Government of South Australia

CDSIRC No CDR00792/2023

Child Death & Serious Injury Review Committee

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Dear Commissioner Lawrie

Thank you for the opportunity to provide a written submission to your inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle (the principle) in the removal and placement of Aboriginal children in out-of-home care.

The Child Death and Serious Injury Review Committee (the Committee) is committed to improving the safety and wellbeing of children and young people in South Australia. It does this by collecting information about the circumstances and factors that contribute to child deaths in South Australia, analysing and reviewing this information, making recommendations and monitoring the implementation of those recommendations.

Aboriginal children and young people are over-represented in the deaths of children and young people in South Australia. The Committee's submission and recommendations relate to our review of the circumstances of death for Aboriginal children and young people who died while in the care of the state between 2005 and the present. It was written in close collaboration with the Committee's Oversight and Advocacy Authority for Aboriginal Children and Young People (the Authority) which reviews the deaths of Aboriginal children and young people informed by cultural knowledge in a culturally safe and appropriate way. The Authority makes recommendations to be considered by the Committee.

The submission includes recommendations to be considered by the Commissioner. The Committee acknowledges that the recommendations do not include or make comment about how they may be operationalised. The Committee has, however, made recommendations based on some important underlying principles that aim to improve the social and wellbeing outcomes for Aboriginal children and young people. The Committee considers that even small improvements will be relatively important and worthwhile, given the scale of the problem, and that improvements will only come where Aboriginal voices and experiences are heard and incorporated in a response.

Pursuant to Section 62 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016 SA* (the Act), the Committee also attaches a de-identified in-depth review into the death of an Aboriginal young person. This information is included to highlight some of the complexities that existed in this young person's life relevant to the application of the principle. Pursuant to Section 66 of the Act, please do not

divulge or communicate this part of the submission further (e.g. do not make this part public). Please also note that this particular case was not considered by the Oversight and Advocacy Authority for Aboriginal Children and Young People, as the review was completed before the Authority was established last year.

Thank you in advance for considering the Committee's submission and I look forward to reading the findings of your inquiry.

Yours sincerely

Jane Abbey SC

Chair
Child Death and Serious Injury Review Committee

28/02/2023

CHILD DEATH & SERIOUS INJURY REVIEW COMMITTEE

Submission from the Child Death and Serious Injury Review Committee.

Inquiry by the Commissioner for Aboriginal children and young people into the application of the Aboriginal and Torres Strait Islander Child Placement Principle in the removal and placement of Aboriginal children in South Australia

February 2023

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Contents

Acknowledgements

The Committee acknowledges that it meets and works on Kaurna land.

The death of a child or young person is tragic and the Committee recognises the impact it can have on a family and all the people who have cared for or supported that child in some way. The Committee recognises the importance of looking at what can be learned and changed to prevent the same kind of death from happening again.

The Committee and the Authority

Child Death and Serious Injury Review Committee (CDSIRC)

The intent of the Committee is to improve the safety and wellbeing of children and young people in South Australia. It does this by collecting information about the circumstances and causes of all child deaths in South Australia, analysing and reviewing this information, making recommendations to relevant agencies, and monitoring the implementation of those recommendations. The Committee reviews specific cases of child death, and from time to time also reviews and analyses information about serious injuries.

Oversight and Advocacy Authority for Aboriginal Children and Young People - CDSIRC

Aboriginal children and young people are over-represented in the deaths of children and young people in South Australia. In 2020, the death rate was over two times higher than their non-Aboriginal peers. The Committee's in-depth reviews of Aboriginal child deaths have shown that their lives were complex and that there were many factors contributing to that complexity.

To support the Committee to better understand this complexity, it established the Oversight and Advocacy Authority for Aboriginal Children and Young People (the Authority). Eight Aboriginal leaders and thinkers were appointed to the Authority in August 2022 to review deaths and service delivery through the lens of their cultural knowledge and in a culturally safe and appropriate way. An important part of this work is the development of guidelines that will ensure reviews of the deaths of Aboriginal children and young people are culturally informed. The Authority advises the Committee about what is needed to make system changes and how best to advocate for those changes to respect, honour and acknowledge the lives of Aboriginal children and young people, Aboriginal community and culture.

This submission has been developed by the Committee in close collaboration with the Authority.

Scope of this submission

The Committee notes that the inquiry will examine the application of the Aboriginal and Torres Strait Islander Child Placement Principle (the principle), including systemic barriers to its application and its five pillars of prevention, participation, placement, partnership and connection, as they relate to the:

1. removal of Aboriginal children (including the provision of support to family and kin prior to removal and for reunification)
2. placement of Aboriginal children once removed (including connection with family, community and culture).

The Committee's comments about the principle relate to the second of these issues, the placement of Aboriginal children once removed, and focus on the application of the principle through the review of the circumstances of death for Aboriginal children and young people who died while in the care of the state between 2005 and the present.

The Committee commenced its collection of information about the deaths of all children and young people in South Australia in 2005 and its database holds records for nineteen Aboriginal children and young people who died while in state care. These children ranged in age from 1 month to 17 years. Two were aged between 1 and 11 months, five were between 1 and 4 years, three were between 5 and 9 years, four were between 10 and 14 years and five were between 15 and 17 years. Fifteen (80%) of these children and young people were male.

This submission focusses on two groups of deaths:

- nine children and young people who died due to chronic conditions and/or health conditions associated with their disabilities, and
- seven young people who died from external causes (not natural causes), including transport crashes, misadventure (e.g. accidental overdose, falls) and suicide.

The Committee acknowledges the deaths of a further three children in state care that occurred in the same time period but were not part of the above review. These were:

- an infant who died in hospital and was placed under guardianship days prior to their death
- a child who died in the care of kin but their cause of death is still 'pending'
- a child who died by misadventure whose Aboriginal cultural identity could not be confirmed.

