than a case note recording this conversation, there are no further file notes about the incident. There was no CIR, there were no file notes to indicate the matter was referred to police, there was no indication that the relevant Aboriginal Child Care Agency was consulted (as required) or that the girl was supported in any way. There is no indication that the Department instigated a QoC investigation.

As a result of this discovery, the Commission alerted the Department to the circumstances of this case and requested that a review occur. A Department Child Protection Manager acknowledged to the Commission that no action was taken because of 'human error'.¹⁴¹

The Commission remains unclear as to whether the allegations were investigated, whether the young person received any support and whether the male worker is still employed caring for vulnerable children.

¹⁴⁰ Information quoted directly from the young person's DHHS CRIS child protection file.

¹⁴¹ Direct quote from DHHS Child Protection Manager during interview, March 2015.

5. File reviews, staff interviews and sector submissions

INTELLECTUALLY DISABLED 15 YR OLD GIRL REPORTS BEING ABUSED BY WORKER

CASE EXAMPLE 10:

INTELLECTUALLY DISABLED 15-YEAR-OLD GIRL REPORTS BEING ABUSED BY WORKER

The Commission reviewed the child protection file of a 15-year-old girl who was placed in an unfunded contingency residential care unit because of an assessment that she could not be placed with other children. The girl's file indicated that she had a mild intellectual disability. The girl had been a child protection client since the age of four and was noted to have experienced prior physical abuse, sexual abuse and neglect that had led to the Department's involvement. She was placed in residential care on a Guardianship to the Secretary Order.

The girl's child protection file indicates that she would frequently go missing from her placement, that she would drink alcohol and was vulnerable to sexual exploitation and sexual assault by older men in the community. Staff observed that the girl had numerous text messages of a sexual nature from older, unknown men. The girl's child protection file contained many case notes where her text messages to her caseworkers were recorded. She would often disclose the serious nature of the sexual exploitation, rapes and assaults that were allegedly perpetrated on her by older men in the community. The Commission noted that the responses to these disclosures were prompt and involved joint police, Departmental and CSO action to support the girl.

However, in reviewing the girl's file the Commission was concerned to note a differential response to her disclosure of abuse allegedly perpetrated by a direct-care worker in her residential care unit. The response from the Department and the CSO staff involved was not child-focused, nor did it appear to follow procedural guidelines.

The girl disclosed to a CSO staff member that someone in her residential care unit entered her bedroom at night and got into her bed. The file note then states that she 'did not want it to happen... [that she] feels like dying by jumping in front of a train or car... somebody hurt me'. When asked by the worker, the girl said she '...knows who it was but doesn't want to get them into trouble'.¹⁴²

¹⁴² Direct quote from the girl's DHHS CRIS file.

The CSO staff member initiated a CIR about the disclosure and it was noted that the matter would be referred to the Department for a QoC review. The Commission was unable to ascertain the outcome of the QoC review as there was no record of this on the child protection file.

It was clear from the discussion between CSO and Departmental staff on the day of the girl's disclosure that the possibility of the incident having occurred was queried. 'It was discussed the possibility of this having occurred in [her] past and that she is disclosing this now.'¹⁴³

The response was not to offer any support to the girl, but to focus on the wellbeing of the staff by increasing levels at the residential care unit that day '...it has been suggested that having two active staff would be beneficial in safety planning for the night to protect staff at the unit. It was suggested that there be no male staff on'.¹⁴⁴

The girl's behaviour in the days following her disclosure was of concern. She was absent from her residential care unit placement for long periods. During that time, she made contact with her CSO worker indicating her distress at returning to the placement, clearly stating she was fearful of returning and that she was feeling suicidal.

A case note between CSO staff and another specialist worker documented 'it was discussed that [the worker] should respond to [the girl] by stating that [the worker] is unable to talk at this time due to tending to something else and that [the worker] will call [the girl] as soon as they can talk. This response should be enough to hold [the girl]'. The CSO worker then consulted with a manager at the CSO and it was agreed that 'there is no immediacy to [the worker] seeing [the girl] this afternoon'.

Two days after the girl's disclosure, staffing changes occurred at the residential care unit. Staff were spoken to 'about not placing themselves in a situation where they were one on one with [the girl] and that staff are not to enter her bedroom alone.'

A care team meeting was held shortly after the disclosures were made. The minutes of the care team's meeting note the CSO manager's concerns for 'the pressure on staff and their stress levels'.¹⁴⁵ The meeting record does not indicate that the girl's disclosures were regarded with any authenticity.

Three days after the disclosure, the CSO caseworker met with the girl to discuss the allegations. It is documented that the worker tells the girl 'the allegations she has made about staff are serious and [the worker] would like to support [the girl] but this is difficult when [the worker] does not have all of the information due to the text messages [the girl] has sent to [the worker] which are conflicting'.

It did not seem that the girl's disclosure was treated with any possibility of it having occurred. It would appear from the outset that a view was formed about the allegations and the ensuing responses reflected this.

A file note one week after the girl's disclosure makes passing reference that a Departmental QoC meeting occurred the previous day and the allegations were not substantiated. Fourteen months after the girl's disclosure, it was noted by the Commission that there was still no record on the child protection file of the QoC meeting.

The Commission raised this with Departmental staff, who advised that there was confusion about where responsibility lay within the Department to enter the QoC record on the client file and that there was also a backlog of over 12 months in entering QoC investigations on the client file.

¹⁴³ Direct quote from the girl's DHHS CRIS file; conversation between CSO manager and DHHS worker.

¹⁴⁴ Direct quote from the girl's DHHS CRIS file; conversation between CSO manager and CSO residential manager.

¹⁴⁵ Comment from the girl's care team meeting, noted on her DHHS CRIS file.

5. File reviews, staff interviews and sector submissions

16 YR

OLD GIRL REPORTS BEING ABUSED BY WORKER

CASE EXAMPLE 11:

16-YEAR-OLD GIRL REPORTS BEING ABUSED BY WORKER

A 16-year-old girl who was subject to a Custody to the Secretary Order and living in a residential care unit, disclosed to another direct-care residential worker that she felt uncomfortable around a male worker who had been caring for her. The girl stated that a direct-care worker had kissed her on the forehead on one occasion, had touched her thigh while she was in the car with him on another occasion and that she had seen the same worker kiss and grope another child in the residential care unit. The male worker also sent repeated text messages to the girl when he was not working.

A QoC investigation ensued and the allegations were substantiated, leading to the dismissal of the staff member. During the QoC investigation, the Department found that the worker, who was employed by a labour-hire agency, had a string of previous concerning work practices noted by other CSOs. These included 'lewd' behaviour while working in a Secure Welfare Unit and strong circumstantial evidence by another employer about misappropriating items during his employment. This information was not shared or communicated between employers. This highlights the need for improvements to the carer's register to ensure that such vital information is not lost.

In reviewing the girl's file following her disclosures of sexual abuse by a staff member, there appeared to be no efforts by the CSO staff or the Department to support her, reassure her or re-evaluate her safety. It is not clear whether she was advised that there would be a QoC investigation, nor was it clear that the result of the investigation was ever communicated with her.

When asked, Departmental staff who conducted the QoC investigation advised the Commission that the girl was not provided with formal recognition of her experience of abuse in care, nor was she given any advice about her legal rights to seek compensation.

5.3.2 Submissions: staff-to-child sexual abuse in residential care

372. Responses received from submissions to the Inquiry largely focused on the perpetrator of sexual abuse occurring from predatory persons external to the residential care unit or by other children within the residential care unit, rather than staff-to-child sexual abuse.¹⁴⁶
373. Of concern to the Commission was the general lack of attention in the written submissions from the residential care sector towards improving responses and efforts to prevent the risk of sexual abuse perpetrated by staff members on children. This would seem to indicate that the risk of this form of sexual abuse is not forefront on the agenda for CSOs or for the Department.
374. In its submission, the VACCA noted that 'there is insufficient investment in staff training that regularly looks at these issues and in program guidelines that should guide all residential care'.¹⁴⁷
375. The Commission notes the caution advised by the National Crime Agency, UK, that found the historic nature of many cases reaching media attention, together with developments in safeguarding, might give a false perception that institutional sexual offending can no longer occur. Offenders will continue to exploit systemic vulnerabilities where they exist.¹⁴⁸
376. The Centres Against Sexual Assault identified in its submission that for some children who have experienced sexual abuse by a staff member the response can be:
- *the child's disclosure is heard, but at best the perpetrator (if a staff member) is stood down temporarily but the agency rallies around the staff member to protect and support them.*¹⁴⁹

5.3.3 Interviews with staff: staff-to-child sexual abuse

377. During consultations with professionals in the sector, the Commission asked what initiatives are being undertaken to combat the risk of staff-to-child sexual abuse in care. The overwhelming response received was that this was not their role and not their responsibility. One CSO residential care manager notably commented:
- *It's [staff sexual abuse of a child] never happened so I haven't had to worry about it.*
378. A number of Departmental staff interviewed by the Commission indicated that they did not consider initiatives to prevent staff-to-child sexual abuse in residential care to be within the remit of their role; rather they saw it as the sole responsibility of the CSOs. The Commission considers that this view is inconsistent with the National Framework for Protecting Australia's Children that:
- *protecting children is everyone's responsibility.*¹⁵⁰
379. Many responses from those interviewed focused on rigorous front-end recruitment and screening at the time of employment, rather than ongoing practices of vigilance.
380. All CSO managers discussed the use of criminal records checks, referee checks and Working with Children checks as standard procedures for engagement of direct-care residential staff.
381. Most CSOs also discussed induction and orientation requirements, including the use of 'shadow shifts' in the early stages of appointing a new employee.
382. The Commission found, however, that the level of ongoing scrutiny and attention to potentially sexually abusive behaviour by staff to children appeared to diminish following pre-employment screening checks.

¹⁴⁶ Submissions to the Inquiry can be viewed at www.ccp.vic.gov.au.

¹⁴⁷ Victorian Aboriginal Child Care Agency submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccp.vic.gov.au.

¹⁴⁸ National Crime Agency, *CEOP Thematic Assessment*.

¹⁴⁹ Centres Against Sexual Assault Victoria submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccp.vic.gov.au.

¹⁵⁰ Commonwealth of Australia, *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020* (Commonwealth of Australia, 2009).

5. File reviews, staff interviews and sector submissions

383. In the former Child Safety Commissioner's *A Guide for Creating a Child-Safe Organisation*, emphasis is placed on the need for organisations to continually monitor and regularly review practices in order to reduce opportunities for abuse and to provide regular staff supervision, support and training.¹⁵¹
384. Many direct-care residential staff interviewed by the Commission advised that they do not receive regular supervision or the opportunity to debrief with a manager from their CSO. The Commission considers the adherence to required standards and procedures or oversight of the quality of the service provided to vulnerable children is placed at risk when staff supervision, support and debriefing is not regularly provided. It does not provide for reflective practice and ongoing experiential learning.
385. In one example, a direct-care residential staff member advised the Commission that in the four years he had been employed by the CSO, he had only received supervision on three to four occasions. Staff at another residential unit advised that they had not received supervision for more than six months.
386. The Commission asked direct-care residential staff about their knowledge of the procedures or policies for reporting staff misconduct and whether this was an aspect discussed in their orientation and training. In particular, they were asked if they could recall any training to identify possible sexual grooming behaviours by other staff members. Most staff were unsure about such procedures and could not recall specific training that focused on staff-to-child sexual abuse. They were clear, however, that they would have no hesitation in reporting such concerns if they were evident. The Commission found that training and awareness in this area is deficient.

