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CHILD PROTECTION SYSTEMS
ROYAL COMMISSION REPORT
VOLUME 2: CASE STUDIES

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Commissioner

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CASE STUDIES

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PROTECTING THE PRIVACY OF CASE STUDY PARTICIPANTS

In the course of this inquiry, the Commission considered the circumstances of a number of children and young people whose lives have been affected by the child protection system. Their experiences were examined by considering documents and hearing oral evidence.

Four case studies which considered the individual circumstances of young people currently or recently in care were conducted. The Commission did not take formal evidence from the children concerned, although some informal communication occurred in one case.

The fifth case study considered the circumstances in which Shannon McCoole offended against a number of children in care.

All the children referred to in the case studies have been given pseudonyms to protect their privacy. Any details that could identify the children have also been changed, but only where the Commission considers that it would not affect the reporting of their experiences. For the same reason, some adults related to the children have also been given pseudonyms.

Evidence given during the case studies was not confidential; however, some witnesses applied for non-publication orders pursuant to section 16A of the Royal Commissions Act 1917 (SA). Where an application was granted, the witness has not been identified.
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OVERVIEW

On 15 October 2013 South Australia Police (SAPOL) officers were called to a domestic dispute at a house in the northern suburbs of Adelaide. Officers who attended found the house in a state of utter squalor and there was an overwhelming rotten smell coming from the house. Two adults were present, Ms F and Mr G. Both were under the influence of alcohol and/or drugs. One officer, alarmed by the state of the house, asked Ms F if there were any children living inside. Ms F said that their son was inside sleeping. What confronted the police officer when she entered the house was shocking:

I walked towards the rear of the house and to my left was the kitchen. There was an overpowering smell of rubbish and rotting food. I observed every surface to be covered in rubbish, including the floors, bench tops and sink. I turned right down a corridor and continued to step on and over piles of rubbish. Several times I almost fell due to the depth of the rubbish.

The light in the corridor did not work so I used my torch to be able to see to the end where I observed a door to the left and a door to the right of the corridor facing each other. I further observed several shoeaces and cords tied together from each of the doorknobs holding them firmly shut. I attempted to untie the knots to be able to gain entry into the room on the left where I had been told ... that the child was sleeping ... I had to push on the door ... as it was being blocked by something on the other side.

I saw that the bedroom light was on and it was very bright. I looked around behind the door and saw a small clearing on the floor where there was a small, extremely skinny child, who I know to be James, sitting on the floor holding up a blue plate. I observed the child to be male, very pale, with blonde hair and blue eyes, wearing no clothing or a nappy.

He was sitting on a bare floor with his legs tucked into his side. His bones were visible and he was dishevelled and shaking and shivering. The room was filled with items and the only uncovered floor was where the child was sitting. There were several blue plates on either side of the door.

I also observed ... a brown liquid dried on the floor which I assumed to be faeces ... I advised my partner to look into the room as I took off my jacket and wrapped the child in it, picking him up. The child was cold to touch and was dirty. His eyes were sunken and he was unable to move without trembling.¹

‘James’, the little boy inside that room, was four years old. His parents were Ms F and Mr G. James weighed little more than a toddler and was suffering developmental delay and serious malnutrition. In his four years of life he had been the subject of a number of notifications to Families SA (the Agency). That the family was very vulnerable and likely to experience challenges was known to authorities even before James was born.

Neither of James’s parents had enjoyed the advantages of warm consistent parenting in their own childhoods. Ms F had experienced abuse and neglect as a child and had been let down repeatedly by the child protection system in this state. James’s father, Mr G, had also been deprived of stable and consistent care in his childhood. They were both young and socially isolated. While none of these circumstances excuses Ms F’s and Mr G’s behaviour, they help to explain how the young family came to be living in such dire circumstances, and what barriers existed to greater service involvement to support the young family to care for James safely.

The parents’ horrendous treatment of their son was ultimately the subject of criminal charges, which resulted in each of them being imprisoned. The community’s response to the story was understandable outrage about their conduct, the state in which James had been forced to live, and the failure of the system to intervene. This case study investigates why the system had not intervened earlier, and what changes to the system are necessary to promote the visibility of vulnerable children in the birth to school-age period.

This case study also examines the system’s response to James after he was rescued and placed under the guardianship of the Minister.

EVIDENCE

MS F’S AND MR G’S BACKGROUND

Ms F was the second of three children, the eldest of whom was taken into care at an early age and raised by relatives. Ms F’s mother had suffered longstanding mental health and drug issues. In 1993, before Ms F was three years old, a notification was made to Families SA about the conditions of her care. Less than a year later a second notification was received, with Ms F’s parents unable to care for her because they were detoxifying from drugs. In 1997, when Ms F was seven, Families SA received a report that her father had doused her and her mother with petrol, then attempted suicide by carbon monoxide poisoning. His suicide attempt failed, but he was left with brain damage. The notification was not investigated and Ms F remained in the care of her mother.²

Towards the end of the same year, Ms F’s mother left that relationship, but took up with another man who was also violent and abusive towards her, sometimes in the presence of Ms F. In 2001 an ambulance was called to Ms F’s mother. She was semiconscious due to ingestion of
drugs and alcohol. She was reported to have been in that state for about 12 hours. Ms F and her sister, then aged 11 and 3 respectively, were outside playing. Families SA took no action on this notification. In April 2002 Families SA became aware that Ms F had been present when her mother attempted suicide. Families SA confirmed abuse, but the children were not removed. Instead, a safety plan was created to keep the children safe when Ms F’s mother felt unable to cope. In 2002 three separate reports were made to Families SA notifying that Ms F and her sister were being neglected because of domestic violence, alcohol, or a combination of both.¹

In May 2003, after witnessing some frightening events at their mother’s home, Ms F and her sister refused to return home. Ms F’s mother entered a voluntary custody agreement with Families SA, enabling an alternative placement for the children to be secured. Thereafter both children went back and forth between their mother’s care and alternative care. By February 2004 Ms F was living with Mr and Mrs B, the parents of a school friend. By January 2006, at the age of 15, Ms F had left that placement and was staying with another family.²

In 2008 Ms F’s younger sister discovered her mother’s body after she committed suicide at home. Ms F’s sister had recently been reunified to her mother’s care with the support of Families SA. Ms F’s sister had been prepared for the suicide, her mother having given her a telephone number to call if ever she could not wake her up.³

At the time of her mother’s death, Ms F was living in Victoria, having moved there to live with her older sister. That arrangement proved unsatisfactory. Ms F then moved in with Mr G, soon after meeting him. She was still a teenager and he was 20 years old.⁴

Like Ms F, Mr G experienced challenges during his childhood. Concerns about his mother’s ability to care for him were raised with the Victorian authorities. Mr G’s mother was consistently subjected to domestic violence and repeatedly left and returned to a violent partner. Violence was inflicted against her in the presence of Mr G and at times violence was inflicted upon him. His mother also used alcohol and prescription medication in a way that affected her ability to care for her child.⁵

In 2008 Ms F returned to South Australia with Mr G to attend her mother’s funeral. While in South Australia the couple discovered that Ms F was pregnant. They decided to remain in South Australia and moved into Ms F’s mother’s Housing SA rental property in the northern suburbs. The house was full of boxes and property belonging to her late mother. A blood stain on the carpet marked the location of her mother’s suicide.⁶

**SUPPORT FOR NEW PARENTS**

Ms F was 18 years of age when James was born. James was her first child. Neither Ms F nor Mr G had any family support in South Australia.

Unbeknown to South Australian authorities, James’s father, Mr G, had previously had an infant removed from his care in Victoria. The removal was sparked by concerns about Mr G and his then partner’s capacity to provide safe care. The infant was reported to have received no stimulation, been deprived of affection, and given regular doses of Panadol to keep her asleep. She was kept in a dark house in front of a heater and not taken outdoors. After the infant was removed to alternative care, Mr G had no further contact with her.⁸ Jurisdictional boundaries meant that none of this information reached the attention of child protection authorities in South Australia until after James was taken into care.

James was brought to the attention of Families SA before his birth. In November 2008 Ms F’s circumstances were discussed at a high-risk infant meeting held at the Lyell McEwin Hospital. Ms F’s youth, lack of family support and her difficult background were identified as making her especially vulnerable. The meeting noted that Mr G received a disability support pension, although the nature of the disability was not clear. By the time of the meeting, Ms F had already declined a referral for social work support and a referral to a young mothers’ support group.¹⁰

On 23 March 2009 a notification was received at the Child Abuse Report Line (CARL). Ms F was 34 weeks pregnant and had attended for limited antenatal care. Attempts to contact her for follow-up had not been successful. The notifier was concerned that Ms F had no family support and had not attended for social work support. The notification also contained information extracted from the Families SA database that identified Ms F’s history of abuse and neglect, and her mother’s recent suicide. The information was recorded as a Report on Unborn, and attracted no response from Families SA.¹¹

James was born at the Women’s and Children’s Hospital after Ms F attended in an ambulance. Ms F and Mr G were both observed by hospital staff to have ‘dirt stained skin’, poor hygiene, and an unpleasant odour about them. James was born by emergency caesarean section, the result of a breech presentation which was undiagnosed due to Ms F’s lack of antenatal care.¹²
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While Ms F was in hospital a social worker attempted to refer her for support on discharge. The social worker recommended that visiting midwifery staff check the state of the house, particularly in light of the physical presentation of the parents. Ms F was also referred to the Child and Family Health Service (CaFHS). The referral was accompanied by a consent signed by Ms F for the Universal Contact Visiting Service (a service for every child born in South Australia), together with some additional information which recorded the history of suicide in the family, Ms F’s difficult childhood history and her lack of family support. The referral strongly recommended that Ms F be provided with the Family Home Visiting Service, a two-year, more intensive, home visiting program also provided by CaFHS.1

Ms F discharged herself from hospital earlier than recommended, and against medical advice. She told nursing staff that she could not wait because a friend was giving her a lift home.11 As planned, midwifery staff from the Women’s and Children’s Hospital Domiciliary Care visited Ms F’s home on three separate occasions; however, they were unable to gain access to check on Ms F, James, or the conditions inside the home.12

A few days after discharge, Ms F returned to the hospital accompanied by Mr B, the man who had provided foster care to her when she was a teenager and who had continued to provide some limited support. Mr B had been asked to transport Ms F to hospital because neither she nor Mr G could drive.13 James was weighed and had lost 180 grams from his birth weight. Ms F’s caesarean wound was infected. Mr B told midwives he thought Ms F might have avoided the domiciliary care visits because she was embarrassed about the state of the house. Ms F was readmitted to hospital.14

Midwifery staff noted that Ms F needed intensive assistance to understand how to make up formula for feeding. One note recorded that Ms F would ‘need very sound teaching in basic skills like keeping a room tidy, hanging out clothes etc., proper use of a bin!’15

Before Ms F’s discharge from hospital on the second occasion a social worker again spoke with her. Ms F identified Mr B as being a support to her. The social worker discussed a referral to a support service called Kids N You.16 No referral was ultimately made to the Kids N You program because the service was not available in the area in which Ms F was living.

Families SA received a further notification about James. The information provided built on what was already known from the Report on Unborn notification and stated that Ms F had (probably) avoided the home visits by Domiciliary Care, and that James had lost weight after his discharge from hospital.10

This notification was assessed as a Tier 2 priority because notifications involving infants at risk could not be rated at the lower level of Tier 3. Families SA policies gave weight to the particular vulnerability of infants and prevented them from being relegated to a Tier 3.20 The infants at risk policy required workers to make a visit to hospital to sight the infant, as well as a second visit to the family home to assess the infant in its usual environment. The policy suggested this visit might be made in conjunction with the first Universal Contact Visit.21

Both these policies are sensible and workable but neither was applied in this case. The Tier 2 was allocated to a social worker, Kate Crawford, who worked under the supervision of Katrina Taheny. On 12 May 2009, in response to an enquiry, a social worker from the Women’s and Children’s Hospital told Ms Crawford that Ms F had consented to the following service referrals:

- Domiciliary Care (the service Ms F had previously not engaged with when discharged on the first occasion);
- Kids N You (the parenting program which turned out to be unavailable in Ms F’s area); and
- Universal Contact Visit.

Mr B, Ms F’s former foster parent, was identified by her as an ongoing support.22

On the basis of these actions, Families SA closed the notification using the code FNR – Full Investigation Not Required.

Ms Taheny, the supervisor who authorised the closure of the intake without a full investigation, said that she was obliged to make an assessment about what was the most urgent need at the time.23 It was impossible to respond to all notifications, and an assessment of the most urgent cases had to be made. It is impossible now to determine whether the decision to close this matter was correctly made without considering the competing priorities for that day. The point is that a functioning child protection system should not place workers in a position where a properly assessed Tier 2 notification about a newborn infant cannot be responded to in the way its own policies require.

Ms Taheny was asked about the possibility that Families SA might stay involved long enough to assertively engage Ms F in a voluntary program such as the Universal Contact Visiting scheme. It was suggested that a joint home visit might emphasise to Ms F the importance of engaging with that program. Ms Taheny explained that the FNR code can be used only when some work is done on an intake, but without any contact with the family; that is, a worker can carry out investigations short of making contact in order to satisfy themselves that either no further action is needed or a full investigation is...
required. Policy, and good professional practice, do not permit Families SA to perform a partial investigation that involves making contact with a family.

Ms Taheny said there was a danger associated with Families SA workers becoming involved only for a limited purpose. She was concerned that:

- any dangers to the child might not be identified by a narrow or restricted assessment;
- an approach could introduce an organisational risk because the Agency had purported to do something (that is, an assessment) according to its statutory mandate that had in fact not been done in a holistic or complete manner; and
- the risk to the child might increase from the partial involvement of a statutory agency.

A partial assessment in a family that is socially isolated and fearful of engaging with services might also serve to escalate their fear and exacerbate their isolation.

However, Families SA’s strategy not to launch a full investigation on the basis of service referrals having been made was inappropriate. There were no feedback mechanisms that would have enabled Families SA to monitor engagement and assess whether the identified risk to the infant had reduced. Families SA did not check that the referrals were actioned, or that Ms F engaged with the services in a way that addressed the existing risks to James. A verbal assurance that referrals would be made did nothing to change the nature of the risk, a risk that Families SA policies required be given a high priority and a high degree of observation and assessment. Nor did anyone make it clear to Mr B that reliance was being placed on his involvement with the family to secure the safety of the infant.

Ms F received the Universal Contact Visit service available to all new parents. Ms F told the visiting nurse that she had family support on Mr G’s side. The genogram prepared by the visiting nurse recorded that information failed to consider whether the Wyatt Trust might be able to provide social linkages to support optimal parenting.

At the first home visit, sleeping and feeding issues were discussed. Ms F cancelled the next two scheduled home visits. At the following visit Ms F declined a referral to a CaFHS day service to assist with settling and sleeping routines. She had previously declined a referral to Torrens House, a residential service to assist with the same issues. However, Ms F expressed an interest in a young mothers’ group, and flyers for local services were provided.

The visiting nurse continued to follow up Ms F, but without success. A final letter was sent noting that the service had not been able to make contact, and inviting Ms F to make contact. The extended Family Home Visiting Service had been offered to Ms F but she had declined a referral, saying she did not think it was necessary. CaFHS closed its file while Ms F was still residing at her mother’s former premises. James was six months old.

During James’s first year of life Ms F took him to her local GP on four occasions. He received his two, four, six and 12 month vaccinations. James was weighed and measured at each visit and his growth throughout that period was within normal limits.

**SUPPORT TO MOVE HOUSE**

James next came to the attention of services when he was two years and four months old. Ms F was still living at her mother’s premises in the outer northern suburbs. Housing SA had received numerous complaints from neighbours about the condition of the property’s exterior, and a concern about Ms F’s poor health.

A housing officer completed a home inspection and identified areas in the house which posed a high risk to the property and the people residing within it. The risks included the presence of excessive clutter, such as boxes and rubbish bags. The garage was full of furniture and access to the back door was blocked by flammable materials.

Housing SA was piloting a social work initiative and a referral was made for Ms F to access assistance and support from social worker Grant Whitehorn. Mr Whitehorn conducted a home visit and formed the view that the property was simply unsuitable for Ms F and James. He observed that a large quantity of Ms F’s mother’s goods still occupied space in the house, and the boxes piled high upon one another could be hazardous for James. Mr Whitehorn became aware that Ms F was socially isolated and had no family support with raising James. They discussed local playgroups and a toy library situated nearby. Mr Whitehorn agreed to investigate whether the Wyatt Trust might be able to provide assistance to buy a new washing machine. A number of machines were at the house, but none was in working condition.

Ms F, with the support of Mr Whitehorn, completed an application to transfer to a larger, more suitable home. A referral to the Anglicare Intensive Tenancy Support service was also completed. This service is delivered by Anglicare to people who are homeless or at risk of homelessness because of tenancy issues. The issues identified for Ms F were not only the condition of the property, but also her isolation, and the need for her to develop social linkages to support optimal parenting.
Dorle Heinrich was assigned as Ms F’s support worker. Ms Heinrich’s first visit was planned as a joint visit with Mr Whitehorn. Ms F cancelled arrangements for the visit on both 31 August and 9 September 2011. Mr Whitehorn and Ms Heinrich then attended as arranged at the property on 16 September 2011. No-one appeared to be home. The joint visit finally occurred on 25 October 2011. Ms Heinrich spoke to Ms F about the advantages of permitting Families SA to become involved to enable her to access services. Ms F agreed to accept a referral to the Families SA financial counselling team. It was anticipated that this referral would enable Families SA to cover some costs associated with the move to more suitable housing. During this visit Ms Heinrich discovered that there had not been any hot water at the house for some time due to an unpaid gas bill, which had resulted in the gas supply being cut off. The bathroom smelled. Ms F said that she could not use the bathtub because there were faeces in it. She had previously been using the bathtub for washing clothes, doing dishes and washing James.

Mr Whitehorn made a notification to CARL about the state of the house. He did so because he was concerned about the condition of the property, the physical risk to James associated with the clutter, and the family’s social isolation. The CARL worker who received the notification recorded these concerns, along with Ms F’s child protection history and previous notifications received about James’s safety. However, Mr Whitehorn’s notification was assessed as not meeting Families SA’s criteria of risk and was recorded as a Notifier Only Concern (NOC). This classification required no action on the part of Families SA. Mr Whitehorn was aware that it would be difficult for Families SA to become involved, but hoped that his notification might spark a move to make other services available. He took the view that Ms F needed support with her parenting, but things were not at a stage where James needed to be removed.

Mr Whitehorn ultimately managed to secure the involvement of Families SA through a professional relationship at the local level with Megan Birchmore, a Families SA social worker in the Community Partnerships team. The relationship had developed from attending meetings with key workers from other government agencies working in the same region. Ms Birchmore agreed to open a file to establish eligibility for Ms F to access Families SA’s financial counselling. As the Community Partner focused on assisting Ms F to clean and pack up her mother’s property and financially supporting her to move.

A referral for financial counselling was then made. The file created in C3MS for financial counselling was held in Ms F’s name, those services having an adult focus. The financial counselling team, among other functions, provided a limited financial assistance service where clients were clearly unable to pay certain accounts themselves.

Lisa Nelson, a financial counsellor from Families SA, was allocated Ms F’s case. At the time that Ms Nelson received the referral, financial counselling services had been expanded to include broader support than previously, under the concept of ‘integrated practice’. Ms Nelson’s involvement now extended to conducting home visits and general support.

On 4 November 2011, Ms F accepted an offer made by Housing SA for more suitable housing. The various agencies that were involved then began to focus on assisting Ms F to clean and pack up her mother’s property and financially supporting her to move.

Ms F did not engage well with the Anglicare Intensive Tenancy Support service. Of the eight home visits scheduled, three were cancelled, and one was missed without explanation. Of the four which occurred, Ms Heinrich sighted James on only two occasions. Ms F frequently declined offers of assistance from Ms Heinrich and was defensive about Ms Heinrich coming inside the house.

Notwithstanding the relatively few opportunities she had to observe James, Ms Heinrich made important observations about his physical development. She observed that James was carried most of the time by Ms F. On the few occasions he was not being carried she noticed that he walked on his tiptoes, and did not appear to be able to place his heels to the ground. Ms Heinrich shared her concern that Ms F’s parenting was over-protective and deprived James of the space in which to grow and develop. However Ms Nelson stated in evidence that at no time did she have concerns about Ms F’s capacity to parent James. She agreed that she had noticed him tiptoe walking, but as she had no particular training in child development, she did not appreciate that it might be developmentally significant.

Throughout the course of her involvement Ms Heinrich introduced Ms F to the idea of a referral to Anglicare’s Family Support Program. This program had a different focus to the Intensive Tenancy Support service in the sense that it focused on the family, that is, the needs of the parents and children, rather than immediate housing needs. Ms F agreed to accept a referral. By January 2012, Ms Heinrich’s involvement ceased.
Ms Nelson, the financial counsellor, remained involved. Ms F told Ms Nelson that she did not like seeing doctors or counsellors because they would tell her that she had mental health problems, and she feared this made her similar to her mother. The tenor of the conversation was that she did not like counselling not because she did not need it, but because she feared what counsellors would tell her.  

On 14 November 2011, during her sixth visit, Ms Nelson finally appreciated the significance of the rubbish accumulated at Ms F’s mother’s property. Ms Nelson encouraged and supported Ms F to clean the house and discard some of the property in readiness for a move to her new home. Ms Nelson observed rubbish throughout the house, including soiled nappies and food scraps. She thought the house looked as if the occupants did not use a bin at all. She tried to raise the topic with Ms F, but feared she would offend Ms F or appear judgemental. Ms Nelson accepted that she was inexperienced in dealing with this kind of issue.  

In evidence to the Commission Ms Nelson was asked:

Q: Do you think there was a possibility at this stage that if the state of the new house deteriorated then Ms F wouldn’t engage because of the embarrassment she felt?

A: Certainly.

Q: Did you also think that it was important that Ms F knew that the state of the house at [her mother’s old Housing SA rental] was unacceptable?

A: Yes, I did. I felt, at the end, that the final clean-up probably did not happen. I never really knew. I felt that I’d gotten a really large skip and that it wasn’t going to be used. I had the impression in the end that Housing SA weren’t going to push for her to physically pick that rubbish up and put it in the skip, and I guess I had concern about that because it’s a bit like my children, if you don’t pick up after yourself then you’re going to keep making a mess and I just felt that if it was cleaned up ...

Q: Did you think the state of the house was unacceptable for James to be in?

A: I didn’t feel it was unsafe.

Q: Did you feel it was unhygienic?

A: Yes.

Q: Did you ever tell Ms F that it was unhygienic to have a child in that environment?

A: I don’t recall.

Ms Nelson sensed that Ms F began to disengage when she challenged her about the kind of food that James was being fed. After Ms Nelson raised this topic Ms F cancelled the next scheduled home visit. By the time Ms F had moved into the new house that Housing SA had sourced for her, Ms Nelson was aware of a number of worrying circumstances for James. She knew of Ms F’s history with, and distrust of, Families SA. She held concerns about Ms F’s ongoing capacity to keep her house in a hygienic state. She was aware that Ms F was vulnerable to disengaging with services that she might need because she was embarrassed and felt judged. Ms Nelson knew that Ms F had lived at her previous house with James for almost a year with no hot water because of an unpaid gas bill. She had observed the interactions between Ms F and James and their social isolation. Ms Nelson agreed that the aggregation of those factors might give rise to concerns about which she could have spoken to a social worker. She maintained, however, that a social worker could not act on concerns at that level, as there was no evidence of the child being in immediate danger. She said that perhaps her lack of experience at the time hampered her capacity to bring those concerning factors together.

On 17 February 2012 Ms Nelson spoke with Ms F about gathering James’s immunisation records so that he could go to child care. Ms F told Ms Nelson that she was managing well and did not need any assistance. The Families SA financial counselling file was closed on 19 April 2012. By this time Ms F had moved house, and Families SA had provided her with the necessary financial assistance to make that move successful.

In December 2011, the referral for Anglicare’s Family Support Program had been actioned and Jan Player, a family support worker, was allocated. The referral for the program clearly set out that emotional health, parent–child interaction and social isolation were relevant issues. Ms Player was aware that Ms F’s care history raised a risk that she might struggle with parenting, Ms F not having had a healthy parenting experience herself.

Ms Player was involved with Ms F from 21 December 2011 to 28 March 2012. Over this three-month period Ms Player scheduled 11 home visits. Ms F kept only four of those appointments. On only two of those four occasions did Ms Player sight James. On 25 January 2012, Ms Player visited the home for the first time. In the course of taking preliminary information, Ms F told Ms Player she had been diagnosed with borderline personality disorder and schizophrenia.

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Ms Player’s assistance over the next four appointments did not extend beyond establishing rapport. Although the Family Support Program was a home visiting program, Ms Player never entered any part of the house beyond the lounge room. She did not ask to be shown any other area of the house, notwithstanding that she completed a safety assessment with Ms F’s permission, recording that there were no safety hazards in the house.49 Ms Player maintained that it was not her place to look at the house to get a full view of Ms F’s needs. Nor did she regard it appropriate to ask to see the house, on the basis that at this early stage she was focused on relationship-building with the client.49 At no time did Ms Player challenge Ms F about the pattern of cancelled appointments. Ms Player took the view that the need to establish a relationship precluded her from having difficult conversations that might have revealed issues that bore on James’s safety and welfare.

On 28 March 2012, following two missed appointments, Ms Player attended Ms F’s home. She became concerned that a note that she had left at the time of the last missed visit was still in the letterbox, and the home’s air conditioning was running. She became worried about the safety of Ms F and James and contacted the police to conduct a safety check.71

Police officers knocked on the front door and received no response. They then knocked on doors and windows declaring themselves, but there was still no response. In order to gain entry to the backyard, one officer had to push a pile of boxes and general rubbish aside.71 Police then entered the house via an unlocked back door.

The kitchen benches were completely covered with various types of rubbish, including a large number of empty energy-drink cans. There was no clean bench space for food preparation and debris flowed onto the kitchen floor.71 There was also a strong smell of rotting food.71 One officer headed towards a bedroom which had a closed door. As the officer approached, the door opened and Ms F and Mr G emerged. James was inside the room.71 Ms F expressed a high level of concern about the possibility that the state of the house would be reported to Families SA and she repeatedly asked police not to do so.76

Notwithstanding the state of the house, James appeared happy and healthy. Ms F was told that police would be making a CARL notification, as police regarded the house as unhygienic and unsafe for James.71

Police who made these observations spoke to Ms Player, who was waiting outside. They told her that the house interior was ‘like the house of horrors’, a statement Ms Player interpreted as referring to another house in horrendous condition in the northern suburbs where a large number of children had been removed due to child protection concerns. Police told Ms Player they did not know how a child could be living there.74

As Ms Player had never ventured beyond the lounge room she had no idea about the state of the kitchen/dining area of the house.74

Ms F followed police out of the house. She was upset and challenged Ms Player about why she had contacted the police. Ms Player did not attempt a long explanation. She saw no profit in speaking to Ms F while she was agitated and upset. Ms F was shaking and told Ms Player, ‘Now they’re going to blame my mental illness’. Ms F told Ms Player that she was not welcome back at the house. Apart from trying unsuccessfully to make telephone contact later, Ms Player made no other attempts to speak with Ms F after the incident, or to re-engage at a time when Ms F might be calmer.80

**THE MARCH 2012 NOTIFICATION**

Families SA received a notification from the police about the incident at Ms F’s house, which included details about the conditions in which James was living.

The notification was taken by CARL worker Samantha Cookes.81 Ms Cookes screened in the information as she was satisfied that there was an existing risk to James which met the classification of ‘Inadequate basic care—Shelter’. This category requires the worker to consider whether any of the following conditions (or similar) are present:

`Shelter: The child’s living conditions are hazardous for the child. Certain household conditions are present AND are hazardous for the child. Consider the child’s age in relation to the extent and location of the hazards. Examples include, but are not limited to the following:

- human or animal excrement in the living areas
- excessive rubbish or decaying food that threatens health
- broken windows or stairs
- exposed electrical wiring
- insect or rodent infestations
- accessible weapons, drugs or chemicals etc

Once information has been screened in, the worker uses a response priority assessment tool to determine a tier priority.82 In this situation, the neglect decision tree was used. In general terms, a Tier 1 response is dictated only in circumstances where the information establishes that the living situation is immediately dangerous; the child appears seriously ill, injured or in need of immediate medical or mental health attention; or the child is currently unsupervised.84`
A Tier 2 rating might be achieved if the child is school aged, as the next question focuses on whether the circumstances satisfy inter-agency processes for high-risk children who are chronic school non-attenders. As James was under school age, his vulnerability was not captured by this question. The decision tree then asks whether the child has a chronic illness or condition or a significant injury requiring medical, dental or mental health attention that is not being given. As James was, at that time, apparently healthy, the answer to this question was ‘no’.

The next question requires a high level of interpretation and the exercise of professional judgement. The question asks whether there is a severe condition or pattern of caregiver behaviour that presents a significant risk of serious neglect. If the answer to this question is ‘yes’, the information is rated a Tier 2; if ‘no’, it is rated a Tier 3.

Ms Cookes did not consider that she had sufficient information to be satisfied that a pattern or severe condition existed. She emphasised that the severe condition or pattern of behaviour related to the caregiver, not the condition of the home. Ms Cookes took the view that the previous notification (made by Mr Whitehorn) was insufficiently proximate to establish a pattern.95

Ms Cookes was asked about the potential significance of James’s social isolation, and the significance of his mother’s untreated mental illness. She said she would need more information to determine their significance, and would need to be satisfied that social isolation was having an observable impact on the child’s development.

The notification was rated a Tier 3 on the basis that there was insufficient evidence of a severe condition or pattern of behaviour. The notification was referred to the Modbury office. At that time the office had no capacity to provide any family support or investigatory response to Tier 3 notifications. When student social workers were available, they would send out letters framed in standard terms to families notified in Tier 3 matters.96

Aleesha Ruddell, a student social worker completing one of her professional placements in the Modbury office, was asked to send a letter to Ms F and Mr G. Ms Ruddell contacted the Anglicare worker, Ms Player, to ‘get a bigger picture of what was going on’. According to a C3MS note recorded by Ms Ruddell, and her recollection of the conversation, Ms Player did not offer any information about Ms F’s poor engagement. Ms Ruddell did not think to enquire.97 The note taken by Ms Ruddell recorded that Ms Player:

Spoke positively about her relationship with Ms F saying that their rapport was ‘good’ and Ms F was a lovely girl, considering what she has been through in her life. [Ms Player] said there had never been any problems with Ms F. A concern that [Ms Player] spoke about was when she used to visit ... she never saw James or even heard any noise from him and as [Ms Player] stated this is a concern because James is 2 years old and this is unusual for a toddler not to make any noise. [Ms Player] seems to think that MS F stays up late with James and then they sleep all day.98

Given the reality that Ms F had engaged very poorly with the Anglicare support program this was a dangerous and misleading statement, particularly in light of the risk that someone might later refer to that note. The letter sent by Ms Ruddell invited Ms F and Mr G to make contact with a duty social worker to access services to assist with parenting or manage a difficult situation. There was, unsurprisingly, no response to this letter. Ms Ruddell understood that people generally do not respond to such letters.99 Ms F was especially unlikely to respond in view of the events that had given rise to the notification in the first place.

It is impossible to determine how the adults in James’s household responded to the letter. The mere sending of the letter may of itself have caused a heightened risk to James. It may have confirmed Ms F’s fears that allowing services into her home increased the risk that her child would be removed.

James was now approaching his third birthday. The following notifications had been made to CARL during his short life:

- 23 March 2009, Report on Unborn—no action;
- 6 May 2009 with further information added on 8 May 2009, Tier 2 Infant at Risk—full investigation not required;
- 15 August 2011, Notifier Only Concern—no action; and

To enable James’s circumstances to be comprehensively assessed, Families SA needed to know that Ms F had not engaged with the CaFHS Universal Contact Visit program and had declined referrals to other appropriate services, had not engaged with Anglicare’s Intensive Tenancy Support service delivered by Ms Heinrich, and had not engaged well with Anglicare’s Family Support Program delivered by Ms Player. While none of these failures of itself would provide a basis for statutory intervention, when combined with the information about the state of the house, and James’s potential developmental issues, an inquiring and analytical mind might have better understood and assessed the risk to James. The paradox in the response priority tool, which relied on information being available, was that Ms F was able, through isolating James, to forestall a child protection response because simply not enough was known about his developmental delay or challenges to justify a higher tier rating.
The use of assessment tools also discourages the analysis of information behind the immediate safety concern identified and categorised. In order for James’s circumstances to attract a protective response, the actual household conditions that were identified as a risk to his safety must be the focus of the priority assessment. There is no scope for a practitioner to look beyond the symptom (the state of the house) and ask why Ms F and Mr G were unable to keep the house in a habitable condition and what that underlying cause might mean for their ability to care for James. The system did not equip or prompt anyone to ask, ‘If this family cannot keep the house in a hygienic condition, why do we think they are capable of safely parenting a small child?’ or ‘What is the cause of the family living like this, and what impact might that cause or condition also be having on the child?’. The manner in which information available to Families SA at the end of March 2012 was dealt with was unhelpful. Families SA was left with an impression from Ms Player that the Family Support Program had come to an end after six months of accessing the support service and that there had been no issues. Ms Player was silent about the missed appointments, the lack of achievement of goals and the fact that the program was ending at Ms F’s insistence. Although she did share her concerns that she had sighted James infrequently, this had to be viewed against the background of the rest of the picture that was being painted.

These observations are not to suggest that different information would necessarily have led to a different outcome. Evidence heard by the Commission suggests that in March 2012 Families SA was ill-equipped to provide any response to children where notifications were rated a Tier 3 priority. A gathering of all the available information, and a high-level analysis and assessment of it, might not have revealed circumstances that would have justified an investigative response that took priority over other more urgent matters. The nature of neglect, which accumulates in its pervasive impact on child development, is such that at each point in time there will be an acute problem in each Families SA office that will take priority over addressing chronic and growing risk.

