VICTORIAN ombudsman

Investigation into complaints about assaults of five children living in Child Protection residential care units

October 2020

Ordered to be published
Victorian government printer
Session 2018-20
P.P. No. 177

Accessibility

If you would like to receive this publication in an alternative format, please call 9613 6222, using the National Relay Service on 133 677 if required, or email vocomms@ombudsman.vic.gov.au.

The Victorian Ombudsman pays respect to First Nations custodians of Country throughout Victoria. This respect is extended to their Elders past, present and emerging. We acknowledge their sovereignty was never ceded.

Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973* (Vic), I present to Parliament my *Investigation into complaints about assaults of five children living in Child Protection residential care units.*

Deborah Glass OBE
Ombudsman

28 October 2020

Warning

This report contains information some may find distressing or uncomfortable. If you experienced abuse as a child or young person at home or in care, it may be a difficult reading experience.

The report also contains references to views, policies and practices that may not reflect the current views, policies or practices of the Community Service Organisations involved, the Department of Health and Human Services or the State of Victoria.

If you find the report's content distressing, please seek support either from the Department or another agency. If you are not sure how or where to access support, contact the Victorian Ombudsman for assistance:

Email: enquiries@ombudsman.vic.gov.au

Telephone: (03) 9613 6222 or 1800 806 314 (regional only)

In person: Level 2, 570 Bourke Street, Melbourne.
Our office is wheelchair accessible by lift.

Please note: At the time of publishing this report (October 2020), our office is closed to members of the public due to the COVID-19 pandemic. If you are reading this report at a later time, our office may have re-opened. Please call or email us before visiting to check whether our office has re-opened to visitors.

Contents

Foreword

'What's the point of moving a child from a place that is regarded as not safe, but plac[ing] that child into another place that is also not safe?'

– 'Kylie'

This report tells the stories of five young people in State care. While in residential care each said they had been physically and sexually assaulted. All were moved multiple times.

A teenage girl at risk of sexual exploitation was reportedly raped by three men when she absconded from her residential care unit. She missed two years of school while in care and is now so far behind she says she is too embarrassed to return.

A traumatised teenager began drinking, using drugs and attempting self-harm. She was raped by an adult man months after going into care.

An Aboriginal girl said some weeks after arriving at the unit, a local drug dealer was giving her ice. The Police are investigating her allegations of rape, although she reportedly fled before a forensic examination could be conducted. Her cultural plan, intended to support and connect her to her community, took over a year.

A transgender girl told us her experience in residential care destroyed her life. Her sexual identity was deemed a risk to others and her female items were taken away from her. She said she was continually sexually assaulted by another resident.

A non-binary child was the subject of multiple reports of sexual assault. He started using drugs, became involved in criminal offending and missed a year of school while in residential care. His relative is worried he has been 'set up for failure'.

Some were given psychotropic drugs to manage their behaviour. In the disability sector this is known as chemical restraint and required to be carefully controlled. No such controls exist in residential care. One told us: 'I was on so much medication, I was that slow, it'd take me two minutes just to answer a question.'

Their stories are shocking. They are also painfully sad. These young people had lived difficult lives before they went into care, which may have been as a result of family violence, parental substance abuse or other factors causing their complex and challenging behaviours. Residential care is, rightly, a last resort when neither parental, kinship or foster care is appropriate or available. But they were all damaged further by their experience.

The experiences of the five children in this report are not new or isolated: in the last decade, numerous independent bodies have warned of significant and systemic problems with the residential care system. The Commission for Children and Young People, in in its most recent report on out-of-home care, found it to be 'often unsafe for children and young people and places them at an unacceptable risk of harm'.

The Department of Health and Human Services acknowledges that children in residential care 'are often those who have experienced the greatest level of trauma and … require the most expert therapeutic care and support'. It recognises that Aboriginal young people face the added impact of intergenerational trauma and disconnection from culture.

Current legislation requires the Department, and the organisations who deliver services on its behalf, to give effect to the 'best interests' of the child. Our charter of human rights legislation also emphasises this, and the right of children both to be safe and feel safe.

Yet despite the numerous critical reports, solid legislative framework and indeed, the good intentions of the many hardworking and dedicated professionals who work in the system, it continues to fail.

Those working in the system told us of the pressures to take children, of placements based on the 'least-worst' option rather than the best interests of the child, even where the match was risky or unsafe. That placement decisions were dictated by the availability of beds. That the system was not designed or resourced to deal with complex needs and behaviours of concern. That the Department is simply too busy dealing with 'the crisis of the day'. Community Service Organisations told us vital information may not be provided with the placement, and of the pressure by the Department to 'fill targets'.

These cases expose the dark underbelly of our society, that perhaps many of us would rather not see. Troubled, sometimes violent families, children exposed to trauma or substance abuse, needing the State to give them a safe home – but they end up more damaged, with even greater odds to overcome to lead meaningful and productive lives. Young people harmed by residential care - not only at a huge cost to themselves and their families, but ultimately also to the State.

These failures are not the result of deliberate disregard for the welfare and safety of the children, either within the Department or the Community Service Organisations. They stem from a system that is neither resourced nor structured to address the multiple complex demands being placed on it.

There are practical solutions, and we put forward two: moving from a four-bed residential care model to a two-bed model to support better placement decisions and therapeutic care. Establishing an independent advocate for children in care, which we believe sits well with the current functions of the Commission for Children and Young People. These are major reforms that will cost money, but as these cases show, doing nothing may well come at a greater cost.

I welcome the Government's acceptance in principle of my recommendations, and will report further on their implementation in practice.

Nearly a thousand Victorian children lived in residential care at some time in the last year. My profound hope is that this is not simply the latest in a long list of critical reports, from which little seems to change.

Deborah Glass

Ombudsman

Executive summary

Why we investigated

1. If it is not safe for Victorian children to live at home and there are no family or foster carers available, the Department of Health and Human Services Child Protection places children in residential care. Residential care involves units (usually modified houses) where up to four children live under the care of organisations known as Community Service Organisations ('CSOs') which operate under a contractual arrangement with the State Government.

2. References to children in this report include children and young people up to 18 years.

3. In 2019-20, 925 children spent time in residential care. These children tend to have complex needs. The Department's website acknowledges they:

> are often those who have experienced the greatest level of trauma and who, therefore, require the most expert therapeutic care and support.

4. Children in care have the right to 'be safe and feel safe'. But, between July 2018 and March 2019, the Ombudsman received complaints alleging five children were victims of multiple physical and sexual assaults in residential care, either by other children in care or people in the community. Some of the assaults have been proven in court or are currently before the courts. In other cases, there was insufficient evidence for Police to take matters further, or the assaults were not reported or recorded.

5. The complaints all raised questions about the placement, care and supervision of the children by the Department and its Child Protection unit ('Child Protection') and particular CSOs.

6. In light of the common themes in the five complaints, the Ombudsman decided to investigate:

   - the immediate safety of the children still in residential care
   - the suitability of the children's placements
   - the care and supervision of the children
   - responses to the alleged assaults and other major incidents involving the children.

7. The investigation looked at the actions and decisions of Child Protection and the Department, which funds and regulates the CSOs.

8. It also looked at the CSOs involved in caring for the children at the time of the alleged assaults and incidents:

   - Child and Family Services Ballarat Inc ('CAFS')
   - Uniting (Victoria and Tasmania) Limited ('Uniting')
   - Berry Street Victoria Incorporated ('Berry Street')
   - Victorian Aboriginal Child Care Agency Co-operative Limited ('VACCA')
   - Anglicare Victoria ('Anglicare')
   - Junction Support Services Inc ('Junction').

The children's experiences

9. Residential care is meant to provide a safe place for children who cannot live safely at home. In the case of these five children, the investigation found that the system failed.

10. The evidence records assaults or alleged assaults against all five children while they were in residential care. It also shows the behaviour of the children grew more problematic after they went into care.

Quinn

Quinn spent three years in residential care from 2008 to 2011, when she was a teenager. In 2019, she contacted the Ombudsman to say she had been assaulted by an older boy in her residential care unit and had not received a proper response from the Department.

Quinn had been diagnosed with various disabilities at the time, including an autism spectrum disorder. She was transitioning from male to female identity.

The evidence shows:

- Child Protection placed Quinn in a CAFS unit with an older teenage boy with a known history of violent outbursts.
- There were many recorded incidents of threatened or actual violence between the pair.
- Child Protection knew about the incidents. It did not move either child until almost two years later, after the boy reportedly repeatedly punched Quinn to the face and head and was charged by Police.
- Quinn later disclosed the boy 'constantly' sexually assaulted her by grabbing her genitals. CAFS did not investigate the allegations nor notify Police – so the allegations remain unproven. CAFS also did not refer Quinn for counselling.
- It appears that Quinn may have been medicated to try to control her behaviour.
- Quinn was not allowed to have female clothes or items at the CAFS unit. Later, her sexual identity and behaviours were apparently deemed a risk to others.

Kylie

Kylie is a young Aboriginal woman who has been in residential care since 2018, when she was 14 years old. Her mother contacted the Ombudsman with concerns about Kylie's care. She said Kylie had been raped while away from her residential care unit and she feared for her daughter's safety.

The investigation found that since going into residential care, Kylie lived in three different units managed by Uniting, Berry Street and VACCA. The evidence shows:

- Kylie began using drugs after going into residential care and started leaving her unit and meeting older men.
- Around seven weeks after going into residential care, Kylie told workers she had been raped by an adult man in a laneway. In early October 2020, Police advised the investigation into this alleged assault is ongoing.
- Other children in the units also allegedly assaulted Kylie.
- Berry Street and VACCA said Child Protection pressured them to take Kylie, even though there were risks involved in placing her in their units.
- Child Protection is meant to give Aboriginal children a cultural plan to support their connection to their heritage and culture within 16 weeks of going into care. It did not give Kylie her plan for 53 weeks.

Brittany

Brittany is in her teens and has been in and out of residential care since 2018, when she was 11 years old. Her records describe concerning behaviours, including self-harm, and say she is at risk of sexual exploitation. In January 2019, a family friend reported to the Ombudsman that Brittany was raped by three men while she was away from her residential care unit.

The investigation found Child Protection had moved Brittany many times because of her needs and behaviours. It focused on her first two residential placements with Berry Street and Anglicare. The evidence shows:

- Berry Street accepted Brittany in one of its units with an older girl with a history of significant mental health issues. It thought the girl would act like an older sister. But Brittany started mimicking the older girl's behaviours, including self-harming and misusing drugs.
- Three months later, a Berry Street worker witnessed the two girls kissing, and Child Protection agreed to move Brittany.
- After Brittany moved to an Anglicare unit, Anglicare accepted another girl who was also at risk of sexual exploitation. They started running away and Brittany told workers she was getting explicit text messages from men.
- Brittany later told workers she had been raped twice – once by an adult man in an apartment, and another time by three adult men after she and the other girl ran away at night. Regarding the first alleged rape, Police said Brittany did not make a statement and there were insufficient details for it to investigate. The second alleged rape is before the courts.

Avery

Avery is a young woman in her teens who has been in residential care since 2018, when she was 13 years old. She has been diagnosed with an autism spectrum disorder and complex behavioural disorders. She lived in two different Berry Street units during her first year in residential care.

In 2019, Avery's mother contacted the Ombudsman saying that Avery had been raped by an adult man while away from her residential care unit. She also said Avery had started using illegal drugs and self-harming. The investigation found:

- At first, Avery was meant to be the only child placed in her unit because of her complex needs and behaviours.
- Berry Street said Child Protection pressured it to accept other children in the unit. After this, Avery's behaviour deteriorated and she began using drugs.
- Around five months after going into care, Avery was raped by an adult man at his home. Police told the investigation the man was found guilty at court and is currently appealing his sentence. Avery has since been hospitalised many times after self-harming.
- Avery also reported that one of the other children in her unit assaulted her three times.
- Child Protection and Berry Street moved Avery to another Berry Street unit where she was the only child. However, problems continued.
- Berry Street told the investigation there are growing numbers of children with complex disabilities in residential care. It submitted the system was not designed for these children and more support is urgently needed.

Alex

Alex is a young person in his teens with a complex history and behaviours, including mental health conditions. He identifies as non-binary but prefers to be referred to using male pronouns. One of his family members told the Ombudsman that Alex reported he was raped by another boy shortly after going into residential care. The investigation found Alex has been in and out of residential care since early 2019. It focused on Alex's first placement with Berry Street and two later placements with Junction. The evidence shows:

- At first, Child Protection placed Alex in a Berry Street unit with three other boys. Alex told Child Protection he was anxious because he had been sexually assaulted by adolescent boys in the past.
- Records show unit workers allowed a younger boy to stay in Alex's room overnight. Although workers checked on the boys regularly, Alex later said the boy raped him. Police advised it did not lay charges and Berry Street said its own internal investigation did not substantiate the sexual assault.
- After Alex moved to a Junction unit, Child Protection and Junction placed a teenage boy with a history of criminal offending in the unit.
- Alex and the other boy started running away together and using drugs.
- Alex was allegedly seriously assaulted by someone he said was his drug dealer, and spent more than 12 hours in hospital.

Wider issues

11. Evidence shows the experiences of the five children are not new or isolated. Over the last decade, many oversight bodies have warned of significant and systemic problems with the residential care system – this office, the Victorian Auditor-General's Office, the Royal Commission into Institutional Responses to Child Sexual Abuse, the Institute of Child Protection Studies and the Victorian Commission for Children and Young People ('CCYP').

12. This investigation identified several wider issues across the five cases.

Placement pressures

13. The evidence shows Child Protection and the CSOs knew there were risks involved in the placements of these children, either before they moved in or soon afterwards.

14. The investigation found these problems were not the result of deliberate disregard for the welfare and safety of the children. In some cases, the CSOs expressed concerns about the suitability of proposed placements. However, they told the investigation they could not always resist 'pressure' from Child Protection to take the children, even when the 'match' with other children may be risky or unsafe.

15. Child Protection representatives and the Department spoke of a stretched system in which Child Protection workers are forced to make 'least-worse' decisions for children. Placement decisions were dictated by the availability of beds, rather than children's best interests.

Level of care

16. The five cases also raise questions about the level of care available for children with complex needs and behaviours.

17. Supervision in some cases was inadequate and staff were sometimes unclear about the children's safety plans, which are meant to be implemented when a child does not return to their unit.

18. CSOs sometimes lacked critical information about the children to assist workers in providing informed care and support.

19. Child Protection's policy frameworks rely on Care Teams and plans to manage risks to children and coordinate responses. However, there was sometimes confusion between Child Protection and CSOs about who was meant to lead Care Teams or planning.

20. There were also multiple examples of CSOs failing to engage services to address children's needs and behaviours.

Incident reporting

21. The five cases also demonstrate ongoing challenges with Child Protection's incident report and response system.

22. The five children in this report experienced multiple incidents that required an incident report, including alleged assaults and absconding. The CSOs complied with incident report requirements in some cases but, in others, there is evidence that workers failed to complete incident reports, incorrectly categorised incidents as 'non-major', and failed to notify Police of possible offences against children. The Department identified and corrected these problems in some cases, but not all.

23. The investigation observed there is also confusion about what constitutes a report to Police. At times, CSOs seemed to have conflated a police report with a formal victim statement: while the latter must be made by the victim, anyone can make a police report. There were also issues with the way contact between Police and agencies was documented.

Cultural support and planning for Aboriginal children

24. In Kylie's case, Child Protection and two of the CSOs failed to meet some of the requirements designed to support Aboriginal children's connection with culture and community. Some of these issues were not addressed until Kylie moved to VACCA, an Aboriginal Community Controlled Organisation.

25. The VACCA representative said at interview that the failures in Kylie's case are not isolated. They expressed frustration that plans are often delayed and do not seem to be a priority for Aboriginal children.

26. This view is supported by other complaints to the Ombudsman and CCYP's 2015 report on residential care, *"...as a good parent would..."*, which found that:

> [the] current residential care system can contribute to the isolation of Aboriginal children from their culture and community.

Medication and chemical restraint

27. Three of the five children in this report – Quinn, Avery and Alex – had evidence in their files suggesting they may have been medicated to manage or control their behaviour.

28. Use of 'chemical restraints' carries human rights implications. In the disability sector, it is subject to regulation and oversight to protect the rights of people with disabilities. Registered disability providers must obtain authorisation from the Department before using chemical restraints.

29. The investigation identified no such laws or protections for children in residential care. In the three cases in this report, Child Protection and the CSOs investigated could not be sure if the children were given medication for this purpose.

LGBTIQ support

30. Two of the five children in this report – Quinn and Alex – experienced problems in residential care because of their gender identity.

31. The investigation acknowledges Quinn was in residential care some 10 years ago. CAFS says it has since developed more inclusive practices. Alex's more recent experience in 2019, when he was placed in a unit with children who were likely to target him, suggests there is still room for improvement.

32. The investigation did not hear evidence about the experiences of other LGBTIQ children in residential care. However, it notes that during the period under investigation, there was little written guidance for Child Protection or CSO workers about how to support LGBTIQ children.

Recommendations

33. The investigation explored two key potential solutions to part of the problems identified in evidence and recommended:

- a new two-bed residential care model
- an independent advocate to promote the rights of children in care.

A two-bed residential care model

34. Multiple witnesses agreed that the State Government needs to move away from the current four-bed model of residential care.

35. The investigation heard the four-bed model is not in the best interests of children with such complex histories and needs. The Department acknowledged that the placement in one house of four unrelated children with adverse life experiences, trauma and behaviours of concern:

> may result in a high level of incidents that impact on children's safety, their exposure to further trauma and the quality of care they receive.

36. The Department also advised that while demand for residential care services is increasing, the number of beds have remained the same, making placement matching even more challenging.

37. The Department has been considering the benefits of moving the residential care system from a four-bed model to a two-bed model. It said this model would provide capacity for individualised and intensive responses to children, with the support of mental health clinicians, family workers and community workers. It also said it would provide for better matching of children in placements, stability and a sense of belonging for children, and more opportunities to engage with family, community and education.

38. The Ombudsman recommends conversion of standard four-bed residential care units to therapeutic two-bed units with enhanced access for the children to services, particularly mental health and education, while maintaining some capacity in the system for larger groups (ie siblings).

An independent advocate for children in care

39. The investigation also considered practical ways to protect the rights and interests of children in residential care before problems occur.

40. In these five cases, the children's files and other evidence shows the children or their families often voiced early concerns with Child Protection or CSO workers, but with little success.

41. The Department and the CSOs have internal complaints systems available for children and families. In these cases, they were not effective ways to promote the children's interests.

42. Victoria also has two external bodies with an oversight role - CCYP and the Ombudsman. However, there is no independent person who regularly visits individual children in care and advocates on their behalf. Such offices exist in other contexts. South Australia's Office of the Guardian for Children and Young People advocates for the rights of children in care in that state. In Victoria, the Office of the Public Advocate plays a similar advocacy role for people with a disability.

43. The Ombudsman recommends establishing an independent children's advocacy function within the CCYP.

Other recommendations

44. The Ombudsman also made recommendations to:

- regulate the administration of chemical restraints to children in residential care
- ensure all alleged physical and sexual assaults of children in residential care are reported to Victoria Police, regardless of whether the victim wants to make a statement, and recorded in the systems of Police and the reporting agency
- require that the Department conduct a review of the children in this report who remain in residential care to address the deficits in care that were identified.

Government and Department responses

45. On 21 October 2020, after reviewing the final draft report, the Minister for Child Protection responded on behalf of the Victorian Government and accepted all of the recommendations made to Ministers. The Minister noted policy and budget would need to be examined to develop and implement some of the proposed solutions.

46. The Minister also commented on the significance of the investigation, 'which details the distressing circumstances for these five young people' and said the report:

> highlights a range of issues that contributed to an unsatisfactory level of care and safety for some of Victoria's most vulnerable children.

47. In May 2020, after reviewing the draft report, the Secretary of the Department stated:

> The experiences of the five young people, as detailed in your report, are concerning. The Department and Community Service Organisations are committed to reform the residential care system to provide intensive support and stabilisation for young people with complex needs, and to support their transition to family based care and independence.

48. After reviewing the final draft report and having an opportunity to consider the proposed solutions, the Secretary accepted all of the Ombudsman's recommendations, noting some require budgetary and policy consideration.

Background

Why we investigated

49. Between July 2018-March 2019, the Ombudsman received five complaints alleging children had been assaulted while in residential care.

50. References to children in this report include children and young people aged up to 18 years.

51. Residential care involves units (usually modified houses) where up to four children live under the care of organisations known as Community Service Organisations ('CSOs'), which are contracted with the State Government. The Department of Health and Human Services Child Protection places children in the units if it is not safe for them to live at home, and there are no family or foster carers available.

52. The Department's website says children in care have the right to 'be safe and feel safe'. But the complaints claimed the five children were victims of multiple assaults, either by other children in care or people in the community.

53. The first complaint was from an adult who lived in residential care around 10 years ago. She said an older boy in her unit sexually assaulted her, and she never received an adequate response from the Department. She said she experiences ongoing trauma and has been suicidal at times. She was worried about children in care now.

54. The four other complaints involved children who were still in residential care. They were made by concerned family or friends, who alleged the children had been sexually or physically assaulted while in care.

55. The complaints all raised questions about the placement, care and supervision of the children by the Department and its Child Protection unit and CSOs.

56. In light of the common themes, the Ombudsman decided to investigate:

    - the immediate safety of the four children still in residential care
    - the suitability of the five children's placements
    - the care and supervision of the children
    - responses to the alleged assaults and other major incidents involving the children.

57. The investigation looked at the actions and decisions of Child Protection and the Department, which funds and regulates the CSOs.

58. It also looked at the CSOs. There were six CSOs involved with the children at these times (some of the children lived in multiple residential care units managed by different CSOs). They were:

    - Child and Family Services Ballarat Inc ('CAFS')
    - Uniting (Victoria and Tasmania) Limited ('Uniting')
    - Berry Street Victoria Incorporated ('Berry Street')
    - Victorian Aboriginal Child Care Agency Co-operative Limited ('VACCA')
    - Anglicare Victoria ('Anglicare')
    - Junction Support Services Inc ('Junction').

59. The investigation did not look at all aspects of residential care. The Commission for Children and Young People ('CCYP') is the specialist body for these matters and was conducting a systemic inquiry into the lived experience of children in out-of-home care during the investigation.

60. The investigation also did not investigate the alleged assaults, as these are criminal matters. Some of the assaults have been proven in court or are currently before the courts. In other cases, there was insufficient evidence for Police to take matters further, or the assaults were not reported or recorded.

61. Rather, the investigation looked at the experiences of these five children to identify possible wider problems with residential care.

Jurisdiction

62. Under the *Ombudsman Act 1973* (Vic), the Ombudsman may investigate administrative actions taken by or in an authority. The Act defines an 'authority' as a department, such as the Department of Health and Human Services. Child Protection is a business unit in the Department.

63. An 'authority' also includes a 'specified entity' set out in Schedule 1 to the Act. Item 19 of Schedule 1 includes a 'registered community service' (CSO) in accordance with the *Children, Youth and Families Act 2005* (Vic). The six CSOs are registered community services under that Act.

64. Four of the complaints were investigated pursuant to section 15B of the Ombudsman Act, which empowers the Ombudsman to investigate complaints made by 'directly affected' persons (in this instance, the children or their families). The fifth complaint was made by a family friend and the Ombudsman investigated that matter using her 'own motion' powers pursuant to section 16A of the Act.

65. The Ombudsman Act also empowers the Ombudsman to investigate whether an administrative action is incompatible with, or an agency has failed to give proper consideration to, a right set out in the *Charter of Human Rights and Responsibilities Act 2006* (Vic) ('Charter of Rights Act').

How we investigated

66. On 15 April 2019, the Ombudsman notified the Minister for Child Protection and the Secretary of the Department of her intention to investigate the complaints.

67. The Ombudsman notified the six CSOs between 24 and 26 April 2019. The Ombudsman sent an additional notification to Berry Street on 2 August 2019, after the investigation identified Berry Street provided care to an additional child.

68. The people who complained to the Ombudsman were notified between 26 and 29 April 2019.

69. The investigation considered Department policies, Annual Reports and practice guides applicable at the time including:

- *Child Protection Manual* ('Child Protection Manual')
- *Program requirements for residential care in Victoria* (October 2016) ('Residential Care Program Requirements')
- *Program requirements for the delivery of therapeutic residential care in Victoria* (October 2016) ('Therapeutic Care Program Requirements')
- *Placement Coordination and Placement Planning Framework* (December 2012) ('Placement Framework')
- *Placement Coordination and Placement Planning Manual* (December 2012) ('Placement Manual')
- *Client Incident Management Guide Policy Update 1-2020* (20 December 2019, effective 3 February 2020) ('Incident reporting Policy update')
- *Client Incident Management Guide Client Incident Management System, November 2017* ('Incident reporting guide')

- *Incident reporting instruction* (March 2008) (superseded)
- *Responding to allegations of physical or sexual assault* (August 2005) (superseded)
- *Human services standards evidence guide* (September 2015) ('Human Services Standards')
- *Wungurilwil Gapgapduir Aboriginal children and families agreement - a partnership between the Victorian Government, Victorian Aboriginal communities and the child and family services sector* (April 2018) ('Wungurilwil Gapgapduir')
- *Office of the Senior Practitioner, Practice Advice: Important information about medications prescribed for the primary purpose of the behavioural control of a person with a disability* (February 2008) ('Practice Advice restrictive interventions')
- *Administration of medication* (Advice, Child Protection Manual 22 December 2017)
- *Out-of-Home Care Education Commitment* (2018)
- *Minimum qualification requirements for residential care workers in Victoria* (December 2018)
- *Protecting children: Protocol between Department of Human Services – Child Protection and Victoria Police* (2012) ('Child Protection and Police Protocol') and *Addendum: Preventing sexual exploitation of children and young people in out-of-home care* (2014).

70. The investigation also:
    - sought written responses from the Department and the six CSOs
    - reviewed the five children's files
    - examined relevant CSO policies
    - obtained data from the Department and CCYP
    - reviewed relevant academic research
    - attended a national child protection forum focused on the care of Aboriginal children
    - reviewed other significant reports on child protection by CCYP, the Victorian Auditor-General, the Royal Commission into Institutional Responses to Child Sexual Abuse (2013-2017) and public submissions being made to the current Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability
    - conducted enquiries into new complaints to the Ombudsman during the investigation, mostly from other children about their safety and stability in residential care
    - obtained information from:
        - Police and examined the *Victoria Police Manual, Crime and event reporting and recording* (29 March 2019)
        - CCYP
        - WorkSafe Victoria
        - Department for Child Protection, South Australia
        - a child psychologist who worked with one of the children
    - interviewed eleven witnesses. Ten of the interviews were conducted under oath or affirmation. Two witnesses were accompanied by a legal representative and two were accompanied by a support person.

71. During the evidence-gathering phase, the investigation interviewed the adult who made the first complaint, but not the four children still in care. The investigation contacted the children, through the Department, with written information about the investigation. The children were invited to ask questions, raise concerns or contribute. None made contact at the time.

72. The Ombudsman was guided by the civil standard of proof, the balance of probabilities, in determining the facts of this investigation - taking into consideration the nature and seriousness of actions and decisions and the gravity of the consequences that may result from forming any adverse opinion.

73. This report contains adverse comments about the Department and the six CSOs.

74. In accordance with section 25A(2) of the Ombudsman Act, the investigation provided these organisations, and Police, with a reasonable opportunity to respond to the material in a draft version of this report. This report fairly sets out their responses.

75. In accordance with section 25A(3) of the Ombudsman Act, any other persons who are or may be identifiable from the information in this report are not the subject of any adverse comment or opinion. They are named or identified in the report, as the Ombudsman is satisfied that:

    - it is necessary or desirable to do so in the public interest, and
    - identifying those persons will not cause unreasonable damage to those persons' reputation, safety or well-being.

Privacy

76. This report contains sensitive personal information about the five children and their families.

77. The report has changed the names of the children to protect their identities. It has also left out some dates and other details that might identify the children and their families.