5.3.4 Findings: staff-to-child sexual abuse

387. The Commission found that there was a pervading view that the risk of staff-to-child sexual abuse in residential care has been ameliorated by improved pre-employment screening. Submissions barely addressed this form of sexual abuse of children in residential care and many professionals interviewed acknowledged the lack of strategies in place to be proactive in the prevention of staff-to-child sexual abuse, other than initial pre-employment screening.
388. Ongoing vigilance and monitoring of staff interaction with children appears minimal. There are no adequate structures in place to deal with this. There is a lack of ongoing training for direct-care staff about the detection of grooming behaviours and there are no overt policies that promote a culture of speaking up about breaches of any behaviour in the workplace. Coupled with an environment that is often punitive and harsh in its care of children, this provides offenders with the opportunity to exploit systemic vulnerabilities.
389. The present carers' register creates additional vulnerability in the system. Offenders can move without detection across different vulnerable groups, such as caring for children in residential care, people with an intellectual disability or the elderly. Anecdotal evidence provided during sector consultations raised concern that offenders can exploit these systemic weaknesses and move around the sectors freely, particularly through labour-hire agencies.
390. Ratios of staff to children in residential care are inadequate. One staff member overnight is not considered best practice and creates opportunity for abuse to occur undetected.
391. Lack of independence to the QoC processes was a clear concern for the Commission. Presently the funder (the Department) and service provider (CSOs) are the only bodies involved in the investigation of allegations of staff-to-child sexual abuse. This appears to be a conflict of interest.

¹⁵¹ Child Safety Commissioner, *A Guide for Creating a Child-safe Organisation* (Melbourne: Child Safety Commissioner, 2006).

392. The Commission found examples of incomplete QoC investigations, poor or no follow-up with the child concerned and lack of documentation about the process and outcome in numerous examples.
393. Children in residential care are vulnerable to sexual abuse. They have nowhere to make a complaint at present that offers independence. This is an urgent need that requires resolution. Other inquiries¹⁵² have come to similar conclusions.
394. Where children have made disclosures of sexual abuse by a staff member, the Commission found poor systemic responses. Pre-emptive assessments that appeared to influence the investigation were apparent and children did not seem to be believed. There is a strong need for a complaints body where children will feel confident to speak and confident in the integrity of the independence of the authority to conduct the investigation.
395. File reviews indicated that where sexual abuse in care was substantiated, there was poor follow-up and poor care offered to the children. Validation of their experience was not apparent, communication with the child was poor, counselling was not readily offered, they were not provided with an opportunity to obtain legal advice redress and compensation was not offered.
396. The Commission notes that in Queensland there is a prescribed policy that children who have been sexually abused in out-of-home care receive official acknowledgement of the abuse suffered and resulting harm. Additionally, they are assisted to access legal advice to be advised of their rights in pursuing legal remedy or compensation. Such a practice does not presently exist in Victoria.
397. This Inquiry has made recommendations to address the systemic flaws that presently exist where the opportunity for risk of staff-to-child sexual abuse in residential care is facilitated.
398. There is an urgent need for improvements to the practices and environment within residential care to ensure that children are not subject to intrusive and restrictive practices. Greater independence is recommended on a number of levels. There should be an expansion of the Commission's Independent Visitor Program to every residential care unit. The development of an independent complaints body for children and the delegation of QoC investigations to an independent body are essential. An integrated vulnerable person's carer register is recommended to ensure the safety of vulnerable children in residential care and, more broadly, all vulnerable people.

¹⁵² Ombudsman Victoria, *Own motion investigation into Child Protection – Out-of-Home Care*; Victorian Auditor-General's Office Residential Care Services for Children 2014.

6. Site visits to residential care units

399. The Commission visited 21 residential care units in metropolitan Melbourne and rural Victoria during February and March of 2015. Six units were funded as therapeutic units, 12 were funded as standard model units and three were unfunded (contingency) placements.

400. The units visited by the Commission were those where some of the children who were subject to alleged sexual abuse CIRs were living at the time the report was made.

6.1 Departmental standards for provision of residential care

'The philosophies, practices and organisational structures of the CSOs delivering residential care services will affect the standard of care children receive.'

Source: DHHS program requirements for residential care services in Victoria, 2014.

401. The physical environment of care offered to traumatised children has a profound impact on their wellbeing. A warm, appealing environment that offers safety and protection is likely to provide a reparative setting for healing, for children who have experienced trauma, abuse or neglect.

402. The Department's standards for provision of residential care include statements that:¹⁵³

- *Services of the highest quality are required to provide children with their safety, stability and healthy development.*
- *CSOs must ensure wherever possible, a home-like environment is created to ensure children receive nurturing and a positive care experience. The physical environment where a child resides and the material goods they are provided with have a significant impact on their physical, emotional and psychological development and wellbeing.*
- *The physical living environment will reflect community expectations of a 'home'. It will be a place where children feel safe and supported. Children should not be placed at risk of harm due to the physical environment in which they reside.*

403. If these standards and residential care guidelines were appropriately applied in practice by the CSOs, in accordance with funding and contractual obligations, and the Department effectively monitored the residential care units for compliance, then it is likely that the Department's stated objectives of providing high-quality care for children would be achieved.

404. Based on the interviews conducted with CSO and Departmental staff, the site visits undertaken and feedback from current and former residents, the Commission concluded that these guidelines are not always followed by CSOs. The Commission found that the Department does not adequately monitor or enforce compliance with the required practice standards.

¹⁵³ DHHS program requirements for residential care services in Victoria.

6.2 Absent children

405. During site visits, the Commission was troubled to learn that many children were absent from their residential care placement without staff having knowledge of their whereabouts. On numerous occasions the Commission was advised that the children were not attending school or any day program and that the children were simply 'out and about'.
406. In one notable example, when visiting the residential care unit of a 17-year-old boy with an intellectual disability, residential care staff advised the Commission that the boy had been missing for over a week, that they were not sure where he was but suspected he was with 'undesirable' people. The staff had not taken any proactive action to locate the boy, other than informing the Department. It was unclear if a missing person's report had been filed with the police, whether a search warrant had been obtained from the Children's Court, or whether his parents/legal guardian had been advised of him being missing. In discussing the boy's circumstances, the staff seemed resigned to him being absent from his placement and commented that he would turn 18 in three months, at which time the placement would close anyway. The staff did not seem sure about his leaving care plans; however, it was evident that they were not providing any skill development or life skills to him in terms of future independent living.

'Kids tell us "it's shit"... they talk about not being allowed to have friends over, they have nowhere to hang out with their friends so they head into the city. They generally don't like the other kids they are in placement with. They have no connection with placement.'

Source: DHHS senior manager.

6. Site visits to residential care units

6.3 State of disrepair

407. The home environment of some residential care units visited by the Commission was deplorable, they were stark and derelict and some punitive practices were observed. Such environments do not reflect community expectations of a 'home', nor do they create an atmosphere where children feel safe and supported. There seems little incentive for children to stay.

408. Such factors are likely to contribute to children being absent from the residential care unit. Absence from the residential care unit facilitates the risk of sexual abuse occurring, as children may place themselves in unsafe situations where they are at risk of sexual exploitation.

409. It was difficult to understand how the Department, in its role **as a good parent**, could allow children in its legal care to be cared for in such circumstances.

410. During the site visits the Commission observed:

- significant and unrepaired property damage, including broken windows (both an eyesore and a risk)
- widespread graffiti in bedrooms and living areas and on external walls (visible from the street)
- heavy mesh grills on external windows
- properties devoid of personal touches (for example, photographs, wall art)
- stark interiors with minimal furnishings and bare walls
- unacceptably poor standards of hygiene and cleanliness in bedrooms
- minimal bedding and bare, stained mattresses
- decaying food in bedrooms
- chaotic and disorganised bedrooms
- violent and sexually explicit video games in bedrooms
- cigarette butts and strong odours of cigarette smoke in bedrooms
- a makeshift child's bedroom in a lounge room that did not provide adequate privacy for the child
- two children's bedrooms that had surveillance cameras installed
- dirty showering and bathing areas
- towels and linen stored in locked cupboards inaccessible to children
- locks on kitchen cupboards, drawers and pantries to prevent children accessing food
- food stored in fridges that were placed in areas inaccessible to the children, such as in staff offices
- games rooms and art supplies locked and inaccessible to children
- the capacity to disconnect electricity to some children's individual bedrooms at night as a method of behaviour management
- staff offices sectioned away from the living areas with observation windows
- strong odours of cigarette smoke in staff offices.

'Put it this way, I wouldn't want my kids to live in residential care.'

Source: Senior Residential Care Manager of a CSO.

Photograph 2: Child's bedroom in a residential care unit



Source: Photograph taken by the Commission, March 2015.

The Department's *Program requirements for residential care services in Victoria* states: 'Each child will be provided with their own bed and linen'.

Photograph 3: Boy's bedroom in a residential care unit with a sexually explicit and violent R-rated video game and packets of cigarette paper visible



Source: Photograph taken by the Commission, March 2015.

411. During site visits to residential units, the Commission was greatly troubled by the general detention-like atmosphere and the state of disrepair and neglect in some of the residential care units visited. This disrepair and neglect was evident in both types of residential care units – those funded for TRC and those that received standard funding.
412. Of the 21 residential care units visited by the Commission, only three were considered to provide an acceptable and home-like environment. The remaining 18 units could best be described as unsuitable for children to reside in. Some of the staff in the extremely damaged properties appeared exhausted and overwhelmed by the neglectful physical environment. They commented that getting repairs done in a timely way was a difficult and onerous task.
413. The Commission heard from many different CSOs that spoke of experiencing lengthy delays in the Department responding to requests for maintenance and repairs at residential care units. Some CSOs expressed frustration that they were required to justify certain repairs and that the expectation seemed to be that the direct-care staff had to plaster and repaint walls.
414. The Commission visited a property that had extensive graffiti on the internal walls. The staff working at the property reported that the property had been in that state for over 12 months. Direct-care staff advised that they had placed numerous requests for the graffiti to be cleaned, but the Department was not responsive. The CSO staff advised that Departmental staff rarely visited the property, where a child subject to a Guardianship order was placed.
415. Departmental residential care guidelines require that residential care premises must be kept in good repair, that damage is rectified immediately and that children will reside in reasonably clean, hygienic and appropriately furnished premises that meet community standards.¹⁵⁴
416. The Commission was most concerned to note that these guidelines are not adhered to by some CSOs. What was significantly highlighted by the site visits to the residential care units is that although the Department is legally required to monitor that CSOs comply with practice standards and provide services in a manner that is in the best interests of every child residing in their unit, it often fails to do so.

¹⁵⁴ Department of Human Services, *Program requirements for the delivery of therapeutic residential care in Victoria (A reference guide for organisations submitting proposals for delivery of the therapeutic outcomes focused residential care and support service)* (Melbourne: Department of Human Services, 2012).

6. Site visits to residential care units

Photograph 4: Damaged wall of a young boy's bedroom



Source: Photograph taken by the Commission, March 2015.

417. The piece of plywood in photograph 4 was an attempt to 'repair' part of the damaged wall. In 2014–15 this residential care unit was funded by the department at \$942,459 per annum.

'It's about what kids get when they arrive in resi care. Usually they arrive to a bedroom that's been graffitied all over. Let's step up with the kind of care and support a reasonable parent would provide.'

Source: Senior Manager, DHHS.

Photograph 5: Boy's bedroom in a residential care unit



Source: Photograph taken by the Commission, March 2015.