**REFERRAL TO OTHER AGENCIES AND INTER-AGENCY COORDINATION**

Ms F’s social isolation originated in her difficult childhood and her psychological dysfunction. It was exacerbated by a fear that if she allowed others to examine her living conditions James would be removed from her care. She appeared to have a fear that she would be labelled as mentally ill, and that such a diagnosis might have consequences for her continued ability to parent James. The complexity of the circumstances surrounding the family required a commensurate level of skill in service delivery to be effectual.

The Anglicare Family Support Program was ill-equipped to deliver this level of assertive and skilled engagement. Ms F engaged for as long as was convenient and useful to her. She minimised the challenges that faced her and overstated the level of support informally available to her. The high point of her engagement with services was at the time of her move to more suitable housing, when Anglicare, Families SA and Housing SA provided a large investment of time and money in supporting her to clean the house and accomplish the move. Ms F demonstrated a pattern of service disengagement when practical aspects of the support, including financial support, were exhausted.

Ms Player’s involvement with Ms F failed to move beyond initial engagement. Activities during home visits were dictated and shaped entirely by Ms F’s needs, with little focus on James. Ms Player made no assertive attempt to follow up Ms F and have difficult conversations that were necessary after the attendance of the police at the house.

Anglicare was not required as a condition of its funding arrangements to report back to Families SA or any other body about the performance of a client on a program. Even if Families SA had been able to access the records kept by Ms Player, the notes were restricted in their scope to factual observations with no accompanying analysis of the level of engagement or commitment of the client. This approach was in line with an Anglicare policy that case notes recorded factual observations only and that clients be given a copy of all notes. These restrictions inhibit the proper recording and analysis of client progress. They limit the insight available at a later time and the access by other workers who have a legitimate interest to professional records of a program.

By March 2012, when Anglicare withdrew its support, Ms F had been the recipient of services from Housing SA, Anglicare’s Intensive Tenancy Support, Families SA’s financial counselling and Anglicare’s Family Support Program. The fragmentation, lack of coordination and lack of sustainability of the services meant that no single worker had the full picture of what life was like for James. No single worker had the accumulated picture of Ms F’s service avoidance.

At the time that any of these workers was involved, there is no evidence to suggest that the circumstances for James had begun to approach the dire condition in which he was found 18 months later. The lack of information about the circumstances of the family at the time of the final attendance by police makes it impossible to determine whether the statutory hurdles to compulsory assessment and investigation had been cleared. However, what must have been clear was that Ms F was a young mother who was isolated and experiencing difficulties parenting James in a way that would permit him to reach his full potential. Coupled with her personal history and
Dr Terry Donald, the consultant paediatrician who oversaw James’s care during his admission to hospital, attended at the women’s prison and spoke to Ms F about James’s developmental history and challenges. Dr Donald concluded that James’s developmental delays were likely to be primary rather than secondary to his malnutrition. Dr Donald observed in a later report that:

“It is not clear how much of James’s developmental delay was secondary to his isolation and the lack of meeting of his emotional and developmental needs. The undersigned believes that there were manifestations of developmental problems at a time when the level of neglect was much lower than it became before he was admitted to hospital.”

In fact, the undersigned considers that it is possible that many of the challenges with James that Ms F found difficult to manage and did not seek help in managing, were a consequence of his emerging developmental problems. However, the crucial issue in this regard is her lack of apparent attempts to seek advice, when she clearly had a level of understanding of his developmental delays. It is clear that the level of psychosocial adversity within the family, and Ms F’s own poor parenting templates, meant that rather than seeking assistance for the parenting challenges that faced her, Ms F isolated herself from help that may have improved James’s long-term outcomes.

In a report tendered to assist in sentencing Ms F in the District Court, a forensic psychologist noted that:

“Ms F had opportunities to seek assistance for James, but had limited psychological resources with which to seize those opportunities. Her personality functioning was such that she feared abandonment and the loss of the only relationship that had offered her any form of love, safety and stability. She had limited emotional and practical coping and decision-making skills, and was dependent and passive in the relationship. Further, she experienced considerable depressive symptoms including feelings of hopelessness, helplessness and poor motivation and energy.”

THE SERVICE RESPONSE FOLLOWING REMOVAL

The inter-agency response following James’s removal and admission to hospital was a model of action and cooperation. It is to be commended as an example of best practice for all children who are removed from the care of their parents. All parties involved praised the level of cooperation and information sharing that was accomplished at the first strategy discussion, held via telephone on 15 October 2013.
Families SA had the benefit of a thorough police investigation which identified the relevant facts and provided a comprehensive forensic examination of the premises and detailed and skilled interviews of both Ms F and Mr G.\textsuperscript{102} This case study therefore did not require an assessment of the quality and skill of the investigative or assessment process.

Patricia Strachan headed an internal inter-agency review of the circumstances leading to James’s removal. She gave evidence about the nature of the police investigation, and said (responding to a question about the need for service providers to engage more assertively and not be afraid to have direct and difficult conversations):

One of the things that really stood out for me at that first meeting, that first inter-agency meeting, was the intelligence that SAPOL brought to the conversation. I mean, hindsight was wonderful, but, in fact, it was their line of questioning, and … I would like to see that skill replicated in other service providers. Sometimes it is very intimidating to go into a home where there are really difficult circumstances, where partners are really aggressive, and for a young health professional or Families SA worker to feel confident enough to actually ask quite a direct question.

Much of the activity following James’s removal on 15 October 2013 was directed to securing an appropriate long-term foster care placement for him. A therapeutic placement was secured without James being required to endure the rotational care arrangements usually associated with transitional accommodation or emergency care. By 13 November 2013, foster parents Mr and Mrs C, who were trained in delivering therapeutic care to a child with high needs, had been selected.

A great deal of time and energy was invested in providing detailed information about James to management and the Minister. In the early days these updates were daily and later became weekly. The case attracted a degree of attention from the departmental hierarchy and the Minister that was unprecedented, at least for the witnesses involved.\textsuperscript{101}

The intense scrutiny ensured that James was provided with a high level of service. A great deal of attention was focused on realising a good outcome for him. It is commendable that the Department was able to achieve an appropriate and timely result for a child with high level needs. However, the questions posed by the evidence are how this high level of scrutiny was able to produce a result that is denied to a large group of children who have also been the victims of trauma, abuse and neglect\textsuperscript{102}, and how that level of service can be reproduced as a benchmark for all children.

The severity of James’s medical condition meant that he benefited from a lengthy in-patient stay and a comprehensive medical assessment at an early stage in his care journey. His medical and developmental needs were well identified at the time of his discharge and a series of appropriate referrals were made to community health services in the area local to his foster parents. Shelby Nicholson, the social worker primarily responsible for identifying a suitable placement for James, said that she was not encouraged to pursue kinship care options once appropriate foster parents had been found.\textsuperscript{103} It was obvious to the professionals involved in James’s care that his best option was a placement with skilled foster parents willing and able to provide a long-term home. Those involved in his care agreed that James would need stability and what was being put in place was a long-term care arrangement.\textsuperscript{104}

It is easy to see why a skilled long-term placement was the best option for James. Families SA was able to focus on what was best for James and acknowledge that family relationships were best accommodated in ways other than a kinship placement. The decision to select Mr and Mrs C as foster parents was accompanied by a high level of communication to ensure that the family understood James’s high ongoing needs, and that they were equipped to meet those demands.

Once appointed, the transition of James to the care of his foster parents was facilitated through frequent hospital visits and by meetings attended by everyone in the care team. The foster parents were gently introduced to James in hospital and they gradually took over from nursing staff attending to his basic care needs.\textsuperscript{105} Information was freely and directly shared by medical staff who had been caring for James with the family who would care for him on his discharge from hospital. The foster parents received information, particularly about his history of abuse, which was greater than that usually provided to new foster parents. Ms Nicholson told the Commission that it was her practice to freely share information, including a child’s trauma history, with foster parents. However, she would not necessarily share information which related to the parents’ backgrounds and childhoods. Dr Donald regarded it as critical that he be given the opportunity to communicate medical information directly to the foster parents. He thought Families SA had not always been able to convey accurately the level and type of concern that medical staff had for James. His past experience was that it had not been possible to have that level of direct contact with foster parents.\textsuperscript{106}

The best practice that was evident from the placement of James with Mr and Mrs C, and the levels of communication that accompanied it, appears to have been accomplished because James was given a high priority within the organisation. The Placement Services Unit and social workers knew much more about the
foster parents who were proposed, and this enabled them to foresee and plan in a more structured way. Life Without Barriers, the foster care support agency, was able to anticipate and plan for the challenges that the foster family might face, and funded therapeutic support on an ongoing basis, as well as putting in place from the outset respite services that were regular and consistent.

INTERSTATE LIAISON
The most important piece of information that would undoubtedly have made a difference to James’s circumstances at an early stage was Mr G’s conduct towards the infant who had been removed from his care in Victoria. The circumstances, once known, had a chilling resonance in the experience of four-year-old James: it was suspected that the infant received no stimulation, was deprived of affection, was kept in a rocker in front of the heater and given regular doses of Panadol to make her sleep.

A CARL practitioner involved in the assessment of one of the early notifications about James told the Commission that had this information been available to her she might well have concluded that James was at imminent risk, and a child protection response was more likely to have been activated.

At the time that the first notification was received about James (after his birth) Families SA was told that Ms F and Mr G had recently moved back to Adelaide from Ballarat. The practitioner who received that notification did not regard that as sufficient, in the circumstances, to justify seeking a request for information from interstate.

Deciding whether or not interstate information should be sought in relation to a notified family will always be problematic. It is not possible in advance to dictate what would amount to sufficient information for the requisite enquiries to be made. Given the difficulties in making requests for interstate information, it is impractical to suggest that interstate checks should be done for every notification. However, state borders are becoming less significant and populations more mobile. Families with child protection histories wanting to avoid attention in the future may well be motivated to move jurisdictions for a ‘fresh start’. Significant risk factors are likely to be missed if interstate connections are ignored.

OBSERVATIONS
Parents who are reluctant to engage with services, especially parents whose reluctance stems from a fear of having their children removed (because of their own guardianship history), will generally engage with medical services around the time of birth. The period just before, and just after, birth is a critical window of opportunity within which to engage vulnerable parents in programs or services that will be beneficial to them and enable them to develop their parenting skills.

CaFHS SERVICES
At the time James was born, CaFHS offered a limited range of services. A comprehensive service to families with complex issues was not available. Although Ms F’s circumstances meant that she was eligible for the Family Home Visiting service, that program required her consent to participate beyond the Universal Contact Visit. There is no evidence of any assertive attempt to obtain her consent.

However, since James’s birth there have been changes to the way the Universal Contact Visiting program operates. The changes came about with a project called Care Plan Modelling and involve the use of a new contact consent form and priority information form. The priority information form contains more information than was previously available from the birthing hospital and identifies a parent’s particular vulnerabilities.

In training and program scope, the need to assertively engage families with respect to child protection issues now has greater emphasis. The new priority information form includes space for a hospital social worker, if one has been involved, to provide contact details for further follow-up. The program allocates staff on the basis of the complexity and type of issues identified in the forms. It is no longer a matter of allocating the next available member of staff, but rather a clinical process matching resources according to need. The intake and assessment nurse responsible for allocating the new cases may also contact the referring hospital for more information when necessary.

When Ms F disengaged from the Universal Contact Visiting program, there was no assertive follow-up to the standard terms letter she had been sent. CaFHS has now developed a path of escalation where child protection concerns exist within a family who disengages. Those pathways are set out in the CaFHS Decision Making and Escalation Framework. The framework sets out two processes, one to be followed when there are no child protection concerns and the other where such concerns exist. The escalation options include making a CARL notification when appropriate.
These changes, and the increasing focus on postnatal mental health, mean that the visiting service becomes privy to much more information about the family than previously.\textsuperscript{117} This requires clinicians to act upon more complex information and make more use of other referral pathways and services for families, including general practitioners or private mental health services.\textsuperscript{118} The changes to the service promote comprehensive assessments and provide opportunities for multidisciplinary work with families with more complex needs.

CaFHS also delivers a program called Strong Start, which uses a model named Parents Under Pressure that allocates a combination of nursing, allied health and family support workers in accordance with the needs of the particular family.\textsuperscript{119} Referrals to the program are made during the antenatal period, both to provide support during the pregnancy and to build relationships before the baby is born. Referrals to the service are made by the major public birthing hospitals in each region. Referrals, however, depend on a mother attending antenatal services and being referred to the service at that time.

The current range of CaFHS-run programs is under review. CaFHS aims to develop a more seamless response in preference to a number of discrete services. That is, it will not be necessary to identify (to the family at least) the precise program to which a family is allocated, and there will be flexibility in the level of service delivery depending on the family’s need at any particular stage.\textsuperscript{120} The Commission commends the move in this direction.

**HOUSING SA SERVICES**

Housing SA has demonstrated a growing focus on the needs of children of the families that live in their properties. It mandates for all workers an increased focus on sighting children during housing inspections.\textsuperscript{121} All Housing SA staff are being trained in working with children and families in crisis. There is an emphasis on staff being willing to have a conversation with tenants about their children, their whereabouts and their living conditions.\textsuperscript{122}

The change in focus and skill level for Housing SA staff envisages an agency frequently being inside the houses of vulnerable families and having conversations about their particular challenges. These conversations will focus on the part that the residents of the house play more widely in the community, and their responsibility to one another, as well as to the specific premises and the neighbourhood.

The value of Housing SA having these conversations is that it occupies a special position as an agency that provides a benefit to the client. The conversation will occur in the context of the practical and visible advantage of affordable housing, rather than in the context of stigmatising and confronting questions about the adequacy of their care for children.

Staff working in Housing SA are being trained to use a risk identification tool in their everyday practice in assisting clients with their housing needs. Risk factors are categorised as:

- priority risk factors;
- secondary risk factors;
- protective factors; and
- additional factors.

If a priority risk factor is identified a referral is made to a tenancy practitioner, or the Regional Response Team. The staff working in those teams have various skills, but they are led by social workers and have a focus on human and social issues as well as the security of the asset.\textsuperscript{123} Priority risk factors include the following issues with a specific child protection focus:\textsuperscript{124}:

- a member of the household is involved in the family safety framework;
- an intervention order has been issued against or to protect the client;
- a child protection order is in place and the child is under five; Families SA is involved and the child is under five, or there is a child protection issue and the child is under five;
- the condition of the premises presents an immediate risk to the residents, neighbours or visitors; or
- a Youth Court order exists.

If a secondary risk factor is identified then a referral is made to the Regional Response Team. Secondary risk factors that have a specific child protection focus include the following:

- a child protection order is in place and the child is over five, Families SA is involved and the child is over five, or there is a child protection issue and the child is over five;
- domestic violence or Aboriginal family violence has been identified; or
- the condition of the premises presents a risk of harm to the health of residents, neighbours or visitors.

The staff in the Regional Response Team have a case management role. They may take on the role of the lead agency in inter-agency work, or they may work with another agency as the lead. The role is an ongoing one for the life of the management of the risk.\textsuperscript{125}
Tenancy practitioners working with vulnerable families will use a tool known as the Outcomes Star. That tool provides a simple way to identify issues and qualitatively assess progress on those issues.

The Regional Response Team members are using a more complex tool designed to assess and monitor more complex issues. This tool is the Client Assessment and Plan. This tool enables a practitioner to identify and assess risks to children including (but not limited to):

- domestic and family violence;
- social isolation;
- mental health issues;
- substance misuse issues; and
- child protection concerns broadly.

The use of these tools encourages workers to keep the protection of children within the household front of mind.

Changes to Housing SA, and the growth in the quality of information about families that is available to child protection agencies, depend on Housing SA officers passing the right information on, and Families SA both listening to that information and asking the right questions.

CONCLUSION

The study of the service response to James in the first four years of his life highlighted a number of themes which have informed discussions and recommendations throughout this report, but in particular chapters 7, 8 and 10.

Several themes were evident which the Commission regarded as especially important. These are summarised as:

- A regular failure to ‘close the circle’. That is, there was a pervasive practice of referring on, moving on, and failing to follow up or check on progress. This approach meant that follow-up would be undertaken only if there were a re-notification of the child, meaning that the risks had persisted and or the child had suffered harm.
- A prioritisation of relationship-building with the parent as the client over the need to keep the child at the centre of decision making and service provision, and a corresponding reluctance to pursue a conversation that raised difficult issues for fear of the impact such a conversation would have on the adult client’s ‘engagement’.
- An assessment and triage system within Families SA that did not prioritise the risk of cumulative harm, nor attempt any analysis of family circumstances beyond immediate safety concerns.
- The absence of any intensive support program that had the capacity to actively engage Ms F and/or Mr G, and which had strong links back to Families SA for follow-up if required.
- A lack of acknowledgement that persistent failure to engage with services might be a risk factor in itself for a child, especially a child who is under school age.
- Fragmentation of information about a family across different government departments, which undermined the ability to build a comprehensive picture of risk to a child.
- Fragmentation of information about a family across state jurisdictional boundaries that was dangerous, particularly where parents had child protection histories that did not follow them across state boundaries.

Families SA showed itself capable of high quality, child-focused work in the aftermath of James’s removal from his parents’ care. There is reason to believe that the manner in which James’s high needs were accommodated could, with sufficient goodwill and attention, be replicated for other children with a lower profile in the organisation.

It is clear that services delivered by Housing SA and CaFHS have been substantially reformed since those agencies delivered services to James. The evidence suggests that both agencies have moved in a direction that is likely to improve the safety of children engaged with their services.
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4 P Rayment, ‘Psychological report’—Ms F, p. 4; Families SA, CIS records—Ms F, May 2003 – January 2006; Families SA, ‘CYFS case plan’—Ms F.
9 V Profitis (Department of Human Services), email to M Borgas (Families SA), 15 October 2015.
12 Children, Youth and Women’s Health Service (CYWHS), Progress notes—Ms F; internal unpublished document, SA Health, Government of South Australia, date withheld.
13 CYWHS, Progress notes—Ms F; CYWHS, ‘Hospital to home consent’—Ms F, internal unpublished document, date withheld; CYWHS, ‘Additional information form for child and youth health universal contact’—Ms F, internal unpublished document, date withheld.
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22 ibid., p. 16.
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33 Oral evidence: G Whitehorn.
34 Oral evidence: G Whitehorn. Housing SA, Case notes—Ms F, internal unpublished document, 15–19 August 2011. The Wyatt Trust is a charity that provides assistance by way of small grants for individuals to purchase more expensive goods they could otherwise not afford.
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CASE STUDY 1 JAMES—VULNERABLE CHILDREN, BIRTH TO SCHOOL AGE

Oral evidence: J Player; T Sorensen. 30 March 2012.


Families SA, C3MS records—James, internal unpublished document, 14 November 2011.

Oral evidence: J Player.

Oral evidence: K Feeney.

Oral evidence: S Cookes.

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Families SA, C3MS records—James, internal unpublished document, 28 March 2012.


ibid., p. 3.

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Oral evidence: K Feeney.

Oral evidence: A Ruddell.

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Oral evidence: J Player.


South Australia Police (SAPOL) witness statement: Name withheld.

SAPOL witness statement: Name withheld.

SAPOL witness statement: J Castle, pp. 2–4. SAPOL, Record of interview with Mr G, 15 October 2013, p. 29.

Women’s and Children’s Hospital, Discharge summary—James, internal unpublished document, SA Health, 13 November 2013.


Oral evidence: T Donald; S Nicholson; R Willson.

For example, SAPOL witness statements: J Castle; J Davey; D Guezej; P McGowan. SAPOL, Record of Interview with Mr G, 15 October 2013; SAPOL, record of interview with Ms F, 15 October 2013.

Shelby Nicholson gave evidence of being asked to arrange telephone contact and then a home visit between the Minister and James’s foster mother. She and other witnesses said such a thing was unprecedented in their experience.

The evidence of Shelby Nicholson was that a four-year-old child in commercial rotational care was not an unusual scenario. She said it was unusual for a placement to be available so quickly.


Oral evidence: T Donald.

Oral evidence: S Rhodes.

V Profitis (Department of Human Services), email to M Borgas (Families SA), 15 October 2013.

Oral evidence: V Beames.


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Oral evidence: D J Jeffs.

ibid.

Oral evidence: P Strachan.
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NOTES

120 ibid.
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122 ibid.
125 Oral evidence: C Shard.
# CASE STUDY 2
## ABBY—INTERVENING IN HIGH RISK FAMILIES

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### CONCLUSION

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CASE STUDY 2 ABBY—INTERVENING IN HIGH RISK FAMILIES

OVERVIEW

‘Abby’ entered care as a two month old baby. Her mother, Ms B, had a history of child protection concerns, including drug use and exposure to domestic violence. Families SA was warned from the outset that Abby’s need for stability and permanence permitted only a short timeframe in which to pursue reunification with her mother. It was warned to ‘concurrently plan’ for Abby’s return to her mother or for placement with a suitable carer, preferably with identified relatives or other suitable carers in Western Australia.

Abby is an Aboriginal child. Families SA practitioners were obliged to consider how to maintain and strengthen her connection to land, language, community and culture. They were under the specific obligation to consult with a recognised Aboriginal organisation before making decisions about where or with whom she would reside and to observe the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP).

This case study examines how Families SA balanced three considerations in practice:

• supporting Ms B to address her problems to resume the care of Abby;
• meeting Abby’s need for an attachment relationship with a consistent care giver; and
• securing Abby’s right to develop a cultural identity.

The case study identifies the improvements required to ensure that practitioners facing similar practice challenges in the future do not lose sight of the interests of the child in care.

EVIDENCE

EVENTS LEADING TO ABBY’S REMOVAL

Ms B gave birth to her first child, a son, in Western Australia when she was 17 years old. Her son’s father was violent towards her and he was incarcerated soon after the child’s birth. Concerns existed about Ms B’s drug use and her ability to parent her son. She agreed to a shared care arrangement with her son’s paternal grandmother.1

Approximately five years later, in November 2011, Ms B, pregnant with Abby, attended a hospital in Western Australia. She had extensive bruising as a result of domestic violence perpetrated by Abby’s father, Mr J. Mr J was about 13 years older than Ms B, and had a history of domestic violence and illicit drug use. Ms B had been sleeping in a tent on a beach and carrying her belongings around with her. She had no means of contacting family members. She declined help to find refuge accommodation.2

A report was made to the Western Australian Department for Child Protection (DCP). DCP opened a file due to concerns for the unborn child, but was unable to engage meaningfully with Ms B. In late December 2011, Ms B told a DCP caseworker that she had separated from Mr J and had relocated to Adelaide to live with her mother, Ms D. She said she was open to working with support services in South Australia. The DCP closed its case and made an Interstate Child Protection Report to Families SA.3

Ms D was Ms B’s only known family member in South Australia. She was said to suffer from bipolar disorder and had a history of criminal behaviour including illicit drug use. She had been gaoled when Ms B was a young child. Ms B had then been placed under a long-term guardianship order in Western Australia and cared for by a relative.4

In March 2012, Ms B, aged 22, gave birth to Abby at the Flinders Medical Centre. Families SA social worker Carmel Mackie visited Ms B while she was in hospital. Ms B presented well and interacted appropriately with Abby. Ms B said she planned to live with her mother Ms D and that Mr J was returning to Western Australia. Ms B agreed to work with support services and to participate in further assessment once she was discharged. Ms B was in the company of Mr J when she was discharged from hospital. They were reported to be arguing as they left.5

A week later, during an altercation, Mr J damaged a car and cut up Ms B’s clothes. South Australia Police (SAPOL) were contacted and Mr J was charged with an offence. He entered into a bail agreement, with conditions not to contact Ms B, Ms D or Abby.6

The following day, Ms Mackie completed a safety plan with Ms B. The main concerns were domestic violence and Ms B’s engagement with services. Her drug use was not identified as a current concern. At subsequent home visits, Ms B presented as cooperative and willing to work with services.7

On Friday 13 April 2012, Ms B left her mother’s house with Abby, having earlier left Abby in her mother’s care while using drugs. In consultation with the principal social worker and principal Aboriginal consultant, Abby’s removal from Ms B was approved.8

Over the weekend, and before she had been located or the removal effected, Ms B contacted the Crisis Response Unit (now known as Families SA Call Centre) requesting financial assistance to pay for a motel room. The Crisis Response Unit practitioners attended the motel and found Ms B lucid and not under the influence of drugs. Abby appeared well cared for. A supervisor decided that Abby would not be removed.9
Ms B returned to stay with her mother on Monday 16 April 2012. However, Families SA was concerned about the relationship between Ms B and her mother, and they offered Ms B supported accommodation at L House, a staffed residence for young mothers.10

On 24 April 2012, Ms B left Abby with her mother for about 48 hours, during which time Ms B was said to be using drugs and was with an older man. He was known to Families SA as a perpetrator of domestic violence. Two days later Families SA moved Ms B and Abby into L House. Ms B agreed to regular drug screens, and to work with services, attend appointments and have no contact with Mr J.9

The following day Ms B’s drug screen was positive for methylamphetamine and cannabis. On 8 May 2012 she did not attend a prearranged drug screen.12

On 11 May 2012, her drug screen did not detect any drugs, but she had no formula left for Abby and reported that her wallet was missing. Later that evening, she was observed leaving L House with Abby, telling staff she was taking empty suitcases to her mother’s house. She had, in fact, removed all her belongings from her unit. With SAPOL’s assistance, Ms B was located and Abby removed from her care. The following day, Ms B returned to Western Australia where she remained for approximately two weeks.13

THE ASSESSMENT PROCESS

On 21 May 2012, the Minister obtained a custody order for Abby for a period of six weeks to allow for investigation and assessment to inform the future direction of her care.14 This order was later extended for four weeks. Ms B agreed to work with a reunification program so that she could be reunited with Abby and return to Western Australia. Families SA planned that if they could not be reunified, Abby would be cared for by Aboriginal relatives in Western Australia, Ms G and/or Ms H, who would be assessed as suitable carers by DCP.

As part of the assessment process, Families SA psychologist Megan Grigg assessed Ms B’s parenting capacity. She reported that Ms B showed limited insight into the impact of drug use, exposure to domestic violence and transience on her children. Ms B did not believe that she needed to make any changes to regain custody of her children.

While Ms B appeared motivated at the time of the assessment and had made recent improvements, Ms Grigg doubted she could sustain these changes. She questioned Ms B’s ability to regain care of Abby, and to maintain her care in the future without intensive, ongoing support.15 Significantly, Ms Grigg concluded:

Given Abby’s age (in that she will be entering active attachment in approximately five months), it is imperative that a stable caregiving environment be established for her as soon as possible to ensure she is provided with an opportunity to develop attachment relationships with safe, stable and nurturing caregivers ... Ms B will need to improve her parenting capacity and achieve and maintain meaningful change within a six month timeframe if successful reunification is to be achieved. Alternatively, in the event that Ms B does not demonstrate meaningful change within the specified timeframe ... it is crucial that Abby’s long term care is immediately secured to allow for her ‘transfer’ to Western Australia. It is strongly recommended that Families SA concurrently plan for Abby’s return to her mother’s care and the possibility that Abby will require a suitable long-term placement (preferably with her family or a suitable foster parent in Western Australia). This will require Families SA to immediately attempt to identify suitable kinship placements in Western Australia ... returning Abby to Western Australia either in her mother’s care or by transferring her care to Western Australian authorities will allow her to develop and maintain her cultural and familial connections.16

Ms Grigg said that Ms B needed to demonstrate improvements to her parenting capacity, by engaging meaningfully with a reunification service and therapist, obtaining stable accommodation and abstaining from illicit drugs and contact with Mr J. Ms Grigg recommended she be included in planning processes for Abby’s possible reunification with her mother.17

On 3 August 2012, Abby was placed under a 12-month guardianship order.18

A VARIETY OF PLACEMENTS

After her removal from her mother, Abby was initially placed with Anglicare foster parents for one night and with an Aboriginal Family Support Services (AFSS) foster parent for two nights.19

AFSS proposed a placement for Abby in a north-eastern suburb of Adelaide. Ms Mackie declined this placement on the basis that the court would expect Families SA to provide daily contact with her mother, and this was too difficult with Ms B residing in the southern suburbs.

Instead, on 14 May 2012, Abby was placed with an AFSS foster parent in the southern suburbs. The foster parent already had a high number of children in her care and placing Abby with her exceeded the number of children permitted in the placement.20 AFSS advised that the foster parent could only provide emergency care for Abby for seven days. She remained there until the placement broke down on 6 July 2012.
AFSS was unable to offer another placement and Abby returned to the care of the Anglicare foster parents who had initially cared for her, until that placement broke down in early December 2012. On 14 December 2012, aged eight months, Abby entered a placement which was staffed by rotational carers.

In January and April 2013, AFSS offered potential home-based placements for Abby in the north-eastern suburbs. On each occasion, Abby’s new social worker Shae Hoffmann declined the placement because its location would require Abby, a young baby, to travel long distances four times per week for contact. Ms Hoffmann accepted in evidence that perhaps Ms B could have done the travelling, but there was generally a resistance to asking struggling parents to travel to contact. She also described difficulties with asking other offices to provide space for, and to supervise, contact.22

Abby remained in residential care for more than five months. In May 2013, aged about 14 months, Abby was placed with non-Aboriginal Anglicare foster parents, Mr and Mrs K, in the southern suburbs. Abby remained in their care for the next 18 months.

**ENQUIRIES WITH WESTERN AUSTRALIA**

In May 2012, Ms B identified a relative in Western Australia, Ms G, as a possible carer for Abby. Ms Mackie contacted Ms G, who explained she could only offer short-term care, because of her age, but that her daughter, Ms H, could care for Abby on a long-term basis, if required.23

Ms Mackie considered transferring Abby’s case to Western Australia. However, after telephoning someone in the DCP to “sound them out” and consulting with the Crown Solicitor’s Office, Ms Mackie formed the view that it was too difficult to transfer orders and that Western Australia was reluctant to accept them.24

Ms Mackie emailed Mignon Borgas, Families SA’s acting interstate liaison officer, with a generalised enquiry about aspects of the Western Australian court process.24 The email was not a formal request to transfer the case. The first 12-month guardianship order had not been made at the time of this enquiry, so the response from Western Australia’s interstate liaison officer was that there was not yet an order capable of being transferred to Western Australia.

Ms Mackie misunderstood that email response. She concluded that Western Australia had refused to accept the transfer of an order in relation to Abby.25 This error was recorded on the case plan and persisted throughout Families SA’s management of the matter. Apparently on this basis, no-one reconsidered the question even after the 12-month guardianship had been made.26

Ms Mackie declined to escalate this issue to higher levels of management. She did not think it was her role to do so and her supervisor had told her that she did not think it would get them anywhere.27 Ms Mackie also regarded it as significant that Ms B had decided to remain in South Australia.

Ms Mackie also believed that services for Ms B would be better in South Australia. This was based not on any conversation with Western Australian service providers or the DCP, but rather on a conversation with Ms G.28 There would be an obvious benefit to Abby long term if better services could secure the necessary changes to enable Ms B to parent Abby safely. However, there is no evidence of any real analysis of the risks and rewards of not pursuing an interstate transfer.

On 5 June 2012, Ms Mackie consulted with principal Aboriginal consultant Annette Groat. The case note states that Ms Mackie would request the DCP to assess Ms G as a carer. Despite this, Ms Mackie said she did not see it as her role (as an assessment and support worker) to request a carer assessment. It was included in the case plan as a task for the reunification worker, Ms Hoffmann, to whom Abby’s case was transferred in September 2012. Neither Ms Mackie nor Ms Hoffmann initiated any assessment of relatives in Western Australia.29

**THE PLAN FOR REUNIFICATION**

Families SA’s case plan was for Abby to be reunited to Ms B’s care and for them to return to Western Australia to live with or near their relatives, particularly Ms G. Abby’s move to Western Australia would be planned in consultation with the family and the DCP.26 No consideration was given to what would happen if reunification was not possible.

From May to August 2012, Ms B underwent 11 drug screens: eight were clean, two were positive for cannabis and one was positive for methadone. In the same period, she had about 34 scheduled contact visits. She missed one and was late to three or four; on two occasions Abby was very distressed after contact. The remaining contact visits were uneventful and Ms B demonstrated she was able to interact appropriately with Abby.27

A clean drug test in September 2012 and an assertion by Ms B that she no longer took ‘dope or speed’ led to a decision to increase contact from three to four times per week. Ms B also indicated she was willing to engage with a reunification service and financial counselling.25 However, because of a practice not to engage an outside service provider until workers were confident that reunification could be achieved, they did not make a referral to the AFSS reunification service until 4 February 2013.26 This was at the end of the six month window contemplated in the psychological report by Ms Grigg.
In late 2012, Ms B was not abstinent from drugs. In October, she tested positive to amphetamines and, later, benzodiazepines. She missed two drug test appointments. In November, she admitted to having had a relapse. In December, she reportedly attended for contact with her son in Perth under the influence of drugs. In this period, Ms B missed three of about 17 scheduled contact visits with Abby.

In January 2013, Ms B’s behaviour meant that her supported accommodation was at risk. In early March 2013, she was evicted. Thereafter she stayed with friends, on the streets or in a caravan.

Ms B delivered clean drug screening tests on 12 November 2012 and 13 May 2013. Between those dates no screens were done. However, her presentation and behaviour were observed as consistent with her being under the influence of drugs. While Ms B spoke to a Families SA drug and alcohol worker about having relapsed, she was evasive about what drugs she was using. For the most part, she did not attend appointments with the drug and alcohol worker.

Between January and April 2013, Ms B did not attend about eight of 30 scheduled contact visits. When she did attend she was observed to be incoherent, erratic, aggressive towards workers, and spent a lot of time talking on the telephone and texting. Eventually a contact visit had to be stopped because of Ms B’s anger. At a subsequent contact, Ms B shouted at Abby. This behaviour led to contact being reduced.

In February 2013, the drug and alcohol worker suggested Ms B enter a residential rehabilitation program. Over the following months, Ms B vacillated between acknowledging this was her only option to regain care of Abby and contending that she was capable of abstaining from drugs on her own.