78. After preparing the draft report, the investigation consulted the young adult and family members who had complained and shared relevant excerpts of the draft report with them. The investigation also invited the four children to contact the investigation if they wished to discuss or view the report. Two of the children made contact and the report reflects their views.

79. The report also contains information about other children in residential care and people in the community who were involved in the reported assaults. Some of the assaults have been proven in a court, while others remain as unproved allegations. The Ombudsman has formed no opinion about the guilt of any person in relation to any alleged criminal offence.

Child protection and residential care

80. The experiences of the five children in this report require some understanding of Victoria's child protection and residential care systems. This section explains the origins and structure of these systems and the Department's and CSOs' obligations to keep children safe and well.

81. The history of Child Protection services is based on information in the *Australian Institute of Family Studies, History of child protection services* (2015).

History of child protection in Victoria

82. Child protection services in Victoria date to the late nineteenth century. Post-colonised Australia and similar societies considered children to be the property of their parents. In 1870s New York, for example, a concerned authority had to seek protection for a 10-year-old girl with the help of animal protection workers, as there were no laws to protect children from cruelty. The only options for 'abandoned' children were orphanages run by religious and volunteer organisations.

83. Victoria's first child protection service was established in 1894. The service was run by a non-government service, the Victorian Society for the Prevention of Cruelty to Children. The service focused on young children and severe neglect and physical abuse.

84. From the 1960s, public awareness about the physical abuse of children grew due to medical research and media attention about what was then called 'battered-child syndrome'. Into the 1970s and 1980s, there was a move away from institutionalisation of children. Foster care and smaller group homes became the preferred options for children who could not live at home. The concept of child abuse also began to expand from the 1980s and 1990s, to include sexual and emotional abuse.

85. Victoria did not establish a statutory child protection service until 1985. Until 1994, it operated as a 'dual-track' system, where Police dealt with cases that could not be handled by the child protection service.

86. Many past child protection practices were damaging to children and communities, particularly Aboriginal communities. In 2008, the Federal Parliament issued an apology on behalf of the nation to the stolen generations of Aboriginal children who were removed from their families, communities and land. The following year, the Federal Government also made a national apology to children who experienced abuse in out-of-home care.

Victoria's current child protection system

87. Victoria's current child protection system is the result of reforms introduced by the 2005 Children, Youth and Families Act. Amongst other things, the Act focuses on:

    - early intervention and prevention for struggling families
    - community-based services and support for families
    - creating timely and permanent placements for children through case planning (ideally at home)
    - recognition of the continued impact of child protection policies on Aboriginal communities and the importance of maintaining Aboriginal children's connection to culture and community.

88. The system faces significant pressures. The Department advised its Child Protection service received 122,179 reports about children's safety and wellbeing in 2019-20. Nearly 35,000 of these reports required formal investigation.

89. When a child cannot live safely at home, Child Protection has four options for placing children in out-of-home care:

    - kith or kinship care, where children live with friends or family such as grandparents
    - foster care, where children live with approved community members or families with whom they have no pre-existing relationship
    - permanent care, where children live in an ongoing arrangement with a carer who also becomes the child's guardian
    - residential care, which is the focus of this report.

Residential care

90. Child Protection uses residential care when home-based options such as kinship and foster care are not available.

91. Residential care involves placing children into residential care units in the care of paid workers. Residential care units in Victoria are usually modified houses that cater for up to four children. There are two types of units: standard and therapeutic.

92. Therapeutic units deliver specialised care from a trauma-informed perspective, with a focus on healing through relationships and emotional bonds with trusted carers. These units do not provide any therapeutic services directly to the children. Instead, clinical specialists provide advice and support to workers in the units on a part-time basis.

93. The Department also operates a Secure Welfare service, where children at substantial and immediate risk of harm live for short periods in locked single-sex units.

Agencies and organisations

Department of Health and Human Services Child Protection

94. The Child Protection service investigates reports of child abuse; refers children and families to services; takes matters before the Children's Court if children cannot live safely within their families; and arranges and oversees placements for children in care when they cannot live at home.

95. In 2019-20, Child Protection employed more than 2,000 Child Protection Practitioners in four divisional offices and its statewide services group. The statewide services group, introduced in March 2020, is responsible for delivering After Hours Services, Secure Welfare and Intake (where reports are made).

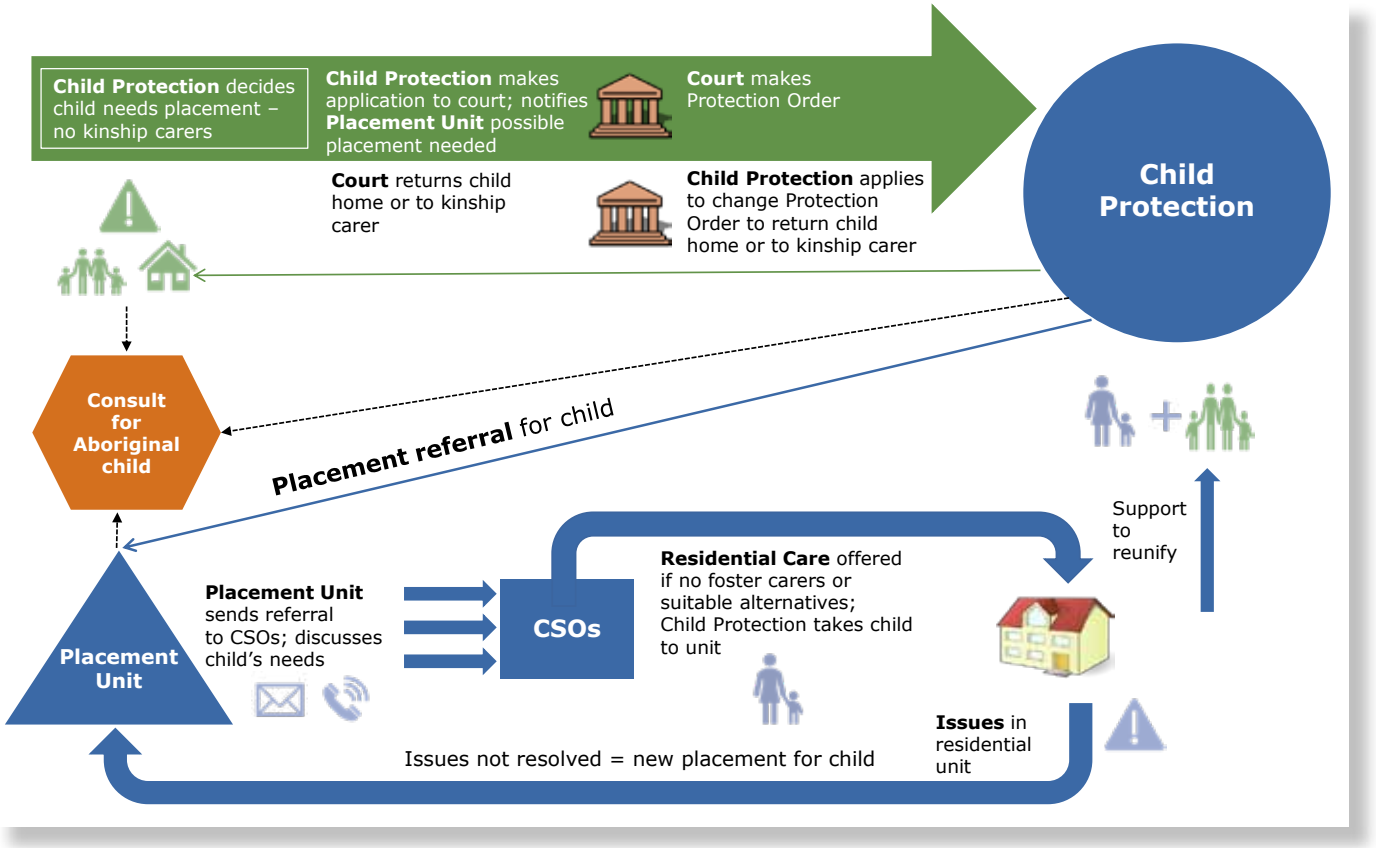
96. Each Child Protection divisional office has a specialist unit called the Placement Support and Placement Coordination Unit ('Placement Unit'). The Placement Units coordinate placements in residential care. A Child Protection Practitioner provides the Placement Unit a 'Placement Referral', which lists the child's needs and the purpose of the placement. The Placement Unit then negotiates with CSOs to find a residential care unit that matches those needs.

97. For Aboriginal children, Child Protection is required to consult Aboriginal services such as Lakidjeka, a specialist Aboriginal consultancy service within VACCA.

98. For placements in therapeutic units, Child Protection establishes specialist referral and selection panels. These include CSO Program Managers, therapeutic specialists, Placement Unit Managers, Child Protection representatives and Aboriginal services as relevant.

99. Figure 1 shows a simplified placement process when a child is placed in residential care.

Figure 1: Example of a residential care placement process



Source: Victorian Ombudsman (incorporating information from Department of Health and Human Services and Community Service Organisations)

100. After children are placed in residential care, Child Protection workers remain involved with the children:

- The Children, Youth and Families Act requires the Secretary of the Department to ensure a case plan is prepared for the child and reviewed at least once a year (sections 166-169).
- Child Protection workers act as the children's case managers, unless the Department appoints a CSO instead.
- Where a CSO is the case manager, Child Protection monitors the CSO's service delivery and takes responsibility for tasks such as preparing reports for the Children's Court.

Community Services Organisations

101. The Department registers and funds CSOs to provide residential care to children.

102. The CSOs in this report are all not-for-profit community organisations. When this report was produced, there were 34 CSOs providing residential care in 175 residential care units around the State.

103. Some CSOs are incorporated Aboriginal organisations that are controlled, operated and governed by Aboriginal people for the purpose of delivering culturally appropriate services to the local Aboriginal community. They are known as Aboriginal Community Controlled Organisations ('ACCO').

104. CSOs take the lead role in supporting children in residential care. They are responsible for children's day-to-day care.

105. Where the Department appoints a CSO to act as a child's case manager as well, the CSO undertakes extra functions including:

    - working with the child and family to achieve case plan goals
    - supporting the placement
    - preparing reports and making referrals for support.

106. The Department funds CSOs based on 'targets' – being the number of children they can accommodate in their units (usually four children per unit), regardless of how many children actually live in the unit.

Children in residential care

107. In 2019-20, the daily average number of children in residential care in Victoria on any single day was 433. A total of 925 children spent time in residential care throughout that year. Most of these children were adolescents; and only 41 children were under the age of 12.

108. Children in residential care tend to have complex needs. The Department's website acknowledges they:

> are often those who have experienced the greatest level of trauma and who, therefore, require the most expert therapeutic care and support.

109. This is supported by McLean's 2018 research in *Therapeutic residential care: an update on current issues* which estimated that in Australia:

    - between 21 and 40 per cent of children in residential care use alcohol and other drugs
    - between two and 36 per cent have autism and other developmental disorders
    - between three and 23 per cent experience depression
    - between six and 30 per cent engage in suicidal behaviour
    - up to 48 per cent demonstrate problem sexual behaviour
    - between 10 and 44 per cent are involved in youth offending.

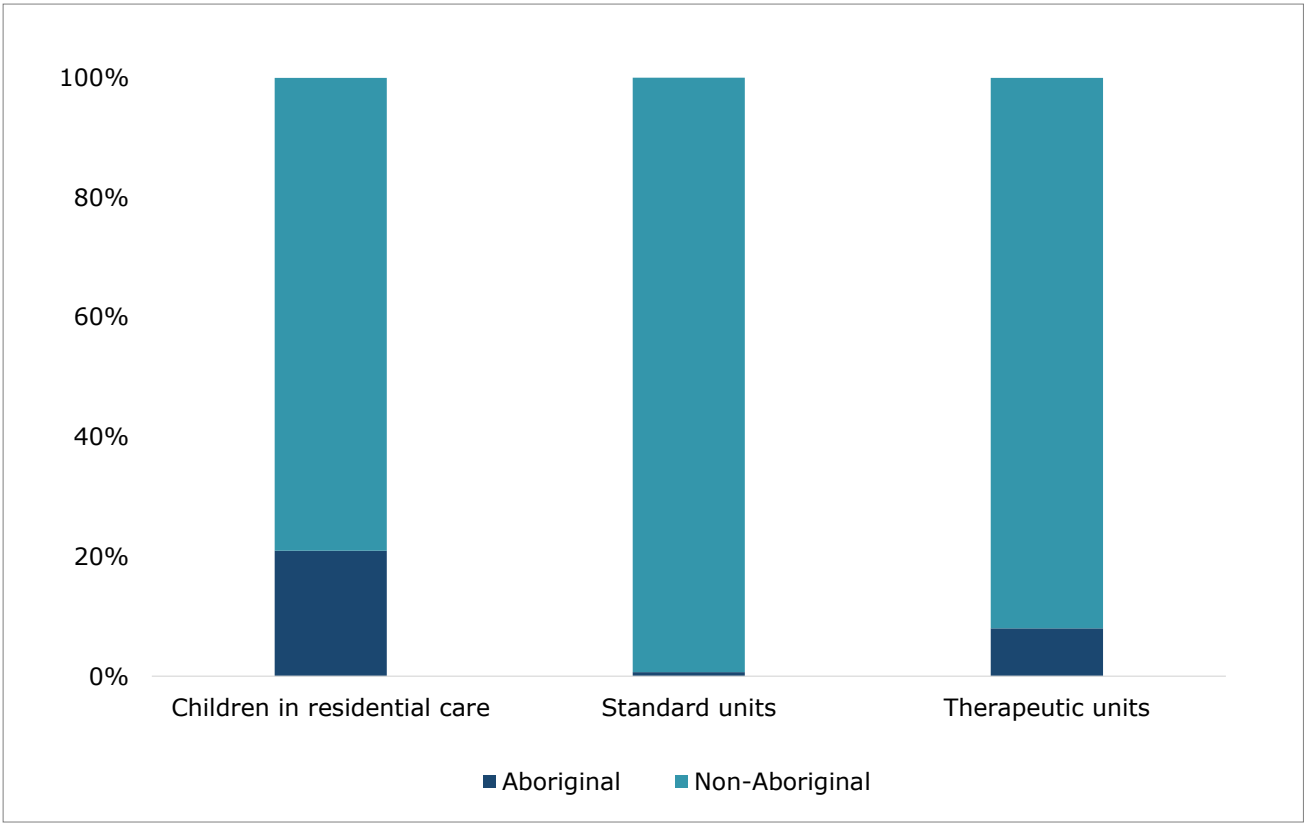
110. In 2016, the Victorian Government budgeted an additional $35.9 million over two years to support CSOs to care for these children. The Department's 2016 Roadmap For Reform stated it would 'begin to transform … the current model to a clinical treatment model'. While most residential care units remain a 'standard' model, every child is now funded at the level for children:

> who display a significant level of complex behaviour, have multiple and complex needs and engage in high-risk behaviours (Residential Care Program Requirements).

111. The Wungurilwil Gapgapduir agreement states that Aboriginal children are significantly over-represented in residential care and other types of out-of-home care – at nearly 16 times the rate for non-Aboriginal children. The rate of Aboriginal child removal in Victoria now exceeds rates of removal during the Stolen Generation period. Australian Census figures show that in 2016 only 0.8 per cent of the Victorian population was Aboriginal. As at 30 June 2020, 21.4 per cent of children in residential care were Aboriginal.

112. There are limited specialist residential care options for Aboriginal children. As at 30 June 2020, only 2.3 per cent of residential care units (one of the 138 standard units and three of the 37 therapeutic units) were managed by an ACCO.

Figure 2: Percentage of Aboriginal children in residential care, compared with Aboriginal-managed residential care available (as at 30 June 2020)



Source: Victorian Ombudsman (incorporating information from Department of Health and Human Services)

Previous reports on residential care

113. Many reports have criticised Victoria's residential care system.

114. In 2014, a Victorian Auditor-General's Office report, *Residential Care Services for Children*, found profound disparities in the safety, well-being and basic living conditions of children in residential care when compared with children in home-based settings.

115. In 2015, CCYP's report *"...as a good parent would..."*, found:

> an alarming level of sexual abuse and sexual exploitation was occurring in Victoria's residential care services, and the system was taking inconsistent approaches to prevent these issues.

116. CCYP made nine recommendations for systemic improvements to prevent sexual abuse and sexual exploitation of children and young people in residential care.

117. In 2016, an Institute of Child Protection Studies report, *Safe and sound: exploring the safety of young people in residential care*, identified problems with lack of stability in residential care placements.

118. The Department's data shows that in 2018-19, children had an average of 2.4 residential care or Secure Welfare placements. In 2019-20, the average number of such placements was 2.3.

119. One child in out-of-home care in 2018-19 had 45 placements, two others had 36 and 29 respectively. In 2019-20, three children experienced 21, 22 and 25 placements respectively.

120. CCYP's 2019 report, *In our own words, Systemic inquiry into the lived experience of children and young people in the Victorian out-of-home care system* ('In our own words') found:

> a pressured, poorly resourced system [that] repeatedly failed to take the views of children and young people into account when deciding where they should live, what they needed from their Child Protection workers and carers, what was happening to them in care, and the contact they had with friends, family and community.

121. Children and young people told CCYP:

> they often felt unsafe in a residential care system that exposed them to violence, drug use and other criminal activity.

122. In 2020, Smales et al found serious flaws in the management and delivery of health services for children in out-of-home care as detailed in *Surviving not thriving: experiences of health among young people with a lived experience in out-of-home care*. These health researchers said children:

> felt their health needs were not adequately met in care, nor did they feel listened to, understood, or educated about health-related matters.

123. Smales et al recommended children's insights be used to guide meaningful and holistic change.

124. Residential care is already the Department's least favoured option for children who cannot live at home.

125. Figure 3 (below) shows the State's out-of-home care placement by type over the last four years.

126. In the last four years, the per cent of children living in out-of-home care in residential care units each day has remained around four per cent, dropping slightly every year.

127. Department documents show it is seeking to 'reduce the number of children in [out-of-home care] who live in residential care'.

128. Since 2016, the Department has funded CSOs to recruit and support more foster carers. However, data suggests these initiatives may have been unsuccessful. At interview, a Child Protection manager reported Victoria had only been able to recruit 33 foster carers in the last year. The Department said that 'the figure cannot be verified … we do not track state wide recruitment'. Figure 3 (below) shows the proportion of children in foster care has reduced every year for the last four years.

129. In response to a draft version of this report, Berry Street referred the investigation to a 2019 research paper by SVA Consulting, *The economic case for early intervention in the child protection and out-of-home care system in Victoria*. That report found demand for out-of-home care is increasing by about 10 per cent each year in Victoria.

Figure 3: Out-of-home care placements from 2016 to 2020 (State daily average)

Year	Foster	Kinship	Permanent	Residential	Totals
2019-20	1,660	7,126	2,963	433	12,182
2018-19	1,697	6,399	2,810	453	11,363
2017-18	1,673	5,581	2,625	424	10,305
2016-17	1,560	5,043	2,407	424	9,446

Note: Columns do not always add up to the total due to a small number of other placement types

Source: Victorian Ombudsman (incorporating information from Department of Health and Human Services)

Standards for residential care

130. The Department and CSOs are bound by laws and standards designed to keep children safe and well in care. They include:

- the Children, Youth and Families Act
- the Department's Human Services Standards, a set of quality standards for Department-funded service providers such as CSOs
- the Department's Child Protection Manual, a guide that covers the full range of child protection services
- the Department's Residential Care Program Requirements, a document setting out specific requirements for children in residential care
- other topic-specific policies and guides.

131. The following section describes the main standards relevant to the alleged assaults mentioned in this report.

The 'best interests' principle

132. The Department and CSOs have an overarching obligation to give effect to the 'best interests' of the child.

133. The Children, Youth and Families Act states 'the best interests of the child must always be paramount' (section 10). It requires the Department and CSOs to have regard to this principle when making decisions or taking action under the Act (section 9).

134. These laws are consistent with Australia's international obligations. The main international treaty on the rights of children, the United Nations Convention on the Rights of the Child (ratified by Australia in 1990), states:

> In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration (article 3(1)).

135. To help the Department and CSOs determine whether a decision or action is in a child's best interests, the Children, Youth and Families Act lists factors that must be considered. They include the need to protect the child from harm and the child's views and wishes (section 10).

Human rights

136. The 'best interests' obligation is aligned with Victorian human rights legislation.

137. The Charter of Rights Act states:

> every child has the right, without discrimination, to such protection as is in his or her best interests and is needed by him or her by reason of being a child (section 17(2)).

138. It is unlawful for a 'public authority', such as the Department or the CSOs:

> to act in a way that is incompatible with a human right or, in making a decision, to fail to give proper consideration to a relevant human right (section 38(1)).

139. Rights contained in the Charter of Rights Act, however, are not absolute and may be limited in certain circumstances. For a limitation to be reasonable (and therefore not unlawful) it must be 'demonstrably justified in a free and democratic society based on human dignity, equality and freedom' (section 7(2)).

140. The Department has also published a list of what children can expect while in residential care, including the right:

- to be safe and feel safe ...
- to have a say and be heard ...
- to tell someone if I am unhappy ...
- to have a worker who is there for me ...
- [to have] careful thought to be given to where I will live so I will have a home that feels like a home.

Specific standards

Placement decisions

141. When placing a child in care, the Children, Youth and Families Act requires the Secretary of the Department to provide for the 'physical, intellectual, emotional and spiritual development of the child in the same way a good parent would'. The Secretary must also have regard to the 'treatment needs' of a child (section 174).

142. The Department's Placement Framework sets out 10 'placement planning principles' for the Placement Unit to consider. They include:

    - Placement planning should focus on appropriately matching the child to a placement which is able to meet their individual needs.
    - Placement must be considerate of the child's history of abuse and trauma and promote a healing environment which is considerate of their individual treatment needs.
    - Children will reside in a safe environment, free of abuse and neglect.

143. The Placement Framework also lists 'placement matching factors' to be considered when negotiating placements with CSOs. They include the age and gender of other children in the house; the child's abuse history; and the views and wishes of the child.

144. The Framework also states:

> the placement of one child should not jeopardise the safety or individual needs of another child (Principle 4.2).

Care and supervision

145. The Department's Residential Care Program Requirements state the CSO providing care to a child 'manages, actions and reviews day-to-day care arrangements for children'. They set out CSOs' responsibilities including:

    - care planning for the child, based on the child's individual needs
    - establishing and leading a Care Team that includes the child's case manager, the supervisor in the residential care unit where the child is living, other key residential care workers and the child's parents
    - using the Department's Looking After Children ('LAC') framework and processes, for managing the day-to-day care of the child 'using a collaborative Care Team approach'.

Incident reporting and response

146. The Department requires CSOs to report allegations of physical and sexual assaults involving children in residential care, as well as other incidents such as medical incidents and children going missing in care.

147. The incident reporting requirements are intended to help agencies respond to adverse events and ensure affected children and staff are safe and supported. They also give agencies the opportunity to learn from incidents so they can reduce risks in future.

148. Before 2018, the Department set out its requirements in two documents: 'Responding to allegations of physical or sexual assault' and 'Incident Reporting Instruction'. They required CSOs to:

    - report alleged physical and sexual assault of children to Police
    - notify children's families
    - consider referring children to specialist counselling and support services in the case of alleged sexual assaults, with the child's consent.

149. This system was criticised by some, including by the Ombudsman. In 2018, the Department replaced it with a new system called the 'Client Incident Management System' (Incident reporting system).

150. The Department's Incident reporting system guide requires CSOs to:

    - Report all incidents that result in harm to the child to Child Protection. These reports are known as incident reports.
    - Report all incidents that may be a crime, such as assaults, to Police. The guide says 'Police should be assisted in conducting their investigation'.
    - Facilitate access to specialist victim support services.
    - Notify the child's next of kin/legal guardian, if the child consents.

151. During the period investigated all major incident reports were to be submitted within 24 hours; non-major incident reports were to be submitted monthly.

152. The Child Protection and Police Protocol deals with cases where children go missing while in residential care. The Protocol states Child Protection and CSOs should conduct risk assessments where children go missing from residential care units. CSOs are responsible for making missing person reports to Police.

153. The Department monitors and oversees CSOs' incident reporting to ensure they follow the policy and procedures. It also provides all 'major' incident reports to CCYP. CCYP may request follow-up information about the incident or the response and may establish an inquiry where it identifies a persistent or recurring systemic issue through these incident reports.

The children's experiences

154. The five complaints to the Ombudsman raised questions about whether Child Protection and CSOs met their obligations to children in care. This section describes the experiences of the five children, and Child Protection and CSOs' handling of their care.

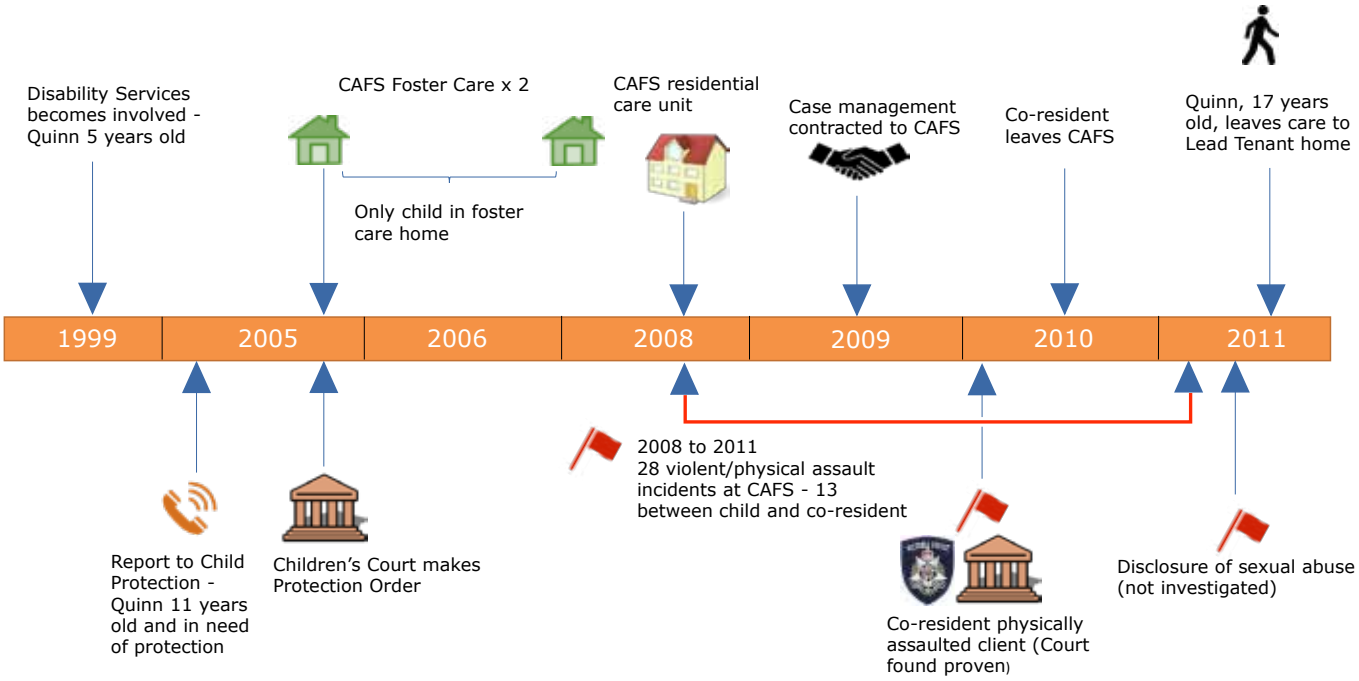
Quinn

Quinn spent three years in residential care from 2008 to 2011, when she was a teenager. In 2019, she contacted the Ombudsman to say she had been assaulted by an older boy in her residential care unit and had not received a proper response.