418. Photograph 5 shows cigarette butts, graffiti and profanity on a young boy's bedside drawers.

'It's completely feral . . . you wouldn't leave your dog there.'

Source: Senior DHHS Manager, discussing a particular residential care unit in metropolitan Melbourne.

Photograph 6: Children's shower in a residential care unit



Source: Photograph taken by the Commission, February 2015.

The Department's *Program requirements for residential care services in Victoria* states: Children will reside in 'reasonably clean' and hygienic premises.

Photograph 7: Cupboard in a child's bedroom in a residential care unit



Source: Photograph taken by the Commission, February 2015.

The Department's *Program requirements for residential care services in Victoria* states: The premises will be kept in 'good repair'... any property damage... will be rectified immediately.

419. Photograph 7 shows graffiti on the walls of a cupboard in a bedroom. The residential care unit shown in this photograph was funded by the Department in 2014–15 at \$1,078,690 per annum for one resident (child in one-on-one care). CSO staff advised the Commission that the graffiti (that was not caused by the child living there) had been in the residential care unit for over 12 months.

6. Site visits to residential care units

Photograph 8: Makeshift bedroom in the lounge room of a residential care unit



Source: Photograph taken by the Commission, February 2015.

The Department's *Program requirements for residential care services in Victoria* states: Each child will be provided with accommodation that reflects their need for privacy and space.

420. The makeshift bedroom shown in photograph 8 used an office partition and pieces of fabric to make a 'bedroom' for a young girl. In 2014–15 this unit was funded by the department at \$819,960 per annum.

Photograph 9: Living area of a residential care unit for Aboriginal children



Source: Photograph taken by the Commission, March 2015.

421. Photograph 9 shows a rare example of a home-like environment encountered by the Commission.

6.4 Therapeutic residential care units

Question: What makes this residential care unit therapeutic?

'Nothing really, it's a joke. We get funded a bit more, that's it.'

Source: Response provided to the Commission by a direct-care residential worker, March 2015.

422. The Commission visited six residential care units that were funded by the department for TRC. The focus of a TRC is on intensive therapeutic care. The model is intended to provide highly trained and skilled carers who can provide trauma informed responses to children with vulnerable and complex needs and behaviours.
423. A number of the TRC units that the Commission visited did not appear to meet the basic standards set by the Department in their practice guide *Program requirements for the delivery of therapeutic residential care in Victoria*.¹⁵³ In fact, these highly-funded residential care units did not meet the basic program standards for the standard funding of residential care units.
424. Significant deficits in the physical environment of some TRC-funded properties were noted. The internal environment in some units was not considered 'home-like', there was significant and unrepaired damage, furnishings were shabby, children's bedrooms were untidy and unhygienic, and food and essential items were locked away in separate areas inaccessible to the children.
425. The look and feel of most of the TRC properties the Commission visited was hostile, bland and institutional. The environments were generally unacceptable and contrary to the very essence of what is expected of a therapeutic model of care.
426. In two TRC-funded residential units visited by the Commission, the staff advised that they provide food to the children from a charitable organisation that collects and redistributes food for people in need. Such surplus food was donated from restaurants, supermarkets and markets to support the homeless, people in crisis and asylum seekers. Both of these residential units had capacity to accommodate four children and each were funded by the Department at over \$1 million per unit for 2014–15. It was not clear to the Commission why food for the children was being obtained from a charitable organisation.
427. Direct-care residential staff working in units with TRC funding are required to undergo 'With Care: Foundations of Therapeutic Care' training, a two-day workshop provided by the Centre for Excellence in Child and Family Welfare,¹⁵⁴ developed and delivered in partnership by Berry Street, Take Two and The Salvation Army Westcare. Until 2013, an additional three-day workshop, 'With Care: Building Practice', was provided for residential direct-care staff who had completed the foundation course. However, the Commission understands that this additional training has not been offered in the last two years.
428. In 2014–15, 10 four-day 'Orientation to therapeutic care' workshops were scheduled for direct-care residential staff working for CSO's that were recipients of TRC funding.
429. Despite these additional training requirements, the Commission was advised by a number of direct-care residential staff employed by CSOs in TRC funded residential care units, that they had not undergone any additional training.
430. This would seem to be contrary to the Department's own guidelines that require:
- *carers working in a therapeutic residential care unit must undergo mandatory staff training in trauma and the theory and practice of working therapeutically.*¹⁵⁵
431. Departmental guidelines state that TRC staff must be specially selected through a documented process that possibly includes psychological assessment. Further, the Department's guidelines recommend that:
- *every effort should be made to minimise the use of relief staff, particularly agency labour-hire staff.*¹⁵⁶

155 Ibid.

156 The Centre for Excellence is the peak body for child and family welfare in Victoria.

157 DHHS Program requirements for residential care services in Victoria, Interim revised edition April 2014.

158 DHHS, *Program requirements for the delivery of therapeutic residential care in Victoria*.

6. Site visits to residential care units

432. The Inquiry found, however, that many labour-hire staff were employed at TRC funded units that the Commission visited.
433. One CSO staff member employed in a TRC-funded residential care unit advised he was a former manual worker and had no formal qualifications for his role other than 'life experience'. In another unit, the direct-care staff advised that they had not been provided with any additional training to equip them to work in an enhanced way. They had not been offered the 'With Care' training, nor had they been provided with any specialised workshops.
434. Departmental guidelines specify that TRC staff must be:
- *Specially selected through a documented selection process... possibly including psychological assessment.*
435. The Commission visited a number of residential units that had retained existing staffing structures prior to becoming funded for provision of TRC. It was not apparent from interviewing the CSO staff that there had been selective recruitment of the direct-care staff in many of these TRC funded units. This led the Commission to question the Department's level of oversight and quality assurance in monitoring the implementation of TRC.
436. The Commission is concerned that 'therapeutic care' lacks sufficient rigour in its application. There was, in some cases, little discernible difference in the physical environment or skill base of the staff in generalist residential care compared to those properties funded for TRC. It is not apparent that the Department's guidelines for provision of TRC have been adhered to by CSOs and there was no evidence that the new model and increased funding was monitored, complied with or regulated by the Department.

Photograph 10: Child's bedroom floor in a TRC funded unit



Source: Photograph taken by the Commission, March 2015.

The Department's *Program requirements for residential care services in Victoria* states: Children will reside in 'reasonably clean', hygienic and appropriately furnished premises that comply with reasonable community standards and expectations.

437. Photograph 10 shows a plate of chicken bones on the floor next to the child's bed in the bedroom, along with a condom wrapper. In 2014–15 the Department funded this residential care unit for \$1.56 million per annum for the provision of therapeutic care.

Photograph 11: Damaged wall in a young person's bedroom in a TRC funded unit



Source: Photograph taken by the Commission, February 2015.

The Department's *Program requirements for the delivery of therapeutic residential care in Victoria* states: The internal physical environment of the TRC unit will be home-like and personalised and ensure physical and emotional safety.

438. Photograph 11 shows a damaged wall in a young person's bedroom. In 2014–15 the Department funded this residential care unit for \$1.56 million per annum for the provision of therapeutic care.

Photograph 12: Damaged walls in the hallway of a TRC funded unit



Source: Photograph taken by the Commission, March 2015.

The Department's *Program requirements for residential care services in Victoria* states: The physical environment where a child resides... [has] a significant impact on their physical, emotional and psychological development and wellbeing.

439. In 2014–15 the Department funded this residential care unit for \$1.56 million per annum, for the provision of therapeutic care.

440. All of the TRC-funded properties that were visited by the Commission had staff offices. This is contrary to the guidelines, which state:

- *the program will not have a staff office from which to 'view' children and young people, therefore increasing the opportunities for interactions in the main areas of the unit.*¹⁵⁷

¹⁵⁹ Ibid.

6. Site visits to residential care units

Photograph 13: Viewing window from a staff office in a residential care unit



Source: Photograph taken by the Commission, March 2015.

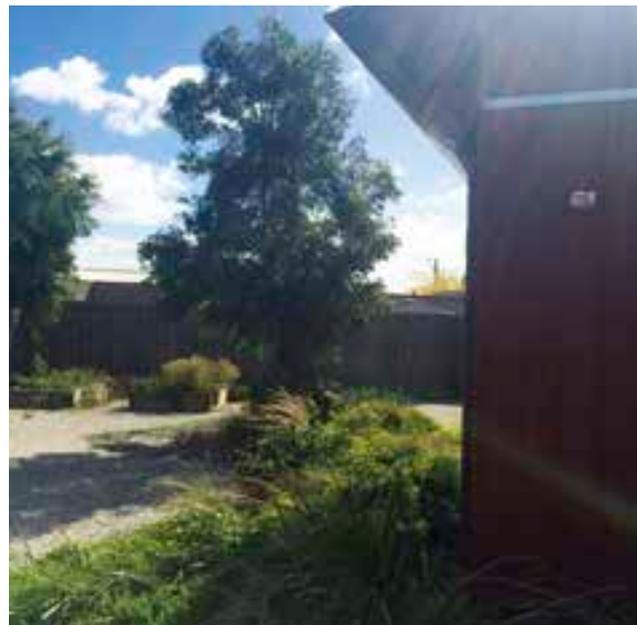
The Department's *Program requirements for the delivery of therapeutic residential care in Victoria* states: The program will not have a staff office from which to 'view' children and young people.

Photograph 14: Living area in a TRC unit funded by the Department for provision of therapeutic care



Source: Photograph taken by the Commission, February 2015.

Photograph 15: Exterior garden of a home-like residential care unit funded by the Department for provision of therapeutic care



Source: Photograph taken by the Commission, March 2015.

'Workers would switch the power off at 8.30 at night. They never ate with the kids. They would just go and sit in the office.'

Source: Young person who has recently left residential care

441. Two of the TRC units visited had vastly different physical environments from the other four units visited. These two units had higher quality furnishings and décor in their interior and exterior areas, as shown in photographs 14 and 15. These physical differences had a strong impact on the atmosphere and ambience that was created in the units. They were 'home-like'. They felt safe.

6.5 Surveillance cameras in bedrooms

442. The use of surveillance cameras in one residential care unit was a shocking discovery. The Commission noted closed circuit cameras in two children's bedrooms, with a monitor located in the staff office. When questioned, the CSO manager was aware of the cameras and advised these had been installed with the knowledge of the Department to monitor the children.
443. The Commission confirmed this information through reviewing the file of a child who had previously been accommodated at the unit. A review of the children's file notes indicated that a senior Departmental manager was present at a meeting where the use of surveillance cameras had been discussed in detail in relation to this particular residential care unit.
444. The Commission was most concerned about the legality of the installation and use of these cameras and possible breaches of the *Crimes Act 1958*, the *Privacy and Data Protection Act 2014*, the Charter and the Rights of the Child. The Commission immediately raised its concerns with the Department and requested that the surveillance cameras be removed, that Victoria Police be advised of the matter and that the Department review the situation and advise the Commission of its response and action.
445. In response, the Department oversaw the removal of the cameras from the residential care unit. The Department advised the Commission that the Department would ensure 'information sharing on human rights/privacy awareness for staff' would occur across all divisions of the Department and that an external consultant review would occur 'to review the decision making and management of this particular matter including oversight of the agency and internal Departmental communication'.
446. At the time of preparing this report, the Commission has not received any further feedback or been provided with the report of the external consultant.

Photograph 16: Surveillance camera in a child's bedroom



Source: Photograph taken by the Commission, February 2015.

Photograph 17: Surveillance camera in a girl's bedroom



Source: Photograph taken by the Commission, February 2015.