**FIRST ULTIMATUM**

On 13 May 2013, Ms Hoffmann told Ms B that she needed to show commitment to her reunification goals (attendance at contact, abstaining from drugs and engaging with her AFSS support worker and drug and alcohol worker) or an application would be made for long-term orders. On 15 May 2013, Ms B travelled to Western Australia. She was due to return to Adelaide by 21 May to have contact with Abby on 22 May and attend an interview at a residential rehabilitation facility on 23 May. On 21 May 2013, Ms Hoffmann telephoned Ms B. Ms B was still in Perth; her speech was slurred and she was difficult to understand, although she denied taking drugs.

On the same day, Ms Hoffmann sent an email to her supervisor Catherine Wood recommending that the reunification assessment tool’s recommendation be overridden. The tool clearly identified that reunification efforts should cease. Instead, Ms Hoffmann proposed to work intensively with Ms B over four to six weeks to decide whether to persist with reunification or to seek a long-term order. She noted that if long-term orders were sought, ‘it would be in Abby’s best interest to source a kinship placement in Western Australia’. In support of overriding the tool, Ms Hoffmann noted that Ms B had demonstrated some positive parenting skills and established a close bond with Abby, including positive interactions during contact. She said that Ms B had demonstrated she could be abstinent from illicit drugs, although this was only recent and she had yet to ‘demonstrate sustained change’. She did not refer to the difficulties encountered during contact or her suspicion that during her telephone conversation that day Ms B had been under the influence of drugs.

Ms B did not return from Western Australia in time for contact, nor for her interview with the rehabilitation program. On 27 May 2013, Ms Hoffmann met with Ms B and explained that her actions showed she was not committed to having Abby back in her care. She gave Ms B four weeks to demonstrate her commitment and to avoid a long-term order. Ms B agreed over this period to attend every contact, engage twice weekly with her AFSS support worker, meet with the drug and alcohol worker weekly, remain drug free and attend an appointment at the residential rehabilitation facility.

Ms B attended one appointment at the rehabilitation facility, but did not otherwise comply with her commitments. Specifically, she continued to use drugs, including cannabis and amphetamines, failed to attend three scheduled contacts and presented drug affected to two others, missed two appointments with her drug and alcohol worker, and engaged so inconsistently with her AFSS support worker that the service questioned the utility of their involvement. She still did not have stable accommodation.

Ms B missed contact on 11 July 2013 and then presented at the office under the influence of methyampetamines. The next day Ms Hoffmann told Ms B that Families SA planned to seek a further short-term guardianship order, based primarily on Ms B’s expressed willingness to enter rehabilitation. However, on 24 July 2013, Ms Hoffmann became aware that Ms B had been removed from the rehabilitation facility’s waiting list as she had failed to telephone them twice weekly as required. Ms B said she was still willing to attend the facility and do what it took to get off the drugs. Families SA did not amend its decision to seek a second 12-month order.
CASE STUDY 2 ABBY—INTERVENING IN HIGH RISK FAMILIES

On 25 July 2013 Ms Hoffmann affirmed an affidavit for the court in support of the 12 month order, annexing a report dated 24 July 2013. The report stated that Families SA expected Ms B to enter the facility in August 2013. Ms Hoffmann could not recall whether she had had a chance to amend the report in light of the new information that Ms B was no longer on the waiting list. She conceded that this was perhaps why court reports should not be left to the last minute.

A second 12-month guardianship order was made on 2 August 2013. Ms B never entered a residential rehabilitation program. There is no evidence that the report to the court dated 24 July 2013 was ever corrected.

ABBY’S CULTURAL NEEDS

At the time of applying for the second 12-month guardianship order, Families SA consulted with AFSS. Leila Plush, a cultural consultant employed by AFSS, provided a report which made a number of recommendations including:

- prepare a genogram to source an appropriate placement as per ATSICPP;
- encourage and educate Abby’s carers to support the development of her cultural identity;
- develop a detailed cultural maintenance plan to meet Abby’s cultural needs; and
- develop a detailed contact plan to ensure significant contact with family and extended family to develop ‘strong positive relationships that are beneficial for her emotional and psychological wellbeing’.

Contrary to this advice, Ms Hoffmann took the view that supporting Abby’s foster carer, Mrs K, to teach Abby about her culture would be ‘tokenistic’. She considered that Abby was receiving cultural input from her mother at contact visits and that preparing a cultural maintenance plan to address the issue more formally also ran the risk of being ‘tokenistic’. In fact, there appears to have been no effort to address any of Ms Plush’s recommendations. Instead, attention continued to be focused on Ms B’s needs, with little regard to planning for Abby’s long-term care and wellbeing. No contact plan of any kind was put into place which would have given Abby the chance to become familiar with her wider family circle, in case she were to transfer ultimately into their care.

SECOND ULTIMATUM

In August 2013, Families SA told Ms B that she was ‘running out of time’ and had three months to demonstrate that she could abstain from drugs and show stability in parenting, or a long-term order would be considered. Over the following three months, Ms B tested positive for cannabis on three occasions, missed seven scheduled contact visits and attended one contact visit under the influence of drugs. On 1 November 2013, Ms B arrived 20 minutes late for contact and was again warned that Abby could no longer wait for her to get her life in order. The reunification assessment tool completed in September and October recommended that Families SA cease reunification and pursue an alternative long-term, stable living arrangement for Abby. These recommendations were consistently overridden.

On 8 November 2013, Ms Hoffmann told Mr and Mrs K’s support worker that Families SA would look to apply for a long-term order and that she expected this would take up to three months. In November, Ms B did not attend any contact visits with Abby and tested positive for methamphetamines and cannabis. No application for long-term orders was made.

In December 2013, as a result of Redesign (which rearranged work management from Families SA local offices to specialist hubs), Abby’s case was transferred to the Families SA Aberfoyle Park office. Jemma Andrew took over from Ms Hoffmann, but only for a short time, before she also moved to a different office. Ilona Merckenshlager was then the caseworker for a few months, followed by Wendy Wallis, the team’s senior practitioner.

FIRST REUNIFICATION ATTEMPT

Abby had settled into her placement with Mr and Mrs K and formed an attachment with Mrs K. The Ks were keen to be considered as long-term carers if reunification was unsuccessful. Ms Hoffmann had encouraged them by suggesting that Ms B might agree to Abby staying with them long term.

On 10 December 2013, Ms B moved into supported accommodation at O Lodge and remained there until late June 2014. However, she spent a third of her nights away from O Lodge and for extended periods did not participate in her case plan, engage in financial counselling or pay her rent. She was aggressive at times while Abby was in her care (though not at Abby) and was suspected on numerous occasions of using drugs.

By late January 2014, Abby was being transported to O Lodge once a week for three hours of contact with Ms B. They also had frequent contact at the Families SA office. Ms B missed contact on four occasions from January to March.

In April 2014, Mr and Mrs K advised Families SA that they wanted to travel interstate for two weeks and were willing to take Abby with them. Families SA were concerned that this would disrupt the reunification plan. A decision was made, in consultation with Tammy Brooks, a principal Aboriginal consultant who assisted while Ms Groat was unavailable, to bring forward
reunification with a view to transferring Abby back to Ms B full time when her foster family went on holidays. The plan was to start two overnight contact visits per week for two weeks, followed by full reunification. No consideration appeared to be given to the fact that if reunification failed, Abby’s foster family would be away on holidays and not available to her.

The reunification attempt failed. After an uneventful first night, Ms B’s new partner, Mr S, attended O Lodge. An altercation occurred, SAPOL attended and Ms B left Abby with O Lodge staff while she argued with Mr S. The following morning, staff found drug paraphernalia belonging to Mr S. Ms B displayed anger, and was careless, towards Abby. Abby cried inconsolably on the journey back to her foster parents and did not stop until she was with Mrs K. Abby’s behaviour was volatile for a couple of days, alternating between physical aggression and wanting to be constantly held.

Families SA persisted with a further overnight contact. On 7 April 2014, Ms Merckenschlager delivered Abby to O Lodge at about 4.00pm. Ms B was asleep and had to be woken. Ms B said she could not do so. Staff at L House agreed to allow Ms B to return until late Sunday night, when she appeared to have time to get dressed. O Lodge staff encouraged Ms Merckenschlager to follow up drug testing Ms B as a priority. Despite this, Ms Merckenschlager left Abby in Ms B’s care and contacted O Lodge staff after about an hour to obtain an update. Ms B was reportedly ‘okay’ and making Abby dinner. The next day, Ms B tested positive for cannabis and methylenedtetrahydrocannabinol.

THIRD ULTIMATUM

On 10 April 2014, Ms Wallis and Ms Wood met with Ms B and Mr S. They discussed the positive drug test and the relationship between the two of them. Families SA decided to stop any attempt at reunification including overnight contact. Ms B was told she needed to demonstrate change in the coming month as Families SA would be making a decision about applying for long-term orders. The following day, Ms Wallis transported Abby to O Lodge for further contact. Again, Ms B had to be woken. Ms B failed to clean or change Abby’s clothes during contact, despite Abby having vomited on them during the trip.

In early May 2014, Families SA asked DCP in Western Australia for help to scope possible relative carers for Abby. The DCP could not assist, but suggested Families SA seek assistance from a non-government organisation.

Ms B’s drug use and failure to attend appointments continued. Her engagement with a counsellor was short lived, ending in mid-May. She tested positive for cannabis twice in the second half of April and did not attend drug tests in May and June. She missed two contact visits in May 2014 and was not present at O Lodge once when Abby arrived for contact. On another occasion, Ms B requested Abby be collected half an hour early as she had a sore back. When the worker arrived, at the original time not early as requested, Ms B yelled at her to pick up the ‘fucking child’.

On 21 May 2014, Mrs K provided detailed feedback to Ms Wallis and Ms Merckenschlager on Abby’s response to contact, including that her behaviour after contact was the worst she had observed: within ten minutes of returning, Abby began to scream, throw tantrums and scratch those around her. At times, she remained unsettled for long periods. For a number of weeks, she had become concerned about falling when lying on the change table and was saying that she wanted to stay with Mrs K in the lead up to contact. This information did not alter the contact regime.

In late June 2014, after residing at O Lodge for about six months, Ms B was told she had to leave.

SECOND REUNIFICATION ATTEMPT

None of this curbed Families SA’s enthusiasm for reunification. On 1 July 2014, Ms B returned to L House and signed an agreement to not allow Mr S into the premises. As Ms B’s housing issues appeared to have resolved, Families SA decided that full reunification could proceed over the next six months. However, her relatives in Western Australia would also need to be assessed, either to support Ms B and Abby when they returned to Western Australia, or to care for Abby should the need arise. Ms Wallis completed a referral for a Family Care Meeting on the basis that Families SA would seek a further six month guardianship order.

Two days later, on 3 July 2014, staff at L House advised Ms Wallis that they were going to ask Ms B to leave. In breach of her agreement, Ms B had allowed Mr S into the premises and he stayed overnight. Ms Wallis advocated for her to remain, indicating if her accommodation broke down, it would end any reunification attempt. When reminded of her decision several months earlier to end her relationship with Mr S, Ms B said she had tried, but could not do so. Staff at L House agreed to allow Ms B to continue to reside there. Contact and reunification attempts continued.

On Friday 4 July 2014, Ms B had supervised contact with Abby. Later that evening, she left L House, failing to return until late Sunday night, when she appeared to be under the influence of drugs. Ms B admitted she had relapsed over the weekend, and she tested positive for cannabis and methylenedtetrahydrocannabinol. Ms B could no longer reside at L House, and Families SA finally decided to cease reunification.
CASE STUDY 2 ABBY—INTERVENING IN HIGH RISK FAMILIES

After consulting with principal Aboriginal consultant, Ms Groat, Ms Wallis decided that Abby needed a strong relationship with a family carer in Western Australia as soon as possible. She sought an assessment by a Families SA psychologist (not Ms Grigg), which was not done because the psychologist could not complete it in time for the court hearing for the long-term order.46

DECISION TO SEEK A LONG-TERM ORDER

On 9 July 2014, Ms Wallis told Ms B that reunification would cease and Families SA would seek a long-term order. Ms B identified Ms G as a possible, though not her preferred, carer for Abby. Ms G confirmed she was still willing to care for Abby with the support of her daughter, Ms H. She agreed to come to Adelaide with Ms H to attend the Family Care Meeting on 30 July 2014.77

Mrs K brought Abby to meet Ms G and Ms H at a playground while they were in Adelaide. No-one had told Mrs K that they were potential long-term carers. She realised that was the case from a comment made during the meeting. The meeting lasted no more than 45 minutes. The following day, Ms G and Ms H spent about 50 minutes with Abby during her contact with Ms B.78

CULTURAL CONSULTATION

The application for a long-term order was first heard on 1 August 2014, Ms B did not attend and the matter was adjourned. On 7 August 2014, Mr and Mrs K emailed Ms Wallis and her supervisor Ms Wood setting out their wish to be considered as long-term carers for Abby, noting Abby’s attachment to their family and their willingness to do whatever was required to maintain Abby’s connection to culture. They wanted Ms B to know their commitment before she decided on her daughter’s future.79

In an email to the Ks on 8 August 2014, Ms Wallis commented:

As you realise long term placement principles and practices for children, especially Aboriginal children, are set out in clear agreed documents which we all have to follow along with PAC and AFSS consultations.80 [Emphasis added]

On 8 August 2014, AFSS Cultural Consultant, Ms Plush, prepared a Cultural Consultation Report, as required by section 5(1) of the Children’s Protection Act 1993 (SA). She discussed the report with AFSS Manager, Anne Nicolaou. While Ms Plush supported the long-term order, she did not support the plan to move Abby from her placement, because it was contrary to Abby’s best interests to disturb her attachment relationship with Mrs K. She recommended that Abby remain with the Ks, with her connection to family and culture strengthened with other strategies.81

Surprised at this view, Ms Wallis spoke with Ms Nicolaou. Ms Nicolaou supported Ms Plush’s position and gave no undertaking that AFSS would review its position. Despite this, the Cultural Consultation Report was filed in Court on 11 August 2014, with an addendum report from Ms Wood stating that AFSS had agreed to review its position on the placement and case plan for the child by about 13 August 2014.82

Ms Wood told the Commission that she included this information in the addendum report on the basis of advice given to her by Ms Wallis. Ms Wallis did not recall any undertaking being made by Ms Nicolaou or Ms Plush to review the report.83

On 11 August 2014, Ms B consented to a long-term order, on the understanding that Abby would be placed with Ms G. On this basis a long-term guardianship order was made. AFSS did not review its position (subsequent to the order being made) and had never intended to do so.

THE TRANSITION PROCESS

After the long-term order was made, Abby had less frequent contact with Ms B. On 25 September 2014, persistent concerns with Abby’s distress at separating from Mrs K at the start of contact came to a head. Abby’s distress led to Ms B becoming upset and Ms B wanted Abby to return home with Mrs K. Ms Wallis and her supervisor, Ms Wood, decided Mrs K would no longer transport Abby to contact or be involved in the plan to transition to Ms G and Ms H, other than a ‘meet and greet’ visit. Ms Wallis considered that Mrs K should not be involved in any direct transfers of Abby to her new carers, on the basis that Mrs K had previously shown reluctance and over-involvement when transferring Abby to Ms B, causing Abby to become upset.84

Relationships within Abby’s care team became strained. On 26 September, foster care supporter of carers, Amber Elliott, recommended to Ms Wallis that Abby should be psychologically assessed. Ms Wallis refused, allowing only the possibility of a psychologist working with Abby during the transition, if required. Ms Wallis refused to accept Ms Elliott’s suggestion that Anglicare’s Aboriginal consultant could help ensure Abby’s cultural needs were being met in her current placement. Ms Wallis explained that if Ms G and Ms H were approved as carers, Families SA would seek to transition Abby to reside in Western Australia. The process was dependent on Abby’s response, but Ms Wallis thought that at that time it would occur over a minimum of two weeks.85

On 23 and 24 October 2014, Ms Wallis travelled to Perth to assess Ms G and her husband. The assessment form recorded no significant concerns. With respect to Abby’s views and needs, the form noted that while Abby did not know Ms G, their relationship would be established during a transition period and Ms G was aware it might
be helpful to maintain contact with Mrs K to support Abby during the transition and afterwards. Ms Wallis recommended that Ms G and her husband be approved as ongoing carers for Abby.36

On 30 October 2014, there was a case consultation between Ms Wood, Ms Wallis, psychologist Rachelle Smith and principal social worker Brenton Carr. Ms Wood supported the plan to transition Abby from her current placement to her Aboriginal family in Western Australia. Ms Wood and Ms Wallis expressed concern that Abby had ‘an attachment disorder (possibly insecure)’—a conclusion not based on any psychological opinion or assessment—and that ‘Abby’s behaviour has never been a concern in contact with the mother but has been an ongoing concern for Mrs K’.37

Following the case consultation, Ms Wallis met with psychologist Ms Smith to discuss a transition plan for Abby. They agreed that the transition should happen as soon as possible, given Abby’s age and that it should be preceded by38:

- an exchange of photographs of people, the home and pets;
- video calls between the Abby and her new carers; and
- Abby being told she would go to live with her new carers and given time to digest this information.

On the same day as the case consultation, Ms Wallis told Mrs K that Abby’s relatives had been approved as her long-term carers and proposed a transition in November. Mrs K agreed to share information on Abby’s daily routines, and her challenging behaviours and strategies for dealing with them. Ms Wallis again refused Mrs K permission to transport Abby during the transition on the basis that it would not be good for Abby. Mrs K asked for a longer transition period than one week and the basis that it would not be good for Abby. Mrs K asked for the transition to be ‘long’. Ms Wallis emphasised to Ms Wallis:

> Abby needs someone she knows well at visits with her, preferably her attachment figure/s, because her new carers are still largely unfamiliar people to her. She also needs us to work from her pace and build up gradually. Ideally, current and new carers should work together in a highly cooperative way that enables Abby to form familiarity and a growing bond with her new carers while she can still hold onto the relationships that have held her (her current carers). Abby should receive the message that her current carers and significant people in her life trust her new carers to meet her needs and are safe people to be around.39

She also identified the need to track Abby through the transition process through observations and by asking those involved in the transition how Abby was responding, and to reassess and alter the plan, if required.40

On 10 November 2014, psychologist Ms Smith emphasised to Ms Wallis:

> Abby needs someone she knows well at visits with her, preferably her attachment figure/s, because her new carers are still largely unfamiliar people to her. She also needs us to work from her pace and build up gradually. Ideally, current and new carers should work together in a highly cooperative way that enables Abby to form familiarity and a growing bond with her new carers while she can still hold onto the relationships that have held her (her current carers). Abby should receive the message that her current carers and significant people in her life trust her new carers to meet her needs and are safe people to be around.40

On 12 November 2014, Ms Wallis attended at Mr and Mrs K’s home to show Abby a book of photographs of her relatives from Western Australia, along with photographs of their home and their pet dogs. Ms Wallis noted that Abby initially ‘whimpered’ on seeing her and ‘went to Mrs K for a cuddle’. Ms Elliott, who was also present, assessed Abby as somewhat more distressed than that. Abby only partly recognised her family in the photographs. After showing Abby the book and talking about who and what was shown in the photographs, Ms Wallis assessed that Abby was not ready to be told that she was moving and asked Mrs K to go through the book with Abby ‘each day in a fun way’. Mrs K agreed to do so and to receive telephone calls from Ms G afterwards.41

Mrs K asked for the transition to be ‘long’. Ms Wallis responded that the new carer had responsibilities to care for other children, but would stay ‘as long as she can’.42 On 13 November 2014, Ms Wallis telephoned Ms G to recommend that she start telephone calls with Abby and to say that Abby did not know yet that she was coming to live with them as she needed time to get to know her first.43

On 18 November 2014, Ms Wallis contacted Ms G who confirmed that she could fly to South Australia with Ms H on Tuesday 25 November. However, Ms H had to return to Western Australia on Monday 1 December and Ms G could not say whether she would need to return at the same time or whether she could stay longer. This depended on her husband getting leave from work. Ms G had not yet telephoned Abby, but would try to do so later that day. When Ms Wallis telephoned Ms G the following day, Ms G explained that she had been sick and had not yet called Abby, but would try to do that day.44

On 9 November 2014, Ms Wallis sought approval for Abby to travel to Western Australia to live with her relatives long-term. She reported that initial stages of the transition plan had been implemented, including an exchange of photographs, telephone calls and Abby being told she would live with her birth family. In fact, none of these steps had yet occurred. The application was approved with a handwritten endorsement on the memorandum ‘Excellent Outcome!’45
On 20 November 2014, Ms Smith and Ms Wallis telephoned Mrs K to discuss the transition plan. Mrs K wanted to prioritise Abby’s needs during the transition by being part of the visits and transports. It was agreed that Mrs K would participate, as requested. Mrs K expressed the view that the transition was very short but that, while she did not agree with the plan, she would work with it. She agreed to tell Abby that she needed to live with her relatives after Abby met them and to reassure her that she supported the plan and would not lose contact with her.27

Ms G and Ms H arrived in Adelaide on 25 November 2014 and the transition began the next day. Six days later, on 1 December 2014, Ms G and Ms H returned with Abby to Western Australia. The transition proceeded as follows.

On 26 November 2014, Ms Wallis took Ms G and Ms H to spend about an hour and a half with Abby at Mr and Mrs K’s home. Ms Wallis did not remain during the whole period. However, she noted that Mrs K and Ms G were ‘talking happily about maintaining contact’ and that Abby was happy in Ms G and Ms H’s company. That evening, Mr and Mrs K told Abby that she would be leaving them to live with Ms G and Ms H. Mrs K was not sure that Abby understood.28

On 27 November 2014, Ms G and Ms H observed contact between Abby and Ms B before spending time with Abby having lunch, at the beach and a playground, without Ms B present, but observed by a support worker. They interacted positively.29

On 28 November 2014, Mrs K transported Abby to spend time with Ms G and Ms H. Ms G and Ms H returned to Mr and Mrs K’s house with Abby and had dinner with them. The events of this day were not observed by Families SA. Ms Wallis telephoned Ms G who reported that the day had been good, with Abby separating from Mrs K that morning without any problem and not asking for her. Ms Wallis recorded that Ms G was sounding happier and more confident as she built her relationship with Abby. Ms G later reported concern that Abby’s mood changed when the Ks arrived, appearing angry towards the K family and acting out. Ms Wallis and Ms G reflected that Abby could be ‘showing them her displeasure about the planned move’. However, this was not noted in the case file until 1 December, the day Abby returned to Western Australia.30

The events on Saturday 29 November and Sunday 30 November also were not observed by Families SA. On Monday 1 December 2014, Ms G reported that Mrs K was three hours late transporting Abby and her belongings to them on the Saturday. Mrs K and her sister remained with Abby for about half an hour. Abby settled herself and presented as ‘OK and not distressed’ when Mrs K left.

Abby asked if she was going home to sleep and was told that she would be sleeping with Ms G and Ms H. She then slept through the night.

On the Sunday, the K family met with Ms G, Ms H and Abby to say goodbye. Ms G reported that Abby was fine in the morning, but changed after the Ks arrived and appeared a different child: angry, lashing out at the Ks and quite difficult to manage. Abby settled after the Ks left and slept well on Sunday night.31

When Ms Wallis arrived on 1 December 2014 to collect Ms G, Ms H and Abby to transport them to the airport, Ms B was present. Ms G said Ms B knew they were staying in Glenelg and had been ‘scouring’ the area to spot them. Ms B left after the car was packed and then met them at the airport. Ms Wallis remained with Ms G, Ms H and Abby at the airport until they checked in for their flight. At 1pm on Monday 1 December 2014, about 18 months after entering the Ks’ care, Abby left South Australia with Ms G and Ms H. Ms B returned to Western Australia on the same flight. That evening Ms G sent a message to Ms Wallis to advise that the flight went really well and that Abby was settling in very well.32

On the evening of 27 November 2014, Mrs K emailed Ms Wallis to express concern about Abby’s reaction to the transition process:

I broached the topic of going to live with Nan and Auntie Ms H and she immediately responded with ‘No, I stay Mummy K!’ and began to cry at which I dropped the subject and comforted her. When I asked her about [contact], what she did and how it was, the first thing she said was, ‘I hit Auntie Ms H’, and looked quite sheepish.

After some reflection on your observations of Abby at [contact] today running up and hugging Ms B and then Ms H, I find it concerning more than heartening that she reacted to Ms H the way she did. What two year old child runs up and hugs a person she only effectively met the day before, a stranger? It is somewhat comforting to see they are making a connection, but Ms H files out to work on Tuesday, the very day after Abby arrives at her new home, and will also be coming and going for work.33

I must express to you my concern that this transition plan is appalling in expectation and length and in my opinion is not child-centred. I know you have been in consultation with professionals and I have heard all the reasoning but that doesn’t mean that I, as the person that knows Abby best, think the Department is doing what is best for her within this plan.34
On 2 December 2014, Mrs K spoke with Abby on the telephone. Abby asked Mrs K when she was coming to pick her up. It appeared that she was very upset during and after the telephone call. Ms Wallis later advised Ms G that she could decide whether to accept further telephone contact. Initially, Ms G did not want further telephone contact for one month and Ms Wallis duly suspended telephone contact for one month. After the month, Ms G still did not accept any further telephone calls from Mrs K.104

About a week after Abby left South Australia, Ms Wallis went on leave before retiring.105

OBSERVATIONS

A SHORT TIMEFRAME

Psychologist Megan Grigg specifically warned at the outset that Abby’s attachment needs would need to be prioritised from about the age of nine months, leaving a window of only six months for reunification. She ‘strongly recommended’ that concurrent planning begin to identify a suitable kinship or foster placement in Western Australia.106

Families SA’s policies also emphasise the importance of prioritising attachment needs, particularly in young children:

Research and practice evidence clearly shows that continuity of attachment ties is essential to the overall healthy development of a child, and that when children and young people are separated from their birth families stable foundations must be re-established as soon as possible with their birth family or, where this is not possible, with an alternative long-term family. When children who have been abused subsequently experience disrupted or unstable care arrangements and the associated attachment and grief difficulties, harm can be compounded and their life potential can become significantly limited.

... 

Timely decision making is particularly important for young children, as the very early years of a child’s life have been identified as the most critical period for both brain development and the development of attachment relationships. After the preschool years, attachment patterns are much more stable and difficult to change.

Expert opinion is that for younger children in particular, a decision about reunification should not take longer than six to twelve months.107

This urgency is reinforced by Families SA’s evidence-based reunification assessment tool that reunification workers are expected to complete every six weeks. The tool recommends for infants who enter care before their first birthday that if the risk remains high after six months in care (or six of the last nine months in care), reunification efforts should cease.108 This reflects the developmental dangers of prolonged short-term arrangements for an infant.

POOR CASE PLANNING

This guidance did not translate into Abby’s case plan or her ongoing case management. In August 2012, Ms Mackie prepared Abby’s case plan in accordance with a pro forma that is no longer used by Families SA. It was a convoluted, repetitive document that did not grasp the critical timing issues with any clarity. The overall plan was for ‘Ms B to be reunified with Abby and then for them both to go and live with or near relatives (Ms G in particular) in Perth, Western Australia for support’.109 The plan noted that ‘Abby is a vulnerable infant who needs a secure primary attachment figure, and stability and consistency in her contact with family’.110 However, it did not set out clearly that this secure primary attachment figure needed to be involved in her life for the long term.

The plan did not grapple with the urgency of Ms Grigg’s warning that Abby could wait only six months for long-term arrangements to be made, nor did it reflect her recommendation that concurrent planning occur. While the case plan recorded the need ‘to prioritise Abby’s attachment need when making decisions regarding her family contact and placement’ and ‘to consult with the Families SA psychologist in regard to Abby’s attachment needs’,111 there is no evidence that these things happened.

In September 2012, after the case transferred to the reunification team, Families SA prepared a Family and Safety-Centred Assessment and Planning Framework, which also did not record the urgency of Abby’s attachment timeframes and the ongoing need for concurrent planning.112 Rather, it appears to have been assumed that Abby’s wellbeing was secured as soon as she was removed from the unsafe situation and placed in alternative care, with no consideration of the ongoing impact on Abby of being in a temporary placement.

The reunification assessment tool helps practitioners weigh the child’s need for permanence and stability against the promise of reunification. A principal social worker must authorise the overriding of the tool’s recommendation.113 In Abby’s case, the tool was repeatedly overridden.
Ms Wood told the Commission that she could not recall an occasion when it had been possible to achieve reunification within six months.\(^{121}\) This suggests that overriding the tool is common Families SA practice, which ignores the emphasis it gives to the infant’s stability and attachment needs. No serious consideration appears to have been given in Abby’s case to the impact overriding the tool would have on her.

The Families SA Care Planning Policy required that:

*Case planning needs to be characterised by open and respectful communication and a process that involves the child or young person (as appropriate), the birth family, carer, professionals and other relevant parties in all elements. The process must clearly articulate the expectations of parents and the changes required before the children can be returned to their care.*\(^{122}\)

The documents in the case file did not clearly identify the changes that would be necessary for Abby to be safely returned to Ms B. The lack of clearly identified goals at the outset meant that, as the matter proceeded, decision making was reactive and crisis driven. Management of the case lacked focus, and the consequences of a failure to make identified and measurable changes were not set out.

**EXCESSIVE OPTIMISM**

Assessments by Families SA in this case were betrayed by excessive optimism about Ms B’s potential to overcome multiple, entrenched, complex problems. The case was allowed to drift without timely decision making to give Abby the stability and permanence she needed.

Families SA practitioners gave Ms B a succession of ultimatums, each giving way to the next without apparent consequence. Threats of long-term orders if Ms B did not change proved hollow time and time again.

Ms Grigg recommended in her report that she be involved in consultations on possible reunification.\(^{123}\) Abby’s case plan stated the Families SA psychologist would be consulted on her attachment needs.\(^{124}\) There is no evidence that this occurred. Ms Grigg told the Commission that, if she had been asked, she would most likely have advised against a second 12-month order. Given the prolonged uncertainty and the trauma of separating Abby from a foster parent who would become her psychological parent, Ms Grigg would have wanted ‘really good signs that mum was almost ... there’ to consider a second 12-month order.\(^{125}\) On any view, Ms B was not ‘almost there’.

There was nothing to prevent Families SA returning to court before the second 12-month order expired to seek a long-term order. Perhaps with this in mind, Families SA gave Ms B a further ultimatum in August 2013 to demonstrate commitment over three months to avoid a long-term order. Ms B continued to take drugs; she missed contact or attended contact under the influence. The reunification assessment tool continued to recommend stopping reunification. In November 2013, Families SA told Mr and Mrs K’s support worker that it would seek a long-term order;\(^{126}\) but no application followed, perhaps due to a loss of focus when the case transferred offices as part of the Redesign process.

The rushed attempt at reunification, in April 2014, was based not on a thorough assessment of Ms B’s readiness for the next step, but on convenience and the needs of the adults in the situation. The summary given to the principal Aboriginal consultant included:\(^{127}\)

- the 2012 psychological assessment recommended reunification;
- Ms B had clear drug screens since December 2013; and
- Ms B was engaged with a Nunkunwarrin Yunti counsellor and seeking assessment for mental health.

Each point was misleading. The psychological assessment had recommended reunification be pursued for six months only. Ms B had not had positive drug screens since November 2013, but she missed scheduled drug screens in February which Families SA would usually treat as positive results.\(^{128}\) Between August 2013 and March 2014, Ms B attended only two sessions with Nunkunwarrin Yunti. She had agreed to meet a new counsellor in April 2014; she had not yet done so. Nunkunwarrin Yunti reported in July 2014: ‘with only three sessions and many missed appointments, I feel it is early days yet to achieve any of Ms B’s goals’\(^{129}\).

As events turned out, Ms B was not abstaining from drugs and could not control her behaviour sufficiently to safely care for Abby. The reunification attempt was aborted, and the process appeared to cause Abby additional distress. A professional and dispassionate view of the situation would have shown that Ms B was nowhere near ready for Abby to return to her care.

Ms Wallis was asked why it was appropriate to consult with a principal Aboriginal consultant (who is not required to, but might, have social work qualifications) rather than a principal social worker on whether to bring forward reunification. Ms Wallis appeared to treat the principal Aboriginal consultant as the equivalent of a principal social worker, where the child concerned was Aboriginal, whatever the nature of the issue.\(^{130}\) It is not possible to determine whether this was a perspective unique to Ms Wallis, or something more pervasive.
than that. If the latter, it is of concern, as it allocates to Aboriginal children a different standard of clinical input to decision making than for non-Aboriginal children.

Families SA pursued reunification throughout mid-2014, despite Ms B continuing to take drugs, to miss contact and, on at least one occasion, to display aggression in Abby’s presence. Signs of distress displayed by Abby before and after contact, including stating that she wanted to stay with Mrs K, were ignored. It is difficult to understand why reunification was pursued.

As late as July 2014, Ms Wallis completed a referral for a Family Care Meeting on the basis that Families SA would seek a further six month short-term order. Twenty-six months after the psychological report recommended reunification attempts be pursued for no longer than six, a further extension was contemplated. This alone underlines the skewed view that workers concerned with the matter had developed.

Time and again, challenges were issued for Ms B to make changes but they were ignored. The practitioners appeared determined to pursue reunification at any cost, without considering the impact on Abby. Only when Ms B was evicted from her second stay at L House, did Families SA finally decide to seek long-term orders.

DEFICIENCIES IN CULTURAL CONSULTATION

Section 5(1) of the Children’s Protection Act requires that a recognised Aboriginal organisation be consulted before any decision or order is made under the Act as to where and with whom an Aboriginal child may reside. The Act gives the Minister power to make arrangements for the placement of children (whether with a guardian, a member of the child’s family, an approved foster parent, or a facility suitable for that purpose). Placement decisions for Aboriginal children in care are therefore made under the Act and trigger the consultation requirements. AFSS also considers that it should be consulted on placement decisions.

When applying for the second 12-month order, Families SA consulted with AFSS. Ms Plush made a series of recommendations to help maintain and strengthen Abby’s cultural identity, taking the idiosyncratic view that to do so would be ‘tokenistic’. Many Aboriginal children need to reside with non-Aboriginal foster parents and supporting their cultural needs in that situation is profoundly important.