Key findings and recommendations

Following the review of these two groups of deaths (see the more detailed findings below in Appendix 1), the Committee concluded the following:

The principle at the forefront of decision-making

The Aboriginal and Torres Strait Islander Child Placement Principle (the principle) provides an important framework by which decisions for the placement of Aboriginal children and young people into state care can be made. In the cases reviewed by the Committee, however, there were often circumstances that made the application of the principle difficult. For example, placement choices for Aboriginal children and young people with a disability were extremely limited because of the intensity or location of support the child required. In other cases when placements broke down the choices for the next placement became fewer and the application of the principle became harder to maintain or did not appear to be revisited. This sometimes led to young people self-placing and consideration given to the child protection service revoking the care order due to non-compliance.

In other cases, connection to family and culture was limited to contact with family/parents and if that was not possible seemed limited by a lack of guidance for carers about what the child or young person needed.

RECOMMENDATION ONE: To ensure the best placement outcomes for Aboriginal children and young people, decision-making for Aboriginal children and young people in state care needs to be led by the Aboriginal community and the child's family.

RECOMMENDATION TWO: To ensure the best placement outcomes for Aboriginal children and young people, services need to keep the principle at the forefront of decision-making throughout the period of care by implementing a regular system of review and reflective practice.

The importance of 'cultural safety'

According to Gollan and Stacey's 2021 report, *Australian Evaluation Society First Nations Cultural Safety Framework*, a culturally safe environment is created when:

Aboriginal and Torres Strait Islander people's presence is welcomed and respected, experiences are believed and validated, cultures are connected and valued, knowledge and skills are recognised and supported, advice is listened to and acted upon and do not experience racism in any form.

The Committee found that the operation of the principle cannot be successful without fundamental change to the ways in which the needs of Aboriginal children and young people, and their families, are conceptualised and met. This includes acknowledging that what makes state care 'culturally safe' may be different from one child and their family to the next. It also requires an acknowledgement that children and their families may be suspicious of state-based services. It is only through the provision of culturally safe services delivered by trusted and culturally safe agencies – that are located within communities and are resourced to act in ways that build on the strengths of Aboriginal culture and connection – that placement in state care can be considered a life-affirming and not a life-limiting choice for Aboriginal children and young people.

RECOMMENDATION THREE: Culturally safe responses and care will ensure that Aboriginal children and young people have an enduring connection to kinship, culture and communities, and are actively engaged in cultural life.

RECOMMENDATION FOUR: Placements must be kept accountable by a recognised Aboriginal cultural authority that is considered culturally safe for each child or young person. The Aboriginal authority must be satisfied with the level of resourcing to undertake this crucial role. This also means there must be depth of choice and expertise in the agencies and organisations providing those services.

RECOMMENDATION FIVE: Intensive early intervention services that are culturally appropriate must include practices and workforce strategies where the recognised Aboriginal cultural authority is leading decision-making in all stages of child protection assessments, interventions and placements to ensure cultural safety and culturally led decision-making.

RECOMMENDATION SIX: Children and young people will have access to an independent and trusted Aboriginal advocate who will facilitate their voice and visibility in decision-making about their lives. The Aboriginal advocate will ensure their enduring connection to kinship, culture and communities, and active engagement in cultural life.

Culturally driven early intervention

Above all, this review highlighted the complexity of these children's lives and the need to address systemic issues for Aboriginal people in South Australia to prevent Aboriginal children and young people entering state care in the first place (see Appendix 2 as an example of this complexity). This requires culturally appropriate responses to their needs when they first encounter child protection services. These needs will be best understood by the Aboriginal community and the child's family. The approach needs to be built around a recognition of the State's treatment of Aboriginal families where parents may be traumatised by their own experiences, intergenerational poverty and despair, and loss of traditional beliefs, practices and language. Approaches also need to be built around a context of higher rates of significant health and social problems including mental health, the effects of alcohol and drug abuse, domestic violence and relatives over-extended as carers.

RECOMMENDATION SEVEN: The complex lives and experiences of children and young people who come to the attention of child protection requires the co-ordination of many agencies. Co-ordination of these services must be inclusive of kinship, community and culture.

RECOMMENDATION EIGHT: A recognised independent Aboriginal cultural authority is best placed to do this. Its role needs to be clearly defined and endorsed by an Aboriginal-led decision-making process.

Appendix 1 Detailed findings and comments

As mentioned above, the Committee's review of the deaths of Aboriginal children and young people focussed on the deaths of nine Aboriginal children and young people with disability and seven Aboriginal young people that died of external causes. The Committee considered these deaths in relation to the Aboriginal and Torres Strait Islander Child Protection Principle's (the principle) five pillars of prevention, participation, placement, partnership and connection as they relate to the placement of Aboriginal children once removed (including connection with family, community and culture).

The deaths of nine Aboriginal children and young people with disability

Nine children died from conditions associated with their disabilities. Seven had lived with disabilities associated with neurodegenerative disorders, genetic conditions or birth defects, and two had severe disabilities associated with acquired brain injuries. These children and young people ranged in age from under one to 14 years. Five were in the care of non-Aboriginal foster carers, three were in residential care and one child was in the care of non-Aboriginal kin.

The efforts made to attain the goals of the principle through the application of the five pillars were not consistent, bearing in mind that child protection practices may have changed over the 17 years during which these deaths occurred, but the records available gave some insight into the ways in which they were applied in relation to these children.

The Committee's comments are:

Prevention

- Two of these children acquired brain injuries following a deliberate act by another person while in the family's care.
- The importance of culturally driven early intervention is highlighted when considering the complexity in their lives and that their deaths occurred within the context of violence while in the family's care.

Participation

- Some of these children were born with or acquired, life-limiting health conditions. When this was known, the best ways in which participation was practised was the involvement of the child's family (usually the mother and/or father) in palliative care, end-of-life planning and funeral arrangements.
- When these issues did not involve family, there was confusion and mis-understanding between non-Aboriginal foster carers and the child's family when cultural ways of doing things were not understood.
- In other cases the circumstances of the child's removal made contact with immediate family impossible/unsafe.

Placement

- The most consistent issue that drove placement choices for these children and young people was their high care needs. These needs were the over-riding consideration in terms of placement decisions and the best interests of the child or young person were frequently couched in terms of meeting their high and complex care needs.
- For example, one child remained in hospital for over two years until suitable carers, who were willing to be trained in the management of the child's high care needs, were found. Aboriginal services such as Aboriginal Family Support Services were sometimes engaged to assist in the challenging task of finding Aboriginal carers for these children. Despite their best efforts, because of the children's high and complex needs, they were invariably placed with non-Aboriginal carers.