447. Photographs 16 and 17 show surveillance cameras installed in children's bedrooms in a residential care unit. The cameras were used to monitor the children and the surveillance was viewed live on a monitor in the staff office.

6. Site visits to residential care units

6.6 Punitive and restrictive practices

448. All residential care units visited by the Commission had separate staff rooms that were locked and inaccessible to the children. Small viewing windows were in place in some properties. In others, the staff office was locked with heavy grill doors. It is difficult to see how the physical layout and use of staff rooms is 'home-like'; how it assists staff to engage with the children and young people in their 'home' or how staff can adequately supervise the children from an office.

Photograph 18: Mesh and metal grills on a viewing doorway from the staff office of a residential care unit



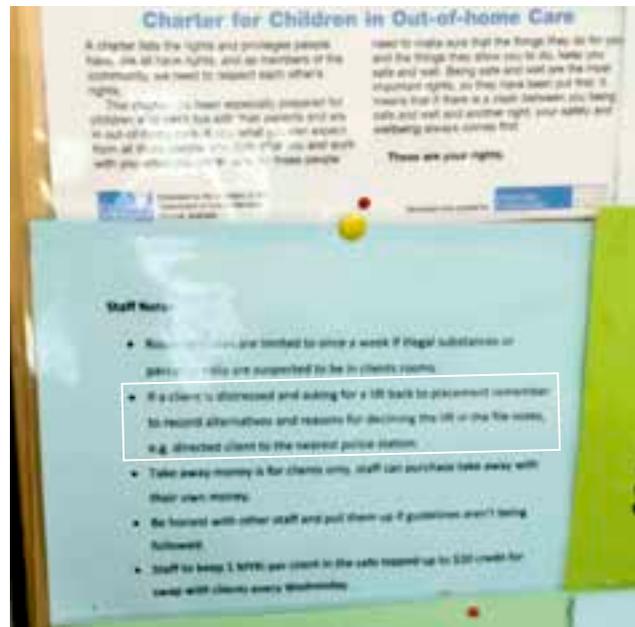
Source: Photograph taken by the Commission, February 2015.

'It's not like a home here... everything is locked up! I have to ask for them to unlock the fk'n cupboard for a towel to have a shower... the toilets are locked, the bathroom is locked... the f**k'n food is locked away... It's not homely!!'**

Source: 14-year-old child living in residential care, March 2015.

449. In one of the TRC units that is funded to provide therapeutic care (\$1,156,616 in 2014–15), the Commission observed a laminated instruction on the notice board in the staff office, as shown in photograph 19. The context for the instruction was that if a child had left the residential care unit and was '...distressed and asking for a lift back to placement remember to record alternatives and reasons for declining a lift in the file notes, for example, directed client to the nearest police station.'

Photograph 19: Sign in the staff room of a residential care unit



Source: Photograph taken by the Commission, March 2015.

450. This particular TRC is funded at \$1,156,616, around \$22,242 per week, or \$3,1774 per day.

451. This is a punitive practice that was openly sanctioned in the residential care unit. The practice does not demonstrate care or understanding of the vulnerable children who reside there. It is this disregard for the welfare of the children in care that continues to place our vulnerable children and young people at risk of sexual abuse and sexual exploitation. It is difficult to see how this practice is therapeutic or how it takes into account the needs and circumstances of each child on each occasion.
452. The Commission was disturbed to find the practice, in some residential care units, of removing the entire power source from a child's bedroom as a means of behaviour management. Some residential care units had electrical fuse boxes that had individual children's bedrooms identified and labelled, as shown in photograph 20. Residential care staff in this unit confirmed that they could isolate electricity in the bedrooms of the children and this approach was used to manage the children's behaviour at night.

Photograph 20: Electrical fuse board in a residential care unit with individual children's bedrooms labelled



Source: Photograph taken by the Commission, February 2015.

453. This practice was confirmed when the Commission conducted file reviews and noted that a CSO had been making daily file notes detailing the practice of removing the electricity to a child's bedroom. These files notes were sent to the Department advising of the daily practice for some children in having electricity switched off in their bedroom at night either as punishment or as a means of trying to get the child to go to sleep.
454. The Commission raised the issue with the Department and the Commission sought assurances that this punitive practice would be cease immediately.
455. During staff interviews at many other residential care units, the practice of isolating electricity was confirmed as a widespread practice by a number of staff.
456. In almost every residential unit visited by the Commission, it was observed that food was regularly locked away from children in cupboards with padlocks or locked away in the staff offices. Fridges and freezers were routinely located in locked cupboards. Commission staff also observed that children's games rooms, art supplies, toilets, bathrooms and linen cupboards were locked in many of the residential care units. The resulting atmosphere was detention-like and hostile.

6. Site visits to residential care units

Photograph 21: Locked cupboards in the hallway of a residential care unit



Source: Photograph taken by the Commission, March 2015.

Photograph 23: Freezer and pantry inside a locked cupboard of a residential care unit



Source: Photograph taken by the Commission, March 2015.

Photograph 22: Fridge and freezer inside a locked cupboard of a residential care unit



Source: Photograph taken by the Commission, March 2015.

Photograph 24: Locked games room in a residential care unit



Source: Photograph taken by the Commission, March 2015.

The Department's *Program requirements for residential care services in Victoria* states: The physical living environment will reflect community expectations of a home.

Photograph 25: Locked linen cupboard in a residential care unit



Source: Photograph taken by the Commission, March 2015.

Photograph 26: Locked pantry cupboards in a residential care unit



Source: Photograph taken by the Commission, March 2015.

The Department's *Program requirements for residential care services in Victoria* states: Children will have reasonable access to a variety of food while residing in a placement.

6. Site visits to residential care units

6.7 Inappropriate behaviour by staff

457. The culture of an organisation has been found to have a strong influence on the degree to which abuse might occur within it.¹⁶⁰ In a child-safe organisation, the commitment to protecting children must be embedded in the organisation's culture.
458. Offenders of child sexual abuse will exploit systemic vulnerabilities where they exist in an organisation and for this reason, CSOs and the Department must continue to be vigilant in ensuring zero tolerance to any misconduct and encourage a culture of reporting and adhering to codes of conduct.
459. The National Crime Agency UK identified that the normalisation of inappropriate sexualised behaviour in the workplace and pushing of boundaries was present in situations where staff went on to sexually abuse children in institutions.¹⁶¹
460. In a site visit to a residential care unit, Commission staff observed a whiteboard in a staff office that posed a 'quiz' question that was of a sexually suggestive nature and plainly inappropriate in a home for children, as shown in photograph 27:
- *Who is your favourite 'smoking' [hot] celebrity?*

Photograph 27: Whiteboard in the staff office of a residential care unit



Source: Photograph taken by the Commission, February 2015.

461. In the context of providing care to traumatised and abused children, this behaviour is considered to have potential to create a workplace culture that normalises sexualised behaviour and therefore creates risk to the children residing in the residential care unit.
462. Evidence of such behaviour suggests that there is a lack of attention and monitoring by the CSO management and oversight by the Department to ensure that services provided to vulnerable children are child-safe.

6.8 Safety of children in residential care

Question: How is the safety of children in residential care measured by your organisation?

'The responsibility lies with kids to tell us when they don't feel safe.'

Source: DHHS Child Protection Principal Practitioner, February 2015.

'I don't know really.'

Source: DHHS Child Protection Operations Manager, February 2015.

'That's not my area.'

Source: DHHS Child Protection Manager, February 2015.

463. Of the 87 Department and CSO staff interviewed by the Commission, only one staff member was of the view that the current system of residential care provided adequate safety to children.
464. During the Inquiry some young people reported to the Commission that they did not feel safe in their placement due to bullying, aggression or sexual exploitation by peers. Some young people reported that they had asked to move placement, but due to lack of options this did not occur.

160 National Crime Agency, *CEOP Thematic Assessment*.

161 Ibid.

465. There does not appear to be any mechanism presently in place that measures children's experiences of care or gauges their sense of safety. Most CSO and Departmental staff could not identify how the safety of children in residential care is measured. Given that the Victorian Government is providing up to \$1.56 million per annum for one residential care unit (which may accommodate three or four children), the question of quality and fiscal responsibility must therefore be raised.
466. The Commission found that no structure exists for children who reside in residential care to raise a complaint or provide feedback about their experience of care and their sense of personal safety. The onus is squarely on the children (some as young as five) and young people to speak up when they are feeling unsafe. This is a task that would seem near impossible for such marginalised and vulnerable children.
467. Adding to the children's sense of isolation is their limited opportunity to engage with their protective worker or provide feedback to the Department. As evidenced by interviews, site visits and file reviews, child protection practitioners rarely visit the young people in placement. The Commission heard this is even more problematic in rural areas where staff are required to service vast distances.

'One worker can have 20 to 25 kids on their caseload. It is impractical for them to be able to get around to them all.'

Source: DHHS Principal Practitioner, February 2015.

468. Children who live in residential care are rarely visited. The Inquiry found that children's friends and family are usually not permitted to visit them (even if it is safe to do so). Departmental staff rarely visit and many CSO managers also advised that they do not regularly visit the residential care units they are responsible for managing.
469. Many CSO staff also raised concerns about children in residential care not having a consistent allocated caseworker. In one residential care unit visited by the Commission, two of the young Aboriginal children had not been allocated a child protection caseworker in almost a year. The residential care staff advised that no one from the Department had visited the children in the residential care unit for almost 12 months. These children lived in this residential care unit for a year with no apparent active case management, case planning or direction.

470. The Commission found this lack of contact and support to the children concerning. This gave no voice to the children, increased their sense of isolation and failed to ensure their connectedness to their culture. It is clearly difficult for decisions to be made in these children's best interests if their voices are not heard and there is no opportunity for them to participate in decisions that are made about their care.
471. It is also difficult to see from this lack of contact with the children how the Department monitors and complies with Court-ordered conditions. These are conditions that the Court has considered, often on the recommendation of the Department, to be in the best interests of the child.

Photograph 28: Window in a child's bedroom of a residential care unit



Source: Photograph taken by the Commission, March 2015.

"Get me out of here... I hate it here."

Source: Writing on the window by a child in residential care.

7. Improving the safety and wellbeing of children in residential care

472. The present model of residential care must be redeveloped. It is obvious that when children as young as seven are being sexually abused in a state 'care' setting, significant reform is required.
473. There is a great deal of evidence that outcomes for children living in residential care are poor, both in the immediate and long term.
474. Of the 32 files reviewed by the Commission, all of the children were noted to have deteriorated in their level of functioning after their placement in residential care. Direct-care staff and CSO managers reported that few children or young people remain in school. They also reported an escalation in undesirable behaviours such as leaving the unit and going missing and increased drug and alcohol use.
475. The current four-bed residential unit model is unfortunately a perfect setting for learning dangerous behaviours. Only one of the 87 staff interviewed by the Commission thought that the current system of residential care provided adequate safety to children and young people.
476. The Commission has heard from many dedicated staff from CSOs and the Department about concepts for reform. The Commission has considered written submissions received to the Inquiry and researched practices in other jurisdictions to assist in forming recommendations and ideas for service improvement.