Ms Hoffmann also ignored advice to prepare a cultural maintenance plan on the basis that this also ‘ran the risk’ of being tokenistic. However, the South Australian Standards for Alternative Care require cultural maintenance plans for all Aboriginal children on entry to care, with input from local Aboriginal services/groups/forums and recognised organisations.

At the time of seeking the long-term order, Families SA again consulted with AFSS. Ms Plush’s report supported the long-term order, but opposed the plan to move Abby from her foster parents. Ms Wood forwarded Ms Plush’s report to the court, together with an addendum report stating that AFSS had agreed to review its position. This statement was wrong. At no time did Ms Nicolaou give such an undertaking. Ms Wallis, the allocated caseworker, never claimed there was such an undertaking. Ms Wood said that she received the information second-hand, but did not take the time to confirm with Ms Nicolaou that what she was presenting to the court was accurate.

It is not necessary to determine how Ms Wood came to incorrectly represent Ms Nicolaou’s position. What is important is that the court was given a misleading note which undermined the impact of a consultation report that the Act mandates be submitted to the court. It was inappropriate for Ms Wood to prepare that note without taking time to confirm its accuracy. There is no evidence that the error communicated to the court was ever corrected.

Ms Wood took the view that she did not need to further consider AFSS’s perspective that Abby should remain with the K family, because ATSICPP ‘talks about placing the child within their kinship as a priority’. She believed that the legislation in its reference to ATSICPP supported the plan to return the child to Western Australia. Ms Wallis told Mrs K that the decision was made on the basis of ‘culturally advised practice and procedure that we consider AFSS’s perspective that Abby should remain with the K family, because ATSICPP ‘talks about placing the child within their kinship as a priority’.

This interpretation is too narrow. The Act requires consultation for any decision or order made under it as to where and with whom an Aboriginal child may reside (see Volume 1, Chapter 16). In Abby’s case, Families SA consulted AFSS only on court applications. It did not consult on other decisions about where Abby should live. Ms Wood maintained such consultation was not necessary.

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When applying for the second 12-month order, Families SA consulted with AFSS. Ms Plush made a series of recommendations to help maintain and strengthen Abby’s cultural identity, but it does not appear that any effort was made to follow them. In particular, Ms Hoffmann rejected AFSS’s advice to support Mr and Mrs K on Abby’s cultural identity, taking the idiosyncratic view that to do so would be ‘tokenistic’. Many Aboriginal children need to reside with non-Aboriginal foster parents and supporting their cultural needs in that situation is profoundly important.

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The failure to follow up an addendum consultation report or to make any effort to properly understand the basis for the difference of views smacks of a determination to proceed with a fixed plan and an unwillingness to listen to alternative points of view. It demonstrates a lack of regard for the views of others, in particular the views of the recognised organisation. A consultation which is given weight only if it supports a pre-determined decision is no consultation at all.
CASE STUDY 2 ABBY—INTERVENING IN HIGH RISK FAMILIES

In her statement to the Commission, Ms Plush said:

“It’s really difficult to know whether anything I put down is actually followed ... The difficulty is the way it is written is that the Department should consult on where and with whom a child is to live, but they use the principal Aboriginal consultants within Families SA for that role, as opposed to my role. They tick a box by requesting my report, but whether it’s genuinely followed or given any sort of consideration, or whether they just go ahead with what they intended to do anyway, I don’t know.”

The consideration given by Families SA to Ms Plush’s consultation reports in both 2013 and 2014 suggests that, in this case at least, the recommendations were entirely disregarded.

THE APPROACH TO PLACEMENT

The requirement in section 5(a) of the Children’s Protection Act to place a child in accordance with ATSICPP establishes the basis for keeping children within their families and communities to maintain their links with family, community and culture (see Volume 1, Chapter 16). Its significance is broader than a mere placement hierarchy. It implies a partnership between government and Aboriginal communities in decision making about children’s welfare. It requires robust, effective consultation with Aboriginal organisations.

At the same time, ATSICPP is subject to the overarching objects of the Act, including the need to keep children safe from harm and to care for them in a way that allows them to reach their full potential. It is plain that pursuit of ATSICPP must not compromise a child’s rights to safety and the opportunity to reach their full potential.

Because Aboriginal children have the same need for stability and permanence as other children, ATSICPP should be applied early and potential carers identified at the outset. Wherever possible, this means helping Aboriginal carers to care safely for Aboriginal children; it also means not setting up long-term connections of Aboriginal children with non-Aboriginal carers only to sever them by the belated application of ATSICPP.

In Abby’s case, Families SA practitioners were strongly motivated by a desire to comply with ATSICPP and, more generally, to maintain and strengthen Abby’s connection to land, language, community and culture. One obstacle was the limited range of suitable Aboriginal carers that AFSS could offer Abby, and she resided with a number of non-Aboriginal carers, including Mr and Mrs K.

At the same time, Families SA repeatedly turned down potential Aboriginal foster parents because they lived too far from the mother and would have required too much travel for contact. Considerable weight was given to Ms B’s convenience, without countenancing Ms B, not Abby, travelling to contact. In May 2012, Abby was thus placed in a short-term emergency foster placement with more than the maximum number of children for whom the foster parent had been approved. As at early 2013, Abby had remained in residential care with rotational carers for five months, an arrangement which offered her no chance to develop a secure attachment relationship.

Ms Hoffmann, Abby’s caseworker was ‘horrified’ by the idea of an infant being cared for in rotational care. Ms Grigg, the psychologist, described rotational care for infants as ‘highly detrimental’. Rotational care, quite simply, prevents infants from forming the secure attachment relationships they need for their brain development.

The pattern of decision making in this case failed to prioritise Abby’s attachment needs. Nor did it comply with ATSICPP.

INTERSTATE TRANSFER

Abby had relatives in Western Australia who were apparently willing to care for her long term, and could meet both her attachment and cultural needs. Where a child’s community of origin is located outside the jurisdiction, ATSICPP permits consideration of placement outside the jurisdiction. Jurisdictional difficulties should not get in the way of making decisions that prioritise a child’s best interests.

Interstate transfers of child protection orders (as defined in section 54) may be transferred by administrative arrangement between respective departmental chief executives, or by application to court. The Act also contemplates the transfer of proceedings, defined as any proceedings brought in a court for the making of a finding that a child is in need of care and protection. The Children and Community Services Act 2004 (WA) provides for the registration of orders transferred under an interstate law in the Western Australian court and for the resolution of transferred child protection proceedings in Western Australian.

In each scenario, the relevant departmental chief executive must consent to the transfer. A protocol governs the relationships between states for the transfer of care and protection orders. The protocol provides that the receiving state must accept a transfer unless it is contrary to the child’s interests, or is an exceptional case where it is clearly impractical to accept the transfer or is not legally possible.

A receiving state declining to accept a transfer must provide a written statement outlining the reasons for their decision. A sending state may request that the decision to decline be reviewed by a senior officer. The protocol provides that decisions about accepting
transfers must be made within three months, as long as the request is accompanied by all the necessary information.\textsuperscript{140}

In this case a transfer either of the proceedings (the application for a 12-month guardianship order) or the order, once it was made, was legally possible. The relevant legislation contemplated the transfer and a protocol was in place which could be considered if resistance to the transfer was encountered.

An early transfer of the case to Western Australia was clearly the best option for Abby. It offered her a potential placement that would serve her immediate needs while reunification with Ms B was pursued, or a long-term, alternative placement should the need arise. Consistent with ATSICPP, this option allowed her to remain connected to family, culture and community.

It is inexplicable that Families SA (believing erroneously that DCP had refused the transfer) did not regard the case worthy of escalation to executive level. Abby was an Aboriginal infant entering her active attachment phase and the case notes suggested it was likely that a suitable kinship placement would be available in WA. The gravity of the situation warranted a formal letter of request, and if that did not succeed, escalation of the issue in accordance with the protocol.

The approach displayed a lack of understanding of the protocol governing the transfer of orders and proceedings. Ms Mackie appeared not to know, nor to have made any attempt to understand, the process by which a transfer might be accomplished. She appeared to rely on an experiential understanding of what was possible and practicable.

These actions reflect an organisation that failed to analyse the issues from the child’s point of view. Throughout, Families SA adopted the path of least resistance rather than advocating a solution which gave the child the best outcome.

**DELAYS IN CONCURRENT PLANNING**

Ms Grigg ‘strongly recommended’ that Families SA plan concurrently for both Abby’s return to her mother and a suitable long-term placement, in case it was needed, preferably with relatives or a foster parent in Western Australia.\textsuperscript{141} Ms G and Ms H were identified as potential carers and Families SA planned that they would be assessed by DCP. The case plan prepared by Ms Mackie, before transfer to Ms Hoffmann, also noted Ms G’s contact details were recorded on C3MS.\textsuperscript{142}

In evidence, Ms Hoffmann appeared confused about what concurrent planning for a long-term placement in Western Australia might have involved. Case notes revealed that Ms Hoffmann made telephone contact with Ms C, Ms B’s great aunt in May 2013, about three months before the first 12 month guardianship order expired. The call related in part to an enquiry about the whereabouts of Ms B, but concluded with discussion about Ms C’s capacity to provide long-term care. Ms C said that her health prevented this and she did not know of anyone else on her side of the family who would be suitable.\textsuperscript{143}

There is no evidence that Ms Hoffmann contacted Ms G or Ms H, despite the fact that they were clearly identified on the file as relatives willing to be considered as long-term carers. This is supported by Ms G’s statement to Ms Wallis when eventually contacted about providing long-term care that ‘she had been asked to care for Abby about two years ago and she had spoken to her husband about this and they had agreed to do this, but this had not happened.’\textsuperscript{144}

Ms Hoffmann said about concurrent planning, that she:

> asked mum if there were people that she would recommend, out of respect, and spoke to the auntie about if she knew of anyone else. But apart from that, no.\textsuperscript{145}

This overlooked the important work already done to identify suitable carers. When asked if there were barriers to assessing kinship carers and having them get to know Abby a little, Ms Hoffmann said there would simply not be enough time in a social worker’s case load to do a formal assessment.

Ms Hoffmann’s supervisor, Ms Wood, referred to the contact Ms Hoffmann had with Ms C, but maintained in evidence: ‘from my understanding Ms B was very reluctant to give Ms G and Ms H’s names to us and they came very late onto the scene’.\textsuperscript{146} In late 2013, Ms Hoffmann prepared a further case plan stating under the heading ‘concurrent planning’ that Families SA would liaise with Western Australian relatives about an appropriate long-term placement.\textsuperscript{147} This was the same recommendation that Ms Grigg made in July 2012 which had not yet been actioned.\textsuperscript{148}

No concurrent planning was ever done. Ms G and Ms H were assessed as carers and encouraged to build their relationship with Abby only after July 2014 when reunification had clearly ceased.

**CONTACT ARRANGEMENTS**

Ms Wood said in her written statement to the Commission that Ms B’s contact visits were supervised, and that contact would not proceed if she presented under the influence of drugs. Ms Wood also said, ‘Ms B always tried to put Abby’s needs first when she came, and her contact visits were really lovely, they had a good connection the two of them.’\textsuperscript{149}
The observation records suggest that Ms B was not regular in her attendance at contact. The records also show that there were occasions when she could not prioritise Abby’s needs above her own and became angry and behaved in a way that upset Abby. Ms B was observed to be under the influence of drugs at contact, but it was permitted to continue nonetheless. When Abby displayed signs of distress before and after contact and asked not to go, these signs were ignored.

Contact which is pursued incorrectly or for the wrong reasons can undermine a child’s development. Children have a right to safety from harmful contact experiences with their family. They need to know that the caring adults around them see and hear their distress and will protect them.

**A FORESEEABLE OUTCOME**

The haste with which the decision to transition Abby to kinship carers in Western Australia was eventually made highlights that ATSICPP was applied in a mechanistic way, without weight to the other legislative requirements such as stability and the best interests of the child. A proper consideration of those issues might well have come to the same decision, but it was a decision that warranted much closer consideration than appears to have been given.

By July 2014, Abby was two years and four months old. She had spent five of those 28 months in rotational care and 14 of them in the care of Mr and Mrs K and their family.

Families SA became faced with two unpalatable options for Abby: deny her the only family she had come to know and with whom she had developed an attachment, or deprive her of everyday contact with her biological family and the cultural immersion that would offer. The dilemma is aptly described in the AFSS Cultural Consultancy Report:

> Unfortunately AFSS was not consulted earlier in relation to Abby’s situation, and this late presentation of the plan to move Abby to a new placement with interstate relatives who she does not know, leaves the Cultural Consultant with a significant dilemma: whether it is best for this young Aboriginal child to remain in the care of her non-Aboriginal carers, to whom she is attached, and who have given her stable and loving care, or move her to a new placement, with family members who have recently indicated that they are willing and able to provide a culturally appropriate place for her?

> It would have been far preferable had proper planning and consultation occurred early in the piece to avoid such compromised outcomes.511

Ms Wood, who made the decision that Abby would return to Western Australia, told the Commission that remaining with the foster parents was not a possibility that she had ever considered. Although returning to Western Australia in the care of Ms B or kinship carers was an option identified at an early stage as being in Abby’s best interests, it was made on the basis that reunification work would proceed for no more than six months and a prompt decision would be made about a long-term placement. The scenario that faced Ms Wallis and Ms Wood by July 2014 was quite different.

The decision was a difficult one and not necessarily wrong. However, the Families SA workers did not appear to appreciate the complexities that poor case management had introduced into the situation. A lack of planning throughout became a situation of urgency which played out in the months of August to November 2014.

The case notes suggested that a psychological assessment was thought appropriate but was left too late to be completed in time for the Youth Court hearing. Mrs K had been keen for a psychological assessment and Ms Wallis had been aware of that for some time before the hearing. The request was repeated by Mrs K with the support of Ms Elliott at the meeting on 26 September 2014. Ms Wallis thought an assessment with such a young child had limitations, and there was no point having psychological input to help Mrs K to manage Abby’s behaviours.512 Her earlier case note however suggested she believed an assessment would be a worthwhile exercise.

Ms Wallis told the Commission that there was a dual purpose in seeking the psychological report—to help both the Youth Court and transitional planning. Ms Wallis conceded that Abby’s transition from the K family to her kinship carers was a complex event for Abby. She said that once it was clear the report would not be available for the Youth Court, she did not pursue it. She said that she had no idea how long she would have to wait to obtain it and there were strict parameters around the circumstances in which such a report could be provided.513

Ms Grigg confirmed that from a psychological point of view transition planning must be approached with great care. She explained that:

> I think there would have to be a high level of information and planning and discussion around the needs of that specific child, and that would really need to involve both the current carer and the new carer. They would both need to be very involved in the process. So a lot of information sharing about what the child’s needs are, what their routines are, what their favourite things are—really detailed planning so that everyone is on the same page about that child.
Ms Wallis both seemed to be unaware that Ms G had been approached earlier and at least appeared to be suitable to provide long-term care.

The reunification process had extended for far too long without any concurrent planning to help the new carers or to enable them to develop their relationship with Abby. However, there was now a rush to move Abby to WA. Ms Wallis said:

\textit{We're talking about the timeframe on attachment running out at three years. We're talking about trying to do this from July onwards. We're talking—so you're talking about did we consider extending it for another two or three months? No we didn't.}

No-one involved in managing this case could satisfactorily explain the lack of concurrent planning. All their efforts were put into reunification, with scant consideration of building the basis for a good transition to permanent alternative care. Ms Hoffmann and Ms Wallis had both seemed to be unaware that Ms G had been approached earlier and at least appeared to be suitable to provide long-term care.

Ms Wallis described Abby getting onto the aeroplane with her new carers as a ‘very calm little girl’. This description brings to mind the evidence of Ms Grigg, that a child involved in a quick transition showing no apparent signs of distress should set off alarm bells. Similarly, Ms Wallis was taken to information from Mrs K that Abby was distressed and aggressive in her care during the transition. She dismissed the observation as being consistent with ongoing problems, and associated with tiredness, rather than reactive to the particular transition circumstances.

Ms Wood was more realistic about the impact of the transition on Abby, noting that it was unlikely that they would see problematic behaviours until after the move had been made. Taking into account the evidence of Ms Grigg about the dangers of relying on an absence of distress as evidence of lack of trauma or lack of coping, the idea that the transition would be slowed if Abby showed signs of distress was meaningless.
A BROADER VIEW OF THE ROLE OF FOSTER PARENTS

Mrs K was distressed about Abby’s move from her care. She hoped that she and her husband would be considered as long-term carers. Ms Hoffmann’s statements encouraged her to believe that might be possible. As Abby’s full-time carer for 18 months, Mrs K had much to contribute to any discussion about support for Abby during any transition. However, little heed appears to have been given to her information and advocacy on behalf of Abby.

Ms Wallis took the view that Mrs K found it emotionally very difficult to let go of the child. Ms Wallis had a clear view of the limits of the role of a foster parent, particularly the foster parent of a child on a short-term order. Ms Wallis recounted an incident where Mrs K, having handed Abby over to her mother at a contact visit, then turned around to kiss Abby. Ms Wallis described that action as ‘crossing boundaries when you’re trying to establish a good relationship with the mother. You expect the foster parent to help support the child to come across’. Rather than discuss the issue and negotiate with Mrs K, Ms Wallis simply decided that Mrs K should no longer transport Abby to contact visits. Ms Wallis speculated in a case note taken during a particularly difficult contact that Mrs K may have told Abby that it was the social worker who said she had to go to contact.

Ms Wallis took the view that foster parents cannot be invited to Family Care Meetings because they are ‘not part of the family’. She noted that some foster parents would be obstructive to the aims of the family court process.

However, section 30(1)(d) of the Children’s Protection Act provides for invitations to be forwarded to ‘any other person who has had a close association with the child and who should, in the opinion of the Co-ordinator, attend the meeting’. In appropriate cases, this could include a foster parent. Permitting Mrs K to attend the meeting and to be a part of the discussion about Abby’s long-term care may also have reassured Mrs K that everyone had Abby’s best interests at heart. It would have allowed her to be a part of planning for transition. The last-minute nature of the planning and decision making and a lack of understanding about the potential scope of the meetings made that approach impossible.

Ms Wallis’s attitude towards Mrs K and her view of the limited role she had to play in making decisions for Abby was obvious during the evidence. A more inclusive and collaborative approach, which assured Mrs K that she was being heard and which placed weight and value on her advocacy for Abby might have lessened Mrs K’s dissatisfaction with the process. If Abby had been assessed by a psychologist and been able to speak to that psychologist, Mrs K may well have found it easier to accept that everyone had Abby’s best interests at the front of their minds.

CONCLUSION

The observations in this case study identified issues and themes that have informed discussions and conclusions principally in Volume 1, Chapters 9 and 16 of this report. Practitioners require additional training, support and clinical supervision to help parents deal with multiple, complex problems, and make realistic assessments of the viability of reunification. The recommendations in Chapter 9 to promote permanency and stability should help prevent cases from drifting as Abby’s did, without due regard to the impact of prolonged uncertainty and instability. The recommendations in Chapter 16 should encourage practitioners to consult meaningfully with Aboriginal organisations and to apply ATSICPP in a way that supports children’s connection to culture and community while not compromising their broader wellbeing.
Case Study 2: Abby—Intervening in High Risk Families

**NOTES**


9. ibid.


11. ibid.


23. ibid.

24. ibid. C Mackie, email to M Borgas, 1 June 2012.


51. Oral evidence: C Mackie; S Hoffmann.
CASE STUDY 2 ABBY—INTERVENING IN HIGH RISK FAMILIES

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59 Healthscope Pathology, Drug screening results—Ms B, 15 November 2013; Families SA, C3MS records—Abby, November 2013.
60 Families SA, Case transfer summary—Abby, internal unpublished document, 6 December 2013; Anglicare, Case notes—Mr & Mrs K, 8 November 2013.
64 Families SA, C3MS records—Abby, January–March 2014.
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67 Mrs K, email to I Merckenschlager & A Elliott, 8 April 2014.
70 Families SA, C3MS records—Abby, 5 May 2014.
72 Mrs K, email to W Wallis and I Merckenschlager, 21 May 2014.
73 Youth Court of South Australia, ‘Referral to a family care meeting’—Abby, internal unpublished document, 1 July 2014.
74 Families SA, C3MS records—Abby, 3 July 2014.
75 ibid., 7 July 2014.
77 Families SA, C3MS records—Abby, 9, 15 & 18 July 2014.
79 Mr & Mrs K, email to W Wallis & C Wood, 7 August 2014.
This was not the first time the Ks had communicated their willingness to provide long-term care for Abby.
80 W Wallis, email to Mr & Mrs K, 8 August 2014.
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89 Anglicare, ‘Meeting minutes’—Mr & Mrs K, 30 October 2014; Families SA, C3MS records—Abby, 30 October 2014.
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91 R Smith, email to W Wallis, 10 November 2014.
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102 Families SA, C3MS records—Abby, 1 December 2014.
103 Mrs K, email to W Wallis, 27 November 2014.
104 Families SA, C3MS records—Abby, 3, 5 & 8 December 2014.
107 Families SA, ‘Care planning policy’, internal unpublished document, 2010 p. 3.
110 Families SA, ‘Case plan’—Abby, 14 August 2012, p. 5.
111 ibid., p. 16.
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115 Families SA, ‘Care planning policy’, p. 11.
117 Families SA, ‘Case plan’—Abby, 14 August 2012.
118 Oral evidence: M Grigg.
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133 Witness statement: L Plush.
134 Oral evidence: S Hoffmann.
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136 Children’s Protection Act, ss. 54A & 54F.
137 ibid, s. 54.
138 Children and Community Services Act 2004 (WA), ss. 170–173, 175.
139 Protocol for the transfer of care and protection orders and proceedings and interstate assistance, April 2009 (amended August 2011).
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143 Families SA, C3MS records—Abby, 22 May 2013.
144 ibid., 18 July 2014.
145 Oral evidence: S Hoffmann.
146 Oral evidence: C Wood.
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166 Oral evidence: W Wallis.
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## CASE STUDY 3
### HANNAH—LEAVING CARE

### OVERVIEW

### EVIDENCE
- Hannah’s early years
- The background to independent living
- July 2012 events
- Commercial care placement
- 2012 annual review
- Acceptance into the Muggy’s program
- Managing relationship issues in independent living
- A return to commercial care

### OBSERVATIONS
- Transition planning and the National Standards
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- Hannah’s point of view

### CONCLUSION
CASE STUDY 3 HANNAH—LEAVING CARE

OVERVIEW

‘Hannah’ was in the care of the state between the ages of nine and 18. During those nine years she experienced multiple placements in both foster care and residential care. At the age of 16 Hannah was disengaged from any education or training, and was cared for in a series of short-term foster placements. Hannah’s treatment in her early developmental years and the subsequent instability that dominated her journey in care rendered her highly vulnerable to exploitation by adults in the community, and made supporting her path to independence challenging. This case study examines the difficulties Hannah faced as she approached the age of 18, in the knowledge that the support of Families SA was about to cease and she would be required to live independently, making her own decisions and supporting herself.

Hannah’s experience of negotiating these challenges between the ages of 16 and 18 may shock many families who would not consider asking the same of their own children at that stage in their lives. Young people transitioning from care to independent living often face greater challenges in establishing themselves, against a background of considerable vulnerability, and are expected to do so at a much younger age than their peers.

This case study examines how Families SA and other service providers supported Hannah to negotiate these challenges, and what improvements are needed to better support children leaving care for adulthood.

EVIDENCE

HANNAH’S EARLY YEARS

Hannah was born in South East Asia in 1996. Her mother suffered from ongoing mental health issues and Hannah was her eighth child. While still an infant Hannah was abandoned at a hospital when the relationship between her parents broke down. She was then cared for in an overseas orphanage until the age of three-and-a-half. Hannah was then transferred to a family-based placement to prepare her for adoption. An Australian couple adopted Hannah when she was four years old.

Hannah’s early childhood experiences left her with emotional and psychological challenges, with which her Australian family struggled. They sought professional assistance from many organisations, including Child and Adolescent Mental Health Services. Hannah had just turned nine when her adoptive parents relinquished her to the care of the Minister. Although contact with them initially continued for a few hours a week, this soon ended at Hannah’s request. Hannah had no contact with her adoptive family thereafter.

On her entry into care Hannah was placed in short-term emergency foster care before being moved into a large residential care unit. The unit housed boys and girls and was staffed by carers who worked rotating shifts. She was nine years old when she entered this placement. At the age of 11, Hannah was placed in specialist foster care in a country town with Ms T. This placement lasted three-and-a-half years and ended due to Hannah’s mental health and behavioural issues. Afterwards, however, Hannah remained close to her foster mother, Ms T, who continued to be a source of support to her throughout her later teenage years.

By the age of 10, Hannah had been diagnosed with an attachment disorder, conduct disorder, dysthymic disorder and separation anxiety, all of which originated in her early childhood experiences. They had not been ameliorated by her care once she was placed under the guardianship of the Minister.

THE BACKGROUND TO INDEPENDENT LIVING

In December 2011, at the age of 15, Hannah was living in a residential care facility run by a non-government organisation. She struggled to cope emotionally in that environment. Her distress culminated in an attempt to commit suicide and a subsequent admission to the Women’s and Children’s Hospital. Following her discharge, Hannah was placed in short-term emergency foster care. She had become disengaged from education, and the fact that no long-term care could be found made it difficult for her to settle sufficiently to re-enrol in any education or training program.

The short-term arrangement drifted into the longer term, notwithstanding that the agency supporting the foster placement held concerns that the carer did not have good parenting skills, and was unwilling to accept support and guidance. Particular concerns existed that the carer would use physical restraint, and was unwilling to recognise the inappropriateness of this approach. Ultimately the carer terminated the placement, indicating she had no idea how to handle Hannah’s behaviour.1 Hannah was moved on to yet another short-term foster placement.

When Hannah was still 15, Families SA became aware that she was associating with an adult by the name of Mr B, who was known to harbour children under the guardianship of the Minister when they went missing. Families SA feared that Mr B was exploiting Hannah for sexual purposes.

The concerns held by Families SA about this relationship came to a head in June 2012. Fifteen year old Hannah went missing for an extended period and Families SA staff were unable to locate her, although it was strongly suspected that she was staying with Mr B.2
A case conference was convened, attended by Hannah’s caseworker, Nadine Franklin, and the supervisor, Keiron Andrews, along with other social workers who might be able to help. The case conference identified a number of strategies to find Hannah and bring her home safely.

One of the strategies was to ‘follow up with legal measures (written directives etc.).’ A cautionary letter was to be sent to Mr B, warning him of the potential legal action if he did not cooperate with Families SA. Mr Andrews told the Commission that the legal action being contemplated was the criminal offence of harbouring a child who is under the guardianship of the Minister and who is absent from a placement. There was no evidence that the proposed cautionary letter was sent. No such letter was uploaded to the C3MS system, although Mr Andrews and Ms Franklin both thought that they had seen a draft at some point.

Another option available to Families SA, and discussed at the case conference, was to issue a written direction to Mr B pursuant to section 52AAB of the Children’s Protection Act 1993. This would require Mr B to refrain from communicating or attempting to communicate with Hannah, placing the obligation on Mr B to cease the relationship. Disobedience to a written direction is a criminal offence.

A short time later, however, Hannah was located at a suburban shopping centre and returned to her foster care placement. No written direction was issued to Mr B by Families SA. Ms Franklin continued to manage this issue by emphasising in discussions with Hannah that the relationship with Mr B was unhealthy and not in her best interests.

JULY 2012 EVENTS

Hannah again went missing on 2 July 2012. Families SA filed a missing person report which recorded a suspicion that she had returned to the home of Mr B. On Friday 6 July 2012 Ms Franklin spoke with Hannah and Mr B. Hannah would not disclose where she was but confirmed that she was safe. Ms Franklin explained that Mr B was breaking the law if he continued to harbour Hannah. During the telephone call Ms Franklin arranged for Hannah and Mr B to meet with workers to develop a plan to stop Hannah running away from her placement. Ms Franklin told Hannah to ‘keep safe’ and that she would call her on the Monday. Although Hannah had been contacted, the missing person report filed with the police was not deactivated by Families SA.

Ms Franklin accepted in evidence that her statement to Hannah that she should ‘keep safe’ and she would call her after the weekend might have given Hannah the impression that Families SA was content for her to remain with Mr B for the moment. She told the Commission that she had emphasised to Hannah that Families SA did not support her relationship with Mr B, but she did not necessarily repeat that during the telephone call.

At this time Hannah’s placement was in short-term foster care supported by Life Without Barriers (LWB), a registered foster care agency. LWB sought clarity from Families SA about how Hannah was going to be managed over the weekend of 7–8 July 2012. On ascertaining that Families SA had determined not to make any assertive effort to locate her, and as she was not at her foster care placement, LWB took the view that they were not prepared to manage her wellbeing over that weekend.

LWB staff sought an assurance that Families SA would ‘risk manage’ the placement over the weekend. The request for confirmation was met with the following email authored by Mr Andrews and addressed to Hannah’s caseworker:

As we discussed earlier today, we don’t actually know where Hannah is. We believe she will be with Mr B, we believe there’s a more than reasonable chance that she’s staying there, but you’ve had to think that she’d be expecting us to turn up. As you can recall from our phone call with Hannah earlier today, neither party is feeling obliged to tell us where they are.

Under these circumstances, Families SA’s hands are tied. We could go to Mr B’s home again, bang on the door and not have them answer it. We could even ask the police to open the door for us, not that they would. We could force or goad Hannah into going to another carer and she will be gone before we close the front door. I am inclined instead to leave it for the next 2 days, we have a commitment from Hannah that she will talk with yourself and Ann about how they can make their relationship work while remaining in a stable placement. I believe that pushing any further at this moment without being sat in front of her will only drive Hannah deeper underground.

It isn’t a matter of Families SA choosing for Hannah to stay with Mr B; it’s a matter of Families SA choosing not to pursue the matter for the next 2 days in the hope that we can talk some sense into her on Monday.

Feel free to share this email with ... Ann from LWB

On Saturday 7 July 2012, Hannah was located by police who were acting on the missing person report. The police intended to return Hannah to her foster care placement and contacted LWB on its after-hours telephone number to make the arrangements. On the strength of the email and the other conversations that had occurred, LWB told police that Families SA was content for Hannah to remain with Mr B over the weekend. Hannah therefore remained at Mr B’s home with the apparent agreement of Families SA.
Mr Andrews accepted in evidence that in hindsight, the message that ‘Families SA [was] choosing not to pursue the matter’ could have been misinterpreted. In context, aspects of the email authored by Mr Andrews were capable of being interpreted as an acceptance, in the short term, of the status quo.

The possibility of legal orders to prevent Mr B from having contact with Hannah was raised again with Mr Andrews in an email sent on 25 July 2012 by a staff member from LWB. Mr Andrews responded to the email, asserting that he was ‘fully aware of the existence and use of intervention orders in many contexts including this one and the recommendations of the Mullighan inquiry’. He explained that Hannah was ‘not willing to be a party to the application’ and therefore he did not think that such an order would change her behaviour. He told LWB that the police already had the option of charging Mr B with a criminal offence in relation to the sexual relationship if they were so inclined.

Mr Andrews was asked in evidence whether he saw a role for the use of written directions in securing the safety of young people. His view of their application was very limited:

I think, if Hannah was absconding to a well-meaning adult member of society’s home who was convinced that Families SA just wasn’t caring for her, and we were having trouble having that reasonable adult help us provide a safe place, then yes, there is a role for them.

Mr Andrews was asked about the circumstances in which he might revisit the question of a written direction to keep Hannah safe. He said that:

I’m not sure that we were able to plan that long term with Hannah, at the time, to be honest. It was more like whenever we had an opportunity to reach her and talk to her, we would try and cram as much guidance and common sense into those little windows as we could.

Mr Andrews held the firm view that issuing a written direction would have no impact on Mr B’s behaviour. He told the Commission that given that Mr B was prepared to risk the legal consequences of having a sexual relationship with 15 year old Hannah, he saw no reason to think that a written direction would dissuade him. Neither did he think that the written direction would curb Hannah’s determination to run away to stay with him. Mr Andrews believed, on the basis of a telephone conversation he had with Mr B, together with reports of interactions that Ms Franklin had with him, that Mr B had contempt for the law. He took the view that Mr B was unrepentant about his conduct towards Hannah and appeared ‘disinterested about the degree of trouble he may be finding himself in’.

Mr Andrews also feared that the issuing of a written direction might drive Hannah towards Mr B, because in Hannah’s mind, if she was prevented from doing something she would pursue it with even greater vigour.

Mr Andrews’ various responses suggest that he was not as aware of the reasoning of Commissioner Mullighan QC as he claimed. Written directions were specifically designed to overcome the barriers involved in proving offences that required the cooperation of the young person at risk of exploitation. They were designed to be easy to obtain and enforce without requiring a court application. Mr Andrews failed to appreciate that the critical difference between police action on a written direction and police action in relation to an alleged sexual offence is that the former did not rely in any way on cooperation in the process from Hannah.

COMMERCIAL CARE PLACEMENT

In September 2012, Hannah’s final foster care placement ended. There were no other suitable foster care options that she could be offered, and commercial care became the only remaining option. Although Hannah had not lived with her previous foster mother Ms T for some years, she retained a close supportive relationship with her. Hannah’s preference was to live in a location that permitted her to have frequent visits with Ms T and her family.

The Placement Services Unit was unable to identify a site for commercial care close to Ms T and a placement with commercial carers provided through HenderCare was established at Gawler.

Hannah appeared to enjoy the commercial care placement. She did what she pleased. As the carers attended to her every need, she did not seem to be learning any skills about self-sufficiency or independence. Hannah’s caseworker, Ms Franklin, attempted to have carers work with Hannah on cooking and cleaning skills but her requests appeared to have little effect.

In a memorandum to David Waterford, the then Executive Director of Families SA, dated 25 October 2012, approval was sought to continue commercial care arrangements until the end of December 2012. The total estimated cost for the placement over the entire period was $112,640. The memorandum noted that Hannah was ‘currently incapable of independent living’, and that short-term commercial care was necessary to provide for Hannah’s social and emotional wellbeing.