Quinn had been diagnosed with various disabilities at the time, including an autism spectrum disorder. She was transitioning from male to female identity. The evidence shows:

- Child Protection placed Quinn in a CAFS unit with an older teenage boy with a known history of violent outbursts.
- There were many recorded incidents of threatened or actual violence between the pair.
- Child Protection knew about the incidents. It did not move either child until almost two years later, after the boy repeatedly punched Quinn to the face and head and was charged by Police.
- Quinn later disclosed the boy 'constantly' sexually assaulted her by grabbing her genitals. CAFS did not investigate the allegations nor notify Police – so the allegations remain unproven. CAFS also failed to refer Quinn for counselling.
- Quinn may have been medicated to try to control her behaviour.
- Quinn was not allowed to have female clothes or items at the CAFS unit. Later, her sexual identity and behaviours were apparently deemed a risk to others.

Figure 4: Quinn's timeline of key events



Source: Victorian Ombudsman (incorporating information from Department of Health and Human Services)

155. Quinn is a transgender woman in her 20s. She spent three years in residential care from 2008 to 2011, when she was a teenager.

156. In February 2019, Quinn complained to the Ombudsman that she was assaulted by another child in her residential care unit, with 'physical and sexual harassment almost from the day I moved in'. She also said she had been medicated to try to control her behaviour, and her carers discriminated against her by failing to support her trans identity.

157. Quinn wrote to the government about her experiences in May 2018. The Department responded four months later but did not acknowledge her allegations of assault or offer to investigate.

158. Quinn lived in one unit, which was managed by CAFS during her years in residential care. To understand Quinn's experience, the investigation:

- examined her Child Protection and CAFS files
- obtained written responses from the Department, CAFS and Police
- interviewed Quinn and three Department representatives.

159. The investigation did not interview staff from CAFS because the complaint involving CAFS was historical and CAFS no longer employs the staff with direct knowledge of Quinn's care.

160. The evidence confirmed there were many alleged assaults involving Quinn while she was in care. It raised questions about Child Protection's decision to place her in the CAFS unit, and Child Protection's and CAFS' responses when problems emerged.

Why Quinn was in residential care

161. Child Protection became involved with Quinn and her family when Quinn was 11 years old.

162. Psychologists diagnosed Quinn with an 'intellectual disability and autism' when she was four. She went to school with help from aides and received State-funded disability support. But when Quinn turned 10, an education Department psychologist re-tested her and found her IQ was within 'the average range'. She was no longer eligible for disability support.

163. The following year, Child Protection got a report raising concerns about Quinn's welfare. Quinn's mother admitted to Child Protection she was having difficulty coping, in part because Quinn was displaying aggressive behaviours. There was evidence that Quinn's parents were using physical force against her.

164. Child Protection tried to work with Quinn's family and reconnected them with State disability support. However, after a few months, Quinn went into foster care to protect her from harm. She has had limited contact with her family since.

165. By the time Quinn was 14, her foster carers could no longer care for her. A Child Protection Practitioner wrote on Quinn's file that any new placement needed to provide 'a safe and supportive environment for [her] to live'.

CAFS placement

Placement risks

166. In mid-2008, Child Protection placed Quinn in a CAFS standard four-bed residential care unit.

167. At the time, there were two other children with disabilities in the unit.

168. Child Protection records show one of the children, an older boy, had aggressive behaviours associated with his disability. The records refer to 'aggression, troublesome behaviour and … violent outbursts'. One record said he had 'rages that last 4-6 hours at a time' and at least two staff were required to control him. The record also said kicking and swearing were common.

169. There is no evidence to show how Child Protection and CAFS intended to manage the boy's behaviours to ensure Quinn was safe and supported.

170. Quinn's records also noted she would need to adjust to living with other young people who could, at times, be a 'major source of irritation to [her]' (see Figure 5).

Physical assaults

171. Almost immediately, there were problems. Incident reports show that within days, CAFS workers saw the older boy abuse Quinn verbally. A few days later, he allegedly physically assaulted her. During Quinn's first five months in the unit, there were 10 recorded incidents involving threatened or actual violence between the pair. Some of these involved knives, forks and other weapons. Records show only one of the incidents was reported to Police.

172. Over the following 14 months, there were other incidents. Some involved fights between children in the unit, including Quinn. Others involved alleged assaults by the children on CAFS workers in the unit. Quinn's behaviour reportedly also became more aggressive.

Figure 5: Records from Quinn's file

23/06/2008	[redacted] had a foster care placement breakdown and moved into Residential Care with 2 other residents.	[redacted] had previously in placements where he was the only young person there. Possible feeling of rejection or/and abandonment. He also needed to adjust to living with other young people with issues of their own.	Still learning to manage his feelings of living with others who, at times, are a major source of irritation to him.

Source: Department of Health and Human Services

173. Records show Child Protection knew about these problems soon after it placed Quinn in the unit in mid-2008. Child Protection reviews incident reports as part of its normal processes. A manager made the following notes on the reports:

Notes on an incident report from July 2008:

I'd like information about how long [Quinn and the older boy] have been here, their daytime activities, case direction and family involvement. Then we will meet with CAFS.

Notes on an incident report from August 2008:

Does [Quinn] have a diagnosed Autism Spectrum Disorder? If so, staff need training /education regarding communication. What led up to this incident?

Notes on an incident report from September 2008:

Extra support (staff + counselling) already in place. No action – Systemic – I see we are discussing this residence soon.

Source: Department of Health and Human Services

174. Records show Quinn and the other resident asked to be separated. The month after Quinn moved into the unit, the other resident asked to leave because he could not 'get along' with her. At interview, Quinn said:

> Me and [the older boy] said [we wanted to be moved] so many times. I would say it and he would say it. He's like 'you should move because I was here first'. I was like 'I've always been a good person, the only reason I'm playing up is because he was antagonising me. He plays up all the time. He should be the one to leave'. I didn't care where I was moved to, I never mentioned a specific place, it was just like as long as it's not here.

175. Child Protection records show it planned to move the older boy in mid-2009, just over a year after Quinn moved to the unit. The records state 'violent and threatening behaviours at the resi unit have caused him to face criminal charges'. This referred to charges arising from alleged assaults by the boy on CAFS workers.

176. In early 2010, Police charged the older boy with unlawful assault on Quinn. Records say he asked Quinn to move and she refused, and he 'rushed' her and punched her repeatedly in the head and face. The charge was found proven at court.

177. No records were provided to the investigation to show what follow-up support and care was provided to Quinn.

178. When Child Protection reported to the Children's Court on Quinn's placement two months later, it did not mention the assault. The report said:

> [Quinn] has the right to safe and stable accommodation, which is met through [her] placement through [CAFS].

179. The report also said Quinn 'likes living in [her] current placement'.

180. By contrast, Quinn told the investigation 'I never felt safe there, not for a second'.

181. Child Protection did not move the older boy from the unit until mid-2010, four months after his unlawful assault on Quinn and two years after Quinn moved into the unit.

182. Quinn's file records her reaction to the boy's departure as 'extreme relief' (see Figure 6 on next page).

Figure 6: Record from Quinn's file

14/06/2010	Co-resident has left the unit.	A co-resident that [redacted] dislikes, has left the unit.	Extreme relief!!! Although new female residents are too arrive at the unit, [redacted] believes that nothing could be as bad as previous resident.

Source: Department of Health and Human Services

Alleged sexual assaults

183. In 2011, almost a year after the older boy's departure, Quinn told a CAFS worker that the boy sexually assaulted her 'constantly' while they were in the same unit. CAFS' incident report said:

> [Quinn] became quite angry during the afternoon, yelling and swearing. Staff [name removed] met with [Quinn], who said [she] is going to sue [DHHS] and CAFS as they did not protect [her] against being sexually abused by [an older boy who used to live in the unit, name removed]. [Quinn] disclosed to staff that [the older boy] used to constantly grab [Quinn's] genital area.

184. According to the case worker's notes, Quinn said she had reported the alleged assaults before:

> [Quinn] stated it was reported to staff and nothing was done. [Quinn] stated it had occurred about 100 times over a period of time. [Quinn] thinks it was reported to the case manager at the time.

185. CAFS' incident report incorrectly categorised the incident as a less serious 'Category 2' level assault.

186. The incident report stated that Quinn's 'concerns have been acknowledged and [she] knows that they will be followed up/passed on'. However, CAFS advised the Ombudsman it did not take any action. The incident report recorded that sexual assault counselling was 'not required', and Police were not contacted. There is no record that CAFS advised Quinn's mother, who was still her legal guardian.

187. In a written response to the investigation, CAFS said it may have wrongly categorised the incident as 'Category 2' because:

> the [other boy] had moved out twelve months earlier, therefore the events were not recent and were not likely to occur again.

188. CAFS acknowledged it failed to offer counselling and report the allegations to Police.

189. CAFS told the investigation this was the only time Quinn reported the alleged sexual assaults. CAFS referred to Quinn, who at the time was nearly 18 and was about to move out of the unit, as being 'extremely anxious' about moving on. It said she 'becomes very obsessed about particular issues and plays them over and over' due to her disability.

190. The Department told the investigation that when it reviewed the incident report, it changed the incident to a 'Category 1' and addressed this with CAFS. Its records said Child Protection would conduct a 'Quality of Care' review, but no such review took place. In a written response to the investigation, the Department explained the incident did not meet the criteria for this type of review because it was a 'client to client' incident.

191. The Department said it had planned to report the allegations to Police, interview Quinn and consult disability specialists. But in February 2020, the Department advised the investigation it could find no records that its staff or CAFS had taken that action. Police told the investigation it had never received a report about Quinn's sexual assault allegations. The allegations therefore remain unproven.

Other concerns

192. When the investigation looked at Quinn's records, it identified other concerns about her care.

Health, medication and possible chemical restraint

193. Quinn's records show Child Protection and CAFS did not organise regular counselling for her, despite her history and experiences in the unit. Quinn's records of counselling contain a gap of more than two years.

194. Quinn's records show she was prescribed psychotropic drugs at various times. A letter from Quinn's paediatrician indicates the drugs were used to treat behaviours associated with her autism spectrum disorder.

195. At interview, Quinn said she thought she was given the medication to control her behaviour:

> They told me it was to stop me being anxious, they said my behaviour was out of control. I wasn't out of control for the sake of being out of control.
>
> [The older boy] was actually out of control. I was provoked, I was terrorised, of course I'm going to react aggressive. But they saw it as bad behaviour, so according to their stupid logic, it was bad behaviour for me to defend myself.

196. Quinn said she complained about being medicated at the time. She said two CAFS workers also opposed her medication, but it happened anyway. She said, 'I was on so much medication, I was that slow, it'd take me two minutes just to answer a question'.

197. Registered disability providers must obtain the Department's authorisation before using a 'chemical restraint', as it is termed in the disability sector (*Disability Act 2006* (Vic)). There appear to be no such protections for children in residential care.

198. There is no record that Child Protection or CAFS asked Quinn's doctors if the medication was used as a chemical restraint, and it is not known if this was the case.

199. The current Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability is examining the use of medication being used as a chemical restraint in the disability sector.

LGBTIQ discrimination

200. There is also evidence supporting Quinn's complaint that CAFS did not support her when she started identifying as a girl.

201. The Children, Youth and Families Act recognises the importance of children's gender and sexual identity to their best interests. The Act states that when determining what decision to make or action to take in the best interests of the child, consideration must be given to the child's 'social, individual and cultural identity' as well as the child's 'sex and sexual identity' (section 10).

202. However, the investigation did not identify policies or procedures setting out the Department's and CSOs' practical obligations to LGBTIQ children either then, or now.

203. In 2008 when Quinn moved into the unit, CAFS was aware Quinn liked to dress in girl's clothing. CAFS managed Quinn's earlier foster care placement, and Quinn's foster carers told CAFS about her preference for girl's clothing.

204. At interview, Quinn described the actions of CAFS workers in the unit:

> In the beginning, from the moment I got in, in 2008, they were already thinking of taking everything I had.
>
> About a year or two later, they [CAFS] took everything off me. Everything female. The dresses, clothes, and even a doll. I remember [the case manager] telling me they wanted to take it away straight away, but it was a grey area. Gays had anti-discrimination [protections], but transgenders did not have any discrimination [protections] at the time. They debated if we stop this kid identifying as trans, they didn't use the word 'trans' back then, I think they said 'cross dresser', are we technically breaking the law of gay discrimination? Then [CAFS] decided cross dressing was not the same thing as gay, so we can take them all off him. [The case manager] disagreed with it being taken away.

205. Quinn said she was not allowed to have the hormonal medication she wanted to support her transition, even though she was medicated for other reasons. She said:

> It was weird because I wanted to get on hormones and [CAFS] said no. I ended up getting put on more medication, they were saying I was out of control and a really bad kid.

206. Quinn said CAFS staff members told her 'we're just doing it to protect you', but she felt 'nothing was done to protect me'. She said:

> I wanted to be taken out of that house or have him [the older boy] taken out. Some of it was because of the molestation, but some was because of the discrimination against me for being trans.

207. Some CAFS records confirm Quinn's account. They show staff were concerned after two younger girls moved into the unit in mid-2010. A document prepared by Quinn's case manager said:

> since the arrival of young girls at the house, much of this activity [such as Quinn's sexual behaviour and preference for women's clothing] has been banned as workers were wary of his fascination with younger girls.

208. The investigation did not identify any incidents to support the workers' concerns.

209. A Department representative said at interview it was not Department policy at the time to refuse children their choice of clothing and other items or practices.

Where is Quinn now?

210. Quinn left residential care in 2011. At first, she moved to a different type of supported placement where she could prepare to leave State care. She now lives independently.

211. Quinn told the investigation she has struggled since leaving care, with unstable housing and lack of job opportunities. She said she was recently remanded in custody after getting into a fight with people who were threatening her. She said she has not joined the National Disability Insurance Scheme due to concerns about having to undergo more assessments and her bad experiences with services.

212. Quinn told the investigation her experiences in residential care destroyed her life and have at times left her suicidal.

CAFS' response

213. In its response to a draft of this report in May 2020, CAFS' Chief Executive Officer said:

> CAFS is sorry for the trauma experienced by [Quinn], and wishes to assure [the Ombudsman] that our knowledge and experience in relation to the issues raised by [Quinn] has expanded since she was in our care, and what we know now is very different to what we knew then.

214. The Chief Executive Officer detailed improvements to services and processes since Quinn's time in care. Appendix 1 contains a full copy of CAFS' response.

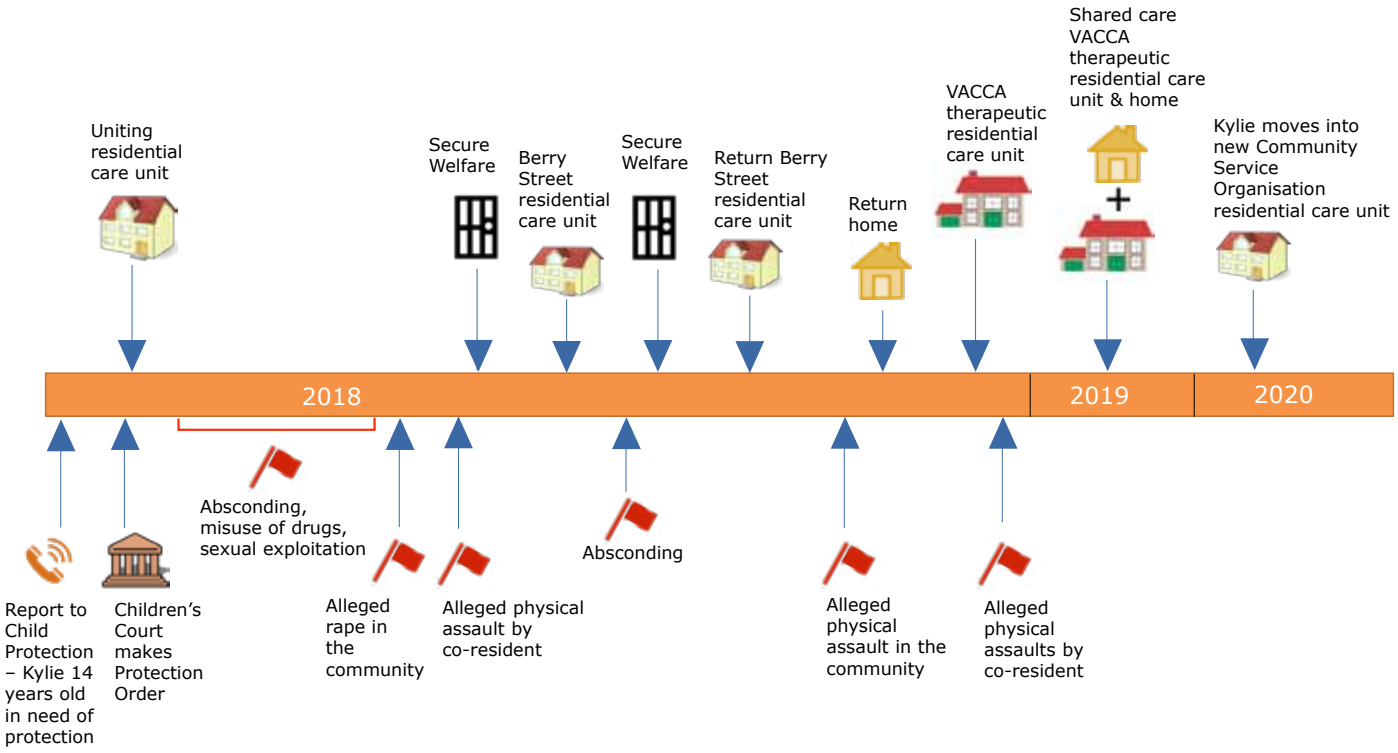
Kylie

Kylie is a young Aboriginal woman who has been in residential care since 2018, when she was 14 years old. Her mother contacted the Ombudsman with concerns about Kylie's care. She said Kylie had been raped while away from her residential care unit and she feared for her daughter's safety.

The investigation found that since going into residential care, Kylie has lived in three different units managed by Uniting, Berry Street and VACCA. The evidence shows:

- Kylie began using drugs after going into residential care and started leaving her unit and meeting older men.
- Around seven weeks after going into residential care, Kylie told workers she had been raped by an adult man in a laneway. Police are continuing to investigate this allegation.
- Other children in the units also allegedly assaulted Kylie.
- Berry Street and VACCA said Child Protection pressured them to take Kylie, even though there were risks involved in placing her in their units.
- Child Protection is meant to give Aboriginal children a cultural plan to support their connection to their heritage and culture within 16 weeks of going into care. It did not give Kylie her plan for more than one year - approx 53 weeks.

Figure 7: Kylie's timeline of key events



Source: Victorian Ombudsman (incorporating information from Department of Health and Human Services)

215. Kylie is a young Aboriginal woman in her teens. She has been in and out of residential care since mid-2018.

216. In July 2018, Kylie's mother contacted the Ombudsman with concerns that Kylie had started taking drugs and was running away and meeting up with older men. Shortly afterwards, she said Kylie had been raped while away from her residential care unit. She said she feared for her daughter's safety.

217. The investigation found Kylie has moved many times since going into residential care. She has lived in three different residential care units, managed by Uniting, Berry Street and VACCA. The Department has also attempted to return her home on some occasions.

218. To understand Kylie's experience, the investigation:

- examined records from Kylie's Child Protection, Uniting, Berry Street and VACCA files
- obtained written responses from the Department, Uniting, Berry Street, VACCA and Police
- interviewed Uniting, Berry Street and VACCA representatives and three Department representatives.

219. The investigation confirmed multiple alleged assaults against Kylie after she went into residential care. It looked at whether the Department and CSOs were aware of these risks and how they responded.

Why Kylie was in residential care

220. Child Protection has been involved with Kylie's family for many years due to family violence, drug use and mental health issues. By May 2018, Kylie's mother and siblings had relocated and were living with friends. There were more reports of family violence in that house.

221. Kylie's mother told Child Protection she could not manage Kylie's behaviour. Child Protection records describe Kylie as having 'behavioural disturbance and anxiety'. The records described incidents during which Kylie 'bang[ed] her head on walls' and threatened self-harm with a knife.

222. Child Protection attempted to support the family. However, it soon removed Kylie from the home.

223. Child Protection could not find family or friends to care for Kylie. In mid-2018, it applied to the Children's Court for a Protection Order and placed Kylie in residential care. She was 14 years old at the time.

Uniting placement

Placement risks

224. Child Protection placed Kylie in a Uniting standard four-bed unit with three girls of similar age.

225. Child Protection initially placed Kylie in the unit on an emergency basis, and her Placement Referral document lacked detail. Child Protection did not update it, despite a request from Uniting. In response to a draft of this report, Kylie's mother stated she provided detailed information to Child Protection about Kylie to support her placement.

226. At interview, a Uniting representative recalled conversations about whether Kylie was a suitable match with the other children. The representative said there were three girls in the unit, two who were settled and the third, like Kylie, was new to residential care. Uniting did not document these assessments.

227. Problems soon emerged. Records show that four days into Kylie's placement, a worker 'smelled substances' from one of the girl's bedrooms. The next day, one of the girls said 'she gave [Kylie] her first bong and … she coughed her guts up'. A week later, a worker again noticed a smell of cannabis. Records say a worker reinforced a 'zero tolerance' approach to illegal drugs. However, that evening a worker found Kylie and one of the other girls with bowls of cannabis. Seven weeks after moving to the unit, Kylie told a worker a local drug dealer was giving her ice.

228. Kylie's mother told the investigation neither Uniting nor Child Protection informed her about Kylie's suspected drug use.

229. Kylie also started running away at night and was reportedly meeting up with adult men.

230. Child Protection records show an adult man was believed to be buying alcohol for the girls in the unit. Child Protection noted the man had made 'full admissions to Police in 2002 regarding the sexual penetration of a child' but the charges were struck out in court. Then in 2017, the man was arrested for an alleged sexual assault of a person with a disability. Those charges had not proceeded.

231. Child Protection and CSOs are meant to use Care Teams and Crisis Management Plans to manage the sorts of risks that arose in Kylie's case.

232. There is no record of Uniting establishing a Care Team for Kylie. Uniting provided conflicting information about who was responsible. At interview, the Uniting representative said CSOs are meant to establish and lead Care Teams. However, Uniting's written response to the investigation said:

> [T]here is a lack of clarity of the responsibilities of the residential service program, primarily in regard to supporting the cultural needs of young people in residential care, arranging, facilitating and recording Care Team meetings and case planning actions, such as health assessments, education etc.

233. Records show Child Protection gave Uniting a 'Crisis Management Plan' for Kylie. However, it was a template document with no reference to Kylie's individual needs. Uniting asked Child Protection to update it, but it did not. The Uniting representative said at interview this was the role of the child's case manager (which, in Kylie's case, was Child Protection), with Uniting's input.

234. Uniting told the investigation:

> staff made active attempts to locate [Kylie] each time she absconded … [but] staff are unable to physically prevent any young person from leaving the house.

Alleged assaults

235. Around seven weeks after Kylie went into residential care, it is reported that she told a worker an adult man raped her in a laneway. Kylie's mother told the investigation, her daughter said she was given the drug 'ice' by this man.

236. Police are continuing to investigate this allegation.

237. Child Protection records reported Kylie had gone missing from the unit at the time of the alleged rape and a Uniting worker was out looking for her.

238. Uniting submitted an incident report to Child Protection and notified Police.

239. Police told the investigation the Uniting worker did not respond to its requests for a statement for several weeks. When the investigation raised this issue with the Department, it said it expects CSO workers to cooperate in a full and timely manner. A senior Uniting manager agreed.

240. On the same day as the alleged rape, one of the girls in the unit told a Uniting worker she had 'bashed' Kylie. Police told the investigation it had no record of this assault. Records show Uniting informed Child Protection, but there was no incident report.

241. There are also records of three earlier incidents involving another girl in the unit. Kylie reported one of the other girls:

- 'Felt her up' when they were sitting on the couch watching TV. Kylie said the other girl touched her leg and put her head on her shoulder.
- Touched her breast.
- Touched her vagina.

242. Uniting reported the first incident to Police, but Kylie did not want to make a statement. Child Protection records say Police interviewed the girl regarding the third matter, but she denied Kylie's allegation.

243. Uniting told Child Protection about the incidents but did not lodge incident reports. There is no record of Child Protection following up the provision of incident reports.

244. Records show Kylie's mother also told Child Protection that one of the girls in the unit had made sexual advances towards Kylie. At interview, the Uniting representative said Uniting was not aware of this report.

Placement termination

245. At interview, the Uniting representative said after Uniting heard about Kylie's alleged bashing, it asked Child Protection to move the other girl. In an email, it told Child Protection and the Placement Unit that Kylie was 'presenting genuinely frightened of [the other girl]' and was 'scared to return' to the unit while she was there.

246. Child Protection initially refused. A Placement Unit manager responded to Uniting's email:

> [A]s a Care Team we will need to discuss how we can best manage the current situation between the two girls as there is no capacity in the residential space to move either girl to a safe placement.

247. Later that day, however, Child Protection decided to move Kylie to Secure Welfare 'due to significant risk issues'.

248. Uniting told the investigation it wanted Kylie to stay in the unit. It said it asked Child Protection not to put her in Secure Welfare because she needed to be with trusted carers while she recovered from the alleged assaults.

249. The Uniting representative raised concerns at interview about Child Protection's handling of the move. Records say Kylie had told Uniting workers that morning that she wanted 'to provide evidence to have this man charged'. Kylie's mother told the investigation Uniting instructed her to tell Kylie she would be moved, just before she was due to go to hospital for a forensic medical examination for the alleged rape.

250. Kylie reportedly fled before the examination could be conducted. Her mother told the investigation she was fearful about the invasive tests.

251. Police told the investigation Kylie made a statement about the alleged rape about a year later.

252. Kylie stayed in Secure Welfare for 11 days while Child Protection looked for a new placement.

Berry Street placement

Placement risks

253. Child Protection asked Berry Street to accept Kylie and she moved into one of its standard four-bed units.

254. Child Protection gave Berry Street limited details about Kylie's experiences at Uniting. They referred to Kylie's cannabis use, but did not mention her absconding or a risk of sexual exploitation.

255. Berry Street told the investigation it accepted Kylie as part of a 'swap' organised by Child Protection. Berry Street wanted Child Protection to move one of the children who had been living in the unit after a 'major incident'. It said Child Protection would only agree if Berry Street agreed to take Kylie and another child.

256. Berry Street said it followed its 'usual matching process' to check Kylie was a suitable match with the other children in the unit. It provided a copy of its 'matching tool' document, but it was blank. At interview, a Berry Street representative said Berry Street had done 'dynamic matching'. Berry Street assessed the match as 'low risk'.

257. Child Protection records show it looked for other options for Kylie, but without success (see Figure 8).

Figure 8: Placement Unit record of efforts to secure placement

Case Note

Client:	[redacted]
Event Date & Time:	[redacted]2018[redacted]
Subject:	[redacted]2018 - No options identified
Created by:	[redacted]

Summary:

Referral emailed to all [redacted] CSO's - no options identified
Responses recorded below
Anglicare: [redacted] No options
Quantum: [redacted] No options
GEGAC: [redacted] No options
Berry Street: [redacted] No options
Salvo Care: [redacted] No options
Uniting: [redacted] No options

[redacted] CSO's
LWB: No options
Berry Street: [redacted] No options
Salvocare: [redacted] No options
Uniting: [redacted] No options
Mackillop: [redacted] No options
Ozchild: [redacted] No options
Anglicare: [redacted] No options
Key Assets: [redacted] No options

Source: Department of Health and Human Services

258. Shortly after agreeing to take Kylie, Berry Street agreed to accept another child. Berry Street said this involved medium to high risks for all the children. It said:

> Berry Street also identified that there was a high risk that [the new child] entering the placement would cause placement disruption for all three young people [already living in the unit], however the placement proceeded because of pressure by the DHHS.

259. Kylie had been in the unit less than a month when Berry Street told Child Protection that she had run away three nights earlier and had not returned. When workers found her, they took her to Secure Welfare for two nights. She returned to Berry Street but continued to run away.

260. Records show Berry Street asked Child Protection if there 'was some kind of safety plan in place for this'. Child Protection had given Berry Street a copy of its Crisis Management Plan for Kylie, but it had not been updated. Berry Street's written response to the investigation said 'this [plan] was not altered while [Kylie] was in Berry Street's care'.