7.1 Improve entry to care

477. Placing a child in out-of-home care is a significant decision.
478. Many CSOs reported being asked to place a child at very short notice and with limited information. There is often no opportunity for a robust assessment of the child or the impact of the placement on the other children already in the placement.
479. Several submissions to the Inquiry recommended the establishment of an assessment centre.¹⁶² A child could be admitted for one or two weeks, allowing time for a comprehensive multi-disciplinary assessment to determine the best possible placement options for them.
480. There is a need for emergency or short-term therapeutic foster care placements where carers have access to 24-hour intensive support. Children could stay in emergency foster care while assessments are made about suitable placement options for them.
481. Comprehensive assessments are required at the point of entry to care. This must include an assessment of the risk of sexual exploitation, patterns of absconding and cognitive functioning.
482. The Commission recommends that the admission of a child to the out-of-home care sector be approved by an expert placement panel. The views of the child should be considered and articulated by an independent advocate. The panel should convene in a timely manner and provide a clear rationale for the decision about placement choice and how the best interest principles are applied in each decision for every child. Advice should also be provided about recommended therapy and treatment for the child.

¹⁶² Submissions to the Inquiry can be viewed at www.ccp.vic.gov.au.

483. When the recommendation is for the child to be placed in residential care, consideration must be given to effective matching of children. Too often a child has been placed in the only available placement at the expense of another child's safety and wellbeing.
484. The children in the 32 client files reviewed by the Commission experienced an average of 16 different placements. Many were admitted to residential care after the breakdown of a foster care or kinship care placement. File reviews revealed little or no effort was made to maintain these placements and prevent placement breakdown.
485. Children are often moved between placements with little or no warning. During a visit to one residential care unit, Commission staff witnessed the distress of a young woman who had just been told she would be moving to another unit the following morning. Her carers were unable to provide any rationale for the move, as they had not been informed of the placement change. Staff stated that her bed would be filled within hours of her leaving, giving them little opportunity to prepare the other children for the change or to refurbish the room for the next child.
486. The Commission recommends that the placement panel should consider any proposed placement change or disruption, and that the views of the child should be represented to the panel by an independent advocate.

7.2 Improve the referral process

487. Many children and young people placed in residential care have experienced sexual abuse prior to placement. The Commission found that details of prior abuse were not always included in the referral to the placement agency.
488. The present referral process has too much reliance on the automatic population of forms, which can lead to errors. Information recorded when a child first enters care is automatically saved into future placement referral forms, even when it is no longer appropriate. The Commission was told about a child whose placement changed but whose information had not been accurately updated from a previous form. Upon arriving at his new placement, staff asked him about his parents only to learn that his father had died six months earlier. This very important information had not been updated.
489. The Commission also heard of instances where crucial information was not made available to the CSO about the nature of a child's behaviours and needs. Examples included children with problematic sexualised behaviours, children with extreme fire-lighting behaviours and children with significant intellectual disabilities. Many CSO direct-care staff reported feeling unprepared and unsure about how best to care for these children entering their residential care unit.
490. Research has shown that direct-care workers cannot provide the necessary levels of care and supervision without accurate information about the child. Adequate knowledge is essential to properly manage transitions in care, and to protect other children already in placement.¹⁶³
491. The Commission considers that an urgent review of the referral process and adequacy of the relevant referral paperwork is required. Referrals should be subject to the same level of scrutiny as Departmental court reports.

¹⁶³ Elaine Farmer and Sue Pollock, 'Managing sexually abused and/or abusing children in substitute care', *Child and Family Social Work*, Volume 8, Issue 2 (2003), pp. 101–112.

7. Improving the safety and wellbeing of children in residential care

7.3 Professionalise foster care

492. Children are often placed in a residential care facility because of the lack of home-based care options. The Inquiry has found that many children in residential care experienced multiple placement changes prior to their entry to residential care, with an average of 16 placement changes per child. Such significant instability is a major contributor to the complex needs of already vulnerable children, leading to attachment difficulties and a system-driven perpetuating cycle of trauma. This highlights the need for other models of care.
493. Many of the submissions received by the Commission, and *all* staff interviewed for the Inquiry, reported that the majority of children currently living in residential care could be cared for in home-based care if there were sufficient specialist home-based placements available.
494. The current model of foster care is based on the provision of home-based care by volunteer carers who have received some form of assessment and training. Caregiver reimbursements are paid to offset the costs associated with caring for the child, with higher rates being made available through enhanced or specialist models of care.
495. The number of registered foster carers is fast declining. There are many reasons for this, including the profile of the carers (for example, more double-income families than in previous decades), the lack of adequate remuneration and the increasing complexity of the children requiring foster care.
496. The government announced in February 2015, investment of \$1.5 million to attract, recruit and retain more foster carers through a public campaign and support program, with the aim of having all primary school aged children in home-based care. Additionally, the government established the Ministerial Advisory Committee for Children in Out-of-Home Care. The immediate priority of the Committee is to address recruitment and retention strategies for foster carers.¹⁶⁴
497. The VVCI recommended the introduction of a professional foster care model and less use of residential care.¹⁶⁵ This view is shared by many working in the sector and seems to have a wave of support.
498. Professional foster care arrangements are in place in a number of countries.¹⁶⁶ The term refers to a model of home-based foster care where carers are employed in a professional capacity to care for children and young people. Models vary in terms of remunerations, tax arrangements and the expectations of carers. In Finland, for example, professional foster carers are required to have a post-graduate qualification in social work, health or education. Respite and leave arrangements are embedded in the different models.
499. The expectation of professional foster care is that there would be an increased pool of tertiary-trained and supported carers who are appropriately remunerated. The carers would be expected to undertake a case management role in their foster child's life, participate in ongoing training and have access to greater support, including a respite component.
500. Residential care is a very expensive model of care, with the average cost per child being more than 10 times that of home-based care.¹⁶⁷ The Victorian Auditor-General suggested that average costs of residential care are likely to be much higher due to the provision of some services that are attributed to other budget categories and which therefore do not show up as direct costs of residential care services.¹⁶⁸
501. The Commission engaged Professor Brett Inder (Monash University)¹⁶⁹ to describe and cost a model of professional foster care based on variations of existing models in Australia and internationally. The costing by Professor Inder indicates substantial savings could be realised by moving towards such a model. It would also provide long-term improved quality of care and improved outcomes for the children concerned.
502. The proposed model is two tiered and includes maintaining the voluntary foster care system (along with increased reimbursement levels) and the introduction of a professional foster care model, which would focus on providing foster care to a priority group of children and young people who would ordinarily be placed in residential care.

164 Mikakos, J. *Better care for our vulnerable kids* [media release], 9 February 2015, Premier of Victoria, www.premier.vic.gov.au/better-care-for-our-vulnerable-kids, accessed 3 July 2015.

165 Philip Cummins et. al., *Report of the Protecting Victoria's Vulnerable Children Inquiry*, Chapter 10.

166 ACIL Allen Consulting, *Professional Foster Care: Barriers, opportunities and options* (Melbourne: 2013).

167 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2014*.

168 Victorian Auditor-General, *Residential Care Services for Children*.

169 Brett Inder and K Gor, *Professional foster care as an alternative to residential care: it makes economic sense* (Melbourne: 2014), unpublished report, view extract at www.cyp.vic.gov.au.

503. The professional carer would be recruited to a professional role, have tertiary training and be remunerated accordingly. They would undertake a greater therapeutic role with the child and some aspects of case management. They would be required at a minimum to undertake continuing professional development and supervision. This structure includes investment in professional support such as access to therapeutic services and a greater level of casework support by the foster care agency.
504. Both Inder and previous studies that have considered the introduction of professional foster care¹⁷⁰ conclude that the payment to the carer would need to be paid on the basis of treating the carer as a contractor, rather than an employee. Inder suggests considering the framework of the current family day care program that operates in Victoria as a basis for how the regulatory and financial arrangements could be implemented for professional foster care.
505. Under the Victorian family day care model, each carer is a contractor, but operates under the auspices of a coordination unit, which ensures compliance with essential standards of care, physical safety and documentation.
506. Inder provides a compelling argument both economically and socially to progress the implementation of alternative forms of home-based care.
507. The Inquiry has highlighted that residential care is not a suitable or long-term solution for vulnerable children in out-of-home care. What is evident is that children in residential care often have complex needs as a result of traumatic backgrounds and experiences; as such, they require more intensive and well-supported individualised care that promotes healing and resilience.

¹⁷⁰ ACIL Allen Consulting, *Professional Foster Care: Barriers, opportunities and options* (Melbourne: 2013).

7.4 Specialist group care

508. It is acknowledged that, for a small number of children, specialist group care may be required for short periods to allow for intensive treatment before these children can transition into an appropriate home-based care option with their services following them. This Inquiry recommends the development of a suite of specialised services to cater for the needs of:
- Aboriginal children
 - sibling groups
 - children with a disability
 - children who have been or are at risk of sexual exploitation
 - children with identified sexually abusive or problematic behaviours
 - pregnant girls and young parents.
509. The Commission had the opportunity to visit a residential and educational care facility for children and families in Jasper, Oregon, USA.¹⁷¹ This treatment facility impressed with its suite of co-located services including an intensive residential treatment program, a therapeutic school, a short-term residential centre, treatment foster care program and community-based support and crisis response services. The holistic manner in which the program operates, involving the whole family, was of note. The Commission considers that such specialist models could be considered in Victoria.
510. The Children's Protection Society in its submission to the Inquiry, noted a model of specialist group care for children with sexually abusive behaviours in New Zealand delivered by Barnardo's.¹⁷² A key feature of these residential programs is the nurturing relationships children are provided with by a small team of consistent direct-care staff that has the expertise, skill set and qualifications to care for this cohort of children, with the support of a therapeutic adviser and other support staff. The Commission considers that key features of this program, that has been in operation for many years in New Zealand, could be considered in Victoria.

¹⁷¹ www.jaspermountain.org.

¹⁷² Children's Protection Society submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccp.vic.gov.au.

7. Improving the safety and wellbeing of children in residential care

7.5 Improve the skill base and qualifications of residential care staff

'There is a lot of disconnect between the skill of staff, the complexity of the children, and the mix of children.'

Source: DHHS Principal Practitioner, March 2015.

511. During the Inquiry, the Commission met many committed and dedicated staff who want to make a difference to the lives of children in out-of-home care. Previous inquiries have commented that some staff in the residential care sector have a low skill base and many lack mandatory qualifications.¹⁷³ This Inquiry has also concluded that the skill base and qualifications of many staff providing care to children must be vastly upgraded in order to meet the highly complex care needs of these children.
512. In Victoria, there are no minimum qualifications required for employment in a residential care unit. While the Department and CSOs indicate it is preferable that workers have an industry-based qualification, such as a Certificate IV in Child Youth and Family Intervention, it is not compulsory. A census of the residential care workforce completed in 2013 by the Centre for Excellence in Child and Family Welfare revealed that less than half the workforce had a Certificate IV and, most significantly, 34 per cent did not possess any relevant qualifications.¹⁷⁴
513. Residential care have a very important role in nurturing, supporting and aiding the trauma recovery of our most vulnerable children. They need and are entitled to ongoing training, professional development and supervision by skilled supervisors. To achieve this, staff caring for the state's most vulnerable children need qualifications commensurate with the roles they are required to undertake.
514. Submissions to the Inquiry have endorsed the introduction of mandatory minimum qualifications for all staff in residential care. The Centre for Excellence commented in its submission 'the absence of an agreed minimum, mandatory staff qualification combined with a highly casualised workforce presents clear risks... unqualified staff, even if highly motivated, are less likely to exhibit the skills and knowledge required to work competently and ethically with highly vulnerable children and young people'.¹⁷⁵
515. Recommendations have been made by this Inquiry for a minimum Diploma-level qualification and consideration of other characteristics, such as aptitude and psychological resilience, to ensure the greatest capacity to work with traumatised children.
516. A key recommendation of this report is that residential staff are appropriately qualified, trained and supported. The majority of CSO and Departmental staff interviewed stated that a Certificate IV in Youth Work should be a minimum qualification for residential care workers. Others felt this qualification did not go far enough.
517. Submissions made to the Inquiry supported the introduction of a statewide benchmark minimum qualification enhanced with ongoing training and regular supervision.
518. Direct-care staff interviewed by the Commission routinely denied that regular supervision was provided to them, and the majority of casual staff were unable to recall ever being provided with supervision. This was in contrast to what agency managers reported to the Commission.