Although Hannah was now 16 years old, nothing had been done to develop her independent living skills. The focus of her case management had been to diffuse the relationship between her and Mr B and keep her living in one place where she was safe. This is
notwithstanding the National Standards requirement that transition planning begin at 15, together with the high likelihood that Hannah would seek independence at an early age.20

At the end of November 2012 the commercial care placement at Gawler ended. Carers made an environmental report to SA Health about the state of the premises and as a consequence the placement could not be sustained.21 Despite the fact that only a month earlier Hannah had been assessed as incapable of living independently, a decision was made to refer her to the Muggy’s program, an independent living program (funded by Families SA and operated by the Salvation Army) that provides case management and supported accommodation for young people leaving care. Hannah’s placement with Muggy’s was preceded by some time at a residential care facility managed by UnitingCare Wesley. It was proposed that Muggy’s staff would begin to work with Hannah at that residential care facility while she waited for a property to become available.22 Hannah was enthusiastic about the Muggy’s program, having identified her ultimate goal as independent living23, and being ‘out of the system’.24

2012 ANNUAL REVIEW

On 11 December 2012, an annual review panel was convened in accordance with section 52 of the Children’s Protection Act, which requires that the circumstances of a child under a guardianship order until the age of 18 be reviewed annually by a panel appointed by the Minister. The panel is required to ‘keep under constant consideration whether the existing arrangements for the care and protection of the child continue to be in the best interests of the child’.25

The panel consisted of three staff members from Families SA. Its conclusions were brief and uninspiring; the following extract was recorded as its recommendations:

Worker to follow up on Muggies [sic] referral with (Placement Services Unit).

Continue to work towards preparedness for independent living.

Follow up on dental check-up.

GP—mental health plan–private psych.

Life story book to commence.

... financial counselling.26

Hannah’s contribution to her annual review is captured in a one-page document which was posted to her to complete. There is no evidence that she was invited to attend. This approach does not meet the Families SA Standards of Alternative Care in South Australia, which require that children and young people be actively encouraged and supported to participate in their annual review process.27

The conclusions of the panel do not refer to Hannah’s future hopes or goals. There is nothing recorded about educational, training or employment planning. Neither do the interventions recorded have an aspirational quality. Despite the panel discussing the influence of Mr B, it developed no plan to manage the relationship. In addition, although the panel noted that work towards independent living was to continue, it gave no clear picture of what independent living for Hannah might look like. There was no acknowledgement that ‘independent living’ is a multidimensional concept, and that working towards it requires more than just securing a house and an income and developing the skills to manage each of those things. There was nothing recorded to identify what phase of transition planning was being engaged in, and to what ultimate goal.

ACCEPTANCE INTO THE MUGGY’S PROGRAM

On 13 December 2012, Hannah attended a meeting with staff from the Muggy’s program and agreed to be involved. The Families SA financial counselling program was approached for financial help to set up her new home—an independent living unit in a small regional town within driving distance of Adelaide.

The Muggy’s program offers a young person the chance to live in independent accommodation and receive support to ultimately transition into independent living. A young person can be referred to the program from the age of 15, but usually will not be allocated a property until they are at least 16 years old. At that age a young person (subject to certain requirements) will be eligible for a youth allowance payable through Centrelink. The young person agrees to pay for rent and food from that allowance, although the costs of utilities are met by the Muggy’s program. Rent of $85 per week is payable no matter what the size or type of property allocated.28

Prior to being allocated a property a young person who has been accepted into the program will be offered regular appointments with key workers, which usually take place at the local Muggy’s office. These appointments are aimed at building relationships but also begin to build the skills that the young person will need for independent living.

In the early stages of her involvement with the Muggy’s program, Hannah was encouraged to engage with the local TAFE: enrolment in education or training was one of the conditions for obtaining the youth allowance that Hannah would need to pay for her rent and food. She was given help to apply for a learner’s driving permit, and appointments were scheduled to assist her with budgeting and cooking skills.
All young people preparing to leave care are eligible for brokerage money, a payment that helps them move into independent living. Muggy’s provides unfurnished accommodation but assists program participants to spend their brokerage money on furnishings in a financially responsible way. Brokerage is usually paid to a maximum of $5000.

Hannah was accepted into the Muggy’s program starting January 201331, and offered a property from March 2013. At the time that she moved into the property she was 16 years of age. Just prior to moving in, Hannah was supported by Muggy’s workers to buy furniture and other items for her home.

MANAGING RELATIONSHIP ISSUES IN INDEPENDENT LIVING

Soon after joining the Muggy’s program Hannah mentioned to workers that she was planning to visit ‘Adam’ in Adelaide. By January 2013, Families SA was well aware that ‘Adam’ was Mr B, the adult with whom Hannah was suspected of being in a sexual relationship. However, Families SA had not shared that information with Muggy’s as part of the referral to the program, thus placing Muggy’s staff who were supporting and supervising Hannah at a significant disadvantage. They had no understanding at this stage of the inappropriateness of Hannah making the trip, and no basis on which to counsel her against it.

VIOLENCE AGAINST HANNAH

Later, in March 2013, Hannah disclosed to Muggy’s staff that Mr B had travelled to see her at her Muggy’s unit and in the course of an argument had punched Hannah in the face; she claimed, however, that it had been ‘accidental’. Hannah told worker Dianne Mitchell that she did not want to involve the police because she did not want to exacerbate Mr B’s trouble with the police. Muggy’s staff made a notification to the Child Abuse Report Line (CARL).40 The report was forwarded to Hannah’s caseworker, but was not actioned for three weeks.41 Notwithstanding that since June 2012 the possibility of issuing a written direction had been discussed several times, this strategy was not revisited despite information that Mr B’s dangerous behaviour towards Hannah had escalated.

Three months later, Muggy’s staff became aware that Mr B had again assaulted Hannah. On 1 July 2013, Holli Bateson from Muggy’s collected Hannah from the bus stop after she returned from a trip to Adelaide. She was in a dishevelled state and complained she had been assaulted by Mr B. Ms Bateson encouraged Hannah to report the matter to the police and discussed strategies to keep her safe.42 Hannah was given help making a report to the police about the assault.

Six days later, Hannah contacted Muggy’s staff and advised them that she was in Adelaide seeing some old friends. Staff suspected that Hannah was not with friends, but had returned to Mr B. Two days later, Hannah again contacted Muggy’s. She was in a distressed state and disclosed that she had been with Mr B and that she had again been assaulted by him. Muggy’s contacted the police on Hannah’s behalf; the police located Hannah and took her to the Women’s and Children’s Hospital for assessment.43

When Hannah was released from the hospital, Families SA supervisor Mr Andrews was asked to organise her return home. He arranged for Hannah to take a taxi from the hospital to the bus depot, and to travel home by public bus. Muggy’s staff collected her from the bus station. Hannah was, at this time, just shy of her seventeenth birthday. It is difficult to imagine a parent requiring their 16 year old child, who had been admitted to hospital following an assault, to make their way home alone on public transport. An arrangement of that kind would hardly have given Hannah a sense that she was cared for or that her welfare was anyone’s priority.

When asked about this arrangement, Mr Andrews told the Commission that it was difficult in hindsight to indicate what other options might have been available, and it was possible that he was attempting to put something in place quickly to prevent her from ‘voting with her feet’. He said that transport in that scenario was ultimately a question of finding out what was available and what was the best fit at the time.44

Following this incident, Mr B was charged with harbouring a child under the guardianship of the Minister, an offence against section 52AAC of the Children’s Protection Act. Despite Muggy’s support, Hannah later determined that she did not want criminal charges to proceed, a decision she formalised in September 2013.45 Hannah said she had ended the relationship with Mr B and wanted to move forward.

A NEW RELATIONSHIP

Hannah’s determination to end the relationship with Mr B at this time appeared to be galvanised to some extent by the arrival of Mr F in her life. Mr F, an adult who lived in the local area, was observed spending time at Hannah’s unit. Hannah was now 17 years old and Mr F was not committing a criminal offence if he was engaging in a sexual relationship with her. His presence and influence, however, began to have a destabilising influence as Hannah tried to build her skills towards transitioning to independence.
By this time Hannah’s case management file had been transferred to a Families SA office closer to her Muggy’s placement. This transfer brought a change of caseworker and supervisor guiding her case. Her new caseworker was Rachel Osborn and the supervisor was Russell Willsmore.

As 2013 progressed, it became increasingly clear that the relationship between Hannah and Mr F was placing her tenancy and her participation in the Muggy’s program at risk. Mr Willsmore described the dilemma that confronted him, recognising that Hannah was now 17 but was still highly vulnerable to exploitation:

You’re caught between a rock and a hard place. She’s under the guardianship of the Minister, and yet she’s over the age of consent. So if she chooses to engage in sexual intercourse with an individual … we might not approve of that, or support that, but it is her choice, as damaging as it might be. But until we got to the point that she said ‘no, he’s actually raping me’, and we’re looking at a criminal act, that’s when we’ve sort of got a bit of ground to push the written directive.32

By October 2013, Hannah was no longer attending TAFE and had been cut off from her Centrelink payments. She fell behind in her rent and Muggy’s staff began to notice alcohol bottles in her unit. They reported to CARL that they suspected Mr F was supplying Hannah with alcohol.33 Hannah’s commitment to attending appointments with her key workers also fell away and workers observed that Mr F was frequently staying overnight at Hannah’s unit, in breach of house rules that restricted the frequency with which she could have friends stay.

In December 2013, Muggy’s staff advised Hannah that Mr F’s influence upon her was creating a situation where her accommodation was at risk. Hannah complained to Muggy’s staff that Mr F was supplying her with cannabis and alcohol, and in exchange he expected sex several times a day.34 This information was reported to CARL. At this point, as long as the information was believed to be credible, there was sufficient evidence of a Part 5 Controlled Substances Act 1984 offence to justify the giving of a written direction to require Mr F to not communicate with Hannah.

At the time a fact sheet concerning written directions had been created by Families SA and was available to staff. The fact sheet is inaccurate in its terms and describes the circumstances in which a written direction can be given in much narrower terms than is provided by the legislation.35 Any staff member who had regard to the fact sheet without returning to a close reading of the legislation would be left with an inaccurate understanding of the scope of written directions (see Vol. 1, Chapter 10).

Mr Willsmore was asked in evidence about his understanding of the scope of a written direction to prevent exposure to illicit drugs. His answer revealed a restricted view consistent with the inaccurate information which was at the time contained within the Families SA fact sheet.36 He said37:

I suppose my understanding of written directives at the time—well, I don’t think that’s really changed over time, but it’s more about the contact—the contact they’re having with an individual, and the implications of that contact with the individual, in terms of if they’re putting their own safety and welfare at significant risk. So, for us, you might not support a person having contact, but unless you’ve got the grounds to suggest that they’re in harm’s way by having that contact, you wouldn’t necessarily seek a written directive … and with an evidence base such as a disclosure that, ‘this is what’s occurring for me when I’m with this person’.

This evidence would explain why the information that had been reported to CARL about Mr F supplying drugs to Hannah was not viewed as being sufficient to form an evidentiary basis for issuing a written direction against Mr F.

It is noteworthy that several witnesses gave evidence that there was a lack of training and consistent understanding across Families SA about how written directions operate and in what circumstances they could be employed.38

In the same month Muggy’s staff told Families SA that Hannah was unlikely to have her lease renewed because of the choices she had been making.39 Hannah was given an ultimatum about engaging in the program and attending appointments, or making a choice to move out of the property.40

On 31 December 2013, Ms Osborn and another Families SA worker met with Hannah. Their purpose was to discuss the danger of her losing her Muggy’s tenancy if she continued to breach the rules of the program. Ms Osborn told Hannah that she was at risk of homelessness if this happened.41 Mr Willsmore told the Commission that the reality was that as a child in care she would not be homeless, but that it was important that Hannah understood that her options were limited. They wanted her to think carefully before she made decisions that would lead to her losing her accommodation.42

Hannah decided that she would move out of her accommodation, and told Muggy’s staff that she would move in with Mr F. She planned to save some money and move to Adelaide. Hannah said she thought that Muggy’s and Families SA had been preventing her from pursuing her goals.43
Once it became clear that Hannah was at risk of homelessness if her lease with Muggy’s was not renewed, Hannah’s caseworker Ms Osborn was directed by her supervisor to lodge a referral with the Placement Services Unit to ensure that an alternative was identified. However, there was no evidence that such a referral was made, or that any alternative placement was ever offered to Hannah.

THE TENANCY ENDS

On 20 January 2014 Families SA learned that Hannah intended to leave her Muggy’s accommodation and move in with Mr F from 23 January 2014. In evidence Mr Willsmore was asked why, when Families SA had been aware for at least a month of the possibility that Hannah would lose her Muggy’s house, there was no referral made to source an alternative placement. Mr Willsmore was practical about the available options. He was pragmatic about the fact that the only option for Hannah was an emergency commercial care placement. Such a placement would not be approved two weeks out from a placement breakdown, and a referral for an alternative placement would be pointless, would involve a lot of paperwork, and would lead to the inevitable conclusion that there were no suitable options.

Hannah’s situation highlights a difficulty for young adolescents making the transition to independent living. The Muggy’s program attempted to replicate real life by allowing Hannah to experience the natural consequences of her decision making. But Hannah had few other options available to her. For a young person with a disrupted placement history who was almost 18, a home-based placement was not appropriate. For most young people who have been living independently, a residential care placement will not be sustainable either.

On 28 January 2014 Families SA staff made contact with Hannah to discuss her accommodation. Ms Osborn, her caseworker, reiterated to Hannah that Families SA did not support her living at Mr F’s house. Hannah told Families SA that it was ‘better than the streets’. In discussions with Families SA Hannah agreed to remain involved with the Muggy’s caseworkers although she no longer wanted to live in their housing. Hannah moved into Mr F’s house with him. It is impossible to determine what influence, if any, Families SA’s statement that she risked homelessness without her Muggy’s tenancy played in that decision, and whether she thought she had any other realistic options.

Hannah remained connected to the Muggy’s program and on 7 February 2014 she dropped into their office. She disclosed to workers that Mr F had been sexually assaulting her, and that she felt obliged to put up with his behaviour because otherwise she would be homeless. This information was reported to CARL and to Ms Osborn.

On 12 February 2014 the notification was acted upon. Families SA attended Mr F’s house in company with the police who were in possession of a general search warrant. Police acting on the authority of the warrant conducted a search for illicit drugs on the premises.

On becoming aware of the presence of Families SA and the police, Hannah became distressed and upset. She eventually agreed to leave Mr F’s house with Families SA staff and return to the local office.

Although Families SA planned the attendance at Mr F’s house with the police, and knew Hannah was still connected to the Muggy’s program, it did not involve Muggy’s in discussions about how Hannah could be supported if she agreed to leave Mr F’s house. Once she became distressed, Muggy’s support workers were contacted to assist her. This was the first time those staff had been informed of Families SA’s actions.

Muggy’s key worker, Ms Bateson, collected Hannah from Families SA and took her to the Muggy’s office. Arrangements were made for a commercial care placement to be established for Hannah at a local caravan park.

The cabin that was sourced for the placement only had one bedroom. This is despite the fact that carers would be present there with Hannah 24 hours a day. The cabins at the caravan park were described as ‘old … in disrepair. Run down. A bit grotty’. There were concerns about the unsavoury character of some long-term residents of the park. Families SA intended to stabilise Hannah in commercial care arrangements, with a view to encouraging her to re-engage with Muggy’s and transition into a new supported living unit.

During a conversation between Ms Osborn and Hannah on 13 February 2014, Hannah expressed the view that even if she could not reside with Mr F, no one could stop her from seeing him if that is what she chose to do. Ms Osborn agreed with Hannah’s observation. At that time, Hannah’s observation correctly reflected the state of affairs, because no written direction had yet been obtained to prevent Mr F from having contact with Hannah, despite the fact that the issue had first been raised in respect to Mr B over 12 months earlier.

It was clear to Families SA that Hannah intended to continue the relationship with Mr F, despite the various disclosures she had made about how he had treated her.
By the evening of 14 February 2014, Hannah was again missing from her commercial care placement. She had not been seen for one night and a day. Families SA decided to terminate the commercial care placement (release the workers and terminate the lease on the property) and to place the onus on Hannah to contact the Crisis Response Unit over the weekend if she needed a place to stay.64 Mr Willsmore, the supervisor responsible for that decision, believed that if Hannah contacted the Crisis Response Unit over the weekend the commercial placement could quickly be reinstated.65 This decision meant that Families SA had chosen to provide no placement for 17 year old Hannah, who was, by law, the responsibility of the Minister.

On 15 February 2014, Hannah told Muggy’s staff that she was back staying with Mr F. She told them that she had returned there because when she went home to her placement at the caravan park, no one was there.76 With the uncertainty associated with where she would be sent if she called the Crisis Response Unit, Hannah preferred to stay with Mr F.

Kelly McLeish, a senior practitioner involved in Hannah’s case, told the Commission that she did not agree with the decision to shut down the placement. She said while Hannah was clearly ‘voting with her feet’ by returning to Mr F, a better approach would have been to leave the placement open, in case she changed her mind. Ms McLeish agreed with the proposition that the only option open to Hannah once the commercial placement was terminated was to return to Mr F.76 Ms Osborn, the caseworker, agreed with that observation.75

By this time, Hannah was subject to a bail agreement following her arrest relating to illegal use of a motor vehicle. Hannah had no other history of involvement in the criminal justice system, and the allegations were isolated. The incident had occurred when she was in the company of another young person. They had both driven the vehicle at high speed and Hannah had been involved in a collision. The conditions of the bail agreement required her to live at the caravan park as arranged by Families SA.

To reflect the fact that she was now living with Mr F, Hannah attended the Youth Court and made an application to change the residential conditions of her bail. The conditions of bail were varied to require Hannah to live at Mr F’s house. Families SA staff were aware of the possibility that the application would be made but were not notified that it was listed for hearing, nor were their views sought about the suitability of that placement.76 Had they been notified, they would not have supported Hannah’s bail conditions being changed, although they were well aware that she was living with Mr F because they had terminated arrangements for the only other place in which she had to live.

THE WRITTEN DIRECTION
A decision to use a written direction against Mr F was finally made on 28 February 2014. Arrangements were made to prepare the documentation and on 12 March 2014 the written direction was served on Mr F. The commercial care placement at the caravan park was reinstated to give Hannah somewhere to live.

After the direction was served, the inconsistency between Hannah’s conditions of bail and the written direction became apparent: the direction prevented Mr F from communicating with Hannah, but Hannah’s bail conditions required her to live at his address. Families SA attempted to have Hannah return to court to have her bail address changed. She refused to do so. Hannah’s non-attendance at court resulted in a warrant being issued for her arrest.

At 11:05am on Friday 14 March 2014 the placement at the caravan park was shut down. Families SA noted that the carers would need to vacate the cabin by noon to avoid an additional night’s charges, so the decision was made early in the day to avoid those fees.76

That evening, during a phone call with Muggy’s staff, Hannah was informed that there was a warrant for her arrest.74 Arrangements were made for Hannah to attend the police station and she surrendered herself on the warrant.77

At 9:48pm police contacted Families SA’s Crisis Response Unit and advised that Hannah would be granted bail if there were a suitable address. The placement at the caravan park had been cancelled and it was not possible for Families SA to obtain commercial care workers at short notice.74 Hannah was refused bail and was taken to the Adelaide Youth Training Centre (‘Cavan’) for the weekend. At this time she had very little exposure to the youth justice system. There is little doubt that Hannah would have been bailed had a suitable placement been organised by Families SA.

A RETURN TO COMMERCIAL CARE
Hannah was bailed on 17 March 2014, with conditions that she reside at the caravan park with a curfew from 9pm to 7am. An additional bail condition was later added preventing her from having contact with Mr F.76

Following Hannah’s experience of custody, her stability improved. Hannah’s caseworker was convinced that her resolve to be at her placement at least nightly was brought about by a combination of the curfew conditions and an overwhelming fear of being returned to Cavan.76
Hannah’s transition to independent living was completed in a one-bedroom cabin, being cared for around the clock by commercial carers. Families SA and Muggy’s became concerned about the effect that environment was having on Hannah’s independent living skills. Ms McLeish observed that all the skills Muggy’s had worked so hard to instil in Hannah were unravelling as the carers attended to her every need. The living conditions in commercial care were inconsistent with preparing a young person for independence. Ms McLeish observed of the commercial care providers that:

they were in cramped accommodation, they didn’t have anything else to do … Because Hannah could be quite challenging, so I think they probably did a lot of things to keep her happy and to make the work go past quicker. But it wasn’t helping support the work that we were doing … with Hannah to try and encourage her into her own accommodation by the time she turned 18.81

Hannah remained at the caravan park until she was offered a direct lease rental through Housing SA.82 She moved into that property one month before her 18th birthday, but vacated it only six months into the lease.83

Hannah turned 18 in late 2014. By that time her court matters were resolved and the written direction preventing Mr F from contacting her had lapsed. Hannah’s caseworker took her out for lunch and gave her a bicycle that had been purchased for her as a birthday present. Hannah’s Families SA file was formally closed shortly after her 18th birthday.84

TRANSITION PLANNING AND THE NATIONAL STANDARDS

The National Standards require that transition planning (preparation) begin when a young person is 15 years of age.85 When Hannah was 15, however, her case management was dominated by her absconding behaviour. There was little attention paid to long-term goals and to the support required to achieve the stability she would need to work towards those goals.

Ms Franklin, Hannah’s caseworker at the time she was 15, told the Commission that the question of transition planning for Hannah had arisen during supervision, but it was thought that she was too young and naïve to manage it successfully. Transitioning her to independent living at 15, she thought, would be setting her up to fail.86

The National Standards contemplate planning from the age of 15, including a focus on the stability of care arrangements. From the age of 14 it was not possible to secure for Hannah a long-term and stable family-based placement. With the majority of case management efforts focused on tracking where Hannah was and what placement options were available to her, there was little space to consider long-term planning. There was no evidence of any planning for Hannah that involved obtaining an understanding of what Hannah’s goals were for the future and the support she would need to achieve them.
The evidence supports the conclusion that the referral to Muggy’s was what Hannah wanted, the timing being by coincidence rather than by design. The Muggy’s program gave Hannah the independence that she sought coupled with the continuity and intensity of support offered by Muggy’s staff. Independent living, with the support that she would need on an around-the-clock basis, offered Hannah her best chance of stability.

Notwithstanding the barriers along the way to Hannah’s engagement with Muggy’s, Hannah developed her skills and knowledge while part of the program. Ms Bateson told the Commission that Hannah was ‘amazing at cooking’ and her literacy skills improved through her engagement at TAFE. Hannah grew in confidence, learned to say ‘no’ and to stand up for herself.97

The barriers to Hannah’s successful transition lay not in an inability to develop the skills and knowledge to negotiate adulthood, but in the relationship distractions which presented themselves along the way. Ms Franklin told the Commission that she thought Hannah’s vulnerability lay in her attachment disorder. She said:

Hannah … wanted to be accepted. She wanted to be loved. They were her words to me, many times. ‘I just want to belong. I just want to be loved’. And when somebody showed her any type of kindness, or you know, just a general, being nice, she held on to that, and would do anything for them, to hold on to that person. So I think it’s about trying to be accepted, and to be loved, and to feel like she belonged somewhere.98

EFFECTIVE USE OF AVAILABLE TOOLS

Controlling teenage relationships is notoriously difficult even in a traditional family structure with the benefits of psychologically stable attachments. The challenge of controlling teenage relationships lacking those structures and attachments should not be underestimated. Families SA, in acknowledgement of the particular vulnerabilities of some children in their care, has available a set of unique tools to manage young people who choose relationships that are not in their best interests.

One tool that is not available in traditional family structures is the power to give written directions to adults in certain circumstances. The power enables Families SA to use the law to intervene between young people under the custody or guardianship of the Minister and unsuitable adults who seek to exploit them. Section 52AAB of the Children’s Protection Act gives the Department’s Chief Executive the power to issue written directions to persons requiring them not to communicate, or attempt to communicate, with a specific child during a specified period.

Exercise of the power requires the Chief Executive to be satisfied that the issue of a notice is reasonably necessary:

(a) to avert a risk that the child specified in the notice will—
(i) be abused or neglected, or be exposed to the abuse or neglect of another child; or
(ii) engage in, or be exposed to, conduct that is an offence against Part 5 of the Controlled Substances Act 1984; or
(b) to otherwise prevent harm to the child.99

Failure to comply with a written direction is an offence that carries a maximum penalty of $4000 or imprisonment for one year.100

Evidence revealed that Families SA staff lacked knowledge about written directions and were reluctant to use them proactively to make adults responsible for staying away from young people. This is surprising given that the power to issue written directions has been available since June 2010.101

The topic of the issuing of a written direction was raised on multiple occasions with supervisor Mr Andrews. Notwithstanding the dangerous position in which Hannah was placing herself, no written direction was issued to Mr B to effectively intervene in her relationship with him in 2012 and leading up to her placement in the Muggy’s program in 2013.

Mr Andrews’ evidence revealed an inflexibility of thinking about the potential of a written direction. Although he told the Commission that a written direction always remained on the table, his evidence suggested a reluctance to attempt such an approach.

Not only was there a reluctance to utilise the available tools, there was a lack of planning about the circumstances in which the matter would be escalated from merely talking to the parties in an effort to persuade them to comply, to the more direct assertive approach of a written direction. Although Mr Andrews spoke to Mr B about the consequences of his behaviour, nothing was done to place the police or Families SA in the best position to use the law against him to secure Hannah’s safety. Reactive case management, coupled with a series of crisis-driven decisions, resulted in the use of a written direction being overlooked.

By 22 June 2012, Families SA had information that Mr B had been using drugs (cannabis and amphetamines) in Hannah’s presence and that she was engaged in a sexual relationship with him.102 There is no doubt that the evidentiary standard required for deployment of a written direction had been achieved at that early stage.
There was a danger, of course, that a written direction employed against Mr B could drive the relationship underground and further endanger Hannah. This appeared to be the ongoing reason for preferring a cooperative approach. But there was no evidence at any time that the cooperative approach was working or that Mr B was amenable to cooperating with Families SA to ensure Hannah’s safety. In those circumstances, Families SA should have given greater consideration in a planned and structured way to issuing a written direction.

At no time did any Families SA staff member discuss with Hannah the possibility that her relationship with Mr B or subsequently with Mr F, coupled with her consistent absconding, might lead to a written direction which would prevent either of them from associating with her. Hannah was left with the impression that her consent was required for any action against Mr B. A case note taken by a Muggy’s worker when a written direction was later served on Mr F records:

> Hannah said that it all doesn’t make sense and doesn’t know how Rachel did what she did [getting a written direction] ... without consent from Hannah. Staff said that Rachel can do this as she is Hannah’s guardian.
> Hannah said that when she wanted a restraining order against Mr B Nadine ... said she couldn’t do it without Hannah signing forms.  

Standard 4.1 of the Standards of Alternative Care requires that a young person will be an active participant in all decision making which relates to them. This became particularly important once Hannah was asked to take a heavy responsibility for herself by living independently. She should have been treated as an active member of the care team and her views sought about the management of her relationships. Had Hannah been engaged actively and honestly in consultation about the range of legal options that were available to control her unhelpful and damaging relationships, it is possible that a different outcome might have been achieved.

It is also possible that a different outcome might have been achieved if Families SA staff had a better understanding of the scope of written directions, and the circumstances in which they might usefully be deployed.

**Collaboration between agencies**

The capacity for Families SA and other programs to work collaboratively will often be determined by the extent to which the Agency is prepared to share the information it has about a young person in its care.

Hannah was effectively left in the care of Mr B over the weekend of 7–8 July 2012 as a result of poor communication between Families SA and the registered foster care agency. The case approach preferred by Families SA did not place weight on the views of the registered agency charged with managing the placement, nor was the strategy of allowing the status quo to continue well thought out. The incident highlights the value of having a clear case direction which is shared with everyone who is involved in a child’s care, and against which all decisions are made. The management of Hannah’s absconding behaviour continued to be incident-based and reactive, and the lack of a clear, shared case direction between LWB and Families SA contributed to significant misunderstanding. The incident highlights the value of identifying contingencies and a joint approach to such contingencies so there is clarity for all parties managing what was potentially a dangerous situation for a vulnerable young person.

Families SA’s communication and information sharing with the Muggy’s program was also deficient. Katie Lawson, the Regional Operations manager for Muggy’s, gave evidence that the information accompanying referrals varied significantly in the level of detail. She emphasised that the more information Muggy’s received about a young person’s needs, the better the service they could offer.

Notwithstanding the need for this cooperative approach, and the fact that Muggy’s staff would be involved in supervising Hannah’s day-to-day welfare, they were given no information about her relationship with Mr B and the challenges it might present for Hannah’s transition. At the time the referral was made to Muggy’s there was a lengthy history of concern about Hannah absconding to Mr B, and yet Ms Bateson, Hannah’s key worker, knew no more about him than that he was Hannah’s boyfriend and he lived in Adelaide.

In circumstances where the key workers were attempting to build relationships with Hannah and mentor her and guide her about healthy relationships, this was critical information. It was especially so when Families SA had chosen to rely on a consistent message to Hannah that the relationship was not healthy, rather than issue a written direction. A cooperative approach would have permitted that message to have been delivered consistently by all agencies with a role in caring for Hannah.

In 2013, when Families SA finally took a more assertive approach to the management of Hannah’s relationships and removed her from the home of Mr F, it failed to involve Muggy’s in either the planning of this action or its execution. This is despite the fact that Muggy’s staff continued to be an ongoing support to Hannah, and much of the important information that Families SA was receiving about her welfare was coming through them.
One staff member explained the difficulties that Muggy’s staff faced when dealing with a crisis situation of which they had no warning:

"Part of the way we want to work with our young people is about being honest … because if you’re honest, it can show caring, concern … and going behind their back is not always … the best thing. So because it was our information that a lot of this was based on, I would probably have preferred to have been able to have this conversation with her about why we’ve reported things … or even to have sat down with Families SA first and look at what the plan would then be."

It is clear that there were people in Hannah’s life whose views she trusted. A consistent theme was that the relationship with her former foster parent, Ms T, was very important, and she would listen to what Ms T had to say about issues relating to her safety and best interests. That Hannah was prepared to place trust in and listen to the advice of people with whom she had secure and continuous relationships is an important observation. It highlights the power of young people having continuity of relationships, particularly during adolescence, when the pull of other relationships might divert them from a healthy transition to adulthood.

**AVOIDING CUSTODIAL PLACEMENTS**

Hannah’s stay in a youth detention facility over the weekend of 14–16 March 2014 was unnecessary. Her detention was not required to protect either her or the public, nor was it necessary as punishment, as she had not yet been convicted of any offence. Hannah was incarcerated because the Agency tasked with providing her care was concerned with the costs of keeping her placement open if it was not needed.

Hannah was not someone whose criminal history would otherwise have justified her being remanded in custody. She was let down by a system that could not keep a placement open for a vulnerable young person. When Hannah made a series of poor decisions, she did not have a safe place to land. Instead, she ended up in the youth justice system because the care system could not respond to her outside business hours. Youth custody should never be used as a placement option for young people under guardianship orders when their incarceration is not otherwise properly justified.

Young people should, at all times, have somewhere to call home, even if that home is a commercial care placement in a cabin at a caravan park. If the Agency stands in the shoes of a good parent, it must ensure that its services reflect what would reasonably be expected of a good parent in such circumstances.

**HANNAH’S POINT OF VIEW**

The Commission had a discussion with Hannah after the hearing of this case study. Hannah is an intelligent, resourceful and resilient young woman who now lives independently. She regrets not finishing her schooling, and wishes that she had had greater stability in her teenage years to enable her to do that. She is being supported by Ms T, her former foster parent. In 2015 Hannah made a freedom of information application to Families SA to obtain her proof of Australian citizenship, tax file number and Medicare information. Twelve months later she had not yet been provided with those documents.

Hannah was aware of the existence of post-care services but found the idea of calling a service with which she was unfamiliar and speaking to someone that she did not know confronting. Hannah emphasised the need for continuity in the relationships of care around her, and felt that changes in staff and placements had been disruptive for her.

She is actively job seeking, but finds it difficult to list her achievements in applications to prospective employers because many of them disclose that she grew up in care, a matter that she still regards as having some stigma associated with it. Although she felt worried about the challenge of independence as she approached 18, she felt elated that she was out of the system, and able to make her own way in the world, making her own friends and becoming her own person rather than constrained by the system.

**CONCLUSION**

The observations in this case study identified issues and themes that have informed discussions and conclusions principally in Chapters 10 and 14 of this report.

It is clear that significant reform is needed to the support that is available to young people transitioning out of care. Planning for this phase is a critical part of casework and must be done in a flexible, sensitive and child-focused way. Hannah’s journey was dominated by reactive decision making and crisis management which did not always serve her best interests and did not always keep her safe. The high standard of care required by young people in the care of the state is not always consistently delivered, and reforms are necessary to improve the journey of these important young people.
CASE STUDY 3 HANNAH—LEAVING CARE

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CASE STUDY 4
NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

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OVERVIEW

Children who come into the care of the state might demonstrate complex behavioural and psychological conditions which have developed as a result of their inadequate or abusive backgrounds. To the untrained or ill-informed observer, these children are identified as behaviourally dysfunctional. It is thought their condition results from a lack of effective discipline that can be remedied by firm boundaries and clear expectations.

A closer examination of the circumstances and a deeper understanding of the psychological development of children reveal a cohort of high-needs children whose development has been disrupted by pathological parenting practices. They have not been given the fundamental relationship building blocks taken for granted in functional families. These children with ‘high or complex needs’ share very similar characteristics, and can be reliably and efficiently identified at an early stage in care.¹

Child protection systems can be poor at recognising and responding to this group. However, resources can be concentrated to support these young people before they experience the series of multiple placement disruptions that appear to characterise their journey in care.

This case study tracks the journey in care of Nathan, a child who falls into the category of having ‘high or complex needs’. It explores:

- his earliest accommodation in foster care placements and emergency care;
- his accommodation in a large congregate care facility (the unit);
- his progress through the education system; and
- Families SA’s planning and decision making on placement choices.

The case study reveals that neither the child protection nor education system responded adequately to Nathan’s condition. Faced with the undeniable complexities of caring for a child such as Nathan, each service was constrained by practices and resources inadequate for the task and, at times, the absence of informed and consistent on-the-ground practices. Nathan is a case of frustrated plans and lost opportunities.