Partnership

- In some cases there were references to family members agreeing to the decisions about placement. For example, when the non-Aboriginal carers decided to move from another state to South Australia there was reference to 'X's mother agreeing that this was in the best interests of X (given the high care needs). The distance involved made connection with the child's family impossible to maintain.

Connection

- Efforts to maintain and support connection to family, community, culture and Country were not well documented. There did not appear to be any particular guidelines or requirements with regard to how these connections should be maintained and the maintenance of contact appeared to be reliant on the efforts of individual workers.
- Connection was usually seen as the arrangement of visits between the child and family. Depending on the circumstances of the guardianship, these were sometimes in the hospital, in the district office, or in the carer's home. It was usually the case that the family were expected to come to the child, given the high needs of these children. This could raise problems at times; for example, visits by family members to one child ceased when the department stopped funding transport costs because the 'parents spent the money on other things'. If parents/family were interstate, these connections were lost.
- It was also found that attempts to connect were most often aimed at the connection to family and/or connection via provision of educational resources to non-Aboriginal carers.
- Connection to 'community' did not seem to be part of efforts when contact with the immediate family was considered to be impossible or unsafe.

In a number of cases we saw evidence of significant efforts to find suitable placements, to secure them, and to make them work. However, if children had high and complex needs, the choices were extremely limited because of the intensity of support the child required. Some placements broke down because carers could not maintain the round the clock care needed. Other placements broke down when respite care was not agile enough, flexible enough or simply not sufficient. If placements broke down multiple times, then the choices for the next placement became fewer and fewer and consideration of the placement principles was overwhelmed by the necessity of finding a suitably trained, and willing carer.

The deaths of seven Aboriginal young people

Between 2005 and the present, the Committee has documented the deaths of seven young Aboriginal people who died from various external causes while in the care of the state. These young people ranged in age from 13 years to nearly 18 years. Six were

male and five were ‘dual involved’, having at some time been involved with the juvenile justice system.

At least three young people had very little or no contact with the department in the weeks or months before their death and at least one was actively avoiding contact with the department – to the extent that the department had considered revoking the guardianship order as there was concern that attempts to avoid contact were further endangering the young person’s safety.

Prior to their death, three young people had been placed in the care of extended family but at the time of their death were ‘self-placing’. One young person was in a supported living arrangement, one in residential care and one in a commercial care arrangement – both of the latter children with a rotational roster of carers.

For these young people, whose vulnerability was associated with intergenerational trauma, the challenges of walking in two worlds and their experiences of cumulative harm, neglect and abuse, placement was not easy to find and the stability of placements was easily disrupted or broken – especially if both the young person and the carer(s) were not well supported.

As a result, all these young people had multiple placements during the course of their guardianship. It was difficult to ascertain the efforts made to achieve the goals of the principle for each placement and the Committee bears in mind that child protection practices may have changed over the 17 years that these deaths occurred.

However, the same pattern was observed for these young people as for children with disability: as placements broke down, the choices for the next placement became fewer and the application of the principle became harder to maintain.

The Committee’s comments are:

Prevention

- The importance of culturally driven early intervention is highlighted when considering the complexity in the lives of these young people and that their deaths often occurred within the context of risk-taking and disengagement, or active avoidance of, support services.
- Prevention is where the most work needs to be done to try to ameliorate harm, build connection and prevent the need for placement in state care.

- The elements that form the basis for the principle should be used to inform any decision made about the safety and wellbeing of Aboriginal children when they come to the attention of the child protection system, not just when they enter the care of the state.

Participation

- There can never be enough importance placed on the need to ensure the child or young person is included in decision-making about their lives.
- This becomes difficult when the agency that seeks their views is also the agency that is imposing state care on them. Several young people who chose to 'protect themselves' from the perceived interference of that agency minimised or actively avoiding contact with them. In these situations, even with the best-intentioned work on the part of the practitioner, the willing participation of the young person becomes challenging.

Placement

- Regardless of whether the principle was used to guide decision-making about placement, the circumstances of these deaths suggest that these efforts failed because:
  - the final placement for 3 young people was said to be with family or extended family, however all three young people had drifted away from these placements and were self-placing at the time of their death
  - the circumstances of death for two young people in residential care suggested that placement with rotational carers should never be considered a long-term option for Aboriginal children as the likelihood of their carers sharing and understanding their culture and meeting their needs are remarkably low.

Partnership

- The lives of these children were complex, both before and during their placement into state care. Their family histories provided evidence of intergenerational trauma and parents did not have the capacity to provide for their needs. One or both parents of two young people had themselves been in state care during their lives.

- When families cannot manage, communities and community agencies need the strength and capacity to support and care for children and young people. This cannot be an informal process but one where the rights and responsibilities for the care of children whose families cannot care for them are ceded to communities and community agencies who are perceived by the child and their family to be trusted allies.

Connection

- We observed a similar view of connection as with children and young people with disability – that it is visualised literally as contact – phone calls, or visits with family, in most cases just mother, father and/or siblings. At the beginning of guardianship, or a particular placement, efforts might be put into sustaining visits between the young person and their family and community. We rarely found a case where these links were maintained over the long term.
- If attempts at connection were tried, it appeared to rely on the efforts of individual workers. The inconsistencies in this practice suggested to us that there was no practice guidance, nor monitoring of the ways in which connection was conceived or fostered.
- The formalisation of contact into arranged visits in places could well be seen by the young person and family members as culturally unsafe/uncomfortable and, as mentioned previously, associated with the agency imposing state care on them.
- This is not to say that these young people did not want contact with family, but records showed that they would seek that contact on their own terms.

Appendix 2 A review into the death of an Aboriginal young person

Section 62 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016* permits the sharing of information between the Commissioner for Aboriginal Children and Young People and the Committee if it is believed that the provision of the information would assist the recipient to perform her official functions relating to the health, safety and welfare of a class of children or young people.