261. The Department said Berry Street did not provide daily update records for Kylie and 'there is very little narrative about what was occurring for [Kylie] while she was at the unit'. In response to a draft of this report, Berry Street said it was not required to provide daily updates under the Residential Care Program Requirements or its service delivery agreements. It said it provided regular email and telephone updates to Child Protection on key issues.

262. The Department said the placement had become characterised by:

> intense and volatile conflict between the [children in the unit] and other young people with whom they were associating in the community.

Alleged assault

263. When Kylie had been in the unit for around three months, records show that her mother contacted Berry Street and reported that Kylie had been physically assaulted by an adult man while away from the unit. The man was a friend of one of the other children in the unit.

264. Berry Street told Child Protection the other child asked the man to 'bash [Kylie] after an incident at the unit'. Berry Street's incident report said Kylie refused to return to the unit until the next day. It said she told workers she 'got strangled again' and was 'okay'.

265. Berry Street and Child Protection records contain detailed information showing they reported the assault to Police (see example at Figure 9).

Figure 9: Child Protection record, November 2018

Police stated they have just been advised that [redacted] was assaulted by an older male but Sergeant said she does not wish to make a formal statement today. She told Police that she will return tomorrow with the support of her residential worker. Police were happy with this arrangement and said she needs to return home for a shower and a sleep and return tomorrow with an adult supporting her.

Sergeant said she has red visible marks on her neck and said that Police are taking photographs of her. Sergeant said Police do not have capacity to transport her home if [redacted] is assessed as appropriate to return to placement. [redacted] agreed to explore if a residential worker can collect her from the Police Station.

Source: Department of Health and Human Services

266. Police told the investigation they had no record of the report. They said they had dealt with the missing person's report about Kylie and had no records about the alleged assault.

267. At interview, the investigation asked the Berry Street representative what else Berry Street did in response. The representative said there were no follow-up actions in the organisation's records. They said Child Protection could have picked this up.

268. In response to the draft report, Berry Street said the characterisation of this incident suggests it did not actively or empathetically respond to Kylie. Berry Street said on the night of the alleged assault, workers went out to look for Kylie twice, made repeated telephone contact with Kylie and her mother and contacted Child Protection and Police. Berry Street noted Police should have been able to confirm report/s were made given officers' details were noted in the records. It said no negative inferences should be drawn from the lack of Police documentation.

269. Kylie reportedly retaliated against the other resident with threats of her own. At the end of 2018, Child Protection decided to move her back home with her mother while it arranged a new placement.

VACCA placement

Placement decision

270. In late 2018, Child Protection placed Kylie in a VACCA residential care unit. It was her third placement in six months and her first placement with an Aboriginal Community Controlled Organisation.

271. The unit was a therapeutic unit. Specialist panels of Child Protection and CSO workers assess placements for therapeutic units, and this is what happened in Kylie's case.

272. Records show Child Protection gave VACCA information about Kylie's history so it could make an informed assessment. However, the VACCA representative said at interview that Child Protection repeatedly refused access to Kylie's Child Protection file, which VACCA ordinarily reviews before accepting placements. An email from Child Protection to VACCA confirms this, saying:

> the file review will not be possible because this is no longer allowed. We are able to provide your office with relevant information.

273. The VACCA representative said Child Protection also pressured VACCA to accept three children, including Kylie, at the time. They said this was to 'fill targets' and the 'matching was not the best'. The representative said:

- two other children in the unit were not ready for therapeutic care
- Kylie's behaviour, which was aggressive at times, posed a risk to the other children
- one of the children had an intellectual disability and behaviours that were too challenging for a four-bed unit run by two workers. The representative said this child 'needed more than the mental health services we are able to provide. We are not a mental health service.'

274. When the investigation asked the representative why VACCA agreed to placements it knew were unsuitable, they said VACCA risked being investigated for under-performance otherwise. They said:

> to be threatened to lose targets of a placement is a real pressure for us … we get the 'but you are underperforming on target'.

Alleged assaults

275. Although records show Kylie's behaviour initially settled in the VACCA unit, she again reported physical assaults by another child in the unit.

276. In the month after Kylie moved to the unit, she told a Child Protection worker and her mother that a younger boy was assaulting her. The Child Protection worker recorded allegations that the boy:

> punched, kicked, pushed, follows [Kylie] in her room and in the community and threw things at her. On one occasion he threw a slide board at her and caused a mark on her cheek. Staff members tried to help, but [Kylie] did not know their names.

277. Kylie reportedly complained 'all DHHS does is separate families' and asked the Child Protection worker:

> What's the point of moving a child from a place that is regarded as not safe, but plac[ing] that child into another place that is also not safe?

278. Kylie told the Child Protection worker she had reported the assaults to VACCA. The worker recorded that she telephoned the unit and was told the unit manager would have a 'chat' with the boy.

279. At interview, the VACCA representative said VACCA had no record of Child Protection's contact about the allegations at the time. They said Child Protection workers did not usually contact the unit directly and communication usually occurred through the Placement Unit. The representative said:

> there were certainly instances of issues between [Kylie and the boy] but nothing that constituted … assault, to my knowledge.

280. The VACCA representative said Child Protection asked VACCA to attend a meeting about the allegations in February 2019. VACCA later wrote to Child Protection setting out its response:

> At no time has Child Protection contacted VACCA to inform them of such allegations. VACCA welcomes such communication and is more than willing to provide immediate response to CP in relation to all issues regarding our shared clients. Under the CMS guidelines it is the responsibility of CP to investigate such allegations if those allegations were made directly to CP.
>
> Discussions were held with the resident who allegedly assaulted the young female and his responses were clear in that he showed no acknowledgement of what he was supposed to have done. He responded several times with statements such as "what are you talking about?" His inability to comprehend may be due to his IQ (around 47) but after much discussion he remained of the view that he did not know anything about what was being discussed.

281. Child Protection and VACCA did not complete an incident report or notify Police about these allegations. In response to the draft report, VACCA maintained it was Child Protection's responsibility to complete the report as it had received the allegations.

282. VACCA also said it was unable to make a Police statement on Kylie's behalf and 'there was, therefore, no means by which to make a Police report'.

283. The investigation notes there is a difference between a Police statement that a victim of a crime may need to make to Police and a Police report of a possible offence that anyone can make.

284. In Police's response to the draft report dated 14 January 2020, the then-Chief Commissioner said there are multiple Police and departmental policies that provide clear direction to Police and agencies to ensure Police reports are made and recorded. He stated one such policy:

> emphasises that all reported incidents are to be recorded [by Police] regardless of where the information is received first, second or third hand, unless there is credible evidence available at the time of reporting to suggest that a crime has not occurred.

285. Regarding alleged assaults in residential care, Kylie told the investigation that sometimes when she reports incidents, including staff behaviour, she gets told 'you're a liar'. She thinks Child Protection needs to do more so that care providers 'don't think they can get away with this as it's just more trauma'.

Other concerns

286. The investigation also observed other problems with Kylie's care.

Cultural planning and support

287. The Children, Youth and Families Act creates specific requirements for placement and care of Aboriginal children in residential care. This recognises the trauma caused by past child protection practices. It also recognises that connection to culture and self-determination in Aboriginal families are strong protective factors for children.

288. Amongst other things, the Act and Child Protection policies say:

- The Department is to consult an Aboriginal agency before deciding to place a child in out-of-home care (section 12).
- The Department and CSOs are to involve the child's Aboriginal community in dealing with incidents and include a relevant member of the community in any investigation about abuse.
- The Department must give every Aboriginal child a 'cultural plan' which identifies their cultural support needs (section 176). The plan assists the child to develop and maintain their heritage and encourages connection to community and culture. Care Teams are to prepare plans for endorsement by the head of an Aboriginal Community Controlled Organisation within 16 weeks.

289. These requirements were not always met in Kylie's case.

290. Child Protection sought advice from Lakidjeka (a specialist Aboriginal consultancy service within VACCA) about Kylie's first placement with Uniting. It also consulted Lakidjeka when she moved to Secure Welfare. However, there is no record of any consultation regarding her Berry Street placement.

291. Uniting and Berry Street did not engage an appropriate member of the Aboriginal community for their investigations of Kylie's incidents.

292. The evidence also shows Child Protection did not give Kylie an endorsed cultural plan until mid-2019, more than 53 weeks after she entered residential care.

293. Uniting and Berry Street outlined steps they took to encourage Kylie to maintain contact with her family and culture while Kylie was in their care. Berry Street said it held a cultural planning meeting with Kylie and her mother just before Kylie's placement ended.

294. In response to the draft report, Uniting said its focus during Kylie's eight-week placement was creating stability and connection with her, which would help it begin the cultural plan.

295. Berry Street's response noted Kylie's cultural plan had not been progressed when she moved into its care and she was only with Berry Street for three and a half months. It said Child Protection told Berry Street it would develop the plan, although it recognised Berry Street also had a role. It said Berry Street has since begun a project to further strengthen its approach to cultural planning and connection for Aboriginal children in its care.

296. VACCA followed up Kylie's cultural plan with Child Protection after she moved into its unit. Its Aboriginal Children's Healing Team also developed a plan to support Kylie's connection to culture and community and engage in cultural healing. Records show Kylie was engaging in weekly cultural activities. At interview, the VACCA representative said VACCA also began supporting Kylie's relationship with her mother through 'co-parenting'.

297. Kylie received her endorsed cultural plan in mid-2019. The Department acknowledges it was:

> not compliant with practice guidelines in relation to the timelines for referral to the Senior Advisor Aboriginal Cultural Planning and the timeframes to facilitate the … approval of [Kylie's] Cultural Plan.

Drug services

298. There is no indication Kylie used drugs before she went into residential care. As this report noted earlier, her records show she began using cannabis days after moving into the Uniting unit. Seven weeks after moving into the unit, she told a worker a local drug dealer was giving her ice.

299. The Residential Care Program Requirements require CSOs to have policies on responding to alcohol and drug use. They also require CSOs to refer children with substance abuse issues to a drug and alcohol treatment service.

300. Records contain no evidence that Uniting referred Kylie to a drug and alcohol treatment service.

Where is Kylie now?

301. At the end of 2019, Child Protection told the investigation that VACCA and Kylie's mother were sharing Kylie's care. Child Protection said it was increasing Kylie's time at home and working to reunify her with her family full-time.

302. In August 2020, Kylie's return home broke down and she is again living in residential care with a new CSO providing care. Child Protection is supporting Kylie to transition to independent living, with cultural and community supports. Kylie told the investigation she had been placed into a residential care unit in Melbourne and that Child Protection were trying to 'force' her to move into a flat with a girl she doesn't get on with and who takes drugs. She said she wants to be in the country near her family, supports and preferred school.

303. In response to the draft report, Kylie's mother said she thinks residential care workers need better training. She said some are:

> unprofessional … [they] become extremely emotional and attached, and it really affects their professional relationship with the children … [they] hide things from documents and [become] real good friends with the child.

304. After discussing the draft report with the investigation, Kylie said:

> I am happy this investigation is being made public so when kids do go into resi they won't have to suffer like we did.

The CSOs' responses

Uniting

305. Uniting's Chief Executive Officer provided a detailed response to the draft report which said: 'I extend my sincere apologies to [Kylie] and her family for her experience while in our care'.

306. Uniting acknowledged it did not follow incident reporting requirements in full for all of the incidents involving Kylie, but said there was contact with Police or Child Protection in all cases.

307. The Chief Executive Officer said an independent review of Uniting's residential care model and practices had been undertaken. They said Uniting is investing in services to ensure placements are safer and decisions are better informed by the child's individual needs and experiences. This includes a new 'Risk Management Tool', stronger relationships with local Child Protection teams and Aboriginal organisations, and better oversight of critical incidents.

308. Uniting said it is developing 'a corrective action plan to address in detail each of the concerns raised in the report'. Appendix 1 sets out its full response.

Berry Street

309. Berry Street cared for four of the children in this report. Its Chief Executive Officer accepted there were areas where it could have done better to care and advocate for the children. They said Berry Street tried its best to deliver quality 'care, supervision and support within the ill-equipped and ill-designed residential care system'.

310. In September 2020, Berry Street told the investigation it would make an unreserved apology to the four children in this report who had been within their care, and offer to meet with them and their families.

311. Berry Street said:

> The placement of these children emphasises the challenges faced by CSOs to act in the best interest of children when placement referral information is incomplete, vital information is not provided and the placement of children is often a resource-driven 'negotiation' ...
>
> In accepting the children, Berry Street actively considered the suitability of the children for placement, identified risks and raised key concerns with Child Protection. Measures were put in place to mitigate these risks for the safety of the children and their co-residents.

312. The Chief Executive Officer said that since March 2019, Berry Street:

- has been 'much firmer in saying no to proposed placements when there are clearly identified risks'
- is reviewing its risk assessment process and tool and its staff capability to make placement decisions.

313. Berry Street said it recently undertook extensive work to support senior staff and external investigators to manage incident reporting. It said this has been done without additional funding from the Department. It also said the Department determines if incident reports have been correctly categorised and refers them back to CSOs if it disagrees.

314. Berry Street also recognised that, in Kylie's case, it could have done better to support development of a cultural plan. It said it is undertaking a 12-month project to increase staff capabilities in this area.

315. Appendix 1 sets out responses from Berry Street's Board President and Chief Executive Officer.

VACCA

316. VACCA's Chief Executive Officer welcomed the opportunity to respond to the draft report and noted the positive comments about Kylie's increased engagement when she moved into VACCA's care.

317. Appendix 1 sets out VACCA's full response to the draft report.

Brittany

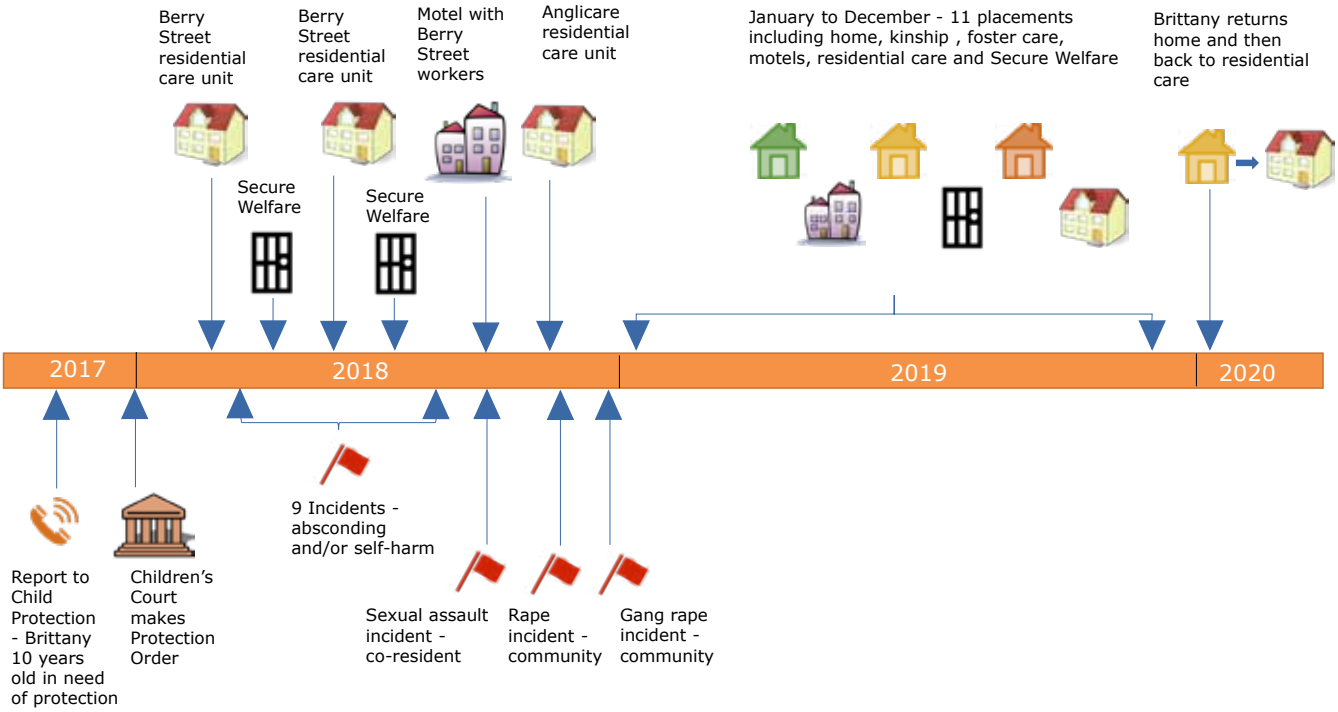
Brittany is in her teens and has been in and out of residential care since 2018, when she was 11 years old. Her records describe concerning behaviours, including self-harm, and say she is at risk of sexual exploitation.

In January 2019, a family friend reported to the Ombudsman that Brittany was allegedly raped by three men while she was away from her residential care unit.

The investigation found Child Protection had moved Brittany many times because of her needs and behaviours. It focused on her first two residential placements with Berry Street and Anglicare. The evidence shows:

- Berry Street accepted Brittany in one of its units with an older girl who had a history of significant mental health issues. It thought the girl would act like an older sister. But Brittany started mimicking the older girl's behaviours, including self-harming and misusing drugs.
- Three months later, a Berry Street worker witnessed the two girls kissing, and Child Protection agreed to move Brittany.
- After Brittany moved to an Anglicare unit, Anglicare accepted another girl who was also at risk of sexual exploitation. They started running away and Brittany told workers she was getting explicit text messages from men.
- Brittany later told workers she had been raped twice – once by an adult man in an apartment, and another time by three adult men after she and the other girl ran away at night. Regarding the first alleged rape, Police said Brittany did not make a statement and there were insufficient details for it to investigate. The second is before the courts.

Figure 10: Brittany's timeline of key events



Source: Victorian Ombudsman (incorporating information from Department of Health and Human Services)

318. Brittany is in her early teens and the youngest of the five children in this report. She has been in and out of residential care since 2018, when she was 11 years old.

319. In January 2019, a concerned family friend contacted the Ombudsman and said Brittany had allegedly been raped by three adult men while away from her residential care unit. The friend said Brittany's mother found out about the alleged rape from one of Brittany's friends via Facebook and was experiencing 'every parent's worst nightmare'.

320. Brittany has moved many times since going into care. The investigation looked at her placements with Berry Street and Anglicare. To understand Brittany's experience, the investigation:

- examined records from Brittany's Child Protection, Berry Street and Anglicare files
- obtained written responses from the Department, Berry Street, Anglicare and Police
- interviewed one representative from Berry Street and Anglicare, and three Department representatives.

321. The investigation confirmed risks to Brittany escalated after she went into residential care, and there are records of three alleged sexual assaults during her time with Berry Street and Anglicare. The investigation looked at what the Department and CSOs did to manage these risks and keep Brittany safe.

Why Brittany was in residential care

322. Brittany grew up in Melbourne with her mother and a younger sibling. When Brittany was 10 years old, Child Protection received reports that her mother could not meet the children's needs due to her drug use. Child Protection obtained a Children's Court order to remove the children from their mother's care.

323. Brittany and her sibling initially lived with their mother's extended family, but Brittany's carers struggled with her behaviour. Child Protection records described Brittany's behaviour as 'very sexualised' and said she sometimes propositioned unknown adult men. It also referred to suicide threats, violence and 'extreme melt-downs'. By mid-2018, Brittany's family placements had broken down.

324. Child Protection began looking for another option. At this stage, Brittany was 11 years old and a Children's Court Magistrate expressed concern about moving her into residential care given her age and care needs.

325. Child Protection's Placement Referral document said Brittany needed:

> a carer with knowledge of child trauma who can offer appropriate supervision and management of challenging behaviours.

Berry Street placement

Placement risks

326. In mid-2018, Child Protection placed Brittany in a Berry Street standard two-bed residential care unit.

327. There was only one other child living in the unit. She was an older girl who had been virtually the sole child in the unit for two years because of her significant mental health issues, including a history of self-harm.

328. Berry Street uses a written 'matching tool' for placements but could not provide a copy to the investigation for Brittany. The Berry Street representative said at interview that workers completed the tool but did not save it.

329. Berry Street told the investigation it believed the match was suitable because the other girl 'did not have a history of high-risk behaviours that aligned with the behaviours outlined in [Brittany's] referral'. It said it hoped the girls' relationship would resemble an 'older and younger sibling relationship'.

330. In response to the draft report, Berry Street said it placed a night supervisor in the unit to enhance staff capacity overnight. It said Brittany appeared to have settled well and had a good relationship with the other resident in the first few days.

331. However, records show Brittany and the other girl started absconding together the following month. They spent long periods of time absent from the unit on multiple occasions. The other girl told Berry Street workers that older men sometimes approached them, and she feared Brittany may have 'gone off' with these strangers if she had not intervened.

332. Brittany and the other girl also told workers they were misusing pharmaceutical drugs. Brittany threatened self-harm and suicide on several occasions and was placed into Secure Welfare two times for her own protection.

333. Within two months, the children's behaviour had escalated. A Berry Street incident report said the other girl was hospitalised twice in three days with 'out of character' medication overdoses and Brittany developed 'increasing high-risk mimicking behaviour'.

334. Berry Street and others began questioning Brittany's placement in the unit. After Brittany was hospitalised due to threatening self-harm, a Berry Street worker wrote:

> The hospital did raise concerns regarding [Brittany] being transported back to her current placement, due to her identifying feeling 'unsafe around her co-young person and unloved'.

335. Records from a Berry Street internal review of the incident said it raised concerns 'promptly' with the Placement Unit.

336. The following day, Brittany and the other resident went missing again and told workers they had overdosed on prescription medication. Berry Street's incident report said it would contact the Child Protection Principal Practitioner (a senior expert in the Department) to discuss the 'suitability of the current placement'.

337. Child Protection did not take any immediate action to end the placement, however, and Brittany remained in the unit.

Alleged sexual assault

338. Almost three months after Brittany moved into the unit, a Berry Street worker observed Brittany and the other girl 'making out' on the couch. Brittany was still 11 at the time and the older girl was 17.

339. Berry Street's report said it contacted a specialist Police unit, which advised:

> the action of passionately kissing in itself was not a criminal offence; however, if [Brittany] wanted to make a report, it would investigate due to the age difference.

340. Police told the investigation it checked with three local specialist units and there was no record of the incident or such advice to Berry Street.

341. At interview, the Berry Street representative acknowledged that due to the age difference between the girls, it should have arranged 'a secondary consult'. The representative also said that upon reflection, Berry Street should have classified the incident as 'major' and a 'sexual assault' in its incident report.

342. In response to the draft report, Berry Street said ultimately the Department determines if incidents are categorised correctly. It said it asked Child Protection to move Brittany following the incident.

343. The next day, Child Protection and Berry Street decided to end Brittany's placement. For three weeks, Brittany stayed in a motel with Berry Street workers while Child Protection sought a new placement.

Anglicare placement

Placement risks

344. Towards the end of 2018, Brittany moved into an Anglicare standard four-bed residential care unit with two other girls.

345. Anglicare does not have a written 'matching tool' for placements. At interview, the Anglicare representative said it discusses placements with Placement Unit staff and consults the CSO that managed the child's previous placement, if any.

346. In a written response to the investigation, Anglicare said it thought Brittany was a suitable match for the unit. Amongst other things, it noted the two other girls were a similar age to Brittany and did not have any sexual exploitation risks.

347. However, a month later, Anglicare accepted a fourth young girl who, according to Child Protection records, had a 'very high risk' of sexual exploitation. The placement proceeded as an interim placement. At Anglicare's request, Child Protection funded extra staff to supervise this new girl and reduce the risks to Brittany.

348. The new girl ran away on her second night in the unit and moved temporarily to Secure Welfare. Before the girl returned, records show Brittany's Child Protection worker and an Anglicare worker both raised concerns with their respective organisations, about her return. They raised Brittany's risk of sexual exploitation and the new girl's potential influence on her.

349. Anglicare's response to the draft report said it 'was not included in any planning or Care Team meetings' regarding the girl's return to the unit. It said the girl's return was solely authorised by Child Protection.

350. However, emails show Anglicare agreed to accept the girl back into the unit, with reservations (see Figure 11 on the next page). At interview, the Anglicare representative said they considered the risk to Brittany and thought the new girl would not take other children with her if she absconded again.

351. The Anglicare representative said Anglicare planned to:

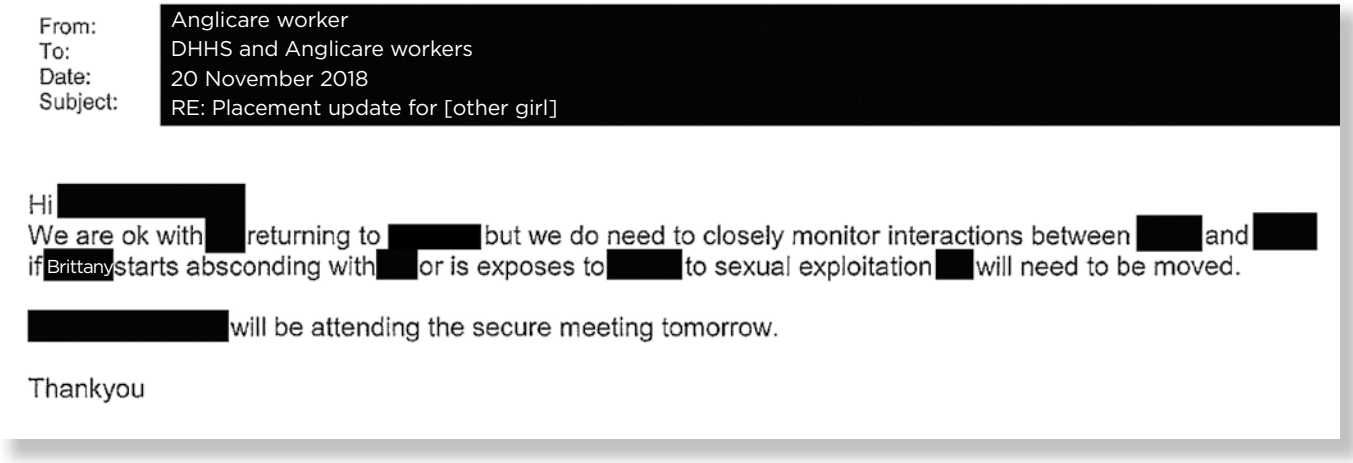
> keep the young girls separated if possible with [the new girl] engaged with her family and [Brittany] engaged with staff at the house.

352. The representative said this plan broke down fairly quickly because the new girl stopped engaging with her family.

353. Brittany's behaviours worsened. Anglicare daily case notes show Brittany and the new girl discussed running away together two days after the girl returned from Secure Welfare. Anglicare workers dissuaded them by taking them for a drive. However, Brittany ran away on other occasions. Records show she sometimes said she drank alcohol or used illicit drugs during these absences.

354. Anglicare told the investigation it held three Care Team meetings for Brittany. In response to the draft report, it also said it 'called placement breakdown' for the new girl, after the first alleged rape (see next page), and Child Protection agreed to fund an extra worker for the unit to manage the situation.

Figure 11: Email from Anglicare to Child Protection, 20 November 2018



From: Anglicare worker
To: DHHS and Anglicare workers
Date: 20 November 2018
Subject: RE: Placement update for [other girl]

Hi [redacted]
We are ok with [redacted] returning to [redacted] but we do need to closely monitor interactions between [redacted] and [redacted] if Brittany starts absconding with [redacted] or is exposes to [redacted] to sexual exploitation [redacted] will need to be moved.

[redacted] will be attending the secure meeting tomorrow.

Thankyou

Source: Department of Health and Human Services record of an email from Anglicare

Alleged sexual assaults

355. About six weeks after Brittany moved to the Anglicare unit, she told workers she had been raped on two separate occasions while away from the unit.

356. Anglicare's incident report for the first assault said Brittany told a worker she was drugged and raped by a 24-year-old man at an apartment in the city. She would not provide information about the date, so it cannot be confirmed if this occurred during her time with Anglicare. In response to the draft report, Anglicare said its records show the worker first became aware of this incident by overhearing Brittany's disclosure to another resident.