173 Ombudsman Victoria, *Own motion investigation into the Department of Human Services Child Protection Program*; Victorian Auditor-General, *Residential Care Services for Children*.

174 Centre for Excellence in Child and Family Welfare, *Victorian Residential Care Workforce Census – at a Glance: Strategic Engagement of Potential Foster Carers* (Victoria: Centre for Excellence in Child and Family Welfare, 2013). The Commission notes that an analysis report is being completed by the Centre for Excellence, but this was not available in its final format at the time of writing this report.

175 Centre for Excellence in Child and Family Welfare submission to the Inquiry. Submissions to the Inquiry can be viewed at www.ccep.vic.gov.au.

7.6 Legal obligation to children

519. The Commission noted more broadly, what appeared at times, to be a lack of understanding of, and compliance with, the Charter, Rights of the Child and the CYFA 2005. This observation is relevant to all CSO and Departmental staff and requires attention to ensure that the best interests of the child are paramount and their human rights are upheld.

7.7 Discontinue the use of labour-hire agency staff

520. Children need the opportunity to form relationships with predictable and caring adults. The current residential care system does not facilitate opportunities for attachment. This is exacerbated by the use of labour-hire agency staff, who are generally unfamiliar with the children and the CSO.

521. The Commission was told about the widespread use of staff from labour-hire agencies. CSOs advised that it was generally difficult to fill rosters and, while there was a preference to use regular staff, casual staff would frequently be hired through a labour-hire agency to fill gaps.

522. One major CSO provided the Commission with statistical data that indicated the use of casual staff from labour-hire agencies made up 82 per cent of their workforce (72 staff) in one region of Victoria.¹⁷⁶ This translates to a large number of unfamiliar adults rotating through a child's residential care unit on a weekly basis.

523. In some residential care units in Victoria, children can experience up to 22 different direct-care staff in one week.¹⁷⁷ The ability for any child to form a meaningful relationship in such a setting is highly compromised – let alone a vulnerable child who is living away from family and friends and has a significant abuse and trauma history.

524. In 2010, the Ombudsman reported that 23 per cent of allegations of abuse in residential care arose in relation to labour-hire agency staff.

525. The Commission considers that the use of labour-hire staff is not in the best interests of children who need to develop trusting, secure relationships. It must therefore be discontinued as a matter of priority. It was noted that one CSO does not use any labour-hire staff because they recognise that this is contrary to the best interests of the children in their care.

7.8 CSO specialist practitioner for every residential care unit

526. It is clear that there is a strong need to have attached to every residential care unit a CSO specialist practitioner with expertise in sexual assault and sexually abusive or problematic behaviours.

527. They should have regular contact with the child to facilitate their healing and recovery. Such CSO specialist practitioners would be involved in responding to and coordinating care and support for a child following an allegation of sexual abuse in care, particularly where children are reluctant to seek external counselling. The CSO specialist practitioner could also provide sexual health education to children and develop preventative strategies with the children and staff to keep children safe from sexual abuse and sexual exploitation.

¹⁷⁶ Unpublished information provided by a major CSO to CCYP, April 2015.

¹⁷⁷ Ibid.

7. Improving the safety and wellbeing of children in residential care

7.9 Improve responses to absent children

528. The Commission is concerned about the lack of a consistent response when young people go missing from their residential unit. Practice varies in relation to when, or even if, they are reported missing and what attempts are made to locate them. Direct-care staff reported there is little they can do to prevent young people from leaving the residential care unit.
529. There is variation in the rigour applied to locating a young person who is absent from a placement. Safety plans must be clearly documented and acted upon when a young person does not return to their placement. This was not evident in the file reviews undertaken.
530. Similarly, when a child returns to the residential unit, there is a lack of uniform response. The Department may wish to consider introducing 'return interviews' for children missing from care, exploring why the child left and where they went. This would provide an opportunity for ongoing discussion about personal safety and future safety planning. Information about sexual predators and sexual exploitation could then be shared with other care team members in a timely manner and inform ongoing care planning. Return interviews are embedded in practice in England and Wales.¹⁷⁸

7.10 Establish an independent visitor program to every residential care unit

531. Currently there is no system to measure the safety of children living in residential care or to 'hear the voice of the child'. The onus is presently on the children and young people to raise their concerns. Direct-care staff do not always recognise the indicators that a child is feeling unsafe.
532. The Commission commenced a pilot independent visitor program in the Department's south division. The role of the independent visitor is to visit children and young people living in residential care in order to learn about their experiences, promote child-safe practices and encourage cultural and community connections. Similar programs are in operation in other states of Australia and around the world.¹⁷⁹
533. An early indication of the success of the pilot program is that the independent visitors are bringing about positive changes for children in residential care. Young people have welcomed the opportunity to speak with adults who are interested in their care experience. It is recommended that a statewide independent visitor' program be established. Such a commitment would be a clear demonstration to children in care that their voice matters.

¹⁷⁸ Tom Rahilly and Enid Hendry (eds.), *Promoting the wellbeing of children in care* (London: National Society for the Prevention of Cruelty to Children, 2014).

¹⁷⁹ For example, the Children's Society Independent Visitor Program in the UK and CASA (Court Appointed Special Advocate) in the USA.

7.11 Establish an independent advocate and complaints body

534. The Commission supports the finding of the Victorian Auditor-General, which observed that there is no independent advocacy for children in residential care to hear complaints. The Victorian Auditor-General recommended that the Department explore the feasibility of establishing an independent advocate to support children in residential care.¹⁸⁰
535. Other jurisdictions have been able to successfully implement such initiatives. Empowering People in Care (EPIC) is an independent association in Ireland that advocates for and hears the complaints of children and young people living in out-of-home care. The Commission considers a similar model could be implemented in Victoria.
536. Significant reform to delivery of out-of-home care is occurring in California, USA, with emphasis on residential care being time-limited and focused on specific treatment goals. The aim is to prepare children for placement in home-based care models.¹⁸¹
537. Initiatives such as a trauma-informed survey for children their families, was recommended by the California Department of Social Services, to better understand the experiences of children in care. The survey focuses on the child's satisfaction during their experience in care, with important factors such as their connection with family, culture, school, the adequacy of the child's involvement in case planning and whether the child's opinions and preferences were considered. Such feedback mechanisms could be implemented for children in Victorian out-of-home care.
538. Another important reform in California has been the move towards greater transparency and accountability through recommendations to publically report on provider performance via a public website. Such reporting includes details about audit visits to sites where children are being cared for, including dates of visits, the provider name and details, substantiated and inconclusive complaints, number of inspections and inspection dates. The Department could consider such initiatives to improve transparency.

7.12 Redress for children who have been abused in care

539. Children in out-of-home care should be able to seek redress and/or civil litigation if they have experienced abuse in care. In Victoria, there does not appear to be consistent or standard responses for children who have experienced sexual abuse in care. The Commission found many examples of children not being offered redress or compensation.
540. The Department of Communities, Child Safety and Disability Services in Queensland has a policy for 'Response to children and young people sexually abused whilst placed in Out-of-Home Care'. These responses, regardless of who perpetrated the abuse, may include an acknowledgement of the abuse and resulting harm experienced, a letter expressing regret, and also a referral to the Legal Services Branch to facilitate access to independent legal advice for the child.¹⁸²

¹⁸⁰ Victorian Auditor-General, *Residential Care Services for Children*.

¹⁸¹ California Department of Social Services, Continuum of care reform. (California, USA, 2015) www.cdss.ca.gov.

¹⁸² Queensland Department of Communities, *The Royal Commission into Institutional Responses to Child Sexual Abuse Issues Paper 4: Preventing sexual abuse of children in Out-of-Home Care* (Queensland Department of Communities, 2013).

7. Improving the safety and wellbeing of children in residential care

7.13 Provide education about sexual abuse and sexual exploitation

541. It was evident during this Inquiry that there is very little consistent education provided to children and young people in residential care about healthy and safe relationships, sexual health and the safe use of the internet and social media.
542. Sexual health and wellbeing education for children in residential care should include, at a minimum, information about sexual health, positive relationships, reproduction, issues related to consent, safe use of the internet and social media platforms, safe sex practices, protective behaviours and information that dispels the influence of pornography.
543. The Commission considers an action plan is required to educate and raise community awareness of child sexual exploitation, similar to the Manitoba (Canada) Strategy, 'Stop Sex with Kids'. The message that protecting children is everyone's responsibility is advertised through billboards, TV and radio publicity.
544. In Suffolk County, Massachusetts, USA, a preventative program facilitated by a clinician and a trained adult survivor educates adolescent girls about sexual exploitation. The group program is delivered in schools, out-of-home care facilities and other community-based services.¹⁸³ It is considered that such a program should be delivered in Victoria.

7.14 Improve service provision and implement client-based funding

545. CSOs that provide out-of-home care are subject to accreditation every three years. This process involves being reviewed against the Department's Registration Standards for Community Service Organisations.
546. The Commission is concerned that the current accreditation process for CSOs lacks sufficient independence. The CSO is presently able to select and finance the review body that conducts the review and also selects the timing of the review. The Commission considers a review is required of the current accreditation process to evaluate its adequacy and independence.
547. The Commission noted a lack of coordination between service providers and poor information sharing. This issue is well documented in many previous inquiries and reports.¹⁸⁴
548. Many children in residential care do not attend school or any other structured day program. Many direct-care staff reported to the Commission that dropping out of school is the first step in the downward spiral for children placed in residential care.
549. For many reasons including their trauma histories, poor peer relationships and lack of educational achievement, many children in residential care require educational options outside mainstream schools. Joint initiatives between the Department of Education and the Department are required to ensure that children in residential care are not excluded from education.

¹⁸³ S Piening and T Cross, *From 'the life' to my life: Sexually exploited children reclaiming their futures. Suffolk County Massachusetts' response to commercial sexual exploitation of children* (Boston: Children's Advocacy Center of Suffolk County, 2012).

¹⁸⁴ Jane Morton, Robin Clark and John Pead, *When care is not enough* (Melbourne: Department of Human Services, 1999).

550. It is essential that universal services can respond to children who have experienced sexual abuse and are victims of sexual exploitation. There must be clear pathways from universal to specialist services with no waiting period. Outreach services must be available to children living in residential care.
551. The Commission considers that improved outcomes for children would be achieved through a child-based funding approach. The VVCI found that funding for vulnerable children needed to be more explicitly linked to past trends and projected demand.¹⁸⁵ The VVCI recommended that the Department should review and consolidate funding arrangements and adopt a broader, more client-based approach of funding as well as engaging the Essential Services Commission to determine appropriate prices for services and thereby provide a greater level of independent oversight.
552. This recommendation made five years ago has yet to be acted on by government. The peak body for child and family welfare in Victoria, the Centre for Excellence in Child and Family Welfare, has urged in its submission to this Inquiry, that the recommendation by the VVCI be fully implemented in order to 'offer a fair, transparent and sustainable approach to the funding of Victorian out-of-home care services'.¹⁸⁶

¹⁸⁵ Philip Cummins et. al., *Report of the Protecting Victoria's Vulnerable Children Inquiry*.