Under Section 62 the Committee releases a de-identified review into the death of an Aboriginal young person, and pursuant to the confidentiality provisions under Section 66 of the Act.

This young person's death occurred in 2009 and a review was undertaken by a non-Aboriginal person. This death has not been reviewed by the Oversight and Advocacy Authority for Aboriginal Children and Young People – Child Death and Serious Injury Review Committee, as the Authority has been recently established. The Committee submits this review to highlight the following:

- the impact of a complex family history
- the circumstances leading to self-placement choices
- the tensions of 'walking in two worlds'
- evidence of service activity but very little in terms of outcomes
- the absence of the young person's voice and views
- the need for connection with family and the difficulties that posed.

The conclusions and recommendations drawn from this review highlight that work needs to occur that leads to a deeper understanding of connection based on Aboriginal ways of knowing, being and doing. This is a lifelong and continuous journey, not something that can be started, fostered or maintained by the simple conceptualisation of connection as 'family visits'.

IN-DEPTH REVIEW SUMMARY

CASE 581

ELIGIBILITY FOR REVIEW

Under Section 52S of the *Children's Protection Act 1993*, the Committee determined that the death of this child was reviewable because:

- 52S 2 (a) The incident resulting in his death occurred in the State; and
- 52S 2 (b) The child was, at the time of death a resident in the State.
- 52S 3 (c) Prior to death this young person was the subject of multiple notifications to Families SA.
- Under Section 52S 4 of the Act, prior to undertaking this review, the Committee determined that their review does not compromise any ongoing coronial or criminal investigation of the case.
- In undertaking this review the Committee notes the purposes for a review that are laid out in Section 52S 6 of the Act and accepts these as the Terms of Reference for the review.

REASONS FOR THE REVIEW

The Committee sought to identify from the circumstances of this case, possible improvements in processes, systems and services for young people.

RECORDS AVAILABLE FOR REVIEW

The committee had before it at review the following records:

Families SA

- Contact files Parts A, B, C, D and E
- Part F Adverse Events Committee Report
- Secure Care
- Youth Justice
- Psychological Services Part 1 and 2
- Crown law referral
- Funeral Assistance

Department of Education & Children's Services

- Parts 1, 2 and 3

Courts Administration Authority

- Youth Court

AC Care

Centrecare Letter

SUMMARY OF AVAILABLE INFORMATION ABOUT C AND HIS FAMILY

1. C was 16 year old at the time of his death. He was the second oldest of four children of Aboriginal parents. Soon after his birth in May 1993 the family was living in the northern suburbs of Adelaide. C had an elder brother and a younger brother and sister.

2. There appear to have been tensions between C's mother's and father's families and from very early childhood C and his siblings witnessed extreme violence at home, mostly perpetrated by C's father against his mother.

3. C's father came and went from the family home during C's infancy and early childhood and C's mother slid into increasingly dysfunctional alcoholism during this time.

4. C and his siblings were the subjects of multiple notifications to Families SA (FSA) from 1998 to 2006 for abuse, witnessing violence, neglect and abandonment and it would appear that the family was known to Families SA or its precursor departments at the time of or soon after his birth.

5. C's mother, who came from a rural Aboriginal community, was said to have been abused by her mother's partner as a child.

6. By the time C was 11 FSA was regularly receiving notifications about his abandonment. His family by this stage appeared to have disintegrated. His father appeared to have vanished, his mother was about to become homeless and her whereabouts were often unknown.

7. The complexity and difficulty of C's situation was clearly apparent before he was eight years old. FSA did not undertake a comprehensive assessment of his situation and his needs or plan what services should be provided to him, even when he threatened to kill himself at the age of 10, was known to attend school infrequently and was known to be left alone, unsupervised and uncared for.

8. The location of his siblings during the period was not clear but they appear to have been sometimes at home with C and their mother, sometimes with relatives and in the case of his older brother, mostly fending for himself.

9. From about age 11, between emergency placements with relatives, C fended for himself. By 2005 he had found himself a home with a non-Aboriginal school friend's mother in the northern suburbs, although he continued to maintain contact with his siblings and relatives.

10. C's school history was characterised by movements between schools. At primary level there were multiple reports for absences and minimal academic progress. At secondary level there were multiple reports for unacceptable behaviour and several suspensions. From age 7 there were reports of him roaming and stealing and he was charged with 3 or 4 property and disorderly behaviour offences between the ages of 13 and 15.

11. In 2007, when he was 13, C was placed under the Guardianship of the Minister for 12 months and in 2008 he was placed under Guardianship until age 18.

12. Sometime in late 2008 C went to live in regional South Australia where his elder brother also lived. In mid-2009, while in Adelaide and intoxicated, C was killed in a motor vehicle accident. He was 16 years old.

CIRCUMSTANCES OF C'S DEATH

13. In the months prior to his death, C moved to regional South Australia to be with a young woman who was pregnant with his child. They had travelled to Adelaide to visit her grandfather in hospital just prior to his death. C, his girlfriend and 2 friends had been in Adelaide on the day of his death and C and others had been drinking. At post mortem, C's blood alcohol level was 0.159%. Compounds consistent with petrol above lung tissue, indicated petrol inhalation.

14. All witnesses agree that C and 2 companions were drunk on a night train from Adelaide to a northern suburban station and disembarked or were asked by security to leave the train, at an earlier station than their intended destination. They started walking and C was reported to be angry and yelling. He stopped in middle of the road. A companion attempted to get him off the road but both were hit by a car. The Police Investigation Summary indicates that C was lying on the road at time of his death. It is unclear if this was deliberate or he fell or became unconscious.

DISCUSSION

15. As Appendix A shows, at least 25 health, human service, education and justice agencies and their various sub units and programs were directly involved with C and with his nuclear family while he was living with them.

16. At least 28 staff from FSA had direct involvement with C and his family while and after he was living with his mother. At least 35 other government and non-government agency staff were involved with him and his family while and after he was living with his mother.

17. These figures, derived from staff names in files, give a very conservative estimate of the actual staff numbers as they do not include the many un-named teachers, youth workers, police officers and others who had contact with him while he was receiving child protection, education and other services.