357. Police confirmed Anglicare reported the alleged rape. It said that Brittany did not make a statement and there were insufficient details for it to investigate.

358. The second alleged rape occurred after Brittany and the new girl went missing from the unit at about 11pm one night. Anglicare workers followed them in a car but lost sight of them. Anglicare reported both children as missing to Police and Child Protection. Early the next morning, the girls returned to the unit on their own.

359. Brittany spoke to a Child Protection worker and said she had been raped by three adult men during the night. She said the men gave her and the other girl alcohol and cannabis.

360. Anglicare completed an incident report and contacted Police, who spoke with Brittany. This matter is before the courts.

361. Child Protection and Anglicare held urgent meetings that day. Child Protection agreed to move the new girl from the unit and Anglicare took Brittany's phone to prevent further contact between them. In response to the draft report, Anglicare noted the new girl's placement ended at its insistence. Child Protection paid for a staff member to follow Brittany if she left the unit.

Other concerns

Sexual exploitation risk

362. The investigation also looked at how Child Protection and the CSOs managed Brittany's absconding from her residential care units, given her age and identified risks of sexual exploitation.

363. The month after Brittany moved into residential care, Child Protection gave Berry Street a Care Plan with advice about how to respond. It said, given Brittany's age and vulnerabilities, workers should call 000 immediately and report her to Police as a missing person (see Figure 12 below). Berry Street's own Care and Safety Plan for Brittany contained the same advice.

364. Berry Street said Child Protection later developed another Safety Plan. It advised workers to give Brittany a 30-minute window to return to the unit if she ran away alone, rather than immediately contacting Police.

365. In response to the draft report, Berry Street said this was Child Protection's decision. It said Berry Street's supervisor in the unit believed the plan was meant to give Brittany time to 'cool down' and return to the unit voluntarily, rather than involving Police and escalating the situation.

366. Records show Berry Street workers went out looking for Brittany when she went missing, and lodged incident reports. They also show Berry Street agreed to develop a 'calendar' of activities for Brittany separate from the other resident. Berry Street and the Department said the Department also funded an extra worker for the unit.

367. At interview, the investigation asked the Berry Street representative how Brittany was able to run away from the unit so often, even with extra supervision. The representative explained:

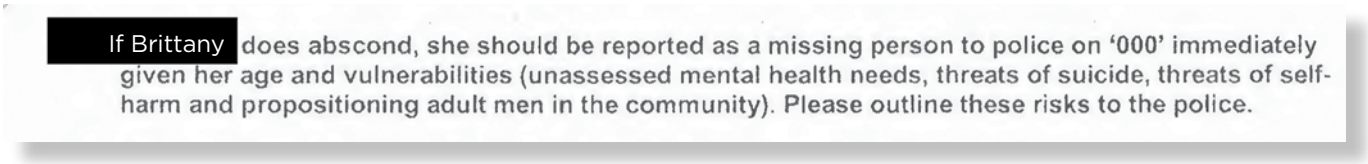
> One of the difficulties about residential care is that we can't stop young people from leaving placement. All we can do is encourage them to try and stay by providing activities that might be more exciting than going out … if a young person wants to leave, we have no recourse to stop them other than encouragement and support.

368. In response to the draft report, Berry Street said:

> its approach is to provide an environment where young people want to be and incentivise staying at placement, as well as responding appropriately when they are absent from placement.

369. Brittany continued running away after she moved to the Anglicare unit.

Figure 12: DHHS Care Plan for Brittany


If Brittany does abscond, she should be reported as a missing person to police on '000' immediately given her age and vulnerabilities (unassessed mental health needs, threats of suicide, threats of self-harm and propositioning adult men in the community). Please outline these risks to the police.

Source: Berry Street

370. The Department said it had funded a second worker in the unit at night so that Brittany could be followed if she left the unit. In response to the draft report, Anglicare said the extra staff member was 'primarily to engage the [other girl at the unit]'. It also noted that while Child Protection's new safety plan said additional staff should be stationed outside Britany's door to prevent her absconding, it 'refuted the feasibility of this'.

371. Records show Anglicare workers took various steps when Brittany went missing. On one occasion, records say workers tried to convince Brittany to stay in the unit after she told them older men were contacting her with explicit messages and she planned to meet an older man in the city. On another occasion, they took the girls on an outing to occupy them. On other occasions, they tried to follow the girls.

372. In one case, Brittany left the unit with the other girl after telling workers they planned to meet a man at a train station. Workers followed them to the train station and noted there was no man waiting for them. They watched the children board a train but did not follow them onto the train.

373. In response to the draft report, Anglicare stated this 'implies staff had a choice not to board the train to follow the two girls'. It noted workers made the appropriate notifications to Child Protection upon returning to the unit.

374. Anglicare completed incident reports for some of the occasions Brittany went missing, but not all. In response to the draft report, Anglicare noted one absence was in the middle of the day on a Sunday and:

> there would be no expectation from Anglicare or DHHS that such an occurrence would be the subject of an incident report.

Where is Brittany now?

375. Child Protection moved Brittany 11 times in 2019, after her Anglicare placement ended. This included attempts to return her home to her mother and her extended family, admissions to Secure Welfare, and emergency stays in motels with paid workers. Brittany then returned to residential care.

376. Brittany's mother told the investigation her daughter had returned home in early 2020 after going missing from residential care for about a month. Brittany has not been to school for about two years now. Her mother said she is working with Child Protection to develop a home-schooling plan to help Brittany catch-up and hopes she can join some local youth groups when COVID-19 restrictions permit so Brittany can make some new friends and start enjoying life again.

377. Towards the end of 2020, Brittany returned to residential care while Child Protection works with her and her mother on the best option for her long-term care.

The CSOs' responses

Berry Street

378. As this report noted earlier, Berry Street's Chief Executive Officer accepted there were areas where it could have done better to care and advocate for the children in this report. They said Berry Street tried its best to deliver quality 'care, supervision and support within the ill-equipped and ill-designed residential care system'.

379. As noted, the Chief Executive Officer said that Berry Street is now 'much firmer' in saying no to proposed placements when there are clearly identified risks. It is also reportedly doing more to support senior staff and external investigators to manage incident reporting.

380. Appendix 1 sets out responses from Berry Street's Board President and Chief Executive Officer.

Anglicare

381. Anglicare's Chief Executive Officer provided a detailed response to the draft report, so the investigation could understand the context around Anglicare's care for Brittany and raised the following issues with the investigation.

382. First, Anglicare said comments in the draft report about incident reporting:

> do not indicate an accurate understanding … of the threshold required for an incident report.

383. Anglicare said that Child Protection's incident reporting guidelines

> outline that if an event or circumstance had the potential to cause harm to a client **but did not do so** [Anglicare's emphasis] it does not meet the threshold required to complete [an incident] report.

384. The investigation notes the missing incident reports related to Brittany being absent from the unit after receiving sexually explicit messages from an adult man wanting to meet her. The incident guidelines state 'an absent client' incident is one in which the child is 'absent without authorisation and there are concerns for their safety'.

385. Second, Anglicare did not accept there were problems with its risk management or supervision of Brittany. It said it worked closely with Child Protection to follow safety plans and endorsed risk mitigation strategies, including rostering additional staff in the house at night, after which no further significant absences occurred.

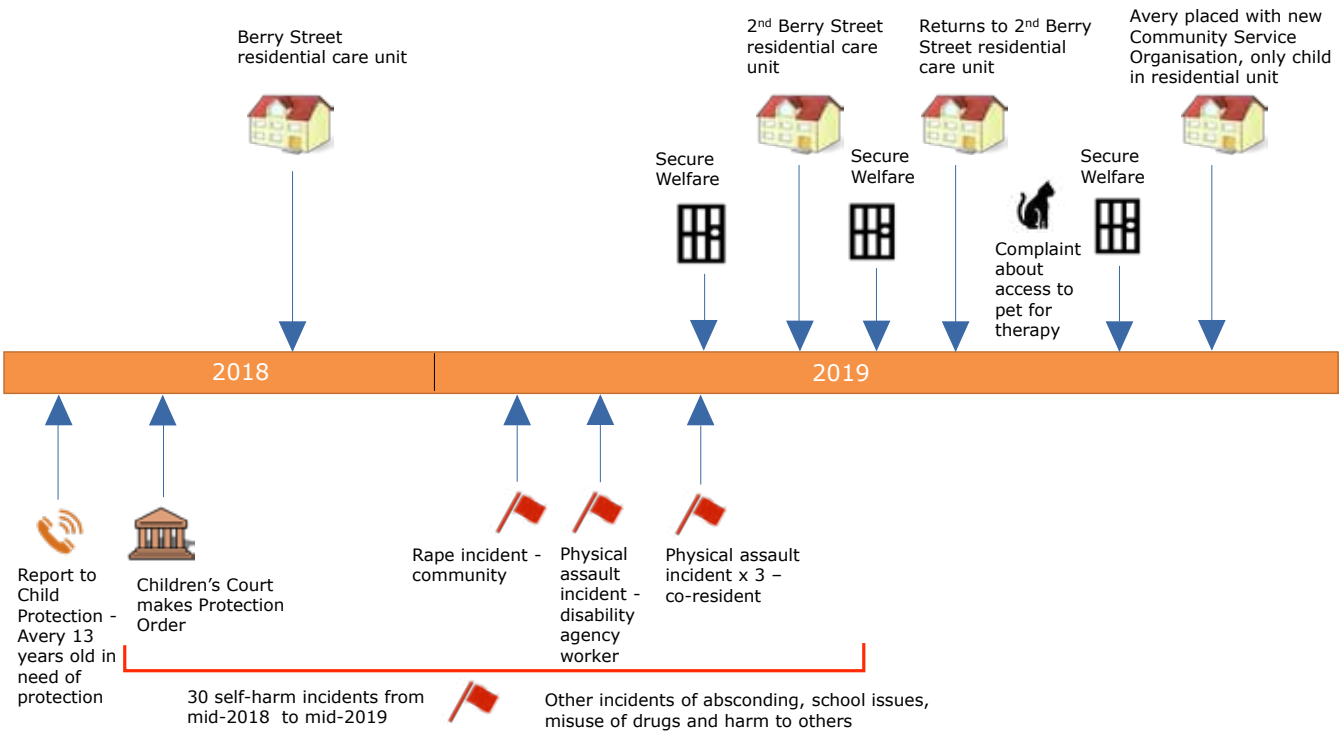
Avery

Avery has been in residential care since 2018, when she was 13 years old. She has been diagnosed with an autism spectrum disorder and complex behavioural disorders. She lived in two different Berry Street units during her first year in residential care.

In 2019, Avery's mother contacted the Ombudsman saying that Avery had been raped by an adult man while away from her residential care unit. She also said Avery had started using illegal drugs and self-harming. The investigation found:

- At first, Avery was meant to be the only child in her unit because of her complex needs and behaviours.
- Berry Street said Child Protection pressured it to accept other children in the unit. After this, Avery's behaviour deteriorated and she began using drugs.
- Around five months after going into care, Avery was raped by an adult man at his home. Police told the investigation the man was found guilty at court and is currently appealing his sentence. Avery has since been hospitalised many times after self-harming.
- Avery also reported that one of the other children in her unit assaulted her three times.
- Child Protection and Berry Street moved Avery to another Berry Street unit where she was once again the only child. However, problems continued.
- Berry Street told the investigation there are growing numbers of children with complex disabilities in residential care. It said the system was not designed for these children and more support is urgently needed.

Figure 13: Avery's timeline of key events



Source: Victorian Ombudsman (incorporating information from Department of Health and Human Services)

386. Avery is in her teens and has been in residential care since 2018, when she was 13 years old.

387. In March 2019, Avery's mother contacted the Ombudsman and said Avery had been raped by an adult man while away from her residential care unit. She also said Avery had started drinking and using drugs and had attempted suicide several times. She said residential care workers were ill-equipped to respond and she was:

> desperate for her daughter to be provided with the treatment and education she requires before she ends up in juvenile [detention] or dead.

388. The investigation found Child Protection had placed Avery in two different residential care units, both managed by Berry Street. To understand her experience, the investigation:

- examined records from Avery's Child Protection and Berry Street files
- obtained written responses from the Department, Berry Street and Police
- interviewed one Berry Street representative and three Department representatives, including a Child Protection Principal Practitioner
- spoke with one of Avery's former psychologists by telephone.

389. The investigation looked at what Child Protection and Berry Street knew about the risks to Avery and how they responded.

Why Avery was in residential care

390. Avery's childhood was marred by significant family violence, including an incident during which Avery's mother said the father tried to kill her and abduct Avery and her younger sibling.

391. Avery has been also diagnosed with an autism spectrum disorder, attention deficit hyperactivity disorder and oppositional defiant disorder. Her conditions result in some challenging behaviours, including self-harm and violence towards others.

392. Child Protection was involved with Avery and her family throughout Avery's childhood. It attempted to help the family through disability, mental health and family support services.

393. In 2018, Avery's mother had become worried that Avery's aggressive behaviour was placing herself and Avery's younger siblings at too much risk. Child Protection removed Avery from the family home.

394. At first, Child Protection tried to place Avery with extended family, but they struggled to manage Avery's behaviour and needs.

395. After exhausting other options, Child Protection looked for a residential care placement for Avery. Its Placement Referral document said Avery needed '2:1 care support' because of her behaviours. This meant Avery needed two workers solely dedicated to her care.

Berry Street placements

Placement risks

396. Child Protection moved Avery into a Berry Street standard residential care unit in 2018.

397. At first, Avery was the only child in the unit. Berry Street provided 2:1 care in the daytime. It only provided 1:1 care at night. In a written response to the investigation, Berry Street said this was because '[the Placement Unit] would not provide additional funding … despite the information in the placement referral'.

398. Berry Street said it accepted Avery on the condition she would remain the only child in the unit for three months 'in response to the high level of complexity that [she] presents with'. However, it said the Placement Unit soon began asking it to accept other children. It said the Placement Unit was:

> insistent Berry Street recommence taking referrals at the unit with no real evaluation of the three-month trial period.

399. In response to the draft report, Berry Street said it repeatedly refused requests from the Department to accept other children in the unit. It said it also advocated for a 'specialised model of care' for Avery. It said the Department rejected its requests and 'described Berry Street as "risk averse" compared to other CSOs'.

400. Three months after Avery moved to the unit, Child Protection and Berry Street started placing other children in the unit. Then, over the next four months, six other children came in and out of the unit. These placements ranged from one night to four months. They meant Avery was no longer receiving 2:1 care.

401. Some of these children also had challenging behaviours. One child had a history of drug use. Another allegedly had a history of assaulting family members.

402. Berry Street said it completed 'matching' assessments for all of the children, but they were 'not saved on file'.

403. Avery's mother and a public hospital psychologist both raised concerns about these placements. They said Avery mimicked other children's behaviour and Avery's mother was worried her daughter would be exposed to drugs and alcohol. The psychologist told the investigation that 'a traumatised kid with extreme behaviours definitely should not have been placed with [Avery]'. Avery's mother said she thought Avery was going to be the only child in a therapeutic unit.

404. Child Protection records show Child Protection told Avery's mother that 'residential placements are not for one child only' (see Figure 14).

Figure 14: Child Protection case note of phone call from Avery's mother, 15 February 2019

Case Note

Client:	Avery
Event Date & Time:	15/02/2019 6:59 PM
Subject:	AHCPES casenote - T/C from Mother regarding current placement
Created by:	Child Protection Practitioner

Summary:

6:58pm T/C from Mother

Mother stated that Avery is currently at her home with a carer from her unit. Avery is concerned that there is another client coming into the placement and Avery has said that this client using ICE.

Mother said that since Avery went into care she has used MDMA and alcohol. She had initially asked for voluntary help with Avery and they were under the understanding that Avery would only be in a therapeutic unit with no other children.

They are calling now to ask that no one else is placed in the unit this evening.

Writer advised that this is not something that is able to be prevented. Staff are in the placement to support clients and if Avery has concerns she can talk to the staff there. Residential placements are not for one client only.

Mother to inform Avery that staff are there to support her in the placement and she is able to talk to them about her concerns.

Source: Department of Health and Human Services

405. The Department told the investigation:

> The demand for residential placements is significant and the support requirements for children being considered for residential care are often complex and challenging. Amelioration strategies are put in place to mitigate the risks posed by [children] to each other such as safety plans and behaviour management plans.

406. At interview, Child Protection's Principal Practitioner said Berry Street assured Child Protection it would have experienced staff working with Avery in the first three months, so they could introduce more children to the unit. They said Berry Street said it would have its 'best staff, handpicked, the best team possible' and they would all be Berry Street employees with a minimum of three-years' experience.

407. However, within days Berry Street rostered agency staff to care for Avery. In response to the draft report, Berry Street said it did not make any such assurances regarding staffing in Avery's unit.

408. Berry Street's records contained several safety and behaviour management plans for Avery, as well as expert advice. However, records show her behaviour deteriorated. She began using illegal drugs, running away and continued acting aggressively towards herself and others. She was suspended from school and had frequent contact with Police and hospitals. At one point, two new children moved into the unit in the same week. Berry Street said this led to eight 'major incidents' in five days.

Sexual assault – rape

409. Around five months after moving into the unit, Avery told workers she had been raped by an adult man.

410. Incident reports show Berry Street workers allowed Avery to leave the unit to meet friends, on the condition she would go to a meeting at her school and then visit her mother. She later called workers and said she had taken the drug MDMA and was planning to go to the house of a 23-year-old man who had given her alcohol.

411. Workers tried to dissuade Avery but did not notify Police. They say they went to a train station where Avery was heading. They did not arrive for over two hours, for reasons that are not explained in the records.

412. Two hours later, after a number of phone calls from Berry Street workers to Avery, she called workers in tears and told them where to collect her. She gave unclear details about an incident with the man. Workers notified Police and Child Protection. Avery told her Child Protection worker the man raped her.

413. Police told the investigation the man was found guilty at court and is currently appealing his sentence.

414. Berry Street conducted its own 'quality of care' investigation into its actions. It did not identify concerns with its care and said the worker had more frequent contact with Avery and her mother than shown in the records. It did not identify workers' failure to notify Police when Avery told them she had taken drugs and alcohol and was going to the man's home.

Alleged physical assaults

415. Around six weeks later, Avery's mother told Child Protection and Berry Street that a new child in the unit had assaulted Avery three times. The alleged assaults involved:

    - pushing Avery
    - threatening to 'punch [her] in the head'
    - slapping and punching her 'several times to the head'.

416. Berry Street lodged incident reports for two of these incidents. It later changed one after wrongly classifying the incident as 'non-major'.

417. There is no record of Berry Street submitting an incident report for the second alleged assault. In response to the draft report, Berry Street said:

> [T]here is no record in its (contemporaneous) case notes that an incident with [another child in the unit] occurred on [date redacted]. Berry Street's records do, however, refer to [Avery] becoming increasingly distressed at having to share her space with another young person and threatening the other young person.

418. Police advised the investigation they did not receive reports about any of the incidents.

Alleged assault by agency worker

419. The investigation also identified records of an earlier alleged assault involving a temporary agency worker. Avery claimed the worker choked her following an incident in the unit.

420. A professional who was visiting the unit at the time told Berry Street's internal investigator she witnessed a disagreement between the agency worker and Avery over Avery's behaviour. Avery tried to follow the worker into the unit office, and he pushed the door onto her foot to stop her. Avery 'gave him a finger gesture and he returned the gesture'. A few days later, Avery said the worker tried to choke her.

421. Avery told a Berry Street worker the agency worker:

> scares her and that if she sees him again, she will hurt herself … and that she prefers having female staff on at night.

422. Avery's preference for female workers was documented in Child Protection's Placement Referral.

423. Berry Street's investigation found Avery assaulted the worker and tried to choke him. Police charged her with assault, but the charges were later struck out.

424. The internal investigation did not substantiate Avery's counter-allegation that the worker assaulted her. However, it identified the worker was not properly trained. It stated:

> It is the belief of the investigator that due to [the agency worker]'s lack of training around de-escalation, that he resorted to restraint in order for him to restrict [Avery's] further assaults … the approach [the agency worker] took [indicates] that he did not know how to respond to [Avery's] cues and behaviours and he was not able to de-escalate.

425. The Department's *Minimum Qualification Strategy for Residential Care Workers in Victoria* policy requires CSOs to allocate tasks to workers that are appropriate for the worker's skill level and education.

426. Berry Street's report on the incident said the worker's agency would review 'his placement into units that are appropriate for his level of experience'. It did not question Berry Street's decision to roster agency workers in the unit.

427. In response to the draft report, Berry Street said its investigation, which was endorsed by the Department, found 'there was no evidence of a physical assault, inappropriate physical treatment or poor-quality care' towards Avery. It said it is not part of the investigation's scope to determine if it should have used agency workers.

428. Berry Street did not notify Police of Avery's assault allegation until four days after the incident. Berry Street said the delay was 'due to a worker error in originally classifying the report as a non-major [incident] report'. It also said it has since centralised oversight of incident reporting. Its central team now supports workers to comply with incident reporting requirements, including advising workers when to report matters to Police.

Placement changes

429. In April 2019, Berry Street decided to end Avery's placement in the unit. The Department said Berry Street made the decision because of 'the level of supervision required for monitoring [Avery's] self-harm and high-risk behaviours'. Berry Street indicated it could not care for Avery under the arrangements 'as it was too unsafe'.

430. Child Protection moved Avery to Secure Welfare. Twenty-four hours later, Berry Street agreed to care for Avery again at a different unit, with extra funding for a higher level of care.

431. Child Protection records show there was an 'urgent planning meeting' about Avery's care. The notes state a four-bedroom unit was unsuitable for Avery and that other children in the unit could not 'tolerate her presentation'. Child Protection and Berry Street decided to move her to a standard two-bed unit, where the workers had success with children with autism. Records say Avery was to be the only child in the unit and would receive 2:1 care in the daytime and 1:1 care at night.

432. Berry Street scheduled training for the unit workers while Avery was in Secure Welfare. They visited Avery daily until she was ready to move to the unit.

433. However, problems continued. After around four months, Berry Street decided it could no longer care for Avery. In response to the draft report, Berry Street said it ended the placement because Avery would benefit from specialist disability support that it could not provide.

Other concerns

434. The investigation also identified other concerns and observations about Avery's time in residential care.

Need for therapeutic care

435. When Avery's mother contacted the Ombudsman, one of her main concerns was the lack of a therapeutic approach to her daughter's care. She wrote:

> Since being in Child Protection care [Avery] has been neglected and exposed to drug use, self-harm, been raped (Vic Police have charged perpetrator and he is pleading guilty), assaulted by another young person in the unit …
>
> After [Avery's] sexual assault [Avery] was strangling herself on a daily basis and ending up in the Emergency Department.
>
> As a result of mismanagement, neglect and [Avery's] disability and emotional needs not being meet, [Avery] ending up being put into Secure Welfare twice for long periods at a time.
>
> [Avery] has now been placed into another unit by herself … Staff were trained by [a consultant]. The recommendations are to support [Avery] with therapeutic treatment.
>
> This didn't happen, [Avery] had irregular staff, no routine, [Avery's] therapeutic needs not being meet and [Avery] not feeling safe with different staff. This resulted in [Avery] assaulting staff, smashing … windows and putting herself at risk by walking on a main road in front of oncoming traffic. Threatening self-harm. It is well documented that these behaviours are an outcome of how severely distressed [Avery] is.

436. Records confirm Avery's behaviour deteriorated in residential care, despite many plans and expert advice about her behaviour and needs. While she had behavioural problems before entering care, there was no record of her using illegal drugs or self-harming.

437. Avery's former psychologist told the investigation that Avery came into care with some 'baggage' but:

> she never took drugs before, she didn't abscond, and she hadn't been raped … when you have information about a disability, and you ignore it, the negligence is way worse than the kid's baggage when they come into the system.

438. At interview, the Berry Street representative said Child Protection did not give Berry Street a referral to provide therapeutic care to Avery. They said Berry Street engaged well with Avery's mother and 'cared well' for Avery, but there needed to be better scrutiny of placement decisions.

439. In response to the draft report, Berry Street also noted that, even if Child Protection had placed Avery in a therapeutic residential care unit, the current therapeutic residential care model would not have met Avery's needs. It said the model is not disability-specific and Avery would still have lived with other children. Berry Street said it provided 'care with therapeutic input' to Avery by advocating for her to be placed in a unit by herself, declining five attempts to place other children in her unit, and working with specialist services to implement a personalised therapeutic plan.

440. When Avery's mother contacted the Ombudsman, she was particularly concerned that Avery needed a therapeutic pet. She said Avery had taken in two stray kittens, but Berry Street was planning to remove them.

441. Records show Child Protection and medical and behavioural specialists had agreed a pet would 'make a dramatic improvement [to Avery's] therapeutic treatment'. The Ombudsman raised the matter with the Department, which reached an agreement with Berry Street so Avery could keep one of the kittens.

442. In response to the draft report, Berry Street said it had supported visits to the unit from Avery's family dog until the dog bit a staff member. It said the kittens were brought into the unit without prior approval and a worker in the unit had a serious allergy to cats. It said this worker had consequentially been rostered to a different unit.

443. In response to the draft report, Avery's mother told the investigation when her daughter had 'melt-downs' following the rape she was often restrained and sedated by emergency services. She said Avery was usually refused admission to mental health hospitals as it was deemed a 'behavioural' problem. Instead, Avery was placed into Secure Welfare, despite her expressing she was suicidal and even jumping in front of cars. Avery's mother estimated these secure placements accounted for 80 per cent of Avery's time in care during a 10-month period in 2019. She said this is not where a child with a disability recovering from trauma should be.

Medication and possible chemical restraint

444. The investigation observed that, as with Quinn, there was some evidence suggesting Avery was given medication to manage or control her behaviour.

445. Berry Street's written response to the investigation said it had identified some of Avery's prescribed medications met Berry Street's definition of 'chemical restraint'. Its definition:

> includes any drugs … that have an effect upon an individual's cognitive functions, and whose prescribed intent is to affect or alter thought processes, mood or behaviour'.

446. Some of Avery's records indicate doctors prescribed her medication to manage changes in her behaviour.

447. There is no record that Child Protection or Berry Street asked doctors to clarify the purpose of the medication.

448. The Department told the investigation it was not aware of any chemical restraints for the five children in this report.

449. In response to the draft report, Berry Street said all medication was administered in accordance with the doctor's prescriptions. It said it has since improved its procedures to bring them in line with best practice. It said there are increasing numbers of children with a disability entering care and administering medication for those children is a relatively new skill for residential care workers.

Where is Avery now?

450. In December 2019, Child Protection told the investigation that an experienced CSO had taken over Avery's care. She was the only child in her unit and was getting extra disability and mental health support.

451. In August 2020, Avery's mother told the investigation Avery had been attending school for half a day each day and work experience in the afternoons. However, her work experience had been restricted recently due to COVID-19 and Avery was now spending afternoons with her mother at home. Avery's mother said Avery was being 'chemically restrained' at her placement after a series of 'meltdowns', limiting the types of services she can access to bring her daughter home. Avery's mother continues to advocate for her daughter's care.

Berry Street's response

452. As noted earlier, Berry Street's Chief Executive Officer accepted there were areas where it could have done better to care and advocate for the children in this report.

453. In response to the draft report, Berry Street noted the Department used to fund specialised disability group homes for children. It said the Commonwealth Government has not continued support for those homes under the new National Disability Insurance Scheme.

454. Berry Street said children with disabilities, such as autism spectrum disorder and intellectual disabilities, are now living in general residential care. It said residential care was:

> not designed to meet the needs of these children and staff do not have the core skill-base or training needed to meet their complex disability related needs in a comprehensive way.

455. Berry Street said it has been training its workforce to respond better. It said it has received no support or additional funding from relevant government agencies or through the disability sector. It said this support is required urgently.

456. Berry Street also said for the majority of incidents outlined in this report, it 'made appropriate and timely incident reports'. Berry Street acknowledged that some reports were incorrectly categorised, but said this should be understood in the context of a relatively new reporting system and the interpretation of reporting requirements evolving over time. As noted earlier, Berry Street said it recently undertook extensive work to support senior staff and external investigators to manage incident reporting.