The inability of each system to tailor responses to Nathan’s needs resulted in a pattern of inappropriate placements and methods of education. The inadequacy of each service affected Nathan’s capacity to succeed in the other. As Nathan’s behaviours escalated in seriousness, he appeared to ‘fall his way’ out of education and placements, and into the criminal justice system. This case study questions the capacity of these systems, in their present form, to provide services to children who require intensive support as a result of their complex behaviours and psychological conditions.

EVIDENCE

NATHAN’S BACKGROUND

Nathan was removed from the care of his mother when he was about 18 months of age. Before his removal, Nathan had experienced serious and sustained abuse at the hands of his mother and her partner. It is likely that only a small portion of Nathan’s total abuse and trauma was ever known to Families SA (the Agency).

The first of two 12-month guardianship orders was made when Nathan was two. He was initially placed in the care of his grandmother and attempts were made to reunify him with his mother. These attempts were abandoned during a second 12-month order after Nathan’s mother was physically and emotionally abusive towards him during contact visits.

Soon after reunification attempts were abandoned, concerns were also raised about the capacity of Nathan’s grandmother to care for him full time, and the appropriateness of the placement was reviewed. A long-term order placing Nathan under the guardianship of the Minister until the age of 18 was made when Nathan was four. Between Nathan’s removal from the care of his mother and the making of the long-term guardianship order, he did not experience stable or secure care arrangements.

REACTIVE ATTACHMENT DISORDER

Nathan was subject to two short-term orders (12 months each) during critical developmental phases when stability was needed to establish healthy attachment relationships. Nathan’s capacity to develop the strong and stable attachment relationships necessary for healthy psychological development was undermined by lengthy uncertainty and subconscious concern about safety during contact visits and repeated moves between the care of his mother and grandmother.²

Nathan was diagnosed with reactive attachment disorder (see Chapter 10) even before starting school. When Nathan was four years old a private psychologist became involved in his care.

The success of therapy for children with reactive attachment disorder depends on a consistent approach to care being maintained within and between the child’s home and educational environments. Yet consistency of responses is frequently unsustainable. In the face of sustained poor behaviour, caregivers might quickly
conclude that the unfamiliar suggested strategies are not working and move through different strategies to try and find something that works. This trying and testing re-enacts ‘the inconsistency and unpredictability that was a feature of the children’s care environment before they came into care’.1

A strict disciplinary approach does not achieve the behavioural changes that parents of children with secure attachments would expect. The approach fails to understand that children with reactive attachment disorder are unable to self-regulate. Practices such as ‘time out’ are entirely ineffective. Disciplinary strategies depend on a relationship existing between child and caregiver in which the child seeks approval from the carer. This relationship does not exist for children with reactive attachment disorder. Such children are motivated by fear of the carer, not a desire to please, and could be actively interested in pushing the person away. In such cases, disapproval can act to reinforce the poor behaviour.2

**EARLY PLACEMENT HISTORY**

**A FOSTER CARE PLACEMENT**

Following a decision that placement with his grandmother was not appropriate, Nathan was placed with foster parents, Mr and Mrs H.

Nathan’s psychologist considered that effective therapy for Nathan should take the form of a combination of psychotherapy (Theraplay) and advice to Nathan’s foster parents and school environment about the care and management of an attachment disordered child.

Mr and Mrs H found management of Nathan’s behaviour difficult and Families SA staff became increasingly concerned that they would lapse into an inappropriate disciplinary approach when Nathan’s behaviour became particularly challenging. This approach was contrary to advice from Nathan’s psychologist. In his opinion the inconsistency of approach was likely to have a ‘profoundly deleterious impact on Nathan’s longer-term development, emotional wellbeing and adjustment in view of his likely perception that those whom he began to trust became mean and uncaring again’.3

The psychologist recommended to Families SA that a final effort be made to support Mr and Mrs H to adopt a more helpful approach, but otherwise to consider transitioning Nathan to a different foster care placement where carers were less likely to cycle through appropriate and inappropriate care and management practices.

That year Nathan completed kindergarten and began his schooling. He had already demonstrated challenging behaviours and an inability to relate to others. During his first year of school concerns surfaced about his conduct towards other students. At the age of five, Nathan was suspended from primary school after he was violent towards two other students. Nathan was not permitted to return to school until a student development plan had been finalised. This was the first of many suspensions.

Mr and Mrs H were becoming increasingly concerned about the sustainability of Nathan’s placement in their family. When Nathan was six, on the advice of his psychologist, a decision was made to end the placement.

**A PERIOD IN COMMERCIAL CARE**

Nathan was placed in rotational care—out-of-home care staffed by rotating commercial carers—where he remained for almost two years until he was eight years old. The problems associated with this form of care are discussed in Chapter 12.

The seriousness of Nathan’s conduct escalated in this form of care, and Nathan’s caseworker, the supervisor and his psychologist all agreed that commercial care arrangements were ‘inadequate for the remediation of his attachment disorder’ and a home-based placement was urgently needed.4 The psychologist recorded that ‘psychotherapy is unlikely to make any significant headway in the absence of there being a stable caregiver who can consistently implement a parenting plan that promotes Nathan’s security’.5

At least twice, the staff paid to care for Nathan exhibited inappropriate conduct towards him. One carer cut the heads off Nathan’s teddy bears as a punishment for poor behaviour, and another carer permitted Nathan to spend the night at his house after some confusion about where Nathan would spend Easter.

Following Nathan languishing in commercial care for 18 months, the Emergency Accommodation Review Panel of Families SA recommended funding approval for a $180,000 specialist package of care, which would be available to source a specialist therapeutic foster care placement. Approval was given by David Waterford, then Executive Director of Families SA.

Four months later, a suitable placement had not yet been located. Nathan’s psychologist reported to Families SA that he had become increasingly emotionally detached from others, despite efforts to maintain a connection with his former foster parents and to establish a regular care team. This response was functional as it permitted Nathan to come to terms with feelings of being unloved and uncared for. However, it was accompanied by extreme behaviour and affective displays with no regard for the effect on others or on relationships. Nathan viewed his actions as justified.6 While the change to commercial care had initially settled Nathan’s behaviour, the long-term detrimental effect of the rotational care placement was now clearly observable.
CASE STUDY 4 NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

NATHAN'S EDUCATION
By the time Nathan was six his educational engagement was breaking down. He was excluded from school and attended a learning centre (designed for students who require intervention beyond the capacity of a mainstream classroom). From that time Nathan's education was interrupted by a series of suspensions, reduced hours and being sent home from school early.

THERAPEUTIC FOSTER CARE
Just after Nathan turned eight, a therapeutic foster placement was found for Nathan with Mr and Mrs P, an older couple with adult children. Nathan’s transition to this home-based placement was associated with some particularly poor behaviour at school.

NATHAN'S ROTATION THROUGH SCHOOLS
Less than one month into the placement with Mr and Mrs P, Nathan was suspended indefinitely from his second primary school. He then rotated through a series of schools, all of which struggled to manage his challenging behaviours.

By the time Nathan was 11, he had attended seven separate schools, including two private schools. His attendance could not be stabilised at any of them. One transition between schools was planned, in an attempt to place him in an environment that would improve his learning outcomes. However, in all other instances he was suspended indefinitely or excluded, or the school asked that another school be located as it was not resourced to meet his needs. Nathan was also excluded from the learning centre.

In each instance the suspensions and exclusions resulted from an inability to manage Nathan’s behaviour, culminating in instances of violence against people and property, including the assault of teachers and students.

In a therapy report Nathan’s psychologist observed that he:

continues to have difficulty forming a close and loving dependency relationship with adult females in a caregiver (and/or teacher) role. He remains susceptible to bouts of extreme emotional and behavioural dysregulation that places others, particularly children, at high risk of serious physical and emotional harm. This is almost exclusively an aspect of his presentation in educational environments, where Nathan’s psychological characteristics are not fully understood or adequately managed. As a result, there are ongoing, significant difficulties with regard to Nathan’s placement in the mainstream education system.

The one period when Nathan’s schooling stabilised was accompanied by ‘wrap around’ services. He attended school for three days per week and was at all times supported by a student services officer (SSO), who was equipped with the understanding and capacity to use appropriate interventions. The behavioural incidents that did continue were managed not with external suspension but with send-homes and in-school suspension. This was the only school from which Nathan transitioned in voluntary circumstances.

Nathan’s schooling difficulties were exacerbated by extended periods between enrolments. It was difficult to locate a school that was able and willing to accommodate his needs. In one instance, it took five to six weeks of negotiations before a school could be located and conditions of enrolment agreed; in another it took three months. Sometimes negotiations between Education and Families SA as to who would pay for additional services, such as SSO support, contributed to the delay. The reluctance of one public school to take Nathan was such that, despite his enrolment, the arrangements required for him to attend were never put in place.

At times Nathan was not permitted to attend because agreements could not be reached between Families SA and the school about the conditions of attendance, including the nature of support services to be provided. For example, Nathan was not permitted to return to one private school as Mr Waterford would not permit the SSO to restrain Nathan, a condition required by the school. On another occasion, 16 prerequisites accompanied an offer to enrol Nathan at a public primary school. Taken together, they would have had the impact of precluding Nathan from any real participation in the school community.

Mr and Mrs P were strong advocates for Nathan’s enrolment and engagement at school. When Nathan was 10, Mrs P calculated that in the six schooling terms since coming into their care, Nathan had attended 95.5 out of a possible 294 days, with 15 send-home early days. Mrs P pointed out how disadvantaged Nathan was becoming educationally and socially. She helped Nathan make a complaint to the Commissioner for Equal Opportunity.

THE EFFECT OF SUSPENSION ON THE PLACEMENT
Nathan’s continued suspension and exclusion from school placed undue pressure on the placement with Mr and Mrs P. During periods when he was not attending school his behaviour would deteriorate.

Mr and Mrs P warned Families SA that the placement was at risk because of delays in finding Nathan appropriate schooling and the consequent pressure on them of having him at home 24 hours a day, without respite.
In a therapy report Nathan’s psychologist said that, despite making great progress with Mr and Mrs P, Nathan remained prone in certain conditions to extreme arousal dysregulation and associated gross acts of violence and destructiveness towards persons and property.

An advocate from the Office of the Guardian for Children and Young People (GCYP) intervened on Nathan’s behalf with Families SA. She advised Nathan’s caseworker that there was a danger that the placement with Mr and Mrs P was not sustainable. In particular, she said that the lack of respite was becoming problematic, and the circumstances required parallel planning in case the placement broke down. However, no alternative placement was planned.

The disintegration of Nathan’s behaviour came to a head when he was 11. Nathan was attending the Families SA office for tutoring (with a private tutor as an alternative to mainstream schooling) when a dispute arose. Nathan had to be physically restrained by Mr P in the Families SA waiting room for more than 50 minutes, and the police were called as a result.

A case conference followed, and Families SA, with Mr and Mrs P in attendance, made the decision to end the placement. Mr and Mrs P emphasised the hurdles to engaging Nathan in education as leading to the placement stress and subsequent breakdown.

Following that decision, a request was lodged with the Placement Services Unit seeking emergency care. An internal memorandum noted that Nathan would pose a ‘significant risk to other young people’ if he were placed in a congregate care environment. Neither congregate care nor home-based placement was recommended.

PLACEMENT AT THE UNIT

A placement was identified for Nathan at a large unit in the northern suburbs of Adelaide. In an email, the acting supervisor at the congregate care unit raised a number of concerns about Nathan joining the unit, in particular about him being admitted just before the weekend, as had been planned. Staffing arrangements were not suited to manage the complexities of a new young person joining the unit over the weekend; and the unit was experiencing high levels of violence and drug use from other particularly complex young people. It was recommended that Nathan’s admission be delayed until the following Monday.

The recommendation was not heeded. Nathan was admitted on a Friday, as originally planned, and he was not informed of the move until the day it occurred.

On the day of his admission, Nathan disappeared from the unit and a missing person report was made. It was the first in a long series of such reports. That night he was twice arrested, first for property damage and then for assault. He was remanded to the Adelaide Youth Training Centre, for the first of many stays.

A missing person’s baseline risk assessment records the risks for a young person if they go missing from residential care. This assessment was completed for Nathan soon after his arrival at the unit. It recorded a low risk rating for offending behaviour, self-harming behaviour, substance misuse and sexualised behaviours. This reflects the reality at that time. Although he had a long history of complex behaviours that were often difficult to manage, Nathan had not yet come into conflict with the youth justice system. He had not been using drugs or alcohol, he had not been missing from his placement, nor was he associating with unsavoury adults in the community.

A TEMPORARY PLACEMENT

Nathan was placed at the unit against expert advice. Despite their concerns about the suitability of the move, Nathan’s caseworkers supported the placement on the basis that advocacy for a therapeutic placement would continue. GCYP was advised by Nathan’s caseworker that Nathan was ‘on the waiting list’ for a therapeutic placement. This was confirmed by the manager of the Families SA office.

Nathan was placed in the unit at a critical time in his development. A case conference on 8 July 2013 was attended by nine professionals, including members of the Placement Services Unit. Psychiatrist Dr Prue McEvoy cautioned, ‘[i]f Nathan were to stay in community residential care, he will continue on an anti-social path’. Angela Davis, a clinical psychologist, described this as a ‘pretty predictable path’ for children with attachment disorders who enter large congregate care units.

Claire Simmons, principal clinical psychologist, observed:

the ones I really worry about going into the units are the kids who haven’t picked up the absconding or the sexualised stuff or the drugs or alcohol. I always feel devastated, I think it is not overstating it, when we have to place a child in that environment who hasn’t got those behaviours yet, because it really does feel like the system’s just helpfully adding … another problem for these kids.

The case conference recommended a placement in a transitional accommodation house, with one other child, and Nathan never being alone in a placement, as his best option. It was also recommended that Families SA consider an intensive therapeutic care (ITC) placement when one became available.
Nathan’s placement at the unit was intended to be temporary, until a more appropriate option could be sourced. At best, the unit was better than commercial care, but still not suitable for Nathan’s needs.

**Nathan’s Experience at the Unit**

Nathan’s experience in the unit followed the ‘predictable path’. It was characterised by conflict and the uptake of risk-taking behaviours he had not previously demonstrated. By mid-August 2013 Nathan was extremely unsettled. He had to be restrained physically almost every day due to his behaviour.

During the first six months at this placement Nathan was reported missing on 40 separate occasions—20 of those times overnight and once for four nights in a row. While off site, Nathan was often assaulted, including by other residents from the unit. One poorly matched group of boys who resided together at the unit had caused a great deal of property damage: 20 critical incident reports had been made over the previous month. While on a missing person report the boys stayed with an adult male, where they obtained and used illicit substances; Nathan reported he did so to ‘numb the pain’.

Investigation of other placement options were recommended for the boys, but none could be located. Nathan continued to cause property damage at the unit. He also began self-harming behaviours, and inhaling aerosol deodorant.

**Nathan’s Vulnerability**

While he was still 11 Nathan was assaulted and suffered a serious injury. Nathan told staff that he had been assaulted by Tim, a fellow resident of the unit. As a consequence of this assault, Tim was moved.

The unit supervisor reported that Nathan did much better in the period following Tim’s removal. Nathan did not go missing and was more engaged. The unit supervisor thought this was due to Nathan’s fear of seeing Tim following the assault, rather than a long-term improvement.

However, Tim and Nathan subsequently reconciled. Tim was said to have ‘forgiven’ Nathan for reporting the assault, and Nathan reverted to his previous pattern of going missing and associating with Tim outside the unit. More dangerous and anti-social behaviour followed.

From mid-2014 to early 2015 Nathan was admitted to hospital:

- twice because of abuse of over-the-counter medication;
- once after spending the evening intoxicated and with a male who he said had been abusive towards him;
- once after a bicycle accident while severely intoxicated by alcohol and cannabis; and
- once after an incident while he was seriously intoxicated and showing responses indicative of amphetamine use. Nathan was examined and detained under the Mental Health Act 2009. He was 12 years old.

**Nathan’s Contact with the Criminal Justice System**

In the first six months of Nathan’s admission to the unit, he committed a total of 22 criminal offences over 16 occasions. Mostly, they were violence against property and people, dishonesty offences and offences involving minor disorderly conduct. During this period he was incarcerated in youth detention on five occasions.

By February 2014, Nathan’s caseworker recorded in a case note that Nathan’s behaviour was escalating, with more assaults on other residents and staff at the unit. Following one assault alleged to have been committed by him, Nathan was bailed to reside at the unit despite residents being ‘petrified’ of his return. Nathan advised a Youth Court Magistrate that he continued to breach his bail because he hated his placement and did not want to be there. He said he would rather be in custody.

**Education While in the Unit**

Nathan’s engagement in education remained poor, except for the periods when he was in custody.

Nathan was referred to the Families SA Mentoring Program to occupy him with some activities during protracted negotiations over his school enrolment. Even though a mentor was not allocated, a mentoring program should not be used as a substitute for educational engagement.

A meeting to consider Nathan’s transition to high school noted that he had engaged very little in education during the past 12 months. On starting high school, Nathan was enrolled on a ‘flexible learning options’ basis. It was hoped that he would engage in some programs through Re-Engage, a youth services program.
RECORDING NATHAN’S EXPERIENCE

Nathan was subjected to almost daily restraints while at the unit. The unit supervisor reported that during one period Nathan’s conduct was explosive, ‘almost like a wild animal being caged and he did not know what to do’. As the current workers did not have a relationship with Nathan and were not able to recognise the signs leading to such behaviour, Nathan would very quickly end up being restrained. The supervisor observed:

Sometimes that would look ugly, in the sense that there’s this tiny little boy and there’s three of us trying to control this young person, and you can imagine what that causes to staff and to him. I mean, I shake every single time after 10 years, if I have to do the restraint, partly because of the natural reaction, adrenalin kicks in, partly because it is traumatic.

Seventy-six critical incident reports on Nathan were produced to the Commission for the period from his admission to the unit in June 2013 until mid-February 2015.

Regulation 14 of the Family and Community Services Regulations 2009 requires an account from the child be recorded in instances where force, including restraint, is used against the child. The vast majority of critical incident reports indicated that no account from Nathan had been taken. Not every critical incident report would require an account to be taken, as force was not used against Nathan in all instances. However, the majority of reports involved some use of force and the records produced displayed a systemic failure to comply with the recording obligations of Regulation 14.

The failure to record Nathan’s version of events ignored an important safeguard for him provided by the Regulations. The monitoring of use of force is intended as protection against the improper or arbitrary use of force. For further discussion of the legislative requirements for recording the child’s account in critical incident reports see Chapter 12.

PLANNING FOR A PERMANENT PLACEMENT

When Nathan was initially placed at the unit aged 11 it was intended as a short-term option. Accordingly, planning decisions that saw Nathan continue to reside at the unit require consideration.

ADVOCACY FOR A NEW PLACEMENT

On several occasions Pam Simmons, who was at that time the Guardian for Children and Young People (the guardian), raised concerns at an Executive level in the Agency about Nathan’s ongoing placement at the unit. Faced with this advocacy and the strong advice from Dr McEvoy that intervention was urgently required, Families SA could not have been in any doubt that urgent attention was required to source an alternative placement for Nathan.

A CHANGE IN POSITION

During the early stages of Nathan’s placement the guardian had received the following information from Families SA:

- Julia Lamont of Families SA’s residential care directorate advised there was no plan to move Nathan from the unit, and that his needs were best managed there, with staff and support from the unit available to manage his anger, in consultation with a psychologist. Ms Lamont expressed the opinion that ITC was not appropriate for his care, as it was designed for children who were incapable of regulating their behaviour. This was not the case for Nathan.
- Four days later, Mr Waterford advised by letter that there were no other suitable placements available at the time, although Families SA supported a move to a placement with fewer children if one became available.
- In a subsequent meeting this position was confirmed and the guardian was advised that Adam Reilly, the soon to be appointed manager of the Families SA office in charge of Nathan’s case would be asked to look for a short-term placement in a smaller residence with extra staff.

These communications demonstrate a marked change from the initial position that the placement would be short term and that ITC would be considered as an alternative. It is worthy of observation that Nathan had been seriously assaulted by another resident at the unit, just a week before Ms Lamont said that Nathan’s needs were best met in the unit.

The position taken by Families SA towards locating a placement for Nathan can be characterised as passive. Sonia Daniel, a supervisor from the local Families SA office in charge of Nathan’s case, expressed the view that ‘should an opportunity present itself for Nathan to move placements where there are less children, the … office would be supportive of exploring this option further.’ The letter sent by Mr Waterford to the guardian on 25 October 2013 also took the same approach.

No longer than three months after Nathan entered the placement on the basis of it being temporary, the Agency stopped looking for something more suitable. No active steps were being taken at an organisation level to locate an alternative for Nathan.
THE SATELLITE PLACEMENT PROPOSAL

Faced with an 11-year-old boy spiralling out of control, Nathan’s caseworker, Zoe Dalton, began to formulate a proposal for an alternative placement. This came to be known as the ‘satellite placement’.

This model allowed for Nathan to be housed in a small residence on his own which was situated sufficiently geographically close to the unit to be considered a ‘satellite’. The proposal permitted consistent care as workers based at the unit, with whom Nathan had established functional relationships, would staff the residence. It was hoped that separating Nathan from the influences of the larger unit would help meet his therapeutic needs. However, the proposal was expensive and would require significant residential care staff resources.

Despite support for the proposal from Dr McEvoy, who performed a consultative role in Nathan’s case, and warnings against continued delay, the satellite placement plan was never put in place. The relevance of the satellite proposal to this case study lies not in the merit of the ultimate decision, but in the process by which it was reached. The process demonstrates deficiencies in the manner in which Families SA makes planning decisions for children in care.

The written proposal contemplated that five people along the chain of command would record their agreement or otherwise with the proposal before it reached Rosemary Whitten, the Executive Director ultimately responsible for such decisions. The proposal did not progress beyond the first two steps of the chain of command and was never formally approved, or disapproved, by any of the managers who saw it.

The concept of the satellite placement was first raised at a meeting of a large number of professionals interested in Nathan’s welfare on 21 February 2014. At that time, Nathan was frequently being restrained, staff were having difficulties building relationships with him and other residents were frightened of him. In the opinion of Srdjan Vajdic, a Families SA psychologist, the gravity of the situation was seriously underestimated.

In March 2014 the proposal first went to Mr Reilly, Manager of the local Families SA office. Mr Reilly wanted to fully exhaust the current placement options by testing a variety of strategies to manage Nathan’s behaviour before significantly changing his placement. He advised the guardian that other strategies should include emphasis on rewards and recognition. He thought that placing gym equipment in the backyard might encourage Nathan not to run away.

In an email on 2 April 2014, Mr Reilly sent the proposal to his line manager, Caroline Keogh. He indicated his understanding that Ms Whitten was awaiting the proposal. He did not recommend the proposal to Ms Keogh. His view was that some options had not been fully explored and he indicated that he had taken a more active role in case direction.

One role of a manager of a local office was to:

provide leadership and direction of critical, complex, and highly political case management issues including children with high and complex needs who are at risk of death or serious injury.

This requirement is consistent with Mr Reilly taking a more active case direction role in Nathan’s highly complex case.

However, local office managers do not need clinical experience or expertise to be appointed to the role, and there are no essential minimum qualifications. They are appointed at MAS3 level in the discipline ‘administrative’. Mr Reilly, for example, progressed to his position through the public service management stream. He had no clinical or child protection expertise.

Mr Reilly’s position required him to become involved in highly complex case management issues and provide leadership on them, yet he was appointed to the role without experience in this area. The role of the office manager, where the position is held by an individual without clinical practice expertise, is one which requires careful consideration.

Mr Reilly took a pragmatic view that the satellite placement proposal was unlikely to attract support at an executive level unless it was possible to demonstrate that other options at a more modest cost had been tried but were ineffective. The more modest ‘creative’ ideas that Mr Reilly believed needed to be attempted did not have the support of the care team who had known Nathan for some time.

At a case conference on 16 April 2014, to which caseworker Ms Dalton and her supervisor Bronwyn Warren were not invited, the satellite proposal was briefly discussed. The Commission heard that it was not unusual for caseworkers to be left out of case conferences.

A freer flow of information from management levels to caseworker level on case work decisions may have resolved some of the subsequent lack of focus surrounding the proposal. The presence of caseworkers at important meetings would help information flow.

Ms Keogh advised Ms Whitten that the proposal and other alternatives would be considered at the meeting, following which the proposal and alternatives would be sent to Ms Whitten. However, the meeting did not produce any further clarity about the viability of the
satellite proposal. Conflicting accounts demonstrate that the meeting participants had different understandings of the outcome of the meeting.

Ms Keogh and Mr Reilly in particular appeared to have conflicting views about whether the satellite placement proposal had been dismissed. Ms Keogh reported to Ms Whitten following the meeting that, before the case conference, a decision that Nathan would remain at the unit had already been made, reportedly at a regular residential care placement meeting. In contrast, Mr Reilly advised the guardian that the proposed placement was not ruled out in the long run.

It appears that two outcomes were determined from the meeting. The first was that matching an older youth to live with Nathan in a smaller placement was to be investigated. A placement of this nature was consistent with the advice of Dr McEvoy as to the appropriate form of placement for Nathan. The second was that, Families SA would also try other behaviour management options, as proposed by Mr Reilly, despite them not being supported by unit supervisor Danijel Kevesevic or principal clinical psychologist Ms Simmons.

Mr Reilly took the view that the key to moving Nathan to a smaller placement was finding another well-matched child or young person who could live with Nathan. Mr Reilly passed these views to the caseworker Ms Dalton. Ms Dalton was left with the belief that her satellite proposal was ‘sitting with executive’. Ms Dalton contacted Janine Searle at the Placement Services Unit to request that efforts be made to identify another young person who would be suitable to live with Nathan in the satellite placement.

Ultimately, no action was taken on the request to source a placement match. Ms Searle held a mistaken belief that Nathan was to remain at the unit. She expressed this view to Mr Reilly, who, in effect, confirmed her mistaken belief. He told Ms Searle the care team wanted Nathan out of the unit, but he was not currently supporting the satellite placement. Ms Searle took the view this clarified the situation and the placement match was not pursued.

Ms Whitten advised Amanda Shaw, the acting guardian, that she took responsibility for not approving the satellite proposal. However, she took that responsibility as the most senior executive involved, not because she had made the decision. She told Ms Shaw that there was ‘potential for a house’ but no staff yet. Any potential for Nathan being moved to a smaller house was contingent on there being an active referral for him with the Placement Services Unit. The evidence supports the conclusion that no such active referral had been made.

The Commission is unable to determine who, if anyone, ultimately determined to reject the satellite proposal. With multiple parts of the Agency involved in decision making, and with decisions made in the absence of key personnel, the lines of communication became fatally confused. Failure to follow the chain of authority of decision making, and to document decisions made, added to the confusion.

With the satellite proposal having ‘drifted into obscurity’, and no effort being made to find a child to reside with Nathan, or an appropriate house, all efforts to secure a more appropriate placement for Nathan stalled. The short-term initiatives implemented did Nathan no harm, but they were no solution to his more fundamental underlying relationship issues. As time passed without remediation, these issues were severely impairing Nathan’s functioning.

THE QUARANTINED WING

A multi-agency meeting was held on 18 June 2014, under the auspices of the Community Protection Panel, to discuss placement options for Nathan. Of all of Nathan’s challenging issues, his placement was regarded as the most pressing. Families SA reported it was exploring a short-term ‘hybrid’ option which came to be known as the ‘quarantined wing’.

The proposal was based on an understanding that Nathan would react negatively, and most likely violently, if forced to have close relationships with one to two people, as would be the case in any placement on his own. The quarantined wing would encourage Nathan to develop such relationships by placing him in a wing of the unit by himself with ‘a consistent team of carers, who could push his capacity to form and maintain relationships, but not to the point where he would become overwhelmed’.

The plan depended on three other residents in Nathan’s wing being relocated. Families SA would incur the cost of three out of four beds in a wing being unoccupied.

It was hoped that Nathan could later transition to a more intense arrangement such as a specialist therapeutic residential care program or foster placement. It was emphasised at the multi-agency meeting, and subsequently by Dr McEvoy, that Nathan’s ability to cope with any changes in care arrangements would need to be carefully assessed. Dr McEvoy reported that ‘overwhelming Nathan with new relationships is potentially harmful and will undermine the plan agreed to at this meeting’.

The plan was approved, Nathan agreed to the change and an action plan was put in place. By the end of July workers had been identified to work alone with Nathan in his wing. Then progress stopped.
On 1 September 2014 the guardian Ms Simmons wrote to the Minister for Education and Child Development about Nathan. She said she did so as a ‘last resort’. She told the Minister that ‘his self-harming and high risk behaviour has escalated in the past two months. I fear that he may unintentionally die.’

Taking into account his time in emergency care and his time at the unit, Nathan had spent almost a third of his childhood in care arrangements that were universally agreed to be inappropriate for his care. A third of his life had been spent waiting for something more suitable.

It was not until June 2015 that the quarantined wing came into operation. The other occupant, a 17-year-old violent male, had refused to leave the unit until he turned 18.

The success of the quarantined wing was in part dependent on the availability of a small group of skilled workers who had been able to build a relationship of trust with Nathan. However, by the time the wing was available, staff originally identified as appropriate had changed. Despite recommendations against changes to the plans, and despite advocacy from GCYP against the move, the unit supervisor Mr Kevesevic, one of Nathan’s key workers, moved away from the unit shortly after.

By July 2015 no long-term plans had been made for Nathan’s case direction or placement transition from what had been intended to be an interim measure. GCYP continued to advocate for planning and a transition to more appropriate care.

In September 2015, Nathan was still residing in the quarantined wing at the unit, but his care team included only one of the original group identified to work closely with him. That worker was to move to a different position soon after.

**OBSERVATIONS**

The case study highlights system deficits in four key areas:

- the effect that emergency rotational care can have on the psychological health and development of children, perhaps particularly, children with pre-existing trauma and neglect histories;
- the extent to which educational systems understand and are capable of providing services to trauma-disturbed children, and the effect of educational disengagement on the stability of care placements;
- the lack of appropriate residential care options for young people with complex needs; and
- the quality of case planning and the manner in which complex, expensive and high profile case management decisions are made in the Agency.

Each of these areas is considered in this section.

**THE EFFECT OF EMERGENCY CARE**

The operation of Nathan’s reactive attachment disorder undermined his ability to settle into his foster placement with Mr and Mrs P, which would otherwise have given him his best chance of stable and sustained long-term care.

From age six to age eight Nathan was placed in emergency rotational care. All the experts who gave evidence regarded the period in emergency care as contributing to Nathan’s high level of dysfunction. In 2010 Nathan’s psychologist reported to Families SA:

> Nathan’s behaviour is no longer regulated by a concern for maintaining close emotional ties with significant people in his life. He is not being properly socialised. He is prone to extreme behaviour and affective displays in association with longstanding difficulties with affect regulation and clinically elevated autonomic (brain) arousal. There are no restraints on him committing such acts. In the absence of him being afforded the opportunity to form and maintain close emotional ties with a consistent carer or caregivers, he is almost certain to experience poor outcomes in most if not all aspects of his life. He is also a significant risk to the welfare and wellbeing of others. He is eight years old.

The experts agreed that the rotational care environment was not helping to give consistency between the care environment, educational environment and messages being delivered through therapeutic engagement. Any progress in remediating Nathan’s psychological dysfunction, and developing the relationship capacity necessary for healthy future functioning, was not possible while Nathan was being cared for by a series of rotational carers with no training in the complex needs of a trauma-damaged child.

**SUPPORTS PROVIDED BY EDUCATION SYSTEMS**

Nathan’s behavioural and psychological issues presented the public education system with a challenge it appeared ill-equipped to meet. Repeated attempts were made to safely engage Nathan in education, yet they all failed. Nathan’s educators attempted the same strategies over and over again expecting to achieve different results. Each school approached Nathan with the expectation that special measures would enable him to fit into the existing system, rather than having the flexibility to change the system to meet his needs.
The failure of these repeated efforts shows that the education system was not equipped to offer a different approach to Nathan’s challenging condition. At the core of these failures a rigid system failed to understand that traditional methods of behavioural management were ineffective for Nathan’s reactive attachment disorder. This approach had troubling consequences for Nathan. A public education system must be able to accommodate young people with behavioural challenges stemming from trauma-related backgrounds. It is the task of Education to accommodate every student: ‘there’s no-one else’. The system should demonstrate an understanding of what is required to support high-needs students to participate in education.

The case study identified failings in five key areas in education services for Nathan:

- transition between schools;
- adherence to departmental policies;
- understanding how to support a child with reactive attachment disorder;
- working with Families SA; and
- missed opportunities.

**TRANSITION BETWEEN SCHOOLS**

When it is necessary to remove a particular child from a particular school, their start at a new school should not be unduly delayed.

Some planning was needed to ensure Nathan’s new school environments were suitable. However, the delays exceeded any necessary planning period. Nathan spent lengthy periods not attending school while members of his care team negotiated and advocated for his enrolment, even after a particular school site was directed to enrol him. These periods saw his growing disengagement from education and an exacerbation of behavioural symptoms.

School principals must provide a safe learning environment for school, staff and every child. Risk planning, special conditions of enrolment and additional support might be needed to secure the enrolment of students who have high needs. However, those conditions cannot be so onerous that they have the effect of precluding high needs students from participating in public education. For Nathan, the conditions sought by one school were prohibitive, and based on a flawed understanding of reactive attachment disorder’s effects. Imposing such restrictive conditions effectively excluded Nathan from attending that school.

**NON-ADHERENCE TO POLICY**

Strict policies operate for the use of part-time schooling for students who are challenged by full-time attendance (see Chapter 10). Specific exemptions, with authorisation at different levels, are required, depending on the duration of the part-time school attendance.

Despite Nathan’s school attendance being based on reduced hours for a number of years, Education held only two exemptions for Nathan attending less than full time. This suggests a failure to comply with the strict processes governing reduced school engagement for students of compulsory school age. Nathan’s behaviour presented particular challenges that might have justified part-time school on occasions, but inconsistent compliance with the necessary safeguards undermined oversight of his educational needs.