A complex case

18. The first thing that must be acknowledged in respect of service provision for C and his family was that their situation was complex. A combination of factors including the legacy of the State's treatment of Aboriginal families, parents traumatised by their own experiences, intergenerational poverty and despair, suspicion of human service agencies, health and mental health problems, alcohol abuse, domestic violence, relatives overextended as carers, and traumatised children, would have made C's case extremely demanding and a challenge for any agency's policies and practices

Quantity and quality of services

19. There was an enormous amount of energetic and well intentioned service activity occurring for and around C at various stages in his life by a wide range of government and non-government agencies and staff. Very little of that activity focussed on assessing C's situation and needs except on an incident-driven, episodic basis.

20. There is no question that some staff members in agencies worked hard at certain times to make practical arrangements for him and or his family. For example during 2001, 2002 and early 2003 there was evidence of active practical FSA case work with C's mother around safer housing, her involvement as a witness in court about her partner's violence, her children's safety and her financial difficulties.

21. During 2007 and 2008, after C came under the Guardianship of the Minister, a Department of Education (DECS) Aboriginal Inclusion Officer (AIO) made multiple referrals in an attempt to connect C to almost any service. During this period at least two FSA case workers seem to have been actively involved in education meetings and communications about C.

22. There were periods of FSA activity at times of crisis. For example when C's mother was hospitalised in 2001 after being stabbed by their father in front of the children, FSA was very busy over a few days seeking emergency placements with relatives. When the Guardianship orders were being sought for C in 2007 and 2008 there was significant FSA activity around report preparation and efforts to contact C's mother.

23. There is also no question that individual staff members in several agencies were genuinely concerned for the safely and well-being of C and his siblings and advocated for intervention. For example a set of notifications to FSA in 2004 and 2005 suggest that school staff were particularly concerned about C and his siblings and keen for FSA to take some action about the children. The AIO previously mentioned appeared to have been very eager to link C with supports and was aware of the extent of C's alienation and disengagement.

24. However the activity across agencies in general was not proactive, timely, consistently attentive, well focussed, precise or individually tailored to C or his family's needs. It was not demonstrative of staff skill and expertise in working with a complex high need family, child and Aboriginal situations.

25. Two critical factors were missing from the FSA activity – an assessment of C focussed on what needed to be put in place to keep him safe, and actual services designed to ensure that he was housed, supervised, cared for, educated on a regular basis and protected from the effects of family violence and substance abuse.

26. Instead, in general the activity appears to have been clumsy, generic, and decidedly crisis and resource driven.

27. There were also several critical times in the life of C and his family during which FSA took no action on multiple notifications. Resource constraints were generally given as the reason. It was not clear how much these multiple 'notifier only concern' (NOC) and 'resources prevent investigation' (RPI) notations on the files reflected FSA policy imperatives or local decisions.

28. There were periods in which C and/or his mother appeared to receive no services what-so-ever and there were periods where FSA was inactive for months while waiting on responses to Aboriginal service referrals. At these times the family received minimal attention. In 2003 there was a hiatus of 8 months while waiting on a response from a non-government Aboriginal support service.

29. There were critical events only actioned much later or at the last minute (eg arrangements for C's carer's planned trip interstate in late 2007). There were many occasions where client need and service response was asynchronous. C's mother on several occasions received a letter from FSA indicating that her case had been closed even though more recent and critical events had reopened it.

30. Several times she made clear her difficulties in coping but her case was closed anyway. When FSA later attempted to involve her in plans, she had lost interest (perhaps trust) and refused to engage.

31. Much of the service activity appeared to be reactive and incident driven rather than confident and strategic. For example almost any Aboriginal family at any time was accepted as an emergency placement by FSA for C and his siblings even when there was evidence to suggest the need for caution if not concern about those families.

32. Thus on at least one occasion (in late 2008) C was placed with an in-law connection where he experienced a repeat of the drinking and neglectful carer behaviour which had so distressed him at home.

33. Similarly at some points in C's life (eg 2007-2008) service referrals were made with a seeming 'scatter gun' approach; that is, referrals were made everywhere with the hope that one service might accept him, or he accept it.

34. No agency appeared to have had the skill, the time or resources over a long period to adequately assess or help C or his family.

35. On the single occasion when he seemed to connect minimally with an education service (Beafield) the short term duration of that program was not adequate for him and applications for an extension absorbed staff energy.

36. In terms of staff skill and tailoring of services, at least one of the FSA case workers (2001) sought cultural advice from Aboriginal agencies. However, from what can be deduced about Aboriginal services they too seemed defeated both by the family's problems and/or their own funding difficulties. On at least two occasions, C was personally confronted by FSA staff in what appeared to have been an insensitive and heavy handed alternative to a formal psychological interview (in 2004 about a picture of a hanging and in 2004 about whether he wanted to live in a safe home).

37. There were several gems of information embedded in case file material, which should have been significant in negotiations about and tailoring services for both C and his mother. For example she expressed concern about confidentiality in respect of an Aboriginal counselling service. There is a note that she was terrified not only of her violent partner but also of members of his family who would punish her if she pursued criminal charges against him.

38. In 2008 C lay down on a road and said he wanted to die.

39. These incidental but vital pieces of information do not appear to have been appreciated or synthesised in professional judgements or to be reflected in assessment and service planning activity.

40. During 2007 and 2008 when Guardianship orders were being pursued, there was an almost perfect correlation between the timing of significant FSA/legal processes and behavioural outbursts by C at school. This pattern was not mentioned in any agency notes or reports and it is likely that neither DECS nor FSA knew what was happening in the other agency on a daily basis.

Service/case coordination and management

41. Service delivery arrangements and coordination are intrinsic to service quality issues in this case.

42. It is not known if a case management model was in use in FSA during C's lifetime but there was little evidence of much needed coordination, monitoring and evaluation of services by one agency with the necessary authority, rationally FSA.

43. Many referrals were made and several plans for work with C's family were written within FSA but there was no evidence of a system in that agency for monitoring whether or not the referrals were being realised and or were resulting in effective direct service.

44. Referrals appeared to have been service ends in themselves.

45. There was very little evidence of intra, let alone inter-service collaboration, coordination and tracking of family progress. There does not appear to have been any comprehensive case conferences, although a couple of DECS and FSA workers did meet together during the latter part of C's life.