457. Appendix 1 sets out responses from Berry Street's Board President and Chief Executive Officer.

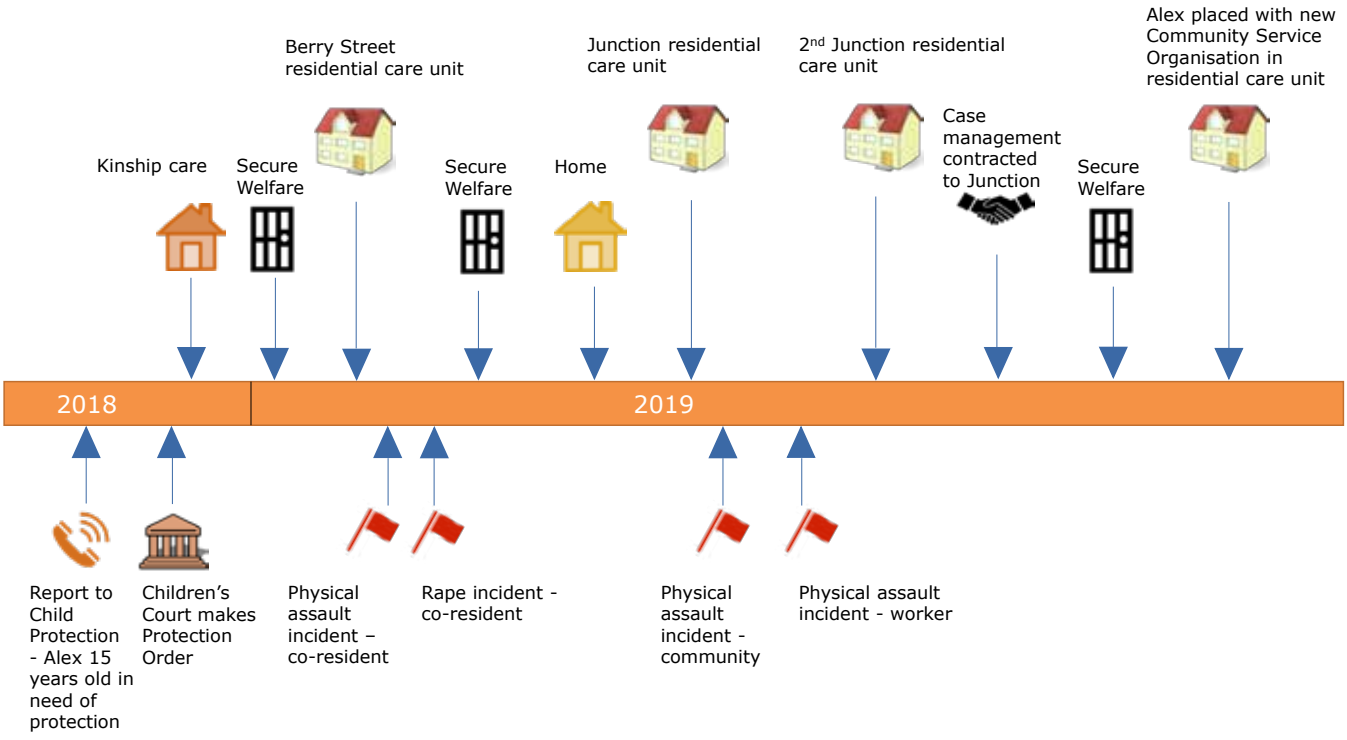
Alex

Alex is a young person in his teens with a complex history and behaviours, including mental health conditions. He identifies as non-binary but prefers to be referred to using male pronouns. One of his family members told the Ombudsman that Alex reported he was raped by another boy shortly after going into residential care.

The investigation found Alex has been in and out of residential care since early 2019. It focused on Alex's first placement with Berry Street and two later placements with Junction. The evidence shows:

- At first, Child Protection placed Alex in a Berry Street unit with three other boys. Alex told Child Protection he was anxious because he had been sexually assaulted by adolescent boys in the past.
- Records show unit workers allowed a younger boy to stay in Alex's room overnight. Although workers checked on the boys regularly, Alex later said the boy raped him. Police advised they did not lay charges and Berry Street said its own internal investigation did not substantiate the sexual assault.
- After Alex moved to a Junction unit, Child Protection and Junction placed a teenage boy with a history of criminal offending in the unit.
- Alex and the other boy started running away together and using drugs.
- Alex was seriously assaulted by someone he said was his drug dealer and spent more than 12 hours in hospital.

Figure 15: Alex's timeline of key events



Source: Victorian Ombudsman (incorporating information from Department of Health and Human Services)

458. Alex is a teenager who identifies as non-binary or gender-fluid and prefers to use male pronouns. His gender identity has been fluid during his placement in residential care. He has lived in residential care since early 2019, when he was 15 years old. He remains close to members of his family, including his mother and grandmother.

459. Shortly after Alex went into residential care, one of his relatives contacted the Ombudsman and said Alex alleged he had been raped by another boy in his residential care unit. The relative said Child Protection said Alex and his family had raised concerns with Child Protection before it placed Alex in the unit.

460. Records show Alex lived in three residential care units during his first year in care – one managed by Berry Street and two managed by Junction. These were all in regional areas, several hours from Alex's family. To understand Alex's experience, the investigation:

- examined records from Alex's Child Protection, Berry Street and Junction files
- obtained written responses from the Department, Berry Street, Junction and Police
- interviewed three Department representatives, one representative from Berry Street and three Junction representatives.

461. The investigation looked at what Child Protection and the CSOs knew about the risks involved in Alex's placements and how they managed them.

Why Alex was in residential care

462. Child Protection became involved in Alex's family when he was a young child. Its reports mainly describe family violence.

463. Alex's mother began turning their lives around. But when Alex was a teenager, Child Protection became involved again due to concerns about his behaviour. Child Protection records say Alex said he was drinking and using illegal drugs. Child Protection also said he was vulnerable to sexual exploitation. While Alex's family told the investigation that reports of alcohol and drug use were untrue, he told the investigation he was drinking and smoking 'weed'. Alex had also been diagnosed with post-traumatic stress disorder and oppositional defiant disorder. Records say he had attempted suicide many times.

464. In late 2018, concerns for Alex reached a crisis point and his mother felt it was unsafe for him to stay at home. Child Protection placed him with relatives and then returned him home with supports.

465. However, Alex's suicidal and other behaviours grew worse. In early 2019, Child Protection placed him in Secure Welfare for his own protection and began looking for a residential care placement. Alex's relative says he was removed from the family for 'no real reason' and these decisions will have a detrimental and long-lasting impact.

Berry Street placement

Placement risks

466. In early 2019, Child Protection placed Alex in a Berry Street standard four-bed residential unit. Berry Street was the only CSO providing residential care in the area. There were three boys already living in the unit when Alex moved in.

467. Records show that Alex told Child Protection he was 'extremely anxious' about living with three males. A Child Protection worker wrote:

> [Alex] stated that he becomes anxious about being around males due to historical assaults ...

> [Alex] further disclosed being raped by a group of adolescent males, again within the last couple of years … [Alex] advised his belief is that these males did not know if [Alex] was male or female, did not accept his gender identity, and that this precipitated the assault.

468. Child Protection went ahead with the placement. It did not record the information about Alex's reports of past sexual assaults on his Placement Referral document. Berry Street said it was never told.

469. Berry Street warned the Placement Unit that one of the boys might target Alex because of his gender identity. It said this boy (and possibly the other boys) would 'expose [Alex] to significant teasing and threats' because they 'would not understand or be open to [his] non-binary status'.

470. At interview, the Departmental representative said there appeared to be some issues with the placement from a LGBTIQ perspective. They said it may have been the only placement available for Alex, and the Department needs to provide more guidance to support best practice in this area.

471. Alex's relative said they also expressed concern the placement would be unsafe for Alex but felt they 'hadn't been heard'. The relative said Child Protection assured them 'there would be 24-hour supervision'.

472. Child Protection did provide additional funding so there would be two staff present at all times, even overnight.

Alleged sexual assault

473. A few days after Alex moved into the unit, records say he became very distressed and workers sent him to hospital for suicide assessment. He said he had been raped by a younger boy in the unit.

474. Berry Street's records say workers observed the younger boy putting Alex in a choke hold twice during the day. They contain inconsistent accounts of what happened next.

475. Berry Street's incident report said the boy stayed in Alex's room overnight. The report said a worker asked the boy to leave 'repeatedly' but 'he consistently refused'. The report said the worker conducted welfare checks every 15 minutes and observed both children asleep by 4:30am, with Alex in his bed and the boy on the couch in Alex's room.

476. However, Berry Street's daily records say the worker checked Alex every 15 minutes until 3am because he had taken some unauthorised medication, and then checked him every 30 minutes. These records do not mention the boy staying in Alex's room.

477. Berry Street and the Department disagreed about whether Berry Street staff should have done more to protect Alex. The Berry Street representative maintained at interview that workers checked Alex every 15 minutes and said, 'we can't force young people out of [an]other's bedroom'.

478. At interview, the Departmental representative said, 'the reality is stand-up staff are funded at night for these reasons … not to act passively'. They said, if the worker felt unable to force the issue, they could have moved Alex from the room for his safety. The representative also said workers can call for back-up when required.

479. In response to the draft report, Berry Street said it had given Child Protection no assurances that there would be 24-hour, line-of-sight supervision, or that such supervision could be provided. It rejected the assertion that the level of supervision was inadequate or passive. It accepted it conducted checks every 30 minutes after 3am. However, it said at all times during the night a worker was steps from Alex's bedroom in an office.

480. Berry Street promptly took Alex to a Police station to report the incident. Upon request, Berry Street gave Police Alex's clothes and bedding, as well as an unwrapped condom that had been found under Alex's mattress. Police have advised the investigation that they did not lay charges.

481. In response to the draft report, Berry Street said its own internal investigation did not substantiate the sexual assault.

482. Two days after the alleged rape, Berry Street told Child Protection the accused boy had previously touched female workers inappropriately on two occasions. The records say 'there were thoughts' by the other boy's Care Team that the boy's actions were 'seeking maternal comfort as opposed to problematic sexualised behaviour'.

483. Child Protection moved Alex to Secure Welfare, and then back home to his family. While at home, Alex made threats of violence and self-harm; and Child Protection began looking for another residential care placement.

Junction placements

Placement risks

484. The following month, Child Protection placed Alex in a Junction standard four-bed residential unit in another area.

485. At the time, there was only one other resident in the unit, an older girl with a disability who was preparing to leave State care.

486. About one week later, Child Protection and Junction placed another boy in the unit, who was around the same age as Alex. The boy had a history of criminal offending. At interview, Junction's representative said the boy associated with drug users and 'would happily take anybody with him'.

487. Child Protection's records note concerns about the boy's potential 'contamination' of Alex. They noted the unit was 'sleepover only', meaning there would be only one worker in the unit at night and they would be asleep, unless needed by the children. Senior managers indicated Alex should only be placed with the boy as a last resort, and with extra workers to give Alex one-on-one supervision.

488. Junction told the Placement Unit it could provide 'active' supervision at night, at an additional cost. It said it thought the match was suitable because the other boy had a strict curfew and his history indicated he 'would be on his best behaviour when he returned to the unit'.

489. Alex told the investigation he did start using the drug 'ice' with the other boy while in this residential care unit and that they both helped each other get drugs. He said they are still friends, 'like brothers', but are now both now 'clean' and have helped each other a lot.

490. In response to the draft report, Junction said it provided 'active night support' on 37 out of 39 nights that Alex was at the unit during his first placement. However, it said it was not included in initial discussions about the need for one-on-one care. It said it did not have any vacant properties or workers to provide such care.

Alleged physical assault

491. A week after Alex moved into the unit, he called workers and said he had been assaulted. He said he had gone out to 'kill [his] drug dealer' because the dealer sexually assaulted a child. A worker collected Alex. He was hospitalised for over 12 hours due to his injuries.

492. Junction's incident report said a worker called the local Police Station to report the assault, but Alex did not want to make a statement and Police told the worker they could not take any action. The incident report did not name the Police officer who provided this advice.

493. Police told the investigation they have no record of a report about the alleged assault.

494. The investigation raised this with the Department and Junction during the investigation. In February 2020, Police told the investigation there had been no subsequent report.

495. At interview, the Departmental representative said CSOs are expected to do what 'you would expect a good parent to do' for a child. They noted Police can take a report without the young person making a statement, and this should have been pursued more vigorously.

496. The investigation also noted:

- Junction's original incident report incorrectly classified the incident as 'non-major'. It did not re-submit the report to correct the mistake until early May 2019.
- Junction did not investigate the matter or change Alex's supervision.
- Child Protection submitted a report to the Children's Court the following month about Alex placements. It did not mention the alleged assault.

497. In response to the draft report, a Junction representative said they asked Alex about the incident when speaking with him about another matter in May 2019, and Alex refused to provide a statement.

498. Alex told the investigation that he didn't remember saying anything about the drug dealer assaulting a child, but he was 'beaten up and nearly stabbed' over a debt to this dealer.

Alleged physical assault by worker

499. Records show that a week later, at the end of March 2019, Alex complained to Junction office staff that a worker assaulted him during the night. Alex said he was hungry and tried to get into the unit office to get food, and a male worker pushed him against a wall or door.

500. Junction carried out an internal investigation but did not suspend the accused worker. One of the other children in the unit also said the worker pushed Alex. The worker agreed there had been an altercation but said they 'tapped' Alex on the shoulder.

501. Junction's investigation concluded the allegation was unsubstantiated. The investigator wrote in their report:

> information supplied by [Alex] is at times fanciful which makes assessing information supplied by him difficult.

502. In response to the draft report, the Junction investigator said:

> Upon investigation, which included the interview of the complainant and witness, inspecting the scene and viewing documents, I found there was no evidence to support the claim of assault and that the evidence supplied by [the complainant and the witness] lacked credibility … there was no evidence to support the removal of the staff member … This investigation was concluded within 24 hours of the initial report.

503. Junction's investigation report identified the subject of the allegation did not record the incident in their daily notes. It did not identify that the subject of the allegation failed to complete an incident report and inform their supervisor about the incident. A second worker who had learned of the allegation the following morning also did not inform the supervisor.

504. Junction submitted an incident report to Child Protection after Alex raised the allegation with office staff.

505. Police told the investigation they did not receive a report about this incident. In response to the draft report, Junction said a worker from the unit said they contacted Police. The representative said:

> That no report exists is an issue for Police. That no record exists in the LEAP system is standard Police practice and the staff member only erred in not obtaining a name of the Police person she spoke to. If she had obtained that name, there would still be no entry in LEAP.

506. The investigation raised the lack of a Police report with the Department and Junction during the investigation. In February 2020, Police told the investigation there had been no subsequent report.

Other concerns

507. The investigation identified other concerns about Alex's care.

Drug use and offending

508. Records show Alex's behaviour deteriorated after he became friends with the boy in his Junction unit. Alex's relative told the Ombudsman:

> [Alex] became friends with hardened teenagers with violent criminal histories … [he] is impressionable and naïve.

509. The relative said Alex is now facing serious criminal charges.

510. At interview, a Junction representative also said Alex was often 'busy with [the other boy], doing drugs' and they 'did a run through' on a friend's home.

511. Junction records show it was aware of the boy's influence. Records of one incident said Alex:

> had engaged in dangerous activities since arriving at [Junction] and his relationship with [the other boy] has seen an escalation in drug use by [Alex], [Alex] requires closer management by carers and needs to be separated from [the other boy].

512. Junction's records refer to:

> the difficulties of housing some young people together and how certain matches can create an increase in criminal activity of an individual, there was little staff could do to prevent [Alex] from leaving the residence and putting [himself] at risk.

513. Records show Child Protection and Junction did not take steps to separate Alex from the boy for some months.

514. At one point, Child Protection and Junction moved Alex to another Junction unit as part of a 'swap' with a child who needed to live alone. Junction and the Department said it was 'more economical' to move this child to the unit where Alex and the boy had been living. But, instead of separating Alex from the boy, they moved them together.

515. In its written response to the investigation, Junction said:

> the placement decision was based on the demands on placements across the state as well as the best interests of [the other child] … also DHHS requested to move [the other child] to [Alex's unit] as he would only be holding three targets to his name instead of four.

516. Junction was referring to the client receiving solo care living in a residential care unit with capacity to accept four children. It would cost the Department less if this child was moved to a cheaper unit with capacity for only three children. If Alex and his co-residents moved to the four-bed unit, there was the potential for another child to be also be placed in there.

517. Junction said discussions about moving the other child to Alex's unit had begun before Alex moved in.

518. Around a month later, after further incidents, Child Protection decided to move Alex to Secure Welfare. At interview, the Junction representative said:

> we didn't end the placement, the professionals decided it was in [Alex's] best interests to go to Secure Welfare.

Medication and possible chemical restraint

519. The investigation observed evidence that Alex, like Quinn and Avery, may have been prescribed medication as a chemical restraint while in care.

520. Alex's relative stated they had 'asked constantly for a medication review' and mental health clinical support but none was provided until Alex was in Junction's care. So, he 'continued to spiral'.

521. Alex's records show doctors prescribed him several medications while he was in residential care, including an anti-psychotic. The medication records viewed by the investigation were sometimes unclear, but there is some evidence that the anti-psychotic was used as a chemical restraint to manage Alex's behaviour. An email from a Placement Unit manager said the medication was to be given when Alex 'was heightened'.

522. The investigation asked a Junction representative whether Alex's medications were used as a chemical restraint. The representative said there are no reporting mechanisms for chemical restraints where children do not have 'registered' disabilities. They said Junction had created a medication policy but:

> found it really hard to get from the Department something to guide [us] about what to do about chemical restraint.

523. In response to the draft report, Junction said it administers medication according to the directions of the prescriber. It also said the two Junction representatives interviewed by the investigation would not be fully aware of any child's specific medications, as this is beyond the scope of their roles.

524. Alex told the investigation he is prescribed an anti-psychotic medication for his behaviour and he thinks that it helps.

Where is Alex now?

525. During the investigation, Alex's relative told the investigation that Alex was 'traumatised' by the system meant to protect him and would live with the psychological consequences for the rest of his life.

526. Alex's relative raised concerns that Alex, who has dyslexia, had missed a year of school while in residential care and he is now so far behind that catching up seems insurmountable. The relative is worried he has been 'set up for failure'. Alex said his schooling now consists of three solo one-hour sessions with a teacher each week but that it is hard to catch up.

527. At the conclusion of the investigation, Child Protection said Alex is now living in another residential care unit operated by another CSO. This unit is closer to Alex's family. Alex's relative said trying to visit when Alex was up to five hours away (round trip) 'was extremely difficult and often impossible [so it] made the situation even more distressing'. They told the investigation that Alex is now much happier, is re-engaging with his family, and is forming positive social relationships.

528. Child Protection's records show it intends to return Alex home at some point, but there is no clear plan yet about how this will be achieved.

529. Alex said he's happy in his current residential care unit but is working towards renting his own flat with a friend. He is now linked with a drug and alcohol counsellor but said he relied on his friends to help him deal with these issues in his other placements. He said that the best thing about residential care is having a comfortable bed, good food and a shower but he'd like workers 'that treat you more like family' and less like they are your 'manager'.

Berry Street's response

530. Berry Street's response to the draft report reiterated the report's position that the Child Protection and out-of-home care systems are:

> characterised by placements based on 'least-worst' options rather than what is in the best interests of children in its care.

531. It further noted the current system is not meeting the needs of Victoria's most vulnerable children.

532. Appendix 1 sets out responses from Berry Street's Board President and Chief Executive Officer.

Junction's response

533. Junction's response to the draft report clarified some of the details about Alex's care and the placement referral process. The investigation has included those details in this report.

534. Junction's internal investigator provided their own, separate response to the draft report. The investigator said the response was based on their own opinion 'and is in no way a representation of the opinions of Junction'. They expressed a view that the content of the draft report was 'at times over generalised, over-reaching and unjust' and lacked an understanding of Police procedures. They said that while there were some shortfalls, the portrayal of Junction was 'quite unfair'.

535. Junction's investigator referred specifically to the extent of Junction's internal investigations. They also stated:

> Police are required to firstly identify that an offence has been committed … [so] minor assaults will only be recorded where there is a victim prepared to provide information and assist the investigation.

536. The investigation has included additional details in this report where relevant. It has also checked the requirements for reporting to Police and is satisfied they are accurately reflected in the report.

Wider problems and potential solutions

537. Evidence shows the experiences of the five children in this report are not new or isolated.

538. Over the last decade, many bodies have warned of significant and systemic problems with the residential care system – this office, the Victorian Auditor-General's Office, the Royal Commission into Institutional Responses to Child Sexual Abuse, the Institute of Child Protection Studies and CCYP.

539. CCYP's most recent 2019 report on out-of-home care, 'In our own words', found:

> residential care in its current form is often unsafe for children and young people and places them at an unacceptable risk of harm.

540. When ABC News asked the Minister for Child Protection if children were safer in residential care than with their parents, he responded:

> Sometimes yes, sometimes no, it depends on the situation; there is no black and white answer to that question (*The lost kids, 4 March 2020*).

541. This section looks at the specific problems raised by the evidence in this investigation:

- placement pressures
- flawed care and supervision
- incident reporting mistakes
- neglected cultural planning for Aboriginal children
- potential chemical restraint of children
- inadequate support for LGBTIQ children.

542. It also looks at two potential solutions to some of the most difficult issues.

Wider problems

Placement pressures

543. The evidence suggests there are pressures on CSOs and Child Protection to place children in residential care units, even when the 'match' with other children may be risky or unsafe. Such placement decisions are inconsistent with the Placement Framework, which states, 'the placement of one child should not jeopardise the safety or individual needs of another child'.

544. When the investigation asked CSO representatives why they accepted children when there were risks, they pointed to pressure from Child Protection.

545. A Berry Street representative said at interview:

> In mainstream residential care, there's a lot more pressure just to take children. You might be told you have the only vacancy in the state … Just guessing, I would say, you need to be at about 80% capacity to match appropriately, and we're at 95/100% capacity.

546. A Uniting representative also referred to the pressure faced when the agency has 'the only vacancy in the region or the state'. They described an:

> often … heated conversation as the pressures for the Department are to place children and the pressures for agencies are to care for children in a safe way. Sometimes those don't match, and it can be difficult.

547. A VACCA representative said Child Protection asks VACCA to accept the highest-risk Aboriginal children when they are an unsuitable match for VACCA's unit and other children:

> We get the referrals for the young kids they don't know what to do with. Then all of a sudden its 'oh they're Aboriginal and they need to be placed with you guys, you have a responsibility to your community' …
>
> They've got nowhere for that young person to go, they're so high risk no other agency wants to take on the risk. So, we often get referred young people who are not right for the placement, they're not safe to be matched with [others in the home], but we are kind of forced into the situation because culture is used as the reason. In my opinion its often kind of an incorrect use of the Aboriginal Placement Principle.

548. When the investigation asked Child Protection representatives why Child Protection placed children in units where there were risks, they pointed to the pressures on the Child Protection system and its workers.

549. One Department representative said:

> [Y]ou can only achieve [best practice] if the system is resourced for best practice.
>
> … the reality is that the [Children's] Court has ordered that [the child] has to be placed in [out-of-home care], and that will trump any other guideline … at the end of the day you have to have that child in a bed … it's an issue of prioritisation and compromise … everyone who works in it attempts to meet their obligations.

550. The representative said:

> you need to run a service at all times with some capacity in order to do appropriate matching, planning and ensure safety, and currently it doesn't [have that capacity].

551. They said Child Protection workers were:

> constantly needing to prioritise and make the 'least-worse' decision because they can't make the best decision.

552. In CCYP's 2015 report on residential care, "*…as a good parent would…*", CCYP found:

- there was inadequate assessment of the suitability of placements
- the mix of children in residential care is sometimes inappropriate
- it seems the availability of beds, rather than the child's best interests, dictates most placement decisions.

553. In response to the draft report, Berry Street made similar observations. It said the:

> current system fails because it is focussed on providing children with a bed and supervision, rather than the specialised care and stability needed by a child.

554. It noted that there is often disagreement between Child Protection and the Placement Unit 'regarding placement decisions that are based on resources rather than the best interests and needs of the child'. It also said:

> lack of capacity, flexibility and diversity of residential (and home-based) options … forces Child Protection and CSOs to make decisions based on the 'least-worst' option available.

Level of care

555. The five cases in this report also raise questions about the level of care available for children with complex needs and behaviours.

556. In a written response to the investigation, the Department described the needs of children in residential care:

> Children and young people in residential care have experienced abuse and neglect, and in many cases significant and enduring abuse and neglect. The impact of this trauma may lead the young person to present behaviours of concern. Relative to all young people, young people in residential care are more likely to present with risk-taking behaviours such as self-harm, aggressive or sexualised behaviours, substance abuse and other activities that place them, or others, at high risk, as a manifestation of the trauma they have experienced.

> Furthermore, young people in residential care may have developmental delays, experience higher incidence of poor mental health, disability, emotional and behavioural difficulties than other young people and are at greater risk of contact with services such as Police and the youth justice system. Additionally, for Aboriginal young people there is the added impact of discrimination, intergenerational trauma and disconnection from culture.

557. Child Protection's policy frameworks rely on Care Teams and plans to manage risks to children and coordinate responses.

558. However, the evidence from the five cases in this report shows there was sometimes confusion between Child Protection and CSOs about who was meant to lead Care Teams or planning.

559. There were also multiple examples of CSOs failing to engage services to address children's needs and behaviours. For example:

- CAFS did not ensure counselling for Quinn for two years despite her history and experiences in residential care.
- Avery's mother highlighted that her daughter needed therapeutic treatment. However, even in therapeutic residential care units, clinicians still do not provide direct support to children, but rather provide advice to staff about trauma-informed care.
- Uniting, Berry Street and Anglicare failed to arrange drug and alcohol referrals or services for Kylie and Brittany, despite evidence they were using illegal drugs or misusing prescription medication.

560. In response to the draft report, Berry Street did not agree Brittany's misuse of prescription medication should be characterised as a substance abuse issue and stated there was no evidence that she would benefit from drug treatment.

561. In its response, Anglicare also said 'drug misuse' was not identified as a concern at Brittany's Care Team meetings or in her Safety Plans, and her Care Team and Child Protection did not identify a need for treatment.

562. The investigation notes the Residential Care Program Requirements state:

> All children in residential care with substance abuse issues must be referred to a drug and alcohol treatment service. CSOs will ensure Care Teams explore any substance abuse issues and co-ordinate an appropriate response in line with case plan goals for the child.

563. In some cases in this report, documented plans for children quickly became out of date due to their escalating behaviours.

564. The Child Protection Principal Practitioner said at interview that for children such as Avery and Brittany:

> … the horse has almost bolted so to speak in terms of the intensity of each day, particularly as their behaviours escalate meaning everyone is scrambling to address the crisis of the day.

565. They said Child Protection recently appointed new 'Practice Leaders' to work on case planning to try to have a 'growing impact in that space'.

566. Berry Street's response to the draft report stressed:

> The education, health, disability and justice systems all play a pivotal and interconnected role in protecting and caring for children in out-of-home care and, arguably, all could have done more to support the five children whose experiences are examined in the Report.

567. Health researchers argue that workers need better support to meet the health needs of those in care because 'the system lets people down' and 'young people's experience of care does not align with the definition of care' (Smales et al, 2020).

Incident reporting

568. The five cases also demonstrate ongoing challenges with Child Protection's incident report and response system.

569. The five children in this report had multiple incidents that required an incident report, including alleged assaults and absconding. The CSOs complied with incident report requirements in some cases but, in others, there is evidence that workers:

    - failed to complete incident reports
    - incorrectly categorised incidents as 'non-major'
    - failed to notify Police of possible offences against children.

570. Appendix 2 compares CSOs' compliance with incident reporting requirements for the main incidents described in this report.