**UNDERSTANDING HOW TO SUPPORT A CHILD WITH REACTIVE ATTACHMENT DISORDER**

Continued efforts were made by Education to put in place supports that would help manage Nathan’s behaviours. However, the same or slightly varied measures were repeatedly adopted by the different schools, despite previous failure. This demonstrates a global inability to communicate and learn from past experience.

At the individual care level, the Commission observed gaps in understanding and responses to the effects of Nathan’s reactive attachment disorder on his behaviour. The support of an SSO was an important feature of the measures adopted to allow Nathan to safely engage in schooling. The evidence raises the possibility that some SSOs engaged to work with Nathan lacked the necessary understanding of his psychological challenges. There was no evidence that any had completed any specialised training to equip them to support Nathan.

A frequent response to Nathan’s more extreme behaviours was the use of suspension. As has been observed, the use of traditional punitive methods is not effective in managing the behaviour of children affected by reactive attachment disorder. The continued use of such methods reinforced Nathan’s negative behaviours and undermined the effect of therapeutic approaches adopted by Nathan’s carers. Nathan’s educators appeared to be unwilling to acknowledge that traditional punitive and exclusionary approaches would not bring about sustainable behavioural change.

Moreover, continued suspension had a damaging effect on the stability of Nathan’s placement. His behaviour worsened, and Mr and Mrs P failed to receive the respite that school attendance would have given them.
CASE STUDY 4  NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

Employees at learning centres receive training in managing abuse-related trauma. The Commission observed that learning centre staff did not demonstrate the level of understanding and acceptance of trauma-related behaviour that would be expected for staff working with the demographic of children who attend learning centres. Instead, instances of staff demonstrating poor understanding and response to Nathan’s behaviour were observed (see Chapter 10).  

During exclusions a student should be referred to a learning centre. The child should be helped to manage their behaviours and seriously work on re-engagement. A learning centre could also be used as a stepping stone to a student attending a new mainstream school. The time Nathan spent at learning centres did not lead to his re-engagement in mainstream education.

WORKING WITH FAMILIES SA

There was little evidence that public education systems were prepared to work collaboratively with Families SA and Nathan to ensure his education was not threatened by long periods of disengagement.

The inability of Families SA and Education to reach agreement about funding school supports is noteworthy. It was not clear where ultimate responsibility rested for financing specific supports. Nathan’s case management was punctuated with discussions about payment for education supports and attempts to shift those costs.

The more significant issue is why Families SA were expected to make a financial contribution to the public education system for supports for Nathan. In the usual course of events, parents or caregivers are not expected to fund one-to-one support for a high needs child where it is considered necessary. Jayne Johnston, the Department’s Chief Education Officer, was unable to explain why Families SA would be expected to contribute to this funding, other than to suggest it had been the practice in the past. In the absence of clear policies, children in care are disadvantaged by futile bureaucratic squabbles about funding.

MISSED OPPORTUNITIES

Nathan’s difficulty in engaging in mainstream education was apparent almost from the outset. Mr and Mrs P were keen for Nathan to attend mainstream school, but it is unclear why opportunities were not taken earlier to enrol him in available intervention programs, which included:

- the Flexible Learning Options program—which provides a case manager funded by Education and alternative programs that focus on engaging Nathan and his carers in his learning.

Patricia Strachan, the former Executive Director of the Office for Children and Young People in the Department, acknowledged that case management would have been an important part of supporting Nathan to re-engage with schooling. Ms Johnston pointed out that the Flexible Learning Options program ‘is designed exactly for students like Nathan … if there’d been a case to be more flexible in the primary years … Nathan’s is the case. We really should have taken it.’

THE EFFECT OF SYSTEM FAILURE

Nathan’s lack of engagement in schooling placed strain on Mr and Mrs P. The eventual placement breakdown should have been foreseen by members of the care team working closely with them.

In addition to the benefits participation in education has for children and young people, there are key benefits for their caregivers. Respite is but one element. Participation in a positive education setting can improve a young person’s social skills, relationship capabilities and self-regulation of behaviour.

School suspensions or exclusions can generate hopeless circularity for children and young people with complex needs. The burden on caregivers can contribute to placement breakdowns which create instability across all aspects of a child’s life. Instability affects a child’s capacity to participate in education, and the cycle repeats.

Given the consistency with which Nathan was suspended and excluded from mainstream schooling, it is not surprising that he was almost completely educationally disengaged even before he began secondary schooling. Nathan’s poor academic outcomes raise the possibility that he will not experience the feeling of accomplishment that comes from making a valuable contribution to the workforce or participating in post-secondary education or training.

THE NEED FOR TRAUMA-FRIENDLY EDUCATION SERVICES

The public education system exhibits a rigidity that does not easily allow or encourage diversion from the norm. It was unable or unwilling to give Nathan the flexible and positive learning environment necessary to support and manage his trauma-related behaviours. Schools need to be able to provide inclusive education to meet the needs of their students irrespective of the profile of disabilities, challenging behaviours, children who have been traumatised.
A culture of preparedness to engage with vulnerable students must be developed. To do so, professional development and practical supports are necessary for teachers to improve the level of understanding of students with significant trauma backgrounds. Specifically trained SSOs could be one aspect of the necessary supports.  

INSUFFICIENT CARE OPTIONS FOR CHILDREN WITH COMPLEX NEEDS

Nathan’s high needs were apparent from an early age. With the exception of his placement with Mr and Mrs P, his care history does not demonstrate placements that appropriately supported his condition. The placement of this child with reactive attachment disorder in emergency care staffed by commercial carers contributed to the worsening of Nathan’s condition. The absence of home-based care options or a more appropriate residential placement equipped to care for Nathan, whose needs were already highly complex at age six, reflects the general absence of specialised residential care services for children with complex needs.

While home-based placements are commonly viewed as the best option for children in care, sometimes children’s needs are better served in other environments. That point for Nathan came on the disintegration of the therapeutic foster placement. Nathan needed a placement that reflected his care needs, which were specifically informed by his reactive attachment disorder.

After the placement with Mr and Mrs P had broken down, was there a realistic prospect of improving Nathan’s condition if he had been placed in different care environments?

A REALISTIC ASSESSMENT OF NATHAN’S PROSPECTS

At the point that Nathan left his placement with Mr and Mrs P, principal clinical psychologist Claire Simmons felt that Nathan’s best chance of a different trajectory was a therapeutic environment that could contain him, available from the time he left his foster placement. She agreed in evidence that the best option for him was a smaller house, although safety issues would need to be worked through because of the lower staff levels. If an intensive therapeutic placement had been available she would have liked Nathan to be given that chance. However, she opined that in all likelihood Nathan would find such an arrangement too intense and would run from it.

Ms Simmons said the extent of Nathan’s trauma, coupled with his anger, his rage and his physical strength set his circumstances apart as a child with especially high and complex care needs.

Ms Simmons was realistic about the prospect of Nathan achieving a different trajectory even if a more appropriate placement was found. Even if Nathan had been placed in a smaller house, with a lower risk of exposure to anti-social and criminal behaviour, his circumstances were nevertheless likely to lead him down that path. She explained:

so my concerns around residential care are that they come into contact with people, pick up new at-risk behaviour from other children or young people, so absconding obviously, or drug use or alcohol use, or becoming involved in high risk sexualised behaviour—all of these things. You get a sense of cross contamination … but kids basically show each other all their other problem behaviours and they pick those up … [C]hildren like Nathan, they run and they find each other.

With such prognosis, it was all the more necessary that, at this critical point, care was provided at a standard and in a form that gave Nathan’s condition the best chance to improve.

THE UNIT

At the time that Nathan was placed in the unit, no-one there was capable of managing the complex trauma behaviours of an 11-year-old boy without resorting to police intervention.

The placement offered a greater capacity than commercial care to control the quality of care for complex children, but otherwise remained an inappropriate choice for Nathan, a conclusion supported by all the experts.

This option was the least-worst option available at the time. It was not a good choice, but it was not as bad as the alternative, that is, emergency care.

The lack of available placement options for children with high needs, such as Nathan, not only leaves them in a holding pattern, it has the effect of contributing to their disadvantage. The effects of poor placement decisions also flow on to other children in the placement. As observed in Nathan’s case, ill-advised combinations of children in placements can contribute to instability and exposure to damaging behaviours such as drug use, absconding and offending.
Placement choices for Nathan's care were made in the context of limited available placement options. Families SA was compelled to act against considered advice from its own experts, who correctly plotted the trajectory of Nathan’s disintegration within the care environment. This does not meet the commitment given by Families SA in 2011 in its policy statement Directions for Alternative Care in South Australia 2011–2015 to:

- deliver a service which provides a range of care placements that are:
  - flexible within and across the whole of the alternative care sector
  - responsive to the individual needs of children in care.\textsuperscript{90}

The problem of limited placement options can be observed not only in the decision to place Nathan at the unit but also in his continued residence for almost two years before arrangements tailored to his needs could be put in place.

OTHER VIABLE OPTIONS

When Nathan was placed at the unit it was on an understanding that it would be an interim measure.

The question arises: were there other options available for Nathan’s care?

ITC was an option under consideration. During the period that Nathan was at the unit, other young people were being accommodated in customised intensive placements. Nathan’s advocate from GCYP, and Ms Davis, a clinical psychologist, were aware of small numbers of children with issues of a similar complexity to Nathan who had been offered placements where they were cared for individually, with two workers available at any one time. Nathan’s advocate from GCYP knew of four such instances in the two years preceding Nathan’s entry to residential care.

However, the path to access ITC is unclear. None of the Commission witnesses intimately involved in the field of residential care and the support of children within that environment, were able to identify the precise pathway by which a child might obtain an ITC placement.

In addition, there was confusion about the availability of any placement for Nathan. Some within Families SA clearly thought that Nathan was on a waiting list, or that he would be eligible for such care if a placement became available. This had been conveyed to GCYP.\textsuperscript{91} However, this conflicts with other information. In October 2013, Ms Daniel, supervisor at the local Families SA office, reported to Mr Waterford that the Placement Services Unit had indicated from the start that no other placement options were available for Nathan.\textsuperscript{91} Even two weeks after Nathan’s admission to the unit, a case note recorded:

> At this time the best option for Nathan is to remain in [community residential care] with Families SA staff to work with him on establishing clear boundaries and support him in developing appropriate skills and coping mechanisms. As he settles and becomes ready to explore alternative care arrangements, a new placement request will be undertaken.\textsuperscript{91}

As late as December 2013 there remained a degree of confusion, at an organisational level at least, as to whether Nathan was in fact on a waiting list for a therapeutic placement.

It is not possible to determine on the available evidence whether ITC was ever a viable alternative for Nathan. Certainly the evidence supports a conclusion that within weeks of his placement at the unit it was removed as an option.

Other placement options subsequently considered for Nathan included the satellite proposal, the placement in a house with an appropriately matched other child and, ultimately, the quarantined wing. Each required additional commitment by way of staff and infrastructure, combined with these resources becoming available. It took two years for the circumstances to arise in which care could be provided to Nathan in an environment mimicking, but not matching, that initially contemplated when he entered the unit.

CARE PLANNING

It is clear that Nathan’s placement at the unit was a decision borne out of what was available rather than what was appropriate. A number of factors contributed to the decision to place Nathan in a large congregate care facility and the case drift that saw him remain there:

- no concurrent planning at an early stage when it was clear that the foster care placement was at risk, which made it necessary to take the first available placement versus planning for the best placement fit for Nathan;
- confusion about the existence of an intensive therapeutic care placement and, if it existed, in what circumstances it would be authorised;
- a lack of attention to the urgency of placing Nathan in an appropriate home environment that considered his developmental timeframe and risk-taking behaviours;
- a disconnect between case planning work at caseworker level and decisions made at the Executive level;
- a lack of clarity about the decision-making authority and responsibility;
• poor communication with the caseworker about what was and was not possible;
• expansion of the care team beyond a core group which dispersed decision making and undermined clarity of purpose;
• the lack of strength in the residential care workforce which hampered the flexible deployment of staff in accordance with the best interests of the child; and
• the large residential care facility which, by design, was unsuitable for accommodating complex young people in a congregate care setting.

By the time Nathan was 10 years old, it was clear to Families SA staff managing him that his foster care placement was in peril and, if it could not be saved, then thought and planning would need to be invested in determining the best alternative. However, rather than proactive case planning at an early stage, the foster placement was permitted to drift towards a crisis which then necessitated reactive decision making.

Early decision making was contaminated by the view that Nathan could be moved into something more appropriate quickly. As observed, some staff believed the waiting list for therapeutic placements existed and Nathan was on it.

The evidence in this case study supports the conclusion that by the time the placement with Mr and Mrs P broke down, the most sophisticated proactive case planning may not have changed Nathan’s outcome. Attributing blame to case planning assumes that what Nathan needed was in existence or could be arranged at the time. The evidence supports the conclusion that the state of the residential care workforce was such that any flexible arrangements for high needs young people were very difficult to staff without resorting to commercial care providers. It also supports the conclusion that by this time Nathan’s needs had become exceedingly complex.

Acceptance of the unsatisfactory placement at the unit as a temporary measure saw Nathan’s priority for placement decrease. Ms Simmons observed that once children are placed in units, they become victims to a process of triage. Their needs are seen as less than those of many other children in other inappropriate arrangements. This process of triage is driven by the highest need on the day.\textsuperscript{44} It can be envisaged that children with complex needs, for whom significant planning is required to achieve an appropriate placement, are at a disadvantage in this process.

When this triage process was added to the observed lack of proactive planning by Families SA during the early part of Nathan’s placement, the available options for Nathan narrowed further.

There came a point in Nathan’s care journey when, despite the inappropriateness of the physical environment, the relationships that he had built with staff at the unit had assumed an importance to him that could not be disregarded in his therapeutic plan. Ms Whitten observed in evidence (in a different context) that ‘young people aren’t packages to be picked up and moved elsewhere because adults make decisions about them’.\textsuperscript{45} Nevertheless, Nathan’s placement in what everyone agreed was an unsuitable environment from the start, carried with it the very real risk that it would drift along and become a permanent, unsuitable, home.

When Ms Dalton finalised her proposal for a satellite placement, there were significant barriers to implementation. As observed, there was no clarity about the status of the proposal. Decisions were made within the residential care directorate about where Nathan would remain without any significant input from his caseworkers or other professionals advising on his care.

The Commission observed a clear disconnect between managers and executives having input into Nathan’s care and the workers that were managing him day to day. High level decision making and identification of issues did not appear to filter down in a systematic way. What was and was not possible was not clear and case direction floundered. Mr Reilly observed that the separation of decision making across residential care, case management and executive level managers led to silos of information and decision making. He favoured a much more transparent approach of making all the information clear and feeding back down to case manager level the known constraints and barriers.\textsuperscript{46}

It is difficult to precisely identify the source of this disrupted information flow. Mr Reilly observed that in contrast to other government agencies in which he had worked, the culture of Families SA tended to emphasise hierarchy and chain of command, with significance on people’s level and responsibility. This, he thought, made it difficult for a worker to have direct conversations with managers who were having direct input into case management on individual children.

It is inappropriate to blame individual workers for the events which saw Nathan’s circumstances deteriorate. Entrenched deficiencies in the flexibility of alternative care restricted the options that could realistically be offered, even with the most proactive and creative case management.
CASE STUDY 4 NATHAN—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

CONCLUSION

This case study reveals that changes are required at a fundamental level in the alternative care sector to provide supportive placements for children with complex needs.

The ability of Families SA to provide such placements depends on the availability of staff and facilities for placements appropriate to the needs of the individual child. This includes staff who understand and can react appropriately to the complicated behaviours demonstrated by children who have experienced trauma. The case study demonstrates that Families SA is not adequately equipped to provide such services to children for whom it cares.

Inappropriate placement choices do more than place children’s needs on hold. They actively foster disadvantage for children. For very young children, at crucial stages in the development of attachment relationships, placement in environments such as rotational care does not help them to form normal attachments. For older children, their placement in congregate care environments, such as units, exposes them to drug use, violence and other risky behaviours. For children with complicated psychological or psychiatric conditions, placements might be staffed by carers who are not sufficiently trained to respond to their needs. Nathan’s placements exposed him to each of these disadvantages during his care journey. Each acted to contribute to the development of reactive attachment disorder and its effect on him.

Attention should be given to a child’s placement throughout the child’s period in care. The need for placement change should be recognised and considered attention should be given to planning for change. In addition, the warning signs of disintegration in an otherwise appropriate placement need to be heeded and steps taken to avert placement breakdown.

For Nathan, targeted intervention at an earlier stage in his placement was the best chance he had to divert from the negative trajectory he took on entering the commercial care placement and, subsequently, the unit. The inability of Families SA to grasp these opportunities can be attributed to the absence of placement planning at an earlier stage, deficits in decision-making processes and communication within the Families SA hierarchy. They also failed to source more appropriate placements when he entered these unsuitable care environments. Possibly the greatest cause was the absence of accessible and available placements for children with complicated care needs.

The manner in which the public education system responded to Nathan’s complex behavioural and psychological needs exhibited similar deficiencies. Lack of understanding of Nathan’s condition, combined with a rigid system which expected him to conform to its standards, prevented him from actively participating in education. Squabbles between agencies and unrealistic conditions placed on enrolment saw Nathan too frequently absent from schooling.

Nathan’s experience demonstrates the importance of schooling on a child’s wellbeing and on the stability of placements for children in care. Education and child protection systems are intrinsically entwined in a child’s experience. For children in care, systems need to work together to support care and schooling placements as a means of supporting and maintaining the wellbeing of the child and helping them develop to their full potential.
CASE STUDY 4 'NATHAN'—CHILDREN WITH COMPLEX NEEDS IN OUT-OF-HOME CARE

NOTES

1 A Osborn & P Delfabbro, National comparative study of children and young people with high support needs in Australian out of home care, School of Psychology, The University of Adelaide, 2006.
2 Oral evidence: C Simmons.
3 Oral evidence: C Pearce.
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49 P McEvoy, letter to A Reilly, 7 August 2014.
50 GCYP, Memorandum to the Minister for Education and Child Development, 1 September 2014.
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61 ibid.; Families SA, Application for exemption from school enrolment/attendance and education enrolment/participation form—Nathan, internal unpublished document, 4 August 2014; see also note 62.
62 This issue is not unique to Nathan. In the experience of Wendy Dale, supervisor of Families SA School Engagement and Mentor Program, children under the guardianship of the Minister who are referred to her program and attending less than full-time generally do not have part-time exemptions in place and generally do not have plans in place outlining their re-engagement strategy (Oral evidence: W Dale).
65 Oral evidence: J Johnston; P Strachan.
67 Oral evidence: J Johnston.
68 Oral evidence: Mr & Mrs P; P Strachan.
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NOTES

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70 ibid.
71 Oral evidence: P Strachan.
73 Ibid., p. 7.
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# CASE STUDY 5
SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

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CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

OVERVIEW

On 10 June 2014 police attended the home of Shannon McCoole. They had been alerted to McCoole by law enforcement authorities interstate and overseas who were investigating a child abuse website. Images on the website appeared to have been produced to share with others. Evidence pointed to McCoole as the creator of images on the website.

McCoole’s computer equipment was seized by the police. They discovered a vast number of images, which included images of McCoole sexually abusing seven different young children. Six of those children, but not the seventh, were identified as being in the care of the state. McCoole had been entrusted with looking after them in the course of his employment, primarily in the southern region of Adelaide. He was charged with offences of sexual abuse with respect to those children and, in addition, offences relating to the production and dissemination of child pornography. The latter offences included his activities in creating the images and acting as the administrator of a website which disseminated child pornography, as well as discussing the sexual exploitation of children.

This case study is concerned with the deficits in the child protection system that enabled McCoole to gain access to his victims and to escape detection for an extended period of time.

On 7 August 2015, Judge Rice in the District Court sentenced McCoole to 35 years imprisonment and fixed a non-parole period of 28 years. In the course of his sentencing remarks, the judge described McCoole’s conduct as evil and depraved—conduct which evoked feelings of rage and revulsion in right-thinking people. He observed that McCoole’s conduct impacted not only the infants and children who were the victims of his offending:

Families SA is another victim because your actions have unfairly and unreasonably clouded its vital functions. Confidence and trust here have been called into question. Individuals in undertaking their important roles feel as though they need to be watchful and even suspicious of those with whom they work. In a sense, no-one is above suspicion.

Although McCoole’s offending conduct was unprecedented in its frequency and severity, the risk of abuse to vulnerable children in institutional environments has been well known for some years, both within Families SA and in the community more generally. Currently, it is the subject of the Royal Commission into Institutional Responses to Child Sexual Abuse. This case study highlights a tolerance of acknowledged risks that developed within Families SA through poor workforce planning and budgetary pressures, which led to a dearth of alternative care options for the increasing number of children entering residential care.

Children removed from their birth families suffer developmental disadvantages which can manifest in challenging behaviours. These disadvantages are amplified when such children are cared for in rotational environments, including emergency and residential care. Knowledge about a child’s behaviour, health, psychological and emotional wellbeing is scattered throughout Families SA. Without a high level of organisation and commitment, it is impossible to obtain the full picture of a child’s experience, as would be possible in a caring environment with no more than one or two consistent carers.

The case study examines McCoole’s employment at an out-of-school-hours care (OSHC) service which helped him obtain a position at nannySA, an agency which supplies staff to residential care facilities. It examines the processes of recruitment and management of workers by nannySA and Families SA to determine the extent to which they protect children from adults who might be inclined to abuse or neglect them. It reviews workplace policies, practices and culture, and examines the conduct of a care concern investigation into McCoole’s behaviour.

Deficiencies were observed in each of these areas, which permitted McCoole to offend undetected for such a long period of time.

The evidence against McCoole was not gained from any of the victims of his abuse, nor from his work colleagues advancing their concerns to the point that they were heard, but rather from his own recordings of his crimes.

EVIDENCE

In 2011, Families SA engaged paid staff to look after children in care in a variety of settings. One residential care program, known as transitional accommodation, provided care to children in small homes staffed by rotating shifts of carers. Most of those staff were employed by Families SA, and were subject to their direct supervision and oversight. A second program began in 2011; it placed children in housing obtained through the Australian Government’s Nation Building Stimulus Package (Nation Building houses). Delays in the recruitment of staff to this program (see Chapter 12) meant most of the staff in these houses were employed through a commercial agency. They were not supervised nor managed with the same rigour as Families SA residential staff.
# CASE STUDY PARTICIPANTS

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<th>POSITION (AT THE RELEVANT TIME)</th>
<th>ORGANISATION</th>
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<tr>
<td>Ms A</td>
<td>Director</td>
<td>OSHC</td>
</tr>
<tr>
<td>Ms B</td>
<td>Youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Ms C</td>
<td>Youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Ms E</td>
<td>Assistant director</td>
<td>OSHC</td>
</tr>
<tr>
<td>Mr F</td>
<td>Recruitment coordinator (selection panel for McCoole)</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Mr G</td>
<td>Senior youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Ms H</td>
<td>Carer, subsequently youth worker</td>
<td>nannySA, subsequently Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Ms K</td>
<td>Carer</td>
<td>nannySA</td>
</tr>
<tr>
<td>Ms L</td>
<td>Carer</td>
<td>nannySA</td>
</tr>
<tr>
<td>Ms M</td>
<td>Youth worker (selection panel for McCoole)</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Ms N</td>
<td>Manager</td>
<td>Special Investigations Unit, DECD</td>
</tr>
<tr>
<td>Ms O</td>
<td>Youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Mr P</td>
<td>Youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Mr Q</td>
<td>Youth worker (selection panel for McCoole)</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Ms R</td>
<td>Human resources consultant</td>
<td>Human Resources Misconduct and Incapacity Unit, DECD</td>
</tr>
<tr>
<td>Ms T</td>
<td>Rostering consultant</td>
<td>nannySA</td>
</tr>
<tr>
<td>Ms U</td>
<td>Trainee youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Ms V</td>
<td>Carer</td>
<td>nannySA</td>
</tr>
<tr>
<td>Mr and Mrs W</td>
<td>Foster parents for Chelsea</td>
<td></td>
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<tr>
<td>Ms X</td>
<td>Placement support worker for Chelsea</td>
<td>Lutheran Community Care</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION (AT THE RELEVANT TIME)</th>
<th>ORGANISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ann Marie Abela</td>
<td>Recruitment coordinator/human resources officer</td>
<td>nannySA</td>
</tr>
<tr>
<td>Marc Beltman</td>
<td>Caseworker for Chelsea</td>
<td>Families SA</td>
</tr>
<tr>
<td>Cate Braham</td>
<td>Chief Clinical Services Coordinator</td>
<td>Child Protection Service, Flinders Medical Centre</td>
</tr>
<tr>
<td>Dr Ken Byrne</td>
<td>Managing Director</td>
<td>Australian Institute of Forensic Psychology (Safeselect testing system)</td>
</tr>
<tr>
<td>Darren Calvert</td>
<td>Senior youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Tanya Cole</td>
<td>Managing Director</td>
<td>Hessel Pty Ltd (nannySA is part of Hessel Pty Ltd)</td>
</tr>
<tr>
<td>Peter Cross</td>
<td>Rostering consultant</td>
<td>nannySA</td>
</tr>
<tr>
<td>Graham Curyer</td>
<td>Youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Katherine Decoster</td>
<td>Supervisor, Transitional Accommodation program</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Wendy Dennis</td>
<td>Carer</td>
<td>nannySA</td>
</tr>
<tr>
<td>Josie Dimond</td>
<td>Carer, subsequently youth worker</td>
<td>nannySA, subsequently Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Brett Dixon</td>
<td>Principal Investigator</td>
<td>Special Investigations Unit, Families SA</td>
</tr>
<tr>
<td>Peter Emmerton</td>
<td>Chief Executive Officer</td>
<td>nannySA</td>
</tr>
<tr>
<td>Janet Gregory</td>
<td>Carer</td>
<td>nannySA</td>
</tr>
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DECD: Department for Education and Child Development  OSHC: out of school hours care
## CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION (AT THE RELEVANT TIME)</th>
<th>ORGANISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert Griffin</td>
<td>Senior youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Simone Hammond</td>
<td>Carer</td>
<td>nannySA</td>
</tr>
<tr>
<td>Corinne Hams</td>
<td>Youth worker (also acting senior youth worker)</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Catherine Harman</td>
<td>Manager</td>
<td>Care Concern Investigations Unit, DECD</td>
</tr>
<tr>
<td>Wendy Harmston</td>
<td>Youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Linda Hurley</td>
<td>Manager</td>
<td>Aberfoyle Park Office, Families SA</td>
</tr>
<tr>
<td>Toni Jezeph</td>
<td>Caseworker allocated to Mikayla and Levi</td>
<td>Aberfoyle Park Office, Families SA</td>
</tr>
<tr>
<td>Daniel Knight</td>
<td>Senior youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Kristin Kuehn</td>
<td>Principal consultant</td>
<td>Human Resources, DECD</td>
</tr>
<tr>
<td>Julia Lamont</td>
<td>Manager</td>
<td>Southern and Country Housing, Families SA</td>
</tr>
<tr>
<td>Julie Lawson Hall</td>
<td>Manager</td>
<td>Human Resources Misconduct and Incapacity Unit, DECD</td>
</tr>
<tr>
<td>Sue Macdonald</td>
<td>Director</td>
<td>Child Protection Service, Flinders Medical Centre</td>
</tr>
<tr>
<td>Christina Manderson</td>
<td>Youth worker (also acting senior youth worker)</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Dr Sarah Mares</td>
<td>Consultant infant, child and family psychiatrist</td>
<td>Expert witness</td>
</tr>
<tr>
<td>Bernadette Martin</td>
<td>Detective Sergeant</td>
<td>SAPOL South Coast Family Violence Section</td>
</tr>
<tr>
<td>Maree McCulloch</td>
<td>Operations manager</td>
<td>Bubble ‘n’ Squeak (child care facilities owned by Hessel Pty Ltd)</td>
</tr>
<tr>
<td>Danielle (Dani) McKenna</td>
<td>Business manager</td>
<td>nannySA</td>
</tr>
<tr>
<td>Noel McLean</td>
<td>Detective Senior Sergeant</td>
<td>SAPOL Special Crimes Investigation Branch</td>
</tr>
<tr>
<td>Lee Norman</td>
<td>Senior youth worker (supervision of McCoole)</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Professor James Ogloff</td>
<td>Clinical and forensic psychologist</td>
<td>Expert witness</td>
</tr>
<tr>
<td>Roslyn Packer</td>
<td>Customer care and administration manager</td>
<td>nannySA</td>
</tr>
<tr>
<td>Jessica Pinos</td>
<td>Youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Louise Purton</td>
<td>Acting senior youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Narelle Reedman</td>
<td>Carer</td>
<td>nannySA</td>
</tr>
<tr>
<td>Dr Jane Richards</td>
<td>Clinical psychologist, project director (implementation of recommendations from Hyde Review)</td>
<td>DECD</td>
</tr>
<tr>
<td>Karen Roberts</td>
<td>Youth worker</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Lincoln Rogers</td>
<td>Senior youth worker</td>
<td>Families SA</td>
</tr>
<tr>
<td>Melissa Rowley</td>
<td>Supervisor of Toni Jezeph</td>
<td>Aberfoyle Park Office, Families SA</td>
</tr>
<tr>
<td>Dana Shen</td>
<td>Director</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Nicole Stasiak</td>
<td>Director (current)</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Shane Sterzl</td>
<td>Supervisor, Nation Building scheme</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
<tr>
<td>Mirjana Vidovic</td>
<td>Case manager for William</td>
<td>Families SA</td>
</tr>
<tr>
<td>David Waterford</td>
<td>Deputy Chief Executive</td>
<td>Office for Child Safety, DECD (Families SA)</td>
</tr>
<tr>
<td>Pamela Watson</td>
<td>Caseworker for Chelsea</td>
<td>Families SA</td>
</tr>
<tr>
<td>Don Williams</td>
<td>Supervisor with oversight of care concerns</td>
<td>Residential Care Directorate, Families SA</td>
</tr>
</tbody>
</table>

DECD: Department for Education and Child Development  OSHC: out of school hours care
Families SA also provided emergency care for children yet to be placed in longer-term environments. Emergency care used places such as motels, hotels and suburban homes, and was also staffed by workers employed through commercial agencies. They, too, received limited supervision by Families SA.

At the start of 2011, McCoole was employed through the commercial care agency nannySA, his first employment to look after children in state care. He worked shifts in all three forms of care through that agency. In May 2012, McCoole was offered a contract as a child and youth support worker in Families SA. He worked shifts in that capacity until just before his arrest on 10 June 2014. During the time he was employed by Families SA, McCoole continued to work shifts through nannySA sometimes two shifts in sequence, one employed by Families SA and the next employed by nannySA.

EMPLOYMENT AT OSHC

Before he worked with children in care, McCoole had had experience working with children in OSHC. Such experience is usually viewed favourably by Families SA and commercial care agencies supplying staff to residential care facilities. McCoole’s experience at an OSHC, at a suburban government primary school, was a stepping stone to his employment with nannySA.

From January 2010, McCoole worked casual shifts at OSHC, in his first remunerated position in Australia caring for children. These shifts continued alongside work for nannySA and Families SA until January 2014.

In about 2006, McCoole had become friends with Ms A, whom he had met socially. She was the Director of OSHC for most of the time that McCoole was employed there and responsible for the daily administration of OSHC. The only other full-time employee, Ms E, focused on supervision of the children. OSHC was otherwise staffed from a casual pool. A high staff turnover created pressure to frequently recruit casual staff.

In late 2009, Ms A suggested to McCoole that he might be able to obtain work at OSHC. McCoole told her that he was enrolling in a teaching qualification at university. Ms A, assisted by Ms E, selected casual staff. The usual process of employment was submission of a curriculum vitae (CV), and a brief meeting with Ms A and Ms E where the applicant’s experience was discussed, followed by a tour of the service. Suitable applicants were then offered trial shifts when the applicant could see how the service operated. Ms A did not conduct referee checks unless more information was required than was available in the CV.

No formal qualifications were required for the position, although experience working with children was desirable. OSHC employment is often an entry point for people who are interested in working with children. It provides an opportunity to develop the skills which might be required for other positions.

The Commission has been unable to determine the specific process by which McCoole was employed at OSHC. Ms A was not able to recall whether the usual process was followed, but maintained that she did not believe she would have diverted from her usual practice. She was aware that McCoole’s only prior experience working with children was in the United States of America at a summer camp. She did not contact referees from his last place of employment in South Australia, where he had worked as a communications technician, because she considered the work not relevant. She felt that her knowledge of McCoole, obtained in a social setting, enabled her to adequately assess his character. Ms E did not participate in the process of appointing McCoole to OSHC; she was not present at any interview, nor was she asked her opinion of him.

The selection process used contrasts with OSHC policies: staff selection processes must be merit based, including the advertising of vacant positions, interviews conducted by a three-person selection panel which recorded processes and decisions, and confirmation or termination of the appointment of casual staff by the governing council after a probationary period. This process was not applied to any staff member appointed to OSHC.

McCoole undertook his first shift with OSHC on Monday 18 January 2010. It is not clear from the evidence whether this was a trial shift. However, it was rare for applicants who were offered trial shifts not to be engaged. The high demand and turnover of staff meant some applicants were not scrutinised to an appropriate degree before they were hired.

McCoole’s recruitment process might seem to have been more casual and ad hoc than the norm but it appears to be usual practice for friends or family. On occasions, when such people were engaged for casual work, it was without a formal consideration of their merits. McCoole did not provide his national police clearance certificate until 26 February 2010, almost a month after his first shift. McCoole completed Responding to Abuse and Neglect (RAN) training, the equivalent of Child Safe Environments training, in August 2010, about seven months after he began his shifts. At the time OSHC did not require employees to complete RAN training until after they had started employment.
CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

Ms A maintained in evidence that the process by which McCoole was appointed was ‘merit based’. She saw no potential conflict in assuming the whole responsibility for hiring a friend. This view demonstrates a lack of understanding of the concepts informing basic human resource processes.