46. Direct service agencies, many of them Aboriginal services, appeared to act independently of any joint planning beyond referral, and FSA and DECS seemed to be content to let them do so.

Assessment and case planning

47. Regardless of whether a case work or a case management approach was being taken in FSA the assessment and case planning processes were not adequate.

48. The assessment procedures were mechanical and risk instrument based. They did not include face-to-face assessment of C by a properly qualified professional.

49. The risk checklists appear to have been used as a substitute for professional judgement and even when they produced high risk scores they did not guide the ensuing commentary or action.

50. This raises a question about their value.

51. The assessment processes were not individualised and they did not seek, explore or synthesise critical information about C and his family.

52. There was also a tendency in DECS school reports throughout, and in FSA assessments of the family in the early years, to paint a positive picture of C. A strengths focus is appropriate but not at the cost of informed professional weighing of the relative values of various bits of information in drawing assessment conclusions.

53. The absence of professional information processing in the assessment processes was also reflected in the case plans which were neither well-crafted nor well-tailored to the family circumstances.

54. The FSA case plans throughout were overly ambitious, containing broad and unrealistic goals (eg 'to have addressed personal issues such as substance abuse'. See Appendix C for more examples).

55. Often the goals seemed to be cut and pasted from one FSA plan to the next and there was no evaluation in any plan of the success or failure of previous plans.

56. There was no voice of C or his mother in any plans. The plans did not appear to be the products of a genuine negotiation with the clients nor did they contain any information about the active involvement of or maintenance of informal and community supports.

57. It was not possible to tell from the files at any one time if a plan was in place and if and how it was being monitored. It would seem more often than not that an FSA plan was overtaken by crises and abandoned in the ensuing flurry of service activity.

58. A case plan from a non-government Aboriginal support service for 2007 comprised a list of tasks without time lines or allocated responsibilities.

Practice leadership

59. Service quality is related to practice leadership.

60. Throughout the files, senior practitioner advice and support was absent. The activity of team leaders and supervisors was only evident in the co-signing of reports and decision-making around resource constraints. On one occasion in 2006 when a FSA case worker consulted a supervisor about the desirability of convening a family

conference prior to seeking a Guardianship order, the supervisor responded that she would take the case worker's advice.

61. Individual workers, with their varying levels of skill and confidence, appeared to be doing the best they could in difficult circumstances.

62. There were many case consultation sheets in the FSA files but they largely detailed emergency tasks and referral options. There was no evidence for example of regular case reviews or in-depth supervisory analyses of the nature and possible trajectory of this family situation, of what the extended family network could realistically offer, of C's unique characteristics and needs, of the pros and cons of using statutory powers, or of the impact of the FSA family reunification policy in this case.

Files and information management

63. The FSA and DECS files provided for this review were not practice friendly and would not support responsive, systematic front line service delivery.

64. The files were cluttered, repetitive, out of sequence, appeared incomplete (eg FSA continuation sheets for C for 2004-05) and generally did not include rationales for action or inaction.

65. In all agencies there appeared to be some sort of procedure for file organisation but it could not be relied upon to find important reports and other significant documents. Reports were often filed in the wrong section, missing, or out of sequence.

66. Two large FSA Psychology Service files contained only generic FSA material about C and his family and some referral communication. Their size obscured the fact that there was no psychology assessment or service provided to C. Unsuccessful attempts to assess him were not detailed in them.

67. The FSA files as presented would not act as aids to practice for a front-line worker wishing to find for example, the most recent and comprehensive case report or assessment, or a case plan for a particular period, or to know if there was a current case plan or to know how it was working.

68. Searching the files for themes and patterns in service and response to service would be too time consuming for case workers, even if they were motivated to do so, or encouraged by practice leaders to do so.

69. The DECS files were equally disordered with an incomplete set of term reports and school enrolment forms and periodic and partial sets of attendance statistics.

70. Documentation kept by an NGO stated that C was not a client of theirs, but of one of their school based programs. The same documentation stated that the NGO had no information because the worker concerned had left its employment; suggesting that client files were the property of the individual worker.

Knowledge of C – the client

71. Another most striking aspect of the service delivery picture for C was that despite the amount of service activity very little was known about him as an individual and the accuracy of some of the claims about him in adolescence was dubious.

72. FSA staff recorded that he was shamed by his mother's drinking and distressed by his father's presence. He was said to want to live with his mother and siblings. He was reported in childhood by school staff to be quiet, lonely, non-communicative and interested in art and sport.

73. DECS Guidance officer and speech pathology reports outlined his intellectual and language capacities.

74. In adolescence he was described by FSA, without any critical analysis of data, as an entrenched offender, to be using drugs and alcohol and to not relate to non-Aboriginal people. In fact his offending record was minor, the extent and pattern of his drug and alcohol use was unquantified and he chose to live with and return on a regular basis to a non-Aboriginal carer.

75. Beyond these few notations, the agencies had nothing to say about C and there was an absence of curiosity about him. There was very superficial information on which to attempt to base individualised service plans for C.

76. In contrast, his carer from 2005 and her connections offered very significant observations about C which were recorded almost incidentally in the files. For example she said: he may be suicidal, his family (including extended) members make him feel guilty for wanting to live with her, he will abscond if placed with his uncle (he did), he only wants to be where his mother is and will stay with relatives when she is present (he did), he is close to his elder brother, and he was sexually abused as a child.

77. These critical fragments of information indicated that there was some depth of communication and understanding between that carer and C, but this information was neither adequately acknowledged in agency files nor utilised by agencies in their service assessments and planning.

Psychological assessment and intervention

78. The only assessment of C undertaken was a basic educational assessment of intellectual capacity conducted by DECS in 2000 when C was 6 years old.

79. The absence of comprehensive psychological knowledge about C contributed to and compounded his shadowy profile. He witnessed extreme and regular violence as a young child, the consequences of which are well detailed in the literature (eg see Shea Hart 2011[1]). He was abandoned many times by his mother. He may have suffered from nutritional deficiencies and/or the effects of prenatal alcohol abuse.