571. The Department identified and corrected these problems in some cases, but not all.

572. The investigation observed there is also confusion about what constitutes a 'report' to Police. At times, CSOs seem to have conflated a Police report with a formal victim statement – while the latter must be made by the victim, anyone can make a Police report.

573. There were also issues with the way contact between Police and agencies was documented. In the cases of Kylie, Brittany and Alex, there were occasions where CSOs provided evidence that workers notified Police about incidents, but Police had no record of this contact. While sometimes the Department and CSO records lacked sufficient detail about the Police contact to investigate further, it is clear that collaboration between the agencies can be improved to resolve these issues.

574. In response to the draft report, the Chief Commissioner of Police accepted there was a number of incidents noted by the investigation where reports of alleged offences were not recorded or followed up by Police. He referenced multiple policies that provide 'clear direction' for Police to record all reported incidents.

575. As such, the Chief Commissioner noted the investigation had highlighted some potential areas for 'Police service improvement' and further collaboration with other agencies. He stated:

> Victoria Police acknowledges its role in working collaboratively with our partners to address and minimise harm and risk for vulnerable children, including those in residential care. Considering findings from the Royal Commission into Family Violence and Royal Commission into Institutional Responses to Child Sexual Abuse, we have commenced a program of work to strengthen our responses to children, and particularly in care. This has included enhanced training and communication to our specialist units, to better protect children, including recognition of the importance of third-party reporting.

576. The Chief Commissioner also provided further information about Police investigations and these have been included in the report where relevant. Appendix 1 sets out the Chief Commissioner's response.

577. CSOs gave evidence that the Department's incident reporting requirements are unclear; feedback from the Department on reports is inconsistent; and only limited training was offered when the new critical incident management system was rolled out, primarily in Melbourne.

578. The Incident reporting policy update, effective 3 February 2020, provides some clarity. Major and non-major incident reports are now to be submitted within three days and there are clear categories of major incidents that must be internally investigated.

Cultural support and planning for Aboriginal children

579. In Kylie's case, Child Protection and two of the CSOs failed to meet some of the requirements designed to support Aboriginal children's connection to culture and community. Some of these issues were not addressed until Kylie moved to VACCA, an Aboriginal Community Controlled Organisation.

580. At interview, the VACCA representative said the failures in Kylie's case are not isolated. They expressed frustration that plans are often delayed and do not seem to be a priority for Aboriginal children.

581. This view is supported by other complaints to the Ombudsman. During the investigation, another Aboriginal girl approached the Ombudsman with concerns about her treatment in residential care. When investigators looked at her case, they found she went into out-of-home care in August 2017 but was not given an endorsed cultural plan until November 2019, more than two years later.

582. CCYP's 2015 report on residential care, "... *as a good parent would*...", also found that the 'current residential care system can contribute to the isolation of Aboriginal children from their culture and community'.

583. The investigation notes that in the 2018-19 State budget, the Victorian Government allocated $11.9 million over four years for a new cultural planning model. The initiative is part of the implementation of *Wungurilwil Gapgapduir*, a partnership between the Aboriginal community, Government and CSOs, which aims to ensure Aboriginal children and young people in out-of-home care are 'better connected to culture, country and community'.

Medication and chemical restraint

584. Three of the five children in this report – Quinn, Avery and Alex – had evidence in their files suggesting they may have been medicated to manage or control their behaviour.

585. Avery's mother also told the investigation that, because Avery is being prescribed a drug as a chemical restraint, specialised disability carers Avery's mother engaged are not permitted to work with Avery in the home. She said this means Avery remains in residential care.

586. Use of possible 'chemical restraints' carries human rights implications. In the disability sector, it is subject to regulation and oversight to protect the rights of people with disabilities. Registered disability providers must obtain authorisation from the Department before using chemical restraints.

587. The investigation identified no such laws or protections for children in residential care. In the three cases in this report, Child Protection and the CSOs investigated could not be sure if the children were given medication for this purpose.

LGBTIQ support

588. Two of the five children in this report – Quinn and Alex – experienced problems in residential care because of their gender identity.

589. The investigation acknowledges Quinn was in residential care some 10 years ago. CAFS says it has since developed more inclusive practices. It is undergoing 'Rainbow Tick Standards' accreditation and employed an Inclusion and Diversity Lead in 2019.

590. Alex's more recent experience in 2019, when he was placed in a unit with children who were likely to target him, suggests there is still room for improvement.

591. The investigation did not hear evidence about the experiences of other LGBTIQ children in residential care. However, it notes that during the period under investigation, there was little written guidance for Child Protection or CSO workers about how to support LGBTIQ children.

Potential solutions

592. The investigation explored two potential solutions to part of the problems identified in evidence:

- a new two-bed residential care model
- an independent advocate to promote the rights of children in care.

A two-bed residential care model

The need for change

593. Multiple witnesses agreed that the State Government needs to move away from the current four-bed model of residential care.

594. Seventy per cent of current standard and therapeutic residential care units have been built to house up to four children.

595. The investigation heard the four-bed model is not in the best interests of children with such complex histories and needs. The Department advised that while demand for residential care services is increasing, the number of beds has remained the same, making placement matching even more challenging.

596. A Berry Street representative said at interview:

> It just seems incredibly flawed to put four children with complex behaviours together. With the best matching in the world, things will still happen.

597. A VACCA representative also said:

> The complexity of our young people is so challenging and individualised, that to ever imagine you can get four young persons, other than a sibling group, that could just live alongside each other, is a bit of a pipe dream in my opinion. I think four bed units in and of itself is a quite unrealistic demand … four young people living together with all their complex needs, with all their trauma.

598. Children with lived experience of residential care sometimes voice similar concerns. The Institute of Child Protection Studies 'Safe and sound' report quoted one child who said:

> You have to think about - instead of just slapping three random people in a house together and hoping for the best. Because that's either going to work out really well or blow up in your face.

599. Quinn also highlighted the risks in her interview with the investigation:

> They can't just randomly mix different backgrounds together that are not compatible, like, they all have problems but they're different types of problems that will clash … the good kids who come from bad family backgrounds, they'll get mixed in with the kid that is bad and the bad kid turns the good kid into being bad, because … the bad kids terrorise the good kids and that psychologically drives them insane, then the good kids become bad kids also and it's a cycle.

600. An investigator employed by one of the CSOs raised similar concerns. They said 'housing some young people together … can create an increase in criminal activity' by the children; and there is little workers can do to prevent children from absconding from care and putting themselves at risk.

601. Psychologists use the term 'social contagion' to describe this effect. According to this theory, when people are exposed to behaviours such as aggression or self-harm by others, they may imitate that behaviour. This kind of mimicking behaviour can be particularly common for adolescents or children with development disorders such as autism spectrum disorders.

602. During the investigation, the Department acknowledged the placement in one house of four unrelated children, with adverse life experiences, trauma and behaviours of concerns, 'may result in a high level of incidents that impact on children's safety, their exposure to further trauma and the quality of care they receive':

> Due to the current four residential care four-bed model, it is not possible to place highly complex children that require a high staff-to-child ratio staffing model and so many children are subsequently placed in contingency units when they may have been accommodated in two bed units.

603. The last statement refers to children needing to be placed into short-term units, because their needs cannot be met in the four-bed model. This results in frequent movements and placement instability for children. The Department acknowledged that some children experienced over 20 placements in out-of-home care during 2018-19 and 2019-20. The four children in this report who are still in residential care had moved between five and 13 times over one to two years.

Alternative models of residential care

The investigation learned of some existing alternative models of residential care that try to meet the needs of children better.

Anglicare's Keep Embracing Your Success (KEYS) trial

KEYS is a Department-funded three-year trial of two single-sex residential care units. The units provide specialist mental health and community supports to children, including 'assertive outreach' with the children and their families once the person leaves the program. The cost of a KEYS unit is $2.38 million, nearly double the cost of a standard residential care unit. It uses a four-bed unit model.

Berry Street's Teaching Family Model (TFM) program

Berry Street's TFM program provides residential care in four-bed units with a focus on interpersonal and living skills and working closely with families to help children build healthy family relationships. The program is designed for six-year-olds to 17-year-olds. It is already offered as a form of specialised residential care in New Zealand.

Mackillop Family Services

Mackillop, another CSO, manages three residential care homes where children are supported by 'professional foster carers', supplemented by 25-30 hours of funded in-home support.

The Department said:

> the model works very well when there are committed carers; but when carers leave the program after several years, recruitment of new foster carers for the program can be difficult. There is no current plan to expand these services.

The proposed two-bed residential care model

604. The Department has been considering the benefits of moving the residential care system from a four-bed model to a two-bed model.

605. The Department provided a summary of its business case to the investigation. It said this model would provide capacity for individualised and intensive responses to children, with the support of mental health clinicians, family workers and community workers. It also said it would provide for better matching of children in placements, stability and a sense of belonging for children, and more opportunities to engage with family, community and education:

> [P]otential benefits lie in the ability to tailor responses to a smaller number of [children] by eliminating the combined impact of four young people with a range of trauma related complexities. Young people in residential care often talk about the disruptive impact of other more complex young people on their sense of safety and stability.

606. The business case identified savings in a two-bed model. It noted the Department is spending a significant amount of money supporting children in short-term temporary arrangements because they cannot be placed in residential care units. These children have highly complex needs that require high staff-to-child support that cannot be met in the four-bed model.

607. The Department said the draft costs of a two-bed model are about $285 million a year. The State Government budgeted $161 million for residential care demand in 2019-20. These figures do not include the temporary placement arrangements funded outside of this budget.

608. The Department estimated it would cost:

- $1.2 million a year to operate a two-bed unit. This includes a 0.6 full-time equivalent clinical specialist to offer more specialised care to children. That means each unit would operate like a therapeutic residential care unit
- $1.2 million a year to operate a standard four-bed unit under the current model
- $1.6 million a year to operate a therapeutic four-bed unit under the current model.

609. The Department said the two-bed model would require extra residential care workers and there would be some capital costs associated with implementation.

610. The Department also noted the residential care system would still need to maintain some larger homes so children from the same family can live together in care.

611. The investigation considers that the two-bed model is a fundamental change to the way residential care is provided.

612. The Department said:

> The ability to release or invest in system capacity to enable a more tailored or individualised intensive response for a small proportion of highly vulnerable young people would assist in providing the flexibility needed within the current system and reduce the need for more expensive emergency placements in contingency arrangements.

613. CCYP supported a two-bed model in its 2019 report, 'In our own words'. It recommended:

> more flexible placement options, including two bed or single bed placements with tailored and appropriately skilled staff (not through current contingency arrangements).

614. Berry Street's response to the draft report commended the Ombudsman for supporting the transition to a two-bed model as part of the solution to current problems in the system. It said this model will not solve the systemic issues on its own. It said there also needed to be:

- professionalised therapeutic foster care models
- better access to health and education
- Targeted Care Packages that enable children to get support and treatment in their home environments, and flexible shared care models with families.

615. Berry Street said other reforms to the child protection system could save money, which could be used to fund these reforms. It noted its recent report on early intervention programs shows these programs have the potential to save Victoria $1.6 billion over the next 10 years.

An independent advocate for children in care

616. The investigation also considered practical ways to protect the rights and interests of children in residential care before problems occur.

617. The Children, Youth and Families Act already requires Child Protection and CSOs to consider the child's views and wishes when determining a child's best interests (section 10(3)(d). In Victoria, Child Safe Standards also say children:

> have a right to be heard and have their concerns and ideas taken seriously, particularly on matters that affect them – including how to keep them safe.

618. In these five cases, the children's files and other evidence shows the children or their families often voiced early concerns with Child Protection or CSO workers, but with little success.

619. The Department and the CSOs have internal complaints systems available for children and families. In these cases, the systems were not effective ways to promote the children's interests.

620. Victoria also has two external bodies with an oversight role - CCYP and the Ombudsman.

621. CCYP is Victoria's specialist body for children and young people. It is independent of the Department and can investigate systemic issues in the child protection system and recommend improvements. It also oversees children's services and advocates for best practice. However, it is not currently set up to act as an advocate for individual children or their families.

622. The Ombudsman takes complaints about public and publicly funded bodies, including the Department and CSOs. It is constitutionally independent and can resolve or investigate complaints from individual children and their families. However, as CCYP noted in its 2019 report, 'In our own words', children may not know how to complain. Of the five complaints in this report, only one came from the child; and that child, Quinn, is now an adult. The other four complaints were made by concerned family and friends.

623. These arrangements lack an independent person who regularly visits individual children in care and advocates on their behalf.

624. Such offices exist in other contexts. South Australia's Office of the Guardian for Children and Young People advocates for the rights of children in care in that state. In Victoria, the Office of the Public Advocate plays a similar advocacy role for people with a disability.

Advocacy models

South Australian Guardian for Children and Young People

South Australia has a statutory Office of the Guardian for Children and Young People to advocate for the rights of children in care. The Guardian's staff:

- visit children and young people in residential care units
- talk to children and observe their situations, and speak with carers
- advocate for individual children and promote their best interests. They can address issues with care providers directly and report to the responsible minister or refer matters to other agencies
- inquire into and provide advice to the Minister about systemic shortfalls in services.

The Guardian is separate from the South Australian Commissioner for Children and Young People. Both the Guardian and Commissioner can lodge complaints on behalf of children and young people with the Ombudsman.

Victorian Public Advocate

Victoria's Public Advocate has statutory powers to promote and safeguard the rights and interests of people with a disability. The Public Advocate:

- advocates for people with a disability on a systemic and individual basis
- operates a 'community visitor' program under which volunteers visit mental health facilities, supported residential services and disability accommodation.

Community visitors can raise concerns with facilities and the Department of Health and Human Services. They can also bring cases of abuse and neglect to the Public Advocate's attention.

The Public Advocate can lodge complaints or refer matters to the Ombudsman for consideration and investigation.

625. Berry Street told the investigation it supported the introduction of an independent children's advocate in Victoria, although it said this needed to 'sit alongside significant reform of the child and family services system'.

626. In Victoria, the advocacy function could be assigned to an existing oversight agency or, as is the case in South Australia, it could be established as a stand-alone agency. The advocate function aligns with CCYP's role as the specialist body for children and young people and with the CCYP's existing statutory objective of promoting improvement to out-of-home care services for children.

627. When consulted during the investigation, CCYP said:

> establishing the [advocacy] function within the CCYP would avoid the risk of duplication between two bodies, make use of the CCYP's knowledge of the out-of-home care system and create efficiency.

628. CCYP also said:

> While adding the advocate function to the CCYP's current roles would require internal separation of the individual advocacy function from the body's systemic and inquiry activities, this is not unusual within a statutory body. The CCYP currently manages diverse functions including inquiry, oversight and regulatory functions. A further benefit of locating an individual advocate function within the CCYP is that the information obtained from working with individual children in care could inform the CCYP's system oversight activities.

629. CCYP's 2019 report recommended a 'specialised independent complaints body' to ensure 'children and young people feel confident to speak about their experiences and care'. CCYP could work with other bodies to advocate for children and resolve concerns where possible. It could lodge complaints on behalf of children and young people with independent offices, such as the Ombudsman, where needed. Such a system would close the current gap in Victoria's oversight.

Conclusions

630. Residential care is meant to provide a safe place for children who cannot live safely at home. In the case of these five children, that system failed.

631. The evidence records assaults or alleged assaults against all five children while they were in residential care.

632. It shows the behaviour of the children grew worse after they went into care. Quinn's behaviour reportedly became more aggressive. Kylie and Brittany began using illegal drugs and running away. Alex became involved in criminal offending and started using more drugs.

633. The evidence shows Child Protection and the CSOs knew there were risks involved in the placements of these children, either before they moved in or soon afterwards.

634. Quinn and Alex were placed with other children with histories or risks of aggression or sexualised behaviour. Kylie, Brittany and Alex were placed with children with histories of drug use or criminal offending or sexual exploitation risks. Avery had other children introduced into her unit, despite early agreement she needed to live alone with dedicated workers.

635. The investigation found these problems were not the result of deliberate disregard for the welfare and safety of the children. In some cases, the CSOs expressed concerns about the suitability of proposed placements. However, they told the investigation they could not always resist 'pressure' from Child Protection to take the children.

636. Child Protection representatives and the Department spoke of a stretched system in which Child Protection workers are forced to make 'least-worse' decisions for children. Placement decisions were dictated by the availability of beds, rather than children's best interests.

637. In some cases, the CSOs' care and supervision of the five children also fell short of what a good parent would expect their child to experience in State-funded care.

638. Supervision in some cases was inadequate. Berry Street workers caring for Alex allowed one of the other boys in his unit to sleep in Alex's room overnight. A Berry Street representative maintained at interview that staff checked the boys regularly and 'we can't force young people out of [an]other's bedroom'. A departmental representative noted workers could have called for back-up or taken Alex from his room to ensure his safety.

639. Kylie, Brittany and Avery all absconded from residential care multiple times before reporting they had been raped by adult men in the community. Staff were sometimes unclear about the children's safety plans, which are meant to be implemented when a child does not return to their unit. The steps taken by workers to locate the children and report them as missing varied.

640. CSOs sometimes lacked critical information about the children to assist workers in providing informed care and support.

641. The investigation also identified examples of other problems with the children's care:

- failure to lodge incident reports or notify Police of possible criminal offences against the children
- potential use of medication as a chemical restraint, without reporting or oversight
- inadequate support for Kylie, a young Aboriginal woman, to maintain her connection with her culture and family
- inadequate support for transgender and non-binary children in care.

642. The problems experienced by these five children are not isolated. This is the latest of many reports to highlight such problems in the residential care system. CCYP identified similar concerns in its 2015 report and again in a 2019 report. Little appears to have changed.

643. Nearly 1,000 Victorian children lived in residential care at some time during 2019-20. They all have a right to be protected.

644. In response to the draft report, Berry Street said these children's stories:

> show that the current child and family services system, as a whole, is not designed to operate in the children's best interests and allow them to thrive.

645. Berry Street stressed there needed to be a major transformation of the child and family services system to ensure families can get help earlier in the community and address their issues without continual involvement of statutory Child Protection services.

646. In response to the draft report, Alex's relative commented on the investigation:

> To protect children and to take steps to ensure the most vulnerable ones receive the proper duty of care they deserve gives me hope in a system I had become very disillusioned with.

647. This investigation considered two possible solutions.

648. The first is a transition from a four-bed model of residential care to a two-bed model, as set out in the previous section. The investigation heard children in residential care have increasingly complex needs and behaviours that makes it hard to 'match' four children in the same unit. Evidence from the Department, CSOs and children with lived experience of care all said it was becoming impossible to place children safely in the current system.

649. The second is an independent advocate to protect and promote the rights of children in residential care. Complaints and systemic oversight bodies play a valuable role. But these cases highlight the need for an independent person who can work with individual children and families, and Child Protection and CSOs to protect children's interests before problems occur.

650. It is also important that the voices of children in residential care matter and that these are included in policies and practice.

651. In response to the draft report on 25 May 2020, the Secretary of the Department stated:

> The experiences of the five young people, as detailed in your report, are concerning. The Department and Community Service Organisations are committed to reform the residential care system to provide intensive support and stabilisation for young people with complex needs, and to support their transition to family based care and independence.

652. On 21 October 2020, after reviewing the final draft report, the Minister for Child Protection responded on behalf of the Victorian Government and accepted all of the recommendations made to Ministers. The Minister noted policy and budget would need to be examined to develop and implement some of the proposed solutions. He also commented that the report:

> highlights a range of issues that contributed to an unsatisfactory level of care and safety for some of Victoria's most vulnerable children. ...
>
> As an immediate action the Department will reinforce to all staff and Community Service Organisations the importance of reporting allegations of physical and sexual abuse of children to the Department and to Victoria Police.

653. The Minister's full response is provided on page 88.

654. After reviewing the final draft report and having an opportunity to consider the proposed solutions, the Secretary accepted all of the Ombudsman's recommendations, noting some require budgetary and policy consideration. The Secretary's full response is provided on page 90.

Opinion

655. Based on the evidence obtained during the investigation, the Ombudsman has formed the following opinions pursuant to section 23(1)(g) of the Ombudsman Act:

Quinn

Child Protection and CAFS acted in a manner that was wrong and inconsistent with the best interests of the child under section 17(2) of the Charter of Human Rights and Responsibilities Act, in:

- placing Quinn in a unit with another child with a known history of assaults, without taking adequate steps to manage the risk
- maintaining Quinn's and the other child's placement in the unit for two years, despite violent incidents between the two children
- failing to ensure incident and Police reporting in response to Quinn's allegations of sexual assault.

Kylie

Child Protection and Uniting acted in a manner that was wrong and inconsistent with the best interests of the child under section 17(2) of the Charter of Human Rights and Responsibilities Act, in:

- failing to submit an incident report and notify Police regarding Kylie's alleged 'bashing' by another child in the unit
- failing to submit incident reports regarding three alleged sexual assaults of Kylie by another child in the unit
- not referring Kylie for drug and alcohol assessment and/or treatment.

Child Protection and Berry Street acted in a manner that was wrong, and inconsistent with the best interests of the children under section 17(2) of the Charter of Human Rights and Responsibilities Act, in:

- placing another child in Kylie's unit despite an assessment that this involved medium to high risks for all of the children.

Child Protection acted in a manner that was wrong and inconsistent with the best interests of the children under section 17(2) of the Charter of Human Rights and Responsibilities Act, in:

- failing to develop for Kylie an endorsed cultural plan until after she had been in care for 53 weeks.

Brittany

Child Protection and Anglicare acted in a manner that was wrong, and inconsistent with the best interests of the child under section 17(2) of the Charter of Human Rights and Responsibilities Act, in:

- placing another child with Brittany when risks to Brittany were identified, without taking adequate steps to manage the risk.

Child Protection, Berry Street and Anglicare acted in a manner that was wrong and inconsistent with the best interests of the child under section 17(2) of the Charter of Human Rights and Responsibilities Act, in:

- not referring Brittany for drug and alcohol assessment and/or treatment.

Avery

Child Protection and Berry Street acted in a manner that was wrong and inconsistent with the best interests of the child under section 17(2) of the Charter of Human Rights and Responsibilities Act, in:

- placing additional children in Avery's unit despite evidence she required dedicated care
- not ensuring alleged physical assaults by another child were reported to Police, and not ensuring an incident report was generated for one of the alleged assaults
- not referring Avery for drug and alcohol assessment and/or treatment.

Alex

Child Protection and Berry Street acted in a manner that was wrong and inconsistent with the best interests of the child under section 17(2) of the Charter of Human Rights and Responsibilities Act, in:

- placing Alex in a unit with three other boys, without taking adequate steps to manage the risk or sharing information relevant to the risk.

Child Protection and Junction acted in a manner that was wrong and inconsistent with the best interests of the child under section 17(2) of the Charter of Human Rights and Responsibilities Act, in:

- maintaining Alex's placement with another child despite evidence of the negative impact on Alex's behaviour
- not reporting the alleged assault by a worker to Police.

Recommendations

Pursuant to section 23(2) of the Ombudsman Act, it is recommended that:

To the Minister for Child Protection and Minister for Mental Health

Recommendation 1

Commence conversion of standard four-bed residential care units to therapeutic two-bed units with enhanced access for the children to services, particularly mental health and education, while maintaining some capacity in the system for larger groups (ie siblings).

Response

Accepted by the Minister for Child Protection on behalf of the Government. See the Minister's full response on page 88.

To the Minister for Child Protection and the Minister for Health

Recommendation 2

Implement a state-wide medication management policy for children in residential care that includes minimum standards and regulation for the prescription, administration and notification of chemical restraints to children.

This should be supported by:

- mandatory training for residential care workers
- updates to the Residential Care Program Requirements and Child Protection Manual
- guidance to medical practitioners.

Response

Accepted.

To the Minister for Child Protection

Recommendation 3

Consider establishing an independent children's advocacy function within the CCYP to enable it to:

- participate in placement decision-making for residential care, to prevent unsafe decision making
- promote the rights of children to participate in decisions about placement, service-delivery and incident investigations that affect them
- support or represent children to make complaints about their care
- make representations on behalf of children identified as high risk
- refer serious concerns to independent complaint handling and investigative oversight bodies such as the Victorian Ombudsman
- regularly visit and inspect residential care settings
- publicly report on its activities and outcomes.

Response

Accepted.

To the Department of Health and Human Services

Recommendation 4

Within 90 days, undertake the following actions for each child to address the deficits in care identified in the report:

- for current clients, conduct a review by a Principal Practitioner of the existing placement to confirm that it is safe and appropriate to meet the child's needs, and that the child's views have been taken into consideration
- ensure reports are made to Police for all allegations of assault
- with the child's consent, engage specialist therapeutic services such as sexual assault counselling to support their recovery from trauma
- confirm the child's eligibility, and make referrals for support, from Victims of Crime, the Redress Scheme and independent legal services for advice about their rights and care.

Response

Accepted. See the Department Secretary's full response at page 90.

Recommendation 5

In consultation with Victoria Police and CSOs providing out-of-home care, review the *Protocol between Department of [Health and] Human Services – Child Protection and Victoria Police (2012)* and the *Addendum: Preventing sexual exploitation of children and young people in out-of-home care (2014)* to ensure all allegations of physical and sexual assaults of children in residential care are:

- reported to Victoria Police, regardless of whether the victim wants to make a statement
- recorded in the systems of Victoria Police and the reporting agency.

Response

Accepted by the Minister for Child Protection, the Chief Commissioner of Police and the Department Secretary.

Minister's response to the final report

Hon Luke Donnellan MP

Minister for Child Protection
Minister for Disability, Ageing and Carers

GPO Box 4057
Melbourne Victoria 3001
Telephone: +61 3 9096 0301
www.dhhs.vic.gov.au

BAC-CO-3734

Ms Deborah Glass
Ombudsman
Level 2
570 Bourke Street
MELBOURNE VIC 3000

Email: [redacted]
Copy to [redacted]

Dear Ms Glass

Thank you for your letter of 3 September 2020 and the final report of your investigation into complaints about assaults of five children living in Child protection residential care units. I appreciate the opportunity to respond to the report and recommendations.

The experience of the five young people, as detailed in your report, highlights a range of issues that contributed to an unsatisfactory level of care and safety for some of Victoria's most vulnerable children.

I am pleased to advise that my Ministerial colleagues and I accept recommendations one, two and three in principle subject to examining the policy and budget requirements to develop and implement these recommendations. They are important contributions to improving the service system. The relevant areas of the Department of Health and Human Services (the department) will develop proposals for consideration in consultation with the Department of Education.

The department has already advised you of the acceptance of recommendations four and five. The children and their care and safety are being regularly reviewed and oversight of this is being monitored by the Chief Practitioner, in the Office of Professional Practice.

The implementation of recommendation five will commence as soon as there is capacity within Victoria Police and the department. As an immediate action the department will reinforce to all staff and community service organisations the importance of reporting allegations of physical and sexual abuse of children to the Department and to Victoria Police.

Again, thank you for undertaking this significant investigation, which details the distressing circumstances for these five young people. My department will continue to work with your office on progressing the issues.

Yours sincerely

Hon Luke Donnellan MP
Minister for Child Protection
Minister for Disability, Ageing and Carers

21 / 10 / 2020

cc: Martin Foley MP, Minister for Health
James Merlino MP, Minister for Mental Health

Department Secretary's response to the draft report

Secretary

Department of Health and Human Services

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

BAC-CO-917

Ms Deborah Glass
Ombudsman
Level 2
570 Bourke Street
MELBOURNE VIC 3000
Sent by email: [redacted]

Dear Ombudsman

Thank you for your letter of 1 July 2020 and the final draft report of your investigation into complaints about the placement and care of five children in residential care by the department and community service organisations. I appreciate the opportunity to review the final report and thank you for considering my comments on the previous draft report and granting an extension of time because of current demands on the department's operations.

The report highlights the challenges of the residential care system in providing care to children who have experienced trauma and are vulnerable. The Department has established a strong partnership with the community services sector aimed at progressing system reform and improving quality of care. The *2020 Residential Care Action Plan* is designed to improve the outcomes for children and refocus the system. Your report reinforces the need for this important work to progress, despite the current public health crisis facing Victoria.