¹⁸⁶ Centre for Excellence in Child and Family Welfare submission to the Inquiry. Submissions to the Inquiry can be viewed at www.cryp.vic.gov.au.

8. Opportunity to respond

553. Section 48 of the CCYP Act 2012 requires, that natural justice be afforded to the Department and any community service, about any adverse comments or opinions in this Inquiry report, before the report is provided to the Minister for Families and Children or the Secretary to the Department.
554. Accordingly, the Commission provided extracts of the draft report to the Department and to CSOs funded by the Department for the provision of residential care services, to allow them an opportunity to respond to any adverse comment or opinion.
555. The Commission received responses from six CSOs within the timeframe requested.
556. The Secretary to the Department provided a response and this is contained in Appendix 6.
557. The Commission considered each response from the six CSOs and the Department. Where necessary, amendments have been made to provide more detailed information and address any factual inaccuracies.
558. All responses stated they welcomed the opportunity to comment on the draft report and indicated that the Inquiry was an appropriate vehicle to make significant reforms to the residential care system. However, many CSOs and the Department commented that in their view the report lacked balance and 'made generalised statements'.
559. One CSO provided a comprehensive and detailed response that considered each paragraph of the draft report.
560. Based on the responses received, it is important to reiterate that the Inquiry focused on 166 children who were subject to serious allegations of sexual abuse or sexual exploitation within a defined 12-month period. This Inquiry found that the extent of the allegations of sexual abuse is far greater than the 189 CIRs examined in this report. The Commission knows that a further 69 CIRs, at least, were not provided by the Department. In addition, the file reviews revealed that there were a number of instances where children had alleged sexual abuse or sexual exploitation and this did not result in a CIR being generated.
561. The Commission stands by the findings of this Inquiry, which are based on the evidence contained in 189 CIRs, 32 detailed file reviews, interviews with 87 staff from the Department and CSOs, the voices of children who have experienced residential care, 21 site visits and a number of public submissions.
562. All of the responses received from the CSOs confirmed that the matching of children in residential care placements is fundamentally flawed and requires urgent improvement. One CSO commented:
'If assessments by child protection practitioners are inadequate from the start of the out-of-home care placement process, it undermines every other stage of the process, particularly client matching, and results in the "heads in beds" approach that exists currently.'
563. There was full support from all CSOs for improved staff capabilities and minimum-level qualifications, with some flexibility about how this might be implemented.
564. There was recognition by many CSOs of the importance for enhanced specialist training in order to respond effectively to children who are at risk of sexual abuse and sexual exploitation. Of note, one CSO commented on difficulties in being able to access appropriate training for staff and was particularly concerned that newly appointed staff were unable to access foundational training in therapeutic care.
565. Another CSO commented about availability of therapeutic training:
'We were not given access to the training and have expressed our disappointment. This should be for all staff... we need more training and it would be helpful to know when it was happening well in advance [to allow for rostering].'
566. Another CSO identified the need for increasing staff awareness of grooming behaviours and being able to increase the competency of staff to manage sexual assaults and sexualised behaviours of children.

567. A number of CSOs stated in their responses that they did not agree with the Commission's comments on the poor physical environment of some of the residential care units visited. These CSOs stated that they did not believe these issues were prevalent in their organisation.
568. The Commission maintains the findings of this Inquiry, as evidenced through many photographs, that the physical environment in a number of residential care units visited by the Commission, was unacceptable.
569. Many CSOs confirmed delays and difficulties in obtaining a timely response from the Department in undertaking property repairs.
- 'We are pleased to note the recognition to improve the responsiveness of the Department to address maintenance or property damage issues.'**
- '... the Department does not back this up with funding for repairs... there should be a rolling repairs budget to ensure the [residential care unit] is kept up to a quality standard.'**
570. With regards to the Department auditing the residential care environment, one CSO commented:
- 'The Department visits are a check box exercise, they are adhered to when remembered.'**
571. With respect to the Commission's observations of restrictive practices in some residential care units, most CSOs did not comment on the observations listed in the report. One CSO commented categorically that such practices are not undertaken in its organisation.
572. Two CSOs acknowledged the importance of staff supervision and maintained that their organisations ensured this is regularly provided to all staff.
573. Regarding the Department's duty to children in care, one CSO commented:
- '... we have evidence that child protection [the Department] are not regularly visiting young people [in residential care units].'**
574. With regard to the Commission's observations that LAC records are poorly maintained, CSOs commented on barriers to compliance. One CSO noted competing accountability requirements and the paper-based nature of the documentation as being problematic.
575. Another CSO commented regarding LAC compliance:
- '... agree [lack of compliance] but also suggest the Department is lacking in their responsibilities in recording on their own systems in agreed timescales.'**
576. In considering the Department's response to the extract of the draft report, the Commission makes the following observations:
- the Secretary recognises the 'very serious issue' of sexual abuse and sexual exploitation of children in residential care; and 'notes with grave concern many of the case examples'
 - the Secretary concedes that the Department 'needs to do better and do more' with regard to protecting children and young people
 - the Secretary acknowledges there are areas in its 'system, policy, and in [its] practice that must be improved'.
577. In response to the six points the Secretary identified on page two of the Department's response, the Commission has reviewed its materials and confirms that the facts, as contained in this final report, are accurate based on the information available at the time of the Inquiry.
578. The Commission welcomes the opportunity to meet with the Department following the release of the Inquiry report.
579. The Commission looks forward to the Secretary providing for children in residential care in the same way **as a good parent would.**

9. Appendices

Appendix 1: Charter for children in out-of-home care

The *Charter for Children in out-of-home care 2007* was developed by the former Child Safety Commissioner and endorsed by the Department of Human Services Victoria.



Appendix 2: Guide to making a submission

Discussing sexual abuse can be difficult.

The Commission for Children and Young People will provide support and referral to counselling services for any person taking part in the Inquiry who requires assistance.

For children and young people

The Commission welcomes the involvement of children and young people to this Inquiry.

If you are a child or young person who has experienced residential care, you might like to be involved in the submission process in some of the following ways:

- making a short video
- providing a drawing or artwork
- writing a letter or email
- meeting with staff from the Commission to make your submission in person (you can bring a support person with you).

All children and young people taking part in the Inquiry **will** be provided with support and assistance. The Commission will make sure that you can access a counsellor who is skilled at helping children and young people.

Submissions responding to *any or all* of the following key points are of particular interest to the Commission:

How does sexual harm or exploitation occur?

1. Why are children and young people in residential care at increased risk of sexual harm or sexual exploitation compared to other types of out-of-home-care?
2. To your knowledge, what are the most common examples of sexual abuse or sexual exploitation that have occurred for the children and young people placed in residential care?
3. What are the main routes or pathways through which children and young people have become victims of sexual abuse or sexual exploitation following their placement in residential care? What are the responses for children and young people?
4. What is the standard response to an incident of sexual abuse or sexual exploitation of a child or young person residing in residential care? Can you offer any comments about the adequacy of the response and associated service systems? Is there consistency in the response? If not, what are the factors that result in variability?
5. How can children and young people be better protected from sexual harm or sexual exploitation in residential care?
6. How adequately are the health needs, education, community and family connections of children and young people met in residential care? Are there ways these connections and needs could be better addressed or improved for children and young people in residential care?
7. What are the policies and common practices in residential units regarding the children and young persons' use of mobile phones, internet, social media and technology?

9. Appendices

8. What form of sexual health education and relationship education is provided to children and young people in residential care, if any? Who provides this education and are their skills, training, supervision and support adequate to perform this role? How formalised is the delivery/content/approach/evaluation? How does this education integrate with what is provided to children and young people in their formal education at school, for those children and young people who attend school?

What would make a difference?

1. What changes would be most helpful in preventing children and young people in residential care becoming a victim of sexual abuse or sexual exploitation and in helping them to escape from it?
2. Do staff who care for and work with these children and young people have adequate skills, training, supervision and support to respond to, manage and prevent children and young people in residential care from being exposed to or becoming a victim of sexual abuse or sexual exploitation? Are there any improvements that could be made in this area?
3. How well do the service systems presently work together to prevent, respond to and support children and young people who have been a victim of sexual abuse or sexual exploitation in residential care? Are there ways the service systems could work differently to improve outcomes for these children?
4. Any other matters or issues that you feel the Commission should consider in its Inquiry.

Source: CCYP, 2014.

Appendix 3: List of people and organisations who provided a submission

Submissions to the Inquiry are available on the Commission's website: www.ccyp.vic.gov.au.

The Commission received written submissions from:

Organisations

- Anglicare Victoria
- Berry Street
- Centre for Excellence in Child and Family Welfare Inc
- Centres Against Sexual Assault, Victoria
- Children's Protection Society
- Department of Health and Human Services
- Gatehouse St Kilda
- Lighthouse Institute
- MacKillop Family Services
- Oz Child
- The Salvation Army Victoria
- VACCA
- Victorian Equal Opportunity and Human Rights Commission
- Victoria Police

Individuals

- Ms Adela Holmes
- Parent of a child (identity suppressed)

Appendix 4: Departmental categorisation of incident type

Incident type categorisation table 2011, Department of Human Services, Victoria, updated December 2012

Incident type categorisation table 2011 (extract)

Updated December 2012

Most circumstances described in incident reports are alleged and yet to be proven.

The classifying of incidents must follow the *Critical client incident management instruction* as a minimum requirement. It is not possible to stipulate every possible incident. Professional judgement by senior staff is required.

Incident type	Category One Must be reported at the latest within one working day	Category Two Must be reported at the latest within two working days	Considerations
	A Category One incident is an incident that has resulted in a serious outcome, such as a client death or severe trauma.	A Category Two incident involves events that threaten clients or staff health, safety or wellbeing.	Considerations are aspects or issues that inform categorising an incident.

Behaviour

Conduct or treatment of others that is, or has the potential to be, a threat to the health, safety and wellbeing of self or others

Sexual

Client sexually oriented actions in inappropriate circumstances.

Behaviour of a sexual nature by a client that places client's safety and wellbeing at risk.

Sexual actions (including sexual play) of concern by a client and/or there is a power imbalance.
Chronic preoccupation with sexually aggressive pornography.

Age, individual capacity and history of the client.
Pregnancy or impregnation of a client under the age of 16 years whilst in care (including out of home care) or in custody of secretary.
Age of consent.
Consider incident type 'sexual assault' if the incident involves criminal behavior.

Sexual exploitation

Involves sex work of a client under the age of 18 years.

Sex work by a client under the age of 18 years

Consider incident type 'Behaviour - sexual'.

Age of client.
Also consider incident type 'Sexual assault' or 'Behaviour - sexual'.

Sexual assault

Involves actions or attempted actions of a sexual nature that have caused or have the realistic potential to cause serious harm.

Rape

Penetration or attempted penetration (anal, oral, vaginal) through the use of physical force, intimidation and/or coercion without that person's consent.

Alleged rape (penetration or attempted penetration) of or by a client.

Exchanging sex with predatory adults for money, goods, substance or favours.

Consider incident type 'Sexual assault - indecent' or 'Behaviour - sexual'.

History and capacity of client.
Balance of power or position between alleged perpetrator and victim. Potential for exploitation.

Indecent

Unwanted sexual actions which are forced upon a person against their will, through the use of physical force, intimidation and/or coercion without that person's consent.

Any indecent act in front of or by a client that is reportable to the police.

Exchanging sexual acts with predatory adults for money, goods, substance or favours.

Production/possession of child pornography.

Public display of verbal and/or physical sexualised behaviour by clients that may be of concern to others.

Pornography includes materials that depict erotic behaviour and are intended to cause sexual excitement irrespective of format or media.