80. Even these known factors should have prompted an early and comprehensive psychological investigation. Questions about mood and anxiety disorders, depression, and attachment disorder remained unanswered.

81. His developmental history, psycho-educational and social functioning profiles and recommendations about therapeutic interventions were never explored.

82. A referral was made by the FSA case worker to FSA psychology services in 2007 for investigation of some of the deeper psychological issues such as attachment. This referral was resisted by the FSA Principal Psychologist on the grounds of non-cooperation by C and his mother in previous attempts to assess him (2004 and 2006 but no details provided in files) and because Aboriginal psychologists were not available.

83. After many months of inaction, FSA contracted out the referral to a private psychology clinic staffed largely by post graduate students, on the grounds that service might be more prompt. C refused to attend any of the appointments made for him (he was informed of these appointments by letter) and the clinic responses to his non-appearance can only be described as irritated.

84. Assessment and intensive therapeutic intervention designed to support educational and placement options for C would not have compensated for the lack of assessment and support in his earlier years. In addition C had disengaged from services in Adelaide.

85. Given the range and depth of C's potentially damaging experiences as an infant and child, the absence of at least a comprehensive psychological assessment for him is indefensible.

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[1] A Shea Hart (2011). "Child safety in Australian family law: Responsibilities and challenges for social science experts in domestic violence cases." Australian Psychologist 46(1): 31-40.

86. There is no question that he would have been difficult to engage, especially as he got older, and that particular psychological expertise around Aboriginality would have been called, for but these challenges are not uncommon in contemporary child protection and young offender work.

87. The files also prompt a question about why main stream specialist services such as CAMHS and DASSA do not feature at all in C's case.

Use of statutory powers

88. Conspicuous in the service response to C was the absence of the use of statutory powers by either FSA or DECS under the *Children's Protection Act 1993* (SA) or the *Education Act 1972* (SA).

89. C and his siblings were the subjects of at least 30 notifications for abuse, neglect and or abandonment. They lived in a home where extreme violence was a common and acknowledged occurrence.

90. Despite these circumstances there was no evidence of a deliberate or strategic use of the powers delegated to FSA, to intervene in or bring about changes in the family situation.

91. A Voluntary Care Order under the *Children's Protection Act* was sought by FSA in 2004 when C's mother was hospitalised after an assault leaving her 4 young children alone at home. The two Guardianship orders sought for C in 2007 and 2008 were the result of constant pressure and threats of complaint from his informal carer after he had been homeless for some years.

92. The children were not protected at law and the law was only invoked once at a time of extreme crisis and once through extensive external prompting.

93. C was a chronic non-attender from early childhood at both primary and secondary schools. There was also no indication that attendance powers under the *Education Act* were considered in relation to his situation.

94. There is no evidence that FSA and DECS had policies or procedures in place requiring collaborative planning and action about the judicious and possibly combined use of statutory powers in cases such as C's.

95. Legal responses do not solve complex social situations but they can underpin and give force to plans for strategic and comprehensive service intervention.

96. For example there was little indication that C's mother (or father for that matter) was engaged by FSA workers, in the early days before her alcoholism was entrenched, in

forthright conversations about the informal and formal consequences and risks to her and her children of abdication of parental responsibilities. These sorts of challenging interactions call for staff expertise and must be carried out in a supportive management, policy and case planning context.

97. It is not known why they did not happen and why C's mother's demands and refusals generally prevailed.

98. It was clear that an extremely high level of violence, dysfunction and non-cooperation and of school non-attendance was tolerated by the bodies with statutory powers in C's case.

Family reunification policy

99. The service response to C and his family was also characterised by the effects of a FSA family reunification policy which had a profoundly negative effect in his case.

100. Throughout the FSA history of C there was only one placement in which he ever felt safe. That placement, which he found for himself was with W, a non-Aboriginal woman.

101. That placement lasted off and on from 2005 until some time in 2008. W continually expressed concern for C. She took him back several times after altercations. She monitored his couch surfing movements when he was not with her. She reported things that he talked about with her. She seemed to understand his needs and conflicted feelings. She asked for assistance in managing him. The FSA safety check she finally underwent indicated nothing of concern.

102. C's placement with W was only ever reluctantly endorsed by FSA and its significance to C only noted by one FSA worker in 2008. The placement was formalised long after it was well established (another example of tardy use of statutory powers) and the formalisation processes were then paralleled by plans to place C with extended family members.

103. During this 2007-2008 period, W reported, and all the indicators confirmed, that C was extremely torn about wanting to live with her because his immediate and extended family members made him feel guilty.

104. There was no evidence that C was helped in any way by any service to resolve these conflicts or that W was genuinely supported in her efforts to care for C.

105. There was evidence that many of C's relatives were asked to take him and that they usually agreed, even when it was clear that they were reluctant or already over extended.

106. Thus C's only real placement option was sabotaged by a policy which placed family reunification above individual needs and circumstances.

107. Strong practice leadership would be needed to manage this issue, but this was not evident in the case consultation notes in the files.

Acknowledgement and confirmation of informal supports

108. The files raise an additional albeit less central question about the extent to which policy and practice in FSA in particular acknowledges, protects and informs family members, neighbours and other community members who come into contact with or assist children and young people like C.

109. C and his siblings in childhood often went to neighbours, or family members or school friends' houses for food and protection or to report difficulties at home. Neighbours sometimes helped and/or reported to FSA even though frightened for their own safety when there was drinking and fighting in the C home.

110. There was no indication that any of these people were ever thanked, or provided with an explanation or checked as to their own well-being.

111. While this sort of community work may not have high priority in an agency such as FSA, focussed attention could educate the wider community about complex social welfare matters, reward those who do attempt to support children in crisis and at the same time enhance the reputation of FSA.

FSA Adverse Events Review

112. The FSA Adverse Events Review Report (p77) found that "*the death of C was neither foreseeable or preventable by Families SA. The Care provided by Families SA was not significant in contributing to his death*".

113. However, the trajectory of C's life, viewed through the lens of practice and historical wisdom about the lives of young Aboriginal males did indicate the foresee-ability of a high risk life and even the likelihood of an early death for him.