The draft report makes five recommendations. Recommendations one, two and three are accepted in principle, and will require budgetary and policy consideration. Recommendations four and five are accepted.

I can confirm the current circumstances of the four children still residing in residential care are being actively monitored and reviewed. The reviews will ensure any outstanding incidents are reported to Victoria Police, and the children receive the specialist services and supports they need.

I look forward to viewing the final report and thank you for the collaborative and respectful manner in which the investigation, whilst challenging in content, has been undertaken.

Yours sincerely

Peake

Kym Peake
Secretary

12/08/2020

VICTORIA
State Government

Appendix 1: CSO and Victoria Police responses

7 May 2020

cafs WE CARE

Deborah Glass
Victorian Ombudsman
Level 2, 570 Bourke Street
Melbourne VIC 3000

RECEIVED
12 MAY 2020
VICTORIAN OMBUDSMAN

Dear Deborah Glass

Response to the investigation into care provided to [redacted]

Cafs would like to acknowledge your letter dated 3 April 2020 and associated report addressing your investigation into the care provided to [redacted] whilst in Cafs care from 2008 to 2011. Cafs is sorry for the trauma experienced by [redacted] and wishes to assure you that our knowledge and experience in relation to the issues raised by [redacted] has expanded since she was in our care, and what we know now is very different to what we knew then.

We would like to update you on a number of improvements to our services / processes since our initial response:

1. Cafs culture and awareness of LGBTIQ+ has expanded to include successful achievement of the Rainbow Tick Accreditation in November 2019, we undertook Over the Rainbow LGBTIQ+ awareness training (from the Board down), and our Diversity and Inclusion Policy, which is located on our website, articulates Cafs Board and Management Team's commitment to inclusive practice for both our staff and our clients.
2. Cafs Feedback and Complaints Policy, which is located on our website has been reviewed and updated to reflect the Cafs Board and Management Team's commitment to contemporary practice, ensuring a strong organizational culture of feedback, complaints management and resolution.
3. The Cafs Board is establishing a Consumer Advisory Board Sub-Committee in 2020, with the remit of ensuring that persons appointed to the Committee are able to represent the views of the communities served by Cafs, and that the value of client, carer and community participation is promoted in Cafs activities.
4. Cafs have developed an Incident Management Framework and procedures which guide staff on identifying and recording incidents, and the development of robust preventative measures to reduce the likelihood or impact of further incidents. These are based around the DHHS CIMS (Critical Incident Management System) guidelines. Cafs has a Child Safety Committee who oversee our alignment to and implementation of the Child Safety Standards, in addition to employing a Child Safety Investigator. Staff undergo

Since 1865

Ludbrook House 115 Lydiard Street Nth, Ballarat 3350
t. 03 5337 3333 f. 03 5332 1724 e. info@cafs.org.au
ABN 93 786 843 940

cafs.org.au

1 | Page

cafs WE CARE

training in incident management and child safety within their first three months of employment, with refresher training provided annually.

5. Cafs aims to act in the best interests of the child at all times, ensuring timely and detailed communication is maintained with the child's care team, with Child Protection ultimately making the final decision where children are within their guardianship.

Cafs is supportive of the recommendations made in your report and would welcome their implementation. In the meantime, Cafs is writing a procedure relating to Client Matching within the Residential Care Program, as we have identified that the mix of clients within a residential house can have a profound long term impact on the young people residing there, both positive and negative.

Cafs feels that we are better equipped now to provide a safer and supportive environment for young people within our Residential Care Program, where diversity in valued and embraced.

If you have any queries relating to our response, please contact [redacted]

Yours Sincerely

Wendy Sturgess
Chief Executive Officer

Since 1865
Ludbrook House, 115 Lydiard Street Nth, Ballarat 3350
t. 03 5337 3333 f. 03 5332 1724 e. info@cafs.org.au
ABN 83 786 643 940
cafs.org.au

Uniting Vic.Tas
ABN 81 098 317 125
Level 8, 505 Little Collins Street
Melbourne Vic 3000

vt.uniting.org

T 03 9662 2355

Thursday 23 April 2020

Ms Deborah Glass
Victorian Ombudsman
Level2, 570 Bourke street
Melbourne, 3000

To the Victorian Ombudsman,

Thank you for the opportunity to respond to your report regarding the safety of children and young people in residential out-of-home care.

On behalf of Uniting, I extend my sincere apologies to [redacted] and her family for her experience while in our care.

Your investigation identified four areas where systemic issues, poor decision making, or failure to take adequate action contributed to [redacted] experience during her eight weeks in Uniting's care including: unsafe residential care placements, care and supervision, response to critical incidents and supporting Aboriginal children's culture.

We have, over the course of the past year, undertaken an independent review of our model and practice, identifying areas for improvement which included those identified in this investigation. These changes, which include a significant additional financial investment in residential out of home care by Uniting, continue to be implemented across our residential care services and are summarised here.

Unsafe residential care placements

The report acknowledged the pressure Community Service Organisations are under to place children within a system where there are limited vacancies, and that this pressure is not conducive to appropriate placement matching. These concerns have been well documented in previous reports into the Victorian residential care system.

[redacted] experience reinforces the importance of placement decisions being informed by the child's individual needs and experiences, and for this decision to be well documented and reassessed throughout the placement.

To address these issues at an organisational level, Uniting has developed a Risk Management Tool to guide and document all new placements. Under the changes, risk assessments will be regularly updated throughout the placement by a Therapeutic Specialist. Significant work has also been undertaken to strengthen the relationship between local Child Protection teams and Uniting Residential Managers to support placement decisions through a collective understanding of the young person, their best interests and needs.

Care and Supervision

Uniting is committed to the care, protection and safety of all children engaged with our services and understands the critical role that Care Teams play to support this, and the responsibility to establish and lead them. Processes have been put in place to ensure this occurs for all children and young people in Uniting's care.

Children and young people in residential care have often experienced high levels of trauma and require expert therapeutic support and care. In 2019 the Uniting management team and Board made the decision to invest in therapeutic specialists for seven of our residential homes where provision for this support is not provided for through Department funding.

A team of Therapeutic Specialists has now been appointed, with dedicated resources for each home. Their responsibility is to understand the individual needs of each child in our care and provide carers with the guidance and support required to minimise the risk of harm to the child and other residents - and most importantly, to support the young person to achieve the best possible life outcomes.

Response to critical incidents

Uniting acknowledges the importance of fully implementing all requirements of the Critical Incident Management System (CIMS) as an integral component of care.

Over the last 12 months, supported by a newly established Incident Investigations Team, Uniting has trained all its out-of-home care staff in critical incident identification, management, response and reporting. Additionally, an internal monitoring system has been introduced to provide insight into how and why incidents occur and allow oversight by senior leaders. This has strengthened our trend analysis to better inform practice improvements.

Supporting Aboriginal children's culture

Uniting understands and is committed to maintaining cultural connections for Aboriginal and Torres Strait Islander children and young people in our care. Our Reconciliation Action Plan further highlights our commitment to learning new ways to strengthen our relationship with Aboriginal and Torres Strait Islander peoples and communities. Uniting has established strong working relationships with local ACCOs across Victoria and Tasmania. Included in this is a stronger relationship with the Victorian Aboriginal Child Care Agency who we work alongside to support the development of Cultural Support Plans for Aboriginal children and young people in care. The development and commitment to implementation of these plans is further supported by Uniting's Therapeutic Specialists.

Next Steps

Uniting has made substantial improvements to the way it provides residential care for vulnerable young people, but we know more needs to be done. We are developing a corrective action plan to address in detail each of the concerns raised in the report. We support the recommendations of the report and we will continue to work with the Department to advocate for the improvement of the system and resources to strengthen out-of-home care services so that they enable provision of safe, stable and loving home environments which every child deserves.

Yours sincerely

Bronwyn Pike
Chief Executive Officer

VACCA

5th May 2020

Ms Deborah Glass
Victorian Ombudsman
Lvl 2, 570 Bourke St,
Melbourne, VIC, 3000

Dear Ms Glass,

Response to the investigation into care provided to [redacted]

Thank you for the opportunity to respond to the draft report that was received on 3 April 2020 in relation to the investigation into the care provided to [redacted]

Whilst we welcome the positive feedback, including [redacted] increased engagement at placement since moving into the VACCA Therapeutic Residential Care residence, we are writing to clarify the comments made about VACCA's obligations within incident reporting processes and the provision of feedback channels to our young people and their families.

In relation to client feedback within our organisation, we provide a child-friendly feedback form that is available to all young people within our Residential Care placements. This form includes phone numbers for overseeing bodies, including the Victorian Ombudsman, and is kept in common areas within the houses. This is also included in the young person's 'Welcome Pack' on entry into placement and is documented to have been received by [redacted] upon her entry into our care.

Additionally, in relation to the allegations made by [redacted] we continue to uphold that in accordance with the DHHS document *'Client Incident Management Guide (Client Incident Management System)'* Child Protection is obligated to complete the CIMS report, as they received the initial allegation(s).

Section 3.7.1 of the CIMS reporting guide details that *"The service provider that first becomes aware of the incident is responsible for ensuring the client's safety and completing the incident report..."*

Furthermore, VicPol maintains that VACCA is unable to make a statement on a young person's behalf. [redacted] was certainly offered opportunity to take her allegations to police, which she subsequently declined. There was, therefore, no means by which to make a police report.

Connected by culture

Victorian Aboriginal Child Care Agency Co Op Ltd ABN 446 6545 5609
Our office is on the lands of the Wurundjeri Traditional Owners

Head Office
340 Bell Street, Preston
Victoria 3072

PO Box 494, Northcote Plaza
Northcote, Victoria 3070

Telephone +61 3 9287 8800
Facsimile +61 3 9287 8999

Email vacca@vacca.org
Website www.vacca.org

VACCA

Again, we thank you for the opportunity to respond to the draft report and welcome any continued dialogue in relation to the aforementioned concerns.

Yours sincerely,

Muriel Bamblett
Chief Executive Officer

BERRY STREET

Believing In Children, Young People, Families & Their Future.

15 May 2020

[redacted]

Deborah Glass
Victorian Ombudsman
570 Bourke Street
Melbourne VIC 3000

Dear Ms Glass

Investigation into the placement and care of five children in residential care [redacted]

I write in relation to the investigation into the placement and care of five children in residential care, four of whom were placed with Berry Street.

Berry Street Victoria's Chief Executive Officer will respond directly to your letter of 3 April 2020 regarding the draft report. However, on behalf of the Board, I want to acknowledge your comprehensive investigation into the placement, care and supervision of these children and its role in advocating for service improvement.

The Report has emphasised the impact that a system under pressure can have on Victoria's most vulnerable children. The letter from Berry Street's CEO outlines the actions Berry Street is taking to address the issues highlighted. As a Board, we will monitor the implementation of these actions.

We appreciate that even after implementation of the actions set out in Berry Street's response there will be further work to do. The Board will consider the findings of your final report, examine any further action required and ensure appropriate governance oversight.

Thank you again for the spotlight you have shone on the experiences of these five young people and the areas where improvement is required.

Yours sincerely

Dr Joanna Flynn AM
President

SINCE 1877

Central Office: 1 Salisbury St, Richmond, VIC, 3121 | **T:** (03) 9429 5160 | **E:** info@berrystreet.org.au | **berrystreet.org.au** | ABN 24 719 196 762

BERRY STREET

Believing In Children, Young People, Families & Their Future.

15 May 2020

[redacted]

Deborah Glass
Victorian Ombudsman
570 Bourke Street
Melbourne VIC 3000

Dear Ms Glass

Investigation into the placement and care of five children in residential care
[redacted]

I write in response to your letter of 3 April 2020 regarding the draft report (**Report**) in relation to this investigation. Berry Street Victoria (**Berry Street**) is grateful for the opportunity to provide further input with respect to the Report and your draft findings.

The Report and investigation serve to emphasise the challenges faced by the child and family services system and the urgent need for reform. Increasing demand and resource limitations create significant barriers to delivering services that meet the best interests of children and young people in out-of-home care.

Berry Street acknowledges the dedication and sustained advocacy of the families and significant others on behalf of these five children. Berry Street also apologises for any harm experienced while the four children were in our care.

The Child Protection and out-of-home care system: A system under pressure

The child and family services system, which includes the Child Protection and out-of-home care systems, is under significant pressure. As the Report notes, it is a system characterised by placements based on 'least-worst' options rather than what is in the best interests of children in its care. Berry Street recognises this is not good enough.

SINCE 1877

Central Office: 1 Salisbury St, Richmond, VIC, 3121 | **T:** (03) 9429 5160 | **E:** info@berrystreet.org.au | **berrystreet.org.au** | ABN 24 719 196 762

This Report echoes what many other inquiries and reports have found – that the child and family services system is in desperate need of transformation. The stories of these five children demonstrate that the current system is not meeting the needs of Victoria's most vulnerable children.

The Report highlights that there are areas where Berry Street could have done better. Berry Street is already taking steps to improve in a range of areas, including placement risk assessment and administration of medication. More broadly, Berry Street has put in place a stronger foundation for quality service delivery and continuous improvement across the organisation and this is expanded on in Annexure 1. This is just a first step and we are considering further action needed to address the issues highlighted in the Report and embed these improvements across our services.

Berry Street believes the child and family services system needs to provide hope for children and families. It should be a place where families and children experiencing multiple issues can get support that builds their strengths and allows them to thrive. Achieving this requires a complete overhaul of the child and family services system and a concerted focus on integration across other service systems, including the health, education and justice systems. The scale of change required cannot be achieved by tinkering at the edges.

Berry Street believes the cases examined through this investigation emphasise the need for reform across four key areas –

1. Reform of the Child Protection system including the out-of-home care placement process
2. Reorientation of the child and family services system toward early intervention
3. Building more contemporary home-based care models
4. Transformation of residential care

Berry Street's call for reorientation of the system toward early intervention is supported by an independent research report analysing the economic benefits of investment in targeted early intervention.

The report was prepared by Social Ventures Australia last year, after being commissioned by Berry Street in partnership with the Centre for Excellence in Child and Family Welfare (**the SVA Report**), and it sets out a compelling case for investment in early intervention. It found that, by investing in targeted early intervention now, over a 10-year period Victoria can save $1.6 billion in the Child Protection and out-of-home care systems alone. More importantly, it could prevent 1,200 children a year from entering out-of-home care.

Further details of Berry Street's actions to deliver quality services within the current flawed system and its position on system reform are set out in **Annexure 1**. We are also pleased to provide a copy of the SVA report at **Annexure 2**.

Berry Street's response to the proposed findings and specific factual matters

This investigation focused on the placement, care and supervision of five children by Child Protection and CSOs, including Berry Street. As an organisation, we are balancing their needs with other children in a system that has not been designed to respond to the level of demand and complexity that now exists.

Berry Street acknowledges that there are areas where it could have done better for the children. This needs to be understood in the context of the broader systemic challenges faced by all CSOs in the child and family services system. CSOs, including Berry Street, are one of many stakeholders that were involved in the children's care and contributed to the decision making throughout their placements.

Child Protection, schools, the police and the health care system also had a part to play in the children's care and development during their placements, and the responses to the incidents being investigated. All of these parties across the child and family services, justice, health and education systems arguably could have done more to support the four children whose experiences are examined in the Report. However, all face resource pressures and the limitations of a stretched system, resulting in barriers to integrated service delivery.

It is also true that in many cases, Berry Street acted proactively to put in place risk mitigation measures, advocate for therapeutic interventions or alternative placement arrangements and to engage the children in education.

The Ombudsman is required to give a person a "reasonable opportunity" to respond to adverse material, if the Ombudsman intends to include adverse comment or opinion about that person in a report.[1] Berry Street's specific response to the proposed findings in the Report is set out in **Annexure 3** and its response to specific factual matters is set out in **Annexure 4**. These annexures include information that contextualises and addresses a range of draft findings related to placement, incident and police reporting, and the care and supervision of the four children who were in Berry Street's care, as well as actions taken to support cultural planning with one of the children and her family.

Several of the proposed adverse comments against Berry Street appear to arise from material or interviews that have been provided by other entities to the Ombudsman.[2] Berry Street has responded to these criticisms as best as it is able based on the information contained in the Report. However, we have been necessarily limited in our ability to respond without seeing copies of materials which criticise Berry Street and which were provided to the Ombudsman by other entities. Berry Street is concerned that some adverse findings are based on evidence provided by other parties that Berry Street has not seen and not had a reasonable opportunity to respond to directly.

The attached annexures also address several adverse inferences drawn against Berry Street in circumstances where other entities have made statements without supporting evidence. These inferences have been drawn despite Berry Street providing documentation that sets out a contrary position.[3]

[1] Section 25A(2) of the *Ombudsman Act (Vic) 1973*

[2] For example, it appears that the department submitted a response to the Ombudsman's investigation in which it expressed concerns about Berry Street's provision of daily updates for [redacted]

[3] See, for example, the Report [167]-[173].

Conclusion

Berry Street has drawn upon a number of primary materials, including case notes, incident reports and emails, to provide the information in Annexures 3 and 4 and respond to the issues raised in the Report. Berry Street is conscious that a large number of documents have been sought and obtained by the Ombudsman's office in the course of this investigation. Accordingly, we have not enclosed copies of all primary materials relied on as we anticipate many of these are likely to be held by the Ombudsman. However, if your office would be assisted by copies of any documents referenced in the Annexures, or a collation of all documents referenced in the Annexures, please let me know and we would be very happy to provide these.

We would also be happy to provide any further information which would assist in the course of the investigation or in response to submissions of other parties.

Thank you again for the opportunity to respond to the Report.

Yours sincerely

Michael Perusco
Chief Executive Officer

encl

VICTORIA POLICE

Shane Patton APM
Chief Commissioner of Police

Victoria Police Centre
637 Flinders Street
Docklands Victoria 3008 Australia
Telephone +61 3 9247 6868

P.O. Box 913
Melbourne Victoria 3001 Australia

[redacted]

Deborah Glass
Ombudsman
Level 2
570 Bourke Street
Melbourne VIC 3000

Dear Ms Glass

Investigation into residential care

Thank you for the opportunity to respond to your draft report *Investigation into residential care*, an investigation into complaints about the placement and care of five children in residential care by the Department of Health and Human Services (DHHS) and community service organisations.

This report has been reviewed and the following comments are provided.

Policy and Guidance Documents

There are a number of incidents noted in the report where it appears that reports of alleged offences were not recorded or followed up by police. Victoria Police has a number of policy documents that provide clear direction in relation to these. The report has referenced the *Victoria Police Manual Crime and event reporting and recording* policy and the *Protecting Children: Protocol between Department of Human Services – Child Protection and Victoria Police* which outline requirements for police to record reports of crime and to take missing person reports for every child reported as missing.

There is an additional Victoria Police document that does not appear to have been reviewed for the purposes of this investigation. The *Family Violence Command – SOCAT Practice Note: Recording of DHHS Notifications* refers to the policy documents above. It also emphasises that all reported incidents are to be recorded regardless of where the information is received first, second or third hand, unless there is credible evidence available at the time of reporting to suggest that a crime has not occurred. A copy of this document has been attached. Note that this practice note was released in 2015, updated in 2017 and is currently being reviewed to be incorporated into a revised *Code of Practice for the Investigation of Sexual Crime*.

In addition, there are two documents to which Victoria Police and the Department of Health and Human Services are signatories which are not referenced and may not have been considered:

- *Preventing sexual exploitation of children and young people in out-of-home care*, addendum to the *Protecting Children: Protocol* noted previously (copy attached)

- *Framework to Reduce Criminalisation of Young People in Residential Care* (copy attached)

The former outlines responsibilities and expectations of each party regarding missing young people in care and the latter reaffirms this in a broader care context.

Case Studies

A review of LEAP entries in relation to each of the cases reviewed in the report was undertaken to identify any updates in police actions. The table below identifies updated information in relation to the cases reviewed:

Victoria Police acknowledges its role in working collaboratively with our partners to address and minimise harm and risk for vulnerable children, including those in residential care. Considering findings from the Royal Commission into Family Violence and Royal Commission into Institutional Responses to Child Sexual Abuse, we have commenced a program of work to strengthen our responses to children, and particularly children in care. This has included enhanced training and communication to our specialist units, to better protect children, including recognition of the importance of third-party reporting.

We have noted some of the potential areas for police service improvement identified in this draft report and await the final report to further contribute to improved responses to children in residential care.

Yours sincerely

Shane Patton APM
Chief Commissioner

14/7/20

Appendix 2: Incident reporting

Quinn						
Incident	**CSO**	**Incident report**	**Correct type & impact on report**	**Report to DHHS 24 hours**	**CSO states Police contacted**	**Report on Police system**
Physical assault by other child in care	CAFS	✔	✔	✔	✔	✔
Alleged sexual assaults by other child in care	CAFS	✔	✗	✔	✗	✗

Kylie						
Incident	**CSO**	**Incident report**	**Correct type & impact on report**	**Report to DHHS 24 hours**	**CSO states Police contacted**	**Report on Police system**
Alleged sexual assault by other child in care – inappropriate touching	Uniting	✗	N/A	N/A	✔	✔
Alleged sexual assault by other child in care – inappropriate touching	Uniting	✗	N/A	✔	✗	✔
Alleged sexual assault other child in care – inappropriate touching	Uniting	✗	N/A	✗	✗	✔
Alleged rape by person in community	Uniting	✔	✔	✔	✔	✔
Alleged physical assault by other child	Uniting	✗	N/A	✔	✗	✗
Alleged physical assault by person in community	Berry Street	✔	✔	✔	✔	✗
Alleged physical assaults by other resident	VACCA	✗	N/A	N/A	✗	✗

Brittany						
Incident	**CSO**	**Incident report**	**Correct type & impact on report**	**Report to DHHS 24 hours**	**CSO states Police contacted**	**Report on Police system**
Absconding and threats of suicide	Berry Street	✔	✔	✔	✔	✔
Absconding and threats of suicide	Berry Street	✔	✔	N/A	N/A	N/A
Absconding and report overdose of prescription medication	Berry Street	✔	✔	✔	N/A	✔
Alleged sexual assault by other resident - kissing	Berry Street	✔	✗	✔	✔	✗
Alleged rape by person in community	Anglicare	✔	✔	✔	✔	✔
Absconding with other resident	Anglicare	✔ (only 1)	✔ (only 1)	N/A	✔ About explicit texts from adult males	✔
Alleged rape by people in community	Anglicare	✔	✔	✔	✔	✔

Avery						
Incident	**CSO**	**Incident report**	**Correct type & impact on report**	**Report to DHHS 24 hours**	**CSO states Police contacted**	**Report on Police system**
Alleged assault by agency worker	Berry Street	✔	✗	✗	✔	✔
Alleged rape by person in the community	Berry Street	✔	✔	✔	✔	✔
Alleged physical assaults by other resident	Berry Street	✔ ✗ ✔	✔ N/A ✗	✔ N/A ✗	✗ ✗ ✗	✗ ✗ ✗
Suspected overdose of prescription medication	Berry Street	✔	✗	✗	N/A	N/A
Access to 'locked' medication at unit	Berry Street	✔	✔	✔	N/A	N/A

Alex						
Incident	**CSO**	**Incident report**	**Correct type & impact on report**	**Report to DHHS 24 hours**	**CSO states Police contacted**	**Report on Police system**
Alleged rape by other child	Berry Street	✔	✔	✔	✔	✔
Alleged physical assault by person in community	Junction	✔	✗	✗	✔	✗
Alleged assault by worker	Junction	✔	✔	✔	✔	✗

Source: Victorian Ombudsman (incorporating information from Department of Health and Human Services and CSOs)

Victorian Ombudsman's Parliamentary Reports tabled since April 2014

2020

Investigation into corporate credit card misuse at Warrnambool City Council
October 2020

Investigation into review of parking fines by the City of Melbourne.
September 2020

Investigation into the planning and delivery of the Western Highway duplication project
July 2020

Ombudsman's recommendations – third report
June 2020

Investigations into allegations of nepotism in government schools
May 2020

Investigation of alleged improper conduct by Executive Officers at Ballarat City Council
May 2020

Investigation into three councils' outsourcing of parking fine internal reviews
February 2020

2019

Investigation of matters referred from the Legislative Assembly on 8 August 2018
December 2019

WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims
December 2019

Investigation into improper conduct by a Council employee at the Mildura Cemetery Trust
November 2019

Revisiting councils and complaints
October 2019

OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people
September 2019

Investigation into Wellington Shire Council's handling of Ninety Mile Beach subdivisions
August 2019

Investigation into State Trustees
June 2019

Investigation of a complaint about Ambulance Victoria
May 2019

Fines Victoria complaints
April 2019

VicRoads complaints
February 2019

2018

Investigation into the imprisonment of a woman found unfit to stand trial
October 2018

Investigation into allegations of improper conduct by officers at Goulburn Murray Water
October 2018

Investigation of three protected disclosure complaints regarding Bendigo South East College
September 2018

Investigation of allegations referred by Parliament's Legal and Social Issues Committee, arising from its inquiry into youth justice centres in Victoria
September 2018

Complaints to the Ombudsman: resolving them early
July 2018

Ombudsman's recommendations – second report
July 2018

Investigation into child sex offender Robert Whitehead's involvement with Puffing Billy and other railway bodies
June 2018

Investigation into the administration of the Fairness Fund for taxi and hire car licence holders
June 2018

Investigation into Maribyrnong City Council's internal review practices for disability parking infringements
April 2018

Investigation into Wodonga City Council's overcharging of a waste management levy
April 2018

Investigation of a matter referred from the Legislative Council on 25 November 2015
March 2018

2017

Investigation into the financial support provided to kinship carers
December 2017

Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre
November 2017

Investigation into the management of maintenance claims against public housing tenants
October 2017

Investigation into the management and protection of disability group home residents by the Department of Health and Human Services and Autism Plus
September 2017

Enquiry into the provision of alcohol and drug rehabilitation services following contact with the criminal justice system
September 2017

Investigation into Victorian government school expulsions
August 2017

Report into allegations of conflict of interest of an officer at the Metropolitan Fire and Emergency Services Board
June 2017

Apologies
April 2017

Investigation into allegations of improper conduct by officers at the Mount Buller and Mount Stirling Resort Management Board
March 2017

Report on youth justice facilities at the Grevillea unit of Barwon Prison, Malmsbury and Parkville
February 2017

Investigation into the Registry of Births, Deaths and Marriages' handling of a complaint
January 2017

Victorian Ombudsman's Parliamentary Reports tabled since April 2014

2016

Investigation into the transparency of local government decision making
December 2016

Ombudsman enquiries: Resolving complaints informally
October 2016

Investigation into the management of complex workers compensation claims and WorkSafe oversight
September 2016

Report on recommendations
June 2016

Investigation into Casey City Council's Special Charge Scheme for Market Lane
June 2016

Investigation into the misuse of council resources
June 2016

Investigation into public transport fare evasion enforcement
May 2016

2015

Reporting and investigation of allegations of abuse in the disability sector: Phase 2 – incident reporting
December 2015

Investigation of a protected disclosure complaint regarding allegations of improper conduct by councillors associated with political donations
November 2015

Investigation into the rehabilitation and reintegration of prisoners in Victoria
September 2015

Conflict of interest by an Executive Officer in the Department of Education and Training
September 2015

Reporting and investigation of allegations of abuse in the disability sector: Phase 1 – the effectiveness of statutory oversight
June 2015

Investigation into allegations of improper conduct by officers of VicRoads
June 2015

Investigation into Department of Health oversight of Mentone Gardens, a Supported Residential Service
April 2015

Councils and complaints – A report on current practice and issues
February 2015

Investigation into an incident of alleged excessive force used by authorised officers
February 2015

2014

Investigation following concerns raised by Community Visitors about a mental health facility

October 2014

Investigation into allegations of improper conduct in the Office of Living Victoria

August 2014

Victorian Ombudsman
Level 2, 570 Bourke Street
Melbourne VIC 3000

Phone 03 9613 6222
Email complaints@ombudsman.vic.gov.au
www.ombudsman.vic.gov.au