Note: All staff/carer to client sexual assaults must be reported as a Category One incident.

9. Appendices

Appendix 5: Data tables

The data analysis in the tables is based on 189 Category One CIRs relating to incidents of alleged sexual abuse or sexual exploitation that were provided to the Commission by the Department between 1 March 2013 and 28 February 2014 (the Inquiry period).

In April 2015, the Department advised the Commission that 402 CIRs relating to incidents (of which 69 CIRs related to sexual abuse or sexual exploitation) occurring between January 2013 to April 2015 had not been provided to the Commission due to an 'oversight'. The Commission was therefore unable to include these additional 69 CIRs in this report. We therefore know that the data presented here significantly underestimates the extent of the problem.

Table 1: Sexual abuse CIRs received by the Commission, 1 March 2013 – 28 February 2014

NUMBER OF REPORTS SUPPLIED BY THE DEPARTMENT	189
NUMBER OF CHILDREN SUBJECT TO THE REPORTS	281
NUMBER OF INDIVIDUAL CHILDREN SUBJECT TO THE REPORTS (A CHILD CAN BE NAMED IN MORE THAN ONE REPORT)	166

Table 2: Children subject to CIR reports, 1 March 2013 – 28 February 2014

NUMBER OF REPORTS PER CHILD	NUMBER OF CHILDREN
1	124
2–4	33
5–10	7
11–13	2
Total	166

Table 3: Source of harm, classification of abuse, gender and Aboriginal status, 1 March 2013 – 28 February 2014

CLASSIFICATION	CHILD-TO-CHILD	OTHER-TO-CHILD	STAFF-TO-CHILD	CHILD-TO-OTHER*	TOTAL	%
Behaviour: sexual	35	28	0	1	64	23%
Girls	15	27	0	1	43	
Boys	20	1	0	0	21	
<i>Aboriginal</i>	4	2	0	0	6	
Behaviour: sexual exploitation	6	71	0	0	77	27%
Girls	6	60	0	0	66	
Boys	0	11	0	0	11	
<i>Aboriginal</i>	1	9	0	0	10	
Sexual assault: indecent	32	31	5	0	68	24%
Girls	12	27	5	0	44	
Boys	20	4	0	0	24	
<i>Aboriginal</i>	4	5	2	0	11	
Sexual assault: rape	14	48	4	6	72	26%
Girls	7	44	2	5	58	
Boys	7	4	2	1	14	
<i>Aboriginal</i>	1	14	0	1	16	
Total children	87 (32%)	178 (63%)	9 (3%)	7 (2%)	281	100%
Girls	40	158	7	6	211	75%
Boys	47	20	2	1	70	25%
<i>Aboriginal</i>	10	30	2	1	43	15%

n = 281 children subject to sexual abuse CIRs during the Inquiry period.

* Upon examination, these cases appear to have been incorrectly categorised by the Department. Six of the incidents should have been classified as other-to-client rather than client-to-other. Only one incident of client-to-other was deemed to have been correctly classified.

9. Appendices

Table 4: Age and classification of sexual abuse, 1 March 2013 – 28 February 2014

AGE OF CHILD AT TIME OF REPORT (YEARS)	BEHAVIOUR: SEXUAL	BEHAVIOUR: SEXUAL EXPLOITATION	SEXUAL ASSAULT: INDECENT	SEXUAL ASSAULT: RAPE	TOTAL
7	1	0	1	0	2
8	2	0	4	0	6
9	1	0	3	0	4
10	1	0	3	0	4
11	4	0	1	0	5
12	5	0	0	4	9
13	11	6	10	6	33
14	12	17	13	9	51
15	18	31	14	20	83
16	7	13	11	14	45
17	2	9	7	19	37
18	0	1	1	0	2
All children	64	77	68	72	281

n = 281 children subject to sexual abuse CIRs during the Inquiry period.

Table 5: Age and source of harm, 1 March 2013 – 28 February 2014

AGE OF CHILD AT TIME OF REPORT (YEARS)	CHILD-TO-CHILD	CHILD-TO-OTHER*	STAFF-TO-CHILD	OTHER-TO-CHILD	TOTAL
7	2	0	0	0	2
8	6	0	0	0	6
9	4	0	0	0	4
10	4	0	0	0	4
11	5	0	0	0	5
12	4	0	0	5	9
13	11	2	1	19	33
14	12	0	0	39	51
15	17	0	3	63	83
16	15	2	3	25	45
17	7	3	2	25	37
18	0	0	0	2	2
All children	87	7	9	178	281

n = 281 children subject to sexual abuse CIRs during the Inquiry period.

* Upon examination, these cases appear to have been incorrectly categorised by the Department. Six of the incidents should have been classified as other-to-client rather than client-to-other. Only one incident of client-to-other was deemed to have been correctly classified.

Table 6: Age and gender, 1 March 2013 – 28 February 2014

AGE OF CHILD AT TIME OF REPORT (YEARS)	MALE	FEMALE	TOTAL
7	1	1	2
8	4	2	6
9	3	1	4
10	4	0	4
11	4	1	5
12	2	7	9
13	12	21	33
14	16	35	51
15	9	74	83
16	10	35	45
17	5	32	37
18	0	2	2
All children	70	211	281

n = 281 children subject to sexual abuse CIRs during the Inquiry period.

Table 7: Gender and Aboriginal status, 1 March 2013 – 28 February 2014

	BOYS	GIRLS	TOTAL
Aboriginal	7	18	25
Non-Aboriginal	50	91	141
Total children	57	109	166

n = 166 individual children subject to sexual abuse CIRs during the Inquiry period.

Table 8: Number of placements, 1 March 2013 – 28 February 2014

NUMBER OF PLACEMENTS	1-5	6-10	11-20	21-50	51-99	100+	TOTAL
Number of children	34	47	50	28	6	1	166

n = 166 individual children subject to sexual abuse CIRs during the Inquiry period.

Table 9: Average number and type of placements, 1 March 2013 – 28 February 2014

TYPE OF PLACEMENTS	RESIDENTIAL CARE	SECURE WELFARE	HOME-BASED CARE	ALL PLACEMENT TYPES
Average number of placements per child	4.5	1.3	10.0	15.9

n = 166 individual children subject to sexual abuse CIRs during the Inquiry period.

9. Appendices

Appendix 6: Response from the Department



Secretary
Department of Health & Human Services

23 JUL 2015

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RECEIVED
23 JUL 2015
BY: 11296

Bernie Geary OAM
Principal Commissioner
Commission for Children and Young People
Level 20
570 Bourke Street
Melbourne VIC 3000

Dear Commissioner *Bernie*

Thank you for your letter of 8 July 2015 and the opportunity to provide comments on excerpts of the Commission for Children and Young People's ('the Commission') draft report on the *Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care*.

The Department of Health and Human Services is strongly committed to protecting and enhancing the health, safety and wellbeing of children and young people who reside in residential care. The department works in collaboration with the not-for-profit sector to achieve this goal.

Thank you for your work on this report – the subject matter is sensitive and important – and I welcome the review by the Commission into this.

The sexual exploitation of children and young people in residential care is a very serious issue and I note with grave concern many of the case examples provided in the report. The report highlights a number of systemic issues that warrant the focus and efforts of many including Government departments, the Victoria Police, the not for profit providers, your office, parents and families, as well as the broader community, to protect these vulnerable young people from exploitation. The department takes very seriously its role and responsibilities to support and protect children and young people. While a number of improvements to policy, practice and oversight are well underway it is clear that we need to do better and do more.

Having reviewed the excerpt of the draft report provided, there are a small number of comments that I wish to make. I ask you consider these when finalising the report.

At the outset, I want to acknowledge the important and great work done by the vast majority of organisations and people who work tirelessly to look after the best interests of our children, particularly those most vulnerable children who come into our care. Nevertheless, as highlighted in the report, there are clearly areas in our system, policy, and in our practice that must be improved and I welcome the Commission's focus on this in the report.



Let me assure you that the department and I are committed to working with you and with the sector to continue to drive improvements in design and practice in this important area. As you and I have discussed, we need to ensure that there is a positive dynamic generated by the work of the Commission and in the response of the department and the sector to the findings of external oversight institutions.

In creating this positive dynamic, can I ask that a number of generalised statements and factual statements get checked for their accuracy prior to the finalisation of the report, so as to minimise distractions from the more substantive recommendations.

- For instance, the excerpt of the draft report contains a number of generalised statements and many factually incorrect statements which imply that the department and community services organisations have failed to act to manage incidents. Such generalisations cannot be substantiated in the majority and hence should be appropriately caveated.
- To be specific in making this point, I highlight Case Example 4 where the draft report states that there was no evidence on file that any action was ever taken to find the missing young person, which may lead the reader to assume that the department took no such action. However, the case file in question contains details of a number of actions taken including warrants issued, work with Victoria Police and efforts by the case manager to locate the young person. There was also considerable effort to secure the safety of the young person while in hospital. There are many other similar examples across the draft report where what is stated is at odds with the action taken by staff.
- I ask that the allegations by Community Service Organisations, that departmental staff deliberately withheld information about a child (pg 55) are double checked as the claim is serious.
- I ask that the claim by the Commission that it 'did not find evidence that such prevention strategies are practised in residential care in Victoria.' (pg 57) is reconsidered given other parts of the draft report comment that the department has prevention strategies in place, such as the work with Victoria Police.
- I ask that consideration be given to appropriate caveats to the statement that '[d]epartmental staff largely indicated that they did not consider initiatives to prevent staff to child sexual abuse in residential care to be within the remit of their role.' (pg 63) as to being a specific case in point, if accurate, rather than a generalised statement given the commitment, role and passion of the staff of this department and in community sector organisations in supporting vulnerable children and families.
- Finally, I ask that consideration be given to appropriate caveats being considered for various generalised statements about the absence of incident analysis, monitoring and compliance enforcement by the department. These important activities do occur and failure in specific cases may not constitute a systems failure (unless, of course, this is the finding of the Commission).

I believe these considerations will enable greater focus being brought to matters of system design, structure, policy, and practice and lead to genuine improvements in both culture and practice and thus lead to better outcomes for even more children.

9. Appendices

The department is strongly committed to improving the outcomes of children and young people in out of home care and will seriously consider the findings and recommendations of the Commissioner's final report. I would appreciate the opportunity to meet with you following the release of the report to detail the work of the department in strengthening responses to safeguard children and young people in out of home care.

Thank you for your consideration of these matters and I wish you and the Commission well in finalising the report.

Yours sincerely



Dr Pradeep Philip
Secretary

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Relevant Acts

Charter of Human Rights and Responsibilities Act 2006 (Vic)

Children, Youth and Families Act 2005 (Vic)

Commission for Children and Young People Act 2012 (Vic)

Community Welfare Services Act 1978 (Vic)

Crimes Act 1958 (Vic)

Crimes Amendment (Protection of Children) Act 2014 (Vic)

Privacy and Data Protection Act 2014 (Vic)

Other relevant documents

United Nations Convention on the Rights of the Child



COMMISSION FOR CHILDREN AND YOUNG PEOPLE

Commission for Children and Young People logo

The logo represents our vision for all children to be strong in health, education, culture and identity; and facing the world with confidence.

The people are connected, equal in size and importance and there is a fluidity that binds them together.
This is the mission of the Commission as an organisation, and also the goals it seeks to achieve for all young Victorians.

The symbol is a Koorie design created by Marcus Lee for the Commission.

The Commission respectfully acknowledges the Traditional Owners of the country throughout Victoria
and pays respect to the ongoing living cultures of First Peoples.