114. What little is known of him through service files showed that he was a troubled, conflicted, angry, mistrustful and very sad young man grieving for his family. The possible circumstances and causes of death in his case were many, for example related to drugs or violence or traffic accidents or suicide attempts and so on.

115. The care provided by FSA and other agencies, if differently organised and managed, might well have rendered him less damaged, less likely to live a high risk life and less likely to experience an early death.

COMMENTS AND RECOMMENDATIONS

The Committee has made 9 recommendations that address systemic issues arising from its review of the circumstances of this young person's death. These systemic issues are identical to those which have been identified in previous reviews. Although written with this case as their focus, the recommendations echo recommendations previously made by the Committee.

Comment 1: *'Despite the amount of service activity occurring on behalf of this young person, little was known about him.'*

Recommendation 1: All agencies working with children and young people should ensure that all practices adequately reflect the voice and needs of children and young people.

Comment 2: *'Service delivery to this young person and his family was often clumsy, generic, crisis and resource driven.'*

Recommendation 2: When working with children and young people and their families where there are multiple needs, continuity of service delivery is essential.

Comment 3: *'It is not known if a case management model was in use, but there was little evidence of much needed coordination, monitoring and evaluation of services by any one 'lead' agency.'*

Recommendation 3: Where an agency considers a case management approach relevant in a client situation, the model of case management should be creative, proactive and coordinated and include all of a client's formal and informal supports and services. Once a case management plan is developed it should be implemented until such time as a decision is made that the child's needs no longer require case management.

Comment 4: *'The files made available to the Committee for review were not practice friendly and would not support responsive, systematic frontline service delivery. They were cluttered, repetitive, out of sequence and appeared incomplete.'*

Recommendation 4: All agencies should review case file and data management systems so as to ensure that client records are organised in logical, sequential order, without multiple copies or repetitions of documents, and with key documents such as assessments and reports, case summaries, and case management plans clearly marked and accessible to front line workers.

Comment 5: *'A case plan from an Aboriginal support service comprised a list of tasks without timelines or allocated responsibilities.'*

Recommendation 5: Agencies run by or for Aboriginal people should be encouraged and supported to further develop program design and management to ensure that they can and do deliver informed, timely, focussed and tailored services.

Comment 6: *'The Families SA records show that this young person was a troubled, conflicted, angry, mistrustful and very sad young man grieving for his family, whose situation was extraordinarily complex and the policy and practice demands were significant.'*

Recommendation 6: That Families SA put resources into further developing depth of expertise of frontline staff in child centred engagement, child-centred assessment and child-focussed service delivery, in particular building effective relationships with children and young people who have experienced abuse and neglect.

Comment 7: *'Despite over 30 notifications for abuse, neglect or abandonment, a home environment that encompassed extreme violence and chronic non-attendance at school, neither child protection nor education agencies considered the use of statutory powers to intervene or bring about changes in C's family situation.'*

Recommendation 7: The education and child protection agencies within the Department of Education and Early Childhood review the use of their statutory powers under their respective acts and ensure the formal and timely assessment of children and risk.

Comment 8: *'The attempts at reunification made by Families SA had a profoundly negative effect in this case.'*

Recommendation 8: Families SA re-assess its reunification policy to accommodate cases where there are individual contra-indications and where family of origin or extended family supports are clearly over-stretched.

Comment 9: *'There is no indication that Families SA has any policies or practices that seek to acknowledge the support provided by family, neighbours or community members and through these opportunities educate the wider community about complex social welfare matters.'*

Recommendation 9: Families SA consider the extent to which it does and might better acknowledge and confirm the work of informal community supports in complex family, domestic violence and child protection cases.

Dymphna Eszenyi
Chair
Child Death and Serious Injury
Review Committee

20 / 1 / 2017

APPENDIX A

Main government and non-government agencies involved with C and his family[2]

Department of Families and Communities-Families SA (FSA) (and its precursors DHS, CYFS, FAYS) eg:

- Salisbury District Centre
- Modbury District Centre
- Elizabeth District Centre
- Pt Augusta District Centre
- Kinship Care
- Northern Youth Justice Team
- Remand Inc. (referral only)
- Magill Training Centre
- Yaitya Tirramangkotti (Aboriginal Child Abuse Report Line)
- Metropolitan Aboriginal Youth and Family Services
- Child Abuse Report Line
- Crisis Response and Child Abuse Service

Department of Education and Children's Services eg:

- Ingle Farm, Maitland Area, Hackham West, Kaurna Plains and Elizabeth Downs Primary Schools
- Valley View High School
- Aboriginal Education and Support Workers
- Aboriginal Liaison and Inclusion Officers
- School counsellors
- Beafield Education Centre
- ICAN (referral considered)
- Flexible Learning Options (referral considered)
- Warriapendi School (referral considered)

[2] This list is not exhaustive and it relates mostly to work with C's family in respect of C and while he was living at home. There appear to have been other agencies involved with C's family, sometimes in respect of C, which are not detailed in the files. The agencies listed here appear to be the most significant ones. Some of the agencies listed here worked extensively with C and his family, while for some there was little evident involvement beyond the referral stage.

Domestic Violence Units

Various police officers and stations

Youth Court

- Courts Assessment and Referral Drug Scheme (CARDS)

Various SA Housing Trust offices (SAHT now Housing SA)

Maitland Health Officer

North Western Community Health Service (NWCHC)

Aboriginal Health Clinic-Elizabeth

Kids 'n' You

Aboriginal Counsellor

SA Aboriginal Sports Training Academy

Wiltanendi

Nunga Miminis Shelter

Men's Group (referral considered)

ASSIST Drug and Alcohol program

St Vincent De Paul Society

Connections@Mission Australia (referral only)

Centrecare eg:

- Student MatterS
- Wandana Community Centre-drug education program

Kumangka Aboriginal Youth Service and Reconnect program

Aboriginal Legal Rights Movement (ALRM)

Aboriginal Family Support Service (AFSS)

Harmony Haven DV Shelter

Brady St Clinic and other doctors in hospitals and clinics

Nunkuwarrin Yunti

Anglicare

AC Care Riverland