MCCOOLE’S CONDUCT AT THE SERVICE

On 7 December 2010, Ms A provided a telephone reference for McCoole to Ms T, who was considering an application by McCoole for casual employment at nannySA. According to notes taken by Ms T, Ms A rated McCoole’s flexibility, maturity and punctuality highly. Ms A did not mention any concerns about his interpersonal skills or the way in which he approached the care of the children. She did not identify any areas needing improvement beyond ‘perhaps more involvement in food prep’. This appeared to accurately reflect Ms A’s opinion of McCoole’s work at that time.

During McCoole’s employment at OSHC he exhibited behaviours which caused a number of his colleagues concern, although there is no evidence to suggest that Ms A was aware of that conduct before providing the reference to nannySA. McCoole’s conduct included attempting to discuss details of children in care with a colleague and showing photographs of such children to others. The latter was brought to Ms A’s attention and she understood it was not appropriate. However, she did not do anything to raise the topic with Families SA or nannySA.

McCoole was observed behaving inappropriately with children at OSHC. He was seen holding hands with children and on one occasion he commented to a colleague that a particular child needed to wear a bra. He exhibited a preference for a small group of children and engaged in play that was rough, and tickling beyond what was appropriate. Ms A was made aware of some if not all of these behaviours and a number of them were raised with McCoole as being inappropriate.

McCoole was also seen behaving inappropriately with children while seated on the floor at OSHC. On one such occasion a female child was seated between his legs and was moving her hands on his legs. Ms A spoke to both the child and McCoole, telling them to get up off the floor. McCoole simply laughed the matter off and no further action was taken.

Ms E became unhappy about McCoole working at OSHC. On more than one occasion she told Ms A that she thought there was something not right about him. In 2013 Ms E told Ms A, ‘if you don’t get rid of him or say something it’s going to come back and bite you on the bum’. Ms E reported McCoole’s conduct and attitude concerning children to Ms A, and identified specific incidents of inappropriate behaviour towards children.

Ms A denied that she was told of Ms E’s concerns about McCoole’s conduct but she was aware of Ms E’s concerns about his personality, arrogance and boisterousness. On this topic, the Commission prefers the account of Ms E.

MCCOOLE’S SUSPENSION

In mid-2013, McCoole was suspended from Families SA (the Agency) while a care concern (discussed below) was investigated. There was no mechanism in the Agency to advise Ms A about this suspension; Ms A was told about it by McCoole. He told Ms A that there was an allegation of inappropriate behaviour involving a child’s bottom. Ms A did not believe McCoole to be capable of the kind of behaviour alleged. She believed the complaint must be false.

Ms A did not seek advice from anyone in the Agency about dealing with a staff member who was suspended from Families SA. Ms A knew she could seek advice from the Agency’s OSHC unit but did not see the need to do so. She made no attempt to ascertain the precise nature of the allegations to assess whether they might impact on McCoole’s suitability for continued employment at OSHC. As events transpired, McCoole did not work any shifts at OSHC while he was suspended from Families SA. However, this was not the result of a specific decision not to roster him while suspended, but rather a fortuitous state of affairs as all shifts were filled by other staff.

The Commission considers Ms A should have placed greater emphasis on the supervision and performance management of McCoole, particularly after she was made aware of incidents of inappropriate conduct and the concerns of other workers.

THE CHAT LOGS

In the course of this case study, the Commission obtained access to a record of online chat logs which set out McCoole’s conversations with other like-minded people about his sexual attraction to children and how to get access to them. Statements made by him in these logs indicate that he was actively contemplating how to gain access to children in care. McCoole’s conversations with other like-minded people about his sexual attraction to children and how to get access to them. Statements made by him in these logs indicate that he was actively contemplating how to gain access to children in care. It is also clear from the chat logs that McCoole had formed an intention to offend against children before he began work with nannySA and Families SA.

The chat logs include discussions about offending against children in care. McCoole consistently turned his mind to how he could to gain access to children through his employment and discussed numerous strategies which could be used to avoid detection for sexual offending.

CHILD PROTECTION SYSTEMS ROYAL COMMISSION REPORT
EMPLOYMENT BY NANNYSA

In late 2010 McCoole applied for casual work with nannySA, part of Hessel Group Pty Ltd, a private company contracted to supply emergency care workers to Families SA. McCoole began shifts with nannySA in January 2011 from its casual pool, which was maintained to fulfill contractual obligations with Families SA. At the time, nannySA consultants recruited and managed staff. They had no expertise in human resources or recruitment and no formal training or guidance as to the skills and capabilities required in an emergency care worker.  

Applicants began the process by submitting their CV to nannySA for consideration. Suitable candidates were then invited to attend an interview at which they completed a registration form that included questions about their state of health. In his form, McCoole claimed a clean bill of health. That conflicts with earlier statements to OSHC staff, and his subsequent application to Families SA, which noted a diagnosis of depression and the use of medication to treat anxiety.  

Ms T’s recommendation on McCoole read (in full):

Seems very level headed  
ticked all the boxes re questions  
had done his homework about nsa  
very happy with his answers presentation and articulation.

Ms T did not make the final decision about the appointment of McCoole. She passed on her recommendation and references to a colleague in a different area of the organisation.

Applicants for emergency care work were not required to hold any minimum formal qualifications. Experience caring for children was desirable rather than mandatory. By way of contrast, applicants for positions in child care centres operated by Hessel were obliged to hold a Certificate III in Children’s Services.

By 2010 some consultants were concerned they were unable to properly perform their recruitment role, that they had insufficient time to perform the function and felt pressure to hire enough carers to fulfil the agency’s contractual obligations. At times, this pressure left Ms T dissatisfied with the standard of staff appointed.

nannySA had a requirement that workers who had not undertaken shifts with them for a period of time needed to reapply through a fresh application process, although there was no fixed rule as to the circumstances in which a new application would be required. In 2012 and again in 2013 McCoole was required to reapply for inclusion in the casual pool.

By 2013 nannySA had consolidated recruitment functions under the management of human resources and recruitment consultant, Ann Marie Abela. Ms Abela told the Commission that re-registration was subject to the same degree of scrutiny as the initial application and was dependent on the merits of each applicant. However, this was not the situation for McCoole’s re-registration in 2013. Ms Abela understood McCoole had been approached to return to nannySA and said her task was limited to completing the necessary paperwork. Ms Abela interviewed McCoole as part of the re-registration process but she agreed that no genuine merit-based selection was applied.

TRAINING

nannySA had to provide training and development to emergency care workers according to the conditions of its contractual agreements with Families SA.

nannySA depended heavily on Families SA for this training, although the training failed to deal with the complexities of providing care to children in emergency and residential care environments. Some deficits in the experience of casual workers were addressed by training delivered by nannySA. For example, McCoole had no experience in caring for young children but nannySA gave him training in infant care and child nutrition—which took only about four and a half hours. It was intended to equip a person with no previous experience caring for young children with the skills required to care for between one and three children at a time, potentially on a single-handed shift. It focused on some of the practical aspects of caring for an infant but child development and milestones were not covered in any detail.

In 2010, Families SA delivered orientation training to nannySA workers who were going to undertake shifts in Families SA facilities. It was four months after McCoole’s first shift with Families SA before he undertook this training. Specialised training outside of the basic induction was provided on the job by Families SA workers, and then only if a nannySA worker was tasked with caring for a child with particular needs.
Some workers engaged through nannySA felt ill-equipped to work in Families SA facilities. They had little if any training about the kinds of behaviours they would see in children with a history of abuse and trauma. From time to time the Managing Director of Hessell, Tanya Cole, received feedback to this effect from new workers. She attributed this to a lack of information from Families SA about the particular needs of the children in the placement, rather than inadequacies in the induction or training process.

When McCoole began his orientation, the training was delivered by a Families SA trainer. Over time this training program has changed. Presently, nannySA trainers deliver the orientation training in accordance with a package developed by Families SA. The package provides more information about dealing with children with trauma-related behaviours than was provided in the past. However, the training is not delivered by experts in the field of caring for children with complex needs. One of the trainers is Ms Abela, whose training and experience is in human resources.

The only training by nannySA on child sexual abuse was a generic course in child safe environments. This did not focus on the challenges of residential or emergency care environments. The only ongoing training was in the form of emailed practice guides dealing with specific issues.

SUPERVISION
When McCoole started his shifts looking after children in care, the Nation Building houses had begun operation. They were staffed exclusively by nannySA workers, under the supervision of Families SA operational services staff at senior and supervisor levels (OPS4 and OPS5).

From the start of this arrangement there was a lack of clarity about lines of responsibility for supervision and performance management of agency staff. Shane Sterzli was the first supervisor OPS5 appointed by Families SA to oversee Nation Building houses. He thought that Families SA senior staff were obliged to report concerns only to nannySA. Ms Cole thought Families SA was responsible for performance management. These conflicting views left gaps in the supervision and performance management of workers.

In addition, lead carers or shift leaders were not identified. At times, this resulted in conflict. Work performance complaints made by nannySA staff were often dismissed as vindictive attempts to gain more shifts for themselves. One rostering consultant consequently adopted a practice of moving staff between houses to find a ‘better fit’, an approach also evident in Families SA. This practice is perceived by other workers as moving problem performers rather than dealing with their issues.

Peter Cross, the nannySA rostering consultant responsible for supervision of McCoole, was aware of complaints that McCoole was too bossy and would tell supervisory staff ‘what they wanted to hear’. However, other workers liked working alongside him because he was prepared to take a leadership role and got things done. Mr Cross thought that sometimes workers with such characteristics ‘got shot down’.

THE ANONYMOUS CALL TO NANNYSA
On 16 March 2011, about two months after McCoole’s first shift with nannySA, Roslyn Packer, the nannySA customer care and administration manager, received a telephone call from a person who remained anonymous. The caller wanted to provide information about a worker he identified as ‘Shannon’. Ms Packer determined that ‘Shannon’ was McCoole.

The caller said he was a friend of McCoole’s. He said McCoole had been discussing looking after three young children, changing nappies, the children wanting kisses and cuddles at bedtime and places he takes the children. The caller also referred to McCoole posting derogatory comments about his employer on Facebook.

Ms Packer took the view that the information provided by the caller raised a concern about a breach of confidentiality on McCoole’s part, rather than an allegation of anything more sinister. The information was passed on to Mr Cross as the relevant rostering consultant.

Mr Cross spoke with McCoole about this report and raised the concern about breach of confidentiality. McCoole claimed that someone was ‘trying to make trouble for him’. He denied taking children anywhere except to collect them from school. He suggested the only comments he might have made about his employer would have related to difficulties with a former employer.

Given the limited information, and lack of context, nannySA took no further action. The information was not passed on to Families SA nor was there any contractual obligation to do so.

ACCESS TO INFORMATION AND RECORDS SYSTEMS
The capacity of commercial carers to access information about the children in their care was very limited. nannySA workers were not able to access the computer-based C3MS case management system and thus could not access or upload information on children in care. They recorded information about children manually, with the expectation it would be uploaded by Families SA senior staff. They also could not access the Families SA email system. Information that needed to be disseminated consistently to all workers in the residential care directorate (the directorate) could be communicated only personally by senior Families SA staff.
nannySA workers expressed concern to the Commission about the level of information they were given about children in their care. Julia Lamont, manager of the southern region and country area within the directorate, was aware of this concern. She understood the practice resulted from a concern about giving access to the system to workers who were not part of the ongoing workforce. Ms Lamont acknowledged this caused difficulties, particularly for nannySA staff who worked on a regular and continuous basis with a group of children, as was the case in the Nation Building houses.

Day-to-day events in residential facilities were recorded manually by workers in hard copy observation logbooks. Significant observations from these logs would then be extracted by a Families SA senior worker and entered into C3MS for the attention of a child’s caseworker.

Critical incident reports are completed to record events that are too serious to be captured in the day-to-day records. Reports can be completed online by Families SA staff and directed to the attention of the relevant senior or supervisor. Agency staff in the Nation Building houses had to manually write reports and leave them to be collected by Families SA staff.16

There was an inconsistent understanding about whether important observations of a child could be communicated directly by an agency worker to a child’s caseworker. Some workers thought the practice was frowned upon, a view shared by some Families SA workers.14 Mr Sterzl accepted the practice was contentious, but he had no issue with direct communication. However, lack of email access meant that contacting a caseworker could be a challenge for commercial carers, especially when hours of work did not align.

THE ORGANISATIONAL CONTEXT 2010–14

When McCooles began work with nannySA in early 2011, approximately 120 children were being cared for in ‘emergency accommodation’. Other children were living in houses owned or managed by Families SA and staffed by commercial carers.17

In October 2011 Nation Building houses in the southern area became available to Families SA. The properties were ready to house children, but the project to put them into operation stalled awaiting Cabinet approval for an increase to the full-time equivalent (FTE) cap that was required to staff them. In the interim, the houses were staffed with commercial carers. Formal approval to increase Families SA staff numbers was not given until June 2013, and from late 2011 until then recruitment in Families SA was limited to short-term contracts. It was during this period that McCool applied for and received employment under a contract with Families SA.

CONTRACTUAL ARRANGEMENTS FOR THE USE OF NANNYSA WORKERS

Over time, nannySA held a series of service agreements for the supply of staff as emergency care workers. It was not until 26 September 2013 that a service agreement was in place which specifically provided for agency staff to work in Nation Building and transitional accommodation houses—both offered more long-term care for children than was contemplated by the service agreements for emergency care workers. In the interim, agency staff were either engaged in environments outside the description of emergency care, or without any agreement in place at all. Between 30 September 2012 and 25 September 2013, no documented agreement covered the use of nannySA workers in Families SA properties; a service agreement entered into on 26 September 2013 was expected to have retrospective operation.16

The agreements in place contemplated workers providing temporary short-term care to children in crisis, where no other care options were available.14 Staff were not obliged to have a high level of knowledge about child development and their training was not rigorous. The service agreements specified a worker to child ratio of 1:1. In practice, ratios of one commercial care worker to three children were commonplace.

In addition, the agreements did not reflect the presence of Families SA supervisors at Nation Building houses, and lacked any written instruction on how the new relationship between nannySA workers and Families SA staff would work. They contained no provisions which referred to oversight of the agreement’s operation.

Residential care grew without the necessary service agreements covering staffing keeping pace. Houses were staffed with disregard for the existing contractual terms, and crucial aspects of service provision and systems oversight developed unchecked. The effect of this is highlighted in the different understanding of nannySA and Families SA as to who bore responsibility for worker supervision and performance management. Training was kept at the basic level, barely sufficient for providing emergency care, for staff deployed to care for children on a long-term basis.

EMPLOYMENT BY FAMILIES SA

By February 2012, McCool had worked for nannySA for just over a year. His offending against children in care had started shortly after he worked his first shift through nannySA. It was well entrenched by the time he applied for work with Families SA.
RECRUITMENT
In 2012, recruitment to Families SA’s residential care directorate was managed by a recruitment coordinator. In late January or early February 2012, Mr F was appointed to this role, and the selection process involving McCoole, the first that he oversaw. Mr F had extensive experience working in residential care, but his exposure to recruitment practices in the directorate was limited to having acted as a peer representative on previous interview panels and from a handover period soon after he began the role.60

Dana Shen was the Head of the Residential Care Directorate at this time and she bore the ultimate responsibility for recruitment decisions. Ms Shen had taken up this role in about October 2011.61 General human resources support was available to the directorate, but Mr F did not consider it extended to specific support for recruitment processes. He sought limited assistance from human resource consultants on some decisions.62

Mr F’s employment as recruitment coordinator coincided with the push to recruit large numbers of staff. He understood that Families SA wanted to be able to replace nannySA staff in Nation Building houses (although they could only do so by employing staff on short-term contracts). Mr F felt under pressure to increase staff numbers and his decisions were influenced by this pressure.

At the time of McCoole’s application, OPS3 youth workers were not required to hold any formal qualifications. Successful applicants were required to ‘undertake training to acquire certification relevant to the role’.63 These conditions must be seen in the context of the responsibilities of the role such as:

- providing day-to-day care and support to infants and children;
- developing and implementing programs to assist and teach children;
- sensitively ascertaining information from children about their situations;
- supporting and counselling them and assisting in the development of a case plan; and
- assisting in training other workers.64

Youth workers were expected to have ‘[d]emonstrated experience in working with vulnerable young people, and use of communication skills, behavioural intervention techniques and the physical capability to manage young people in crisis’ and demonstrated knowledge of relevant child-related legislation.65

MCCOOLE’S APPLICATION
On 16 February 2012 Families SA received McCoole’s application. In addition to background information McCoole provided responses to four behavioural questions which were aligned to the role description.66

In the CV attached to the application, McCoole said he was currently studying for a Bachelor of Education (Primary/Middle) at the University of South Australia. There was a reference to his experience with nannySA and OSHC, at a summer camp in the USA, as a rental technician supervisor at a ski store for children in Canada and in a YWCA Connect 4 Program. The referees named in the CV included staff from nannySA and Ms A from the OSHC program.67

Mr F was joined on the selection panel by two youth workers, Ms M, an experienced senior youth worker, and Mr Q. Neither had previous experience in recruitment, nor had they received any training in recruitment or merit-based selection. Ms M and Mr Q continued to work shifts around their recruitment duties. The process placed significant demands on their time.68

Each application was assessed by a panel member to determine whether it should progress to the next stage, considering the applicant’s previous experience and responses to the behavioural questions.69

McCoole’s CV and written application demonstrated relevant prior experience working with children and young people. His responses to the behavioural questions were reasonable and he satisfied the criteria to advance. It is not surprising that he was advanced to the next stage along with 60 of the original 104 applicants.70

On 28 February 2012 McCoole sat a suite of written tests compiled by the Australian Institute of Forensic Psychology (AIFP).71

The suite had three components: the Ability Test of a reading, numerical and writing component; the Shipley-2 of a vocabulary component and block pattern component; and five separate psychological tests.72

The AIFP Test Event Summary report divided applicants into three categories:

- Recommend Further Evaluation with Comprehensive Report and Structured Interview;
- Recommend Caution—High Risk; and
- Recommend Review Application or Conduct Brief Initial Telephone Interview.73
The advice provided on Recommend Caution—High Risk was:

These applicants have either obtained an Overall Potential of Suitability (OPOS) Rating of Very Unsuitable or Unsuitable, or a COPS (Test 4) Prediction Ranking of Very Poor or Poor, or have tried so hard to ‘fake out’ the test that the results are unreliable. This happens with a Fake good score of 13 or higher. Applicants who have failed to answer a large number of items, or have a very low IQ score, or have answered extremely carelessly, will also be on this list. A Ranking of Very Poor or Poor is obtained by endorsing a LARGE NUMBER of items which reflect psychological disturbance, poor work attitudes, or personality traits that are incompatible with the role.

Extreme caution should be used in advancing a High Risk candidate’s application. A thorough evaluation using the Comprehensive Report and Structured Interview is required. [Emphasis in original]

The Test Event Summary report revealed McCoole was among 14 applicants categorised as Recommend Caution—High Risk. His Prediction (Test 4) Ranking was very poor and his OPOS Rating was very unsuitable.

The reports provided two other measures. The Prediction Ranking was an estimate of job success, and a measure of potential psychological disturbance, negative work attitudes and potential for personality problems. The OPOS was a prediction of the applicant’s potential for success in the particular role applied for. McCoole received the worst possible rating on both of these measures.

A comprehensive report about McCoole, described as a psychological report, was obtained. The report revealed McCoole held a number of attitudes potentially associated with immaturity. He would probably be less sophisticated in evaluating interpersonal situations and would be less willing to accept direction from supervisors. He was somewhat above average in both aggression and impulsivity, signifying some potential for abuse of authority. Possible concerns associated with drug and alcohol use, and gender and racial bias were identified.

The report identified a number of issues that warranted further enquiry—previous depression, isolation, the use of prescription medication for a nervous, psychiatric or emotional problem, and recent poor state of personal relationships.

It is not clear how the panel used the AIFP test results to determine whether or not an applicant would progress through the recruitment process, including on what basis the panel might exclude an applicant. What was clear was that a Caution—High Risk recommendation (coupled with advice that extreme caution should be used in advancing such an applicant), was not regarded as sufficient to exclude an applicant from advancing to the interview stage.

Ms M and Mr Q both concluded that McCoole should not be advanced to interview. They expressed their view but were overruled by Mr F, as the most experienced panel member and recruitment coordinator. Both were willing to defer to his views and did not challenge his decision to progress McCoole notwithstanding his test results.

Mr F thought the high risk assessment was most likely attributable to past emotional concerns of McCoole. He did not consider that any aspects of the results were particularly concerning.

McCoole was one of 23 applicants advanced to the next stage of the selection process. He was not the only applicant with a Caution—High Risk recommendation who progressed.

On 9 March 2012 Families SA was advised by the Department for Communities and Social Inclusion Screening Unit that a National Criminal History Record Check and Screening Assessment had been completed and McCoole had been cleared. This was a prerequisite for employment.

In late March 2012, McCoole undertook two observation shifts in different residential care houses, during which he shadowed a youth worker, who prepared a report for the selection panel. Following both shifts McCoole received positive reports.

The interview process

On 2 April 2012 McCoole was interviewed by the panel. Although the Caution—High Risk recommendation advised an evaluation using the Comprehensive Report and structured interview, this process was not adopted. Mr F did not believe he was in a position to conduct such an evaluation. Instead, Mr F asked McCoole one or two questions about topics of concern identified in the report. Mr F found it difficult to determine which questions to ask. Some questions could elicit very emotional responses from applicants, and others related to sensitive topics, such as suicidal ideation, which Mr F did not consider could be appropriately explored in a panel setting.

McCoole’s responses to the questions asked by Mr F assured Mr F that there were no problems that would prevent McCoole being appointed to the role. During the interview McCoole was asked five standard questions to ask. Some questions could elicit very emotional responses from applicants, and others related to sensitive topics, such as suicidal ideation, which Mr F did not consider could be appropriately explored in a panel setting.
CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

Each panelist recorded some adverse comments about McCoole’s responses. Mr F noted some of McCoole’s responses were non-specific. He had to be prompted in relation to one question, he showed ‘[t]oo much allegiance to staff, not enough benefit of the doubt to [young person]’ and demonstrated ‘NGO Syndrome’, an overconfidence in applicants who were already working in residential care facilities through an agency. Ms M recorded that McCoole answered one question ‘with lots of hesitation to believe the child’. Mr Q noted that McCoole required prompting and was autocratic. He observed a lack of child focus. Ms M and Mr Q both recorded comments relating to McCoole’s anxiety diagnosis.

McCoole achieved scores of 15 from Mr F, 17 from Ms M and 16 from Mr Q.

On 3 April 2012 McCoole underwent a medical examination. The report commented on two main issues: McCoole had a very high body mass index, increasing the risk of manual handling injury, and a history of psychological difficulties, including the past use of anti-anxiety medication. This result did not disqualify McCoole from employment. Unlike his approach to AIFP results, Mr F would refer concerning aspects of medical assessments to a manager senior to him who would determine whether to progress the applicant.

Although referee checks were said to be conducted for external applicants, there is no evidence of such checks during McCoole’s recruitment process.

The panel report
A panel report to Ms Shen bearing a date of 11 April 2012 was prepared from a pro forma.

Only limited reference was made in the report to the AIFP results. The report included the following information:

Of the 61 applicants invited to the AIFP Suitability Assessment:

24 applicants recorded a ‘do not advance’ and were exited out.
...
23 applicants should be ‘Advanced’ to the next step of the selection process.

There was no reference to the fact that applicants who had identified as Caution—High Risk had nonetheless been advanced through the process. Ms Shen was not aware of this practice and assumed, from the wording of the report, that applicants who had received a poor AIFP report were not advanced.

The evidence suggests that the practice of advancing such candidates was in place long before Mr F or Ms Shen took up their positions. Despite asking applicants to undertake the test the directorate continued to use the results inappropriately. Moreover, Ms Shen was asked to approve recruitment decisions acting under a mistaken assumption of some assurance from the proper use of a psychometric test.

McCoole, like other successful applicants, was recommended for a casual contract. The selection committee report noted he would benefit from training and experience with Families SA leadership but did not include any of the adverse impressions of the panel members from interview nor any reference to his history of anxiety.

McCoole’s performance at interview was allocated a rating of 64 per cent. The range for all interviewed applicants was 43 per cent to 88 per cent. In determining the percentage ratings only the interview scores were considered; and no regard was had to AIFP testing nor observation shifts. Of 19 applicants interviewed, 12, including McCoole, were recommended for casual OPS3 contracts. Three applicants were recommended for casual OPS2 contracts.

The offer of employment
All new child and youth support workers were required to undertake a six-week induction and training course. This included learning both on the job and in a class-based setting and included topics such as non-violent crisis intervention, safe care of children and responding to challenging behaviour. During his training McCoole was employed on a full-time temporary contract from 1 May 2012 to 8 June 2012. Following this induction, McCoole was offered a casual contract to 31 August 2012.

TRAINING IN THE USE AND INTERPRETATION OF THE AIFP RESULTS
Mr F received no formal training in the use of the AIFP testing system. He had no broader training in psychology, and other panellists were in a similar position.

Mr F felt unqualified to understand and interpret the test results. Consequently, he considered it unfair to screen applicants out before interview on the basis of those test results. Mr F had no training or expertise in how to elicit information on those topics during an interview, nor in how to use any relevant information that was elicited. The end result was that test results were not considered appropriately.

Mr F said he told Ms Shen he did not feel equipped to properly assess the AIFP test results. He raised the same concerns with senior staff and managers in the directorate. Mr F said that Ms Shen told him in early 2012 the recruitment process had been reviewed by David Waterford, the Deputy Chief Executive, Office for Child
Safety, and he was happy with it. At the time Ms Shen was not concerned about a non-psychologically trained person being responsible for the testing as she assumed unsuitable applicants were not being progressed.109

Mr F did not believe that the AIFP test was an overly credible, appropriate or fair test for residential care workers. He believed the statistical data underpinning the testing originated from studying public safety officials in the USA.110 Mr F thought the reports were an exercise in rubber-stamping reassurance regarding an applicant’s risk of being overly aggressive.

Mr F said Dr Ken Byrne offered him training in the interpretation of the AIFP test. The cost of the training was approximately $7000 for a group of 10. Dr Byrne also raised the topic of training with Ms Shen. Mr F said he was advised by Ms Shen that the Executive had declined to provide this training as it was considered too expensive.111

THE JULY 2012 APPLICATION

In July 2012, McCoole applied for another casual OPS3 youth worker position. This was commonplace when youth workers wanted to transition from an OPS2 to OPS3 position or from casual to full-time employment.72

McCoole was one of 34 internal applicants. Mr F was the recruitment coordinator, assisted by two different panel members. A similar selection process to the original process was adopted, but there were variations for internal applicants.73

As part of this application, McCoole included in his CV that he was studying for a Bachelor of Education at Charles Darwin University. Confirmation of this enrolment was never sought as part of the recruitment process.112 If it had been, the panel would have learnt that McCoole was not in fact enrolled at Charles Darwin University and that he was studying for a Bachelor of Education at the University of the USA.

McCoole was one of 13 applicants recommended for a full-time temporary contract.114

SIMULTANEOUS EMPLOYMENT WITH FAMILIES SA AND NANNYSA

Over some periods, McCoole worked shifts through nannySA while employed as a Families SA casual.115 Many of the directorate’s senior staff were aware of this practice. The reasons put forward for this practice varied:

• The shifts a Families SA casual worker received could fluctuate and were limited to 10 shifts per fortnight. They may therefore choose to be registered with nannySA to get more work and shore up their income.116
• If the shift to be filled was in a strictly nannySA house, it would be offered first to a nannySA worker.117
• The directorate operated two pools of money: one budget for residential care, the other for agency use. At times supervisors were told they were not allowed to use Families SA casual employees because of budgetary issues. Instead they had to use agency staff.118

The reasoning behind the notion of strictly nannySA houses, in which Families SA casual staff would not be used, was unclear and might have been that:

• they did not want to place staff together who had different training and approaches to youth work;
• Families SA had no direct supervision over the houses, or it was a remnant from a time when that was the situation; or
• because of industrial issues they wanted to ensure Families SA casual staff were available as needed to place in houses that were staffed by other Families SA workers.119

A number of senior staff appreciated the practice could lead to some loss of oversight of the hours worked by individuals. For example, when engaged by both Families SA and nannySA, McCoole was able to work two shifts in a row without it being considered overtime. None of the personnel management systems used by Families SA or agencies had capacity to police which shifts individuals were working.120

Employing a worker through a commercial agency who was available on Families SA’s casual list meant that the same service was obtained at a premium cost.

As a current employee, McCoole was not asked to perform an observation shift. Rather, a work report was sought from Lee Norman, a senior youth worker responsible for his supervision. The work report rated his performance in most areas as excellent. Mr Norman commended McCoole’s ‘[a]bility to relate positively to young people’ and ‘[a]bility to manage young people in crisis’, and rated McCoole’s communication abilities as ‘excellent in all areas’. He concluded, ‘Shannon is a well-rounded, confident, strong team player and is task oriented. A great addition to any team!’121

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The processes used by senior staff in houses staffed by Families SA workers to fill isolated or more regular shifts were also inconsistent. Shifts were generally first offered to a Families SA casual staff member, but practices varied as to what steps should be taken before an agency worker could be sought.121
CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

MCCOOLE’S CONTACT WITH CHILDREN

McCoole worked across a number of different residential care houses, bringing him into contact with many children. Some of them had difficult emotional and psychological problems and many expressed these issues behaviourally. Chapter 12 discusses the behavioural indicators of abuse, in particular sexual abuse. It emphasises the importance of monitoring behavioural signs within the residential care setting, both as a means to address the therapeutic needs of children, and to deter and detect potential sexual offenders in these environments.

Some of the children with whom McCoole worked exhibited behaviour that should have raised concerns about their relationship with McCoole. Others exhibited high levels of psychological distress that, while not clearly attributable to any particular source, should have been investigated and addressed.

RICKY JONES

From 29 January 2011 to 18 May 2011 McCoole was employed to work at an emergency care facility at Old Reynella where Ricky Jones and his older siblings resided. Ricky was aged between two and three years, and suffered from a developmental disability which affected his ability to communicate.

McCoole was charged with offences related to Ricky in that period. He pleaded guilty to two counts of indecent assault and one count of committing an act of gross indecency. The charged offences were evidenced by recorded images located on McCoole’s computer.

No criminal charges were laid against McCoole with respect to Ricky’s older sister, Amy. However, contemporaneous statements made by McCoole in the chat logs raise the possibility that he also offended against her and that his offending began as early as his first shift with these children.

TOBY AND JACINTA MASON

Between 26 May and 12 October 2012 McCoole looked after Toby, Jacinta and Cain Mason. The children were initially placed at a property at 11 G Crescent, and subsequently moved to 10 L Street.

The 11 G Crescent property was staffed entirely by nannySA workers with little oversight from Families SA senior staff. nannySA worker Narelle Reedman said that in the time she worked there she never saw a Families SA supervisor in attendance. The Nation Building house at 10 L Street was also staffed by nannySA workers. A higher level of oversight was offered at these premises, with a greater presence of Families SA senior staff. Although the staffing structure at 10 L Street included periods when two staff were rostered on shifts, there were many occasions when McCoole was alone with the two younger children, Toby and Jacinta. A single worker worked the night shift.

McCoole pleaded guilty to persistent sexual exploitation of both Toby and Jacinta. The offences were committed between 15 June 2011 and 11 February 2012, when Toby was aged two and Jacinta three. This offending was also evidenced by images produced by McCoole that were discovered by police.

The Commission heard that staff who worked with the Mason children had a general dislike for McCoole and were relieved when he was moved on to work at other premises. Some noticed unusual behaviours from the children towards McCoole. Ms Reedman noticed that Jacinta would avoid contact with McCoole, particularly when dressing, and that her relationship with McCoole was different from that which she had with other male workers. However, McCoole assured Ms Reedman that Jacinta interacted freely with him on occasions when Ms Reedman was not present.

Ms Reedman described an incident which involved two year old Toby. McCoole was seated on a couch. Toby approached him and touched his crotch. Ms Reedman noticed that McCoole made no effort to remove Toby’s hand or move himself away until about 15 to 20 seconds later when McCoole became aware that Ms Reedman was watching him. Ms Reedman said she did not record this observation in the logbook because of the risk that McCoole would see it and complain. She considered confidentially informing senior workers but was deterred from doing so in the belief that the seniors were friends with McCoole and a fear that her concerns would not be taken seriously.

PAIGE THOMSON

Between 6 and 18 March 2012 McCoole worked a small number of shifts at 6 S Street caring for six Thomson siblings, who ranged in age from three to nine years old. On 10 May 2013 McCoole worked another shift with the Thomsons at another property.

Seven year old Paige Thomson was a bed-wetter. Although workers thought her behaviour originated in emotional problems, they were not made aware of any therapy to offer her or told of ways they could support her. Paige began to experience night terrors. Jessica Pinos, a Families SA worker, observed that Paige became distressed in her sleep. She heard Paige say, ‘get it out of my face’. Another worker told Ms Pinos that she had also heard Paige make a similar comment while asleep. Ms Pinos did not notify Families SA’s Child Abuse Report Line (CARL) because she assumed Paige’s comments were referable to trauma from previous sexual abuse.
nannySA worker Ms V worked night shifts caring for the Thomson children. She observed changes in the behaviour of two of Paige’s siblings. This included regression in four year old Kendall’s toilet training. She started to defecate in the corner of rooms. Bradley, the eldest sibling, told Ms V that none of the children wanted to travel in the car with McCoole. However, Ms V did not record Bradley’s comments in the logbook.132

ROSE HARRIS
Over a period of approximately one month in 2012, McCoole worked four shifts with Rose Harris, who was 18 months old. Another 18 month old child was also cared for in the same placement and two workers were rostered per shift. However, there were occasions when individual workers were left alone with one or both children.

McCoole pleaded guilty to two counts of unlawful sexual intercourse against Rose. Both offences were committed on 7 April 2012 and were evidenced by recordings made by McCoole. He committed these two offences three minutes apart.133

nannySA worker Janet Gregory regularly cared for Rose. At one nappy change, she noticed that Rose’s genital area was red and her vaginal opening appeared abnormal.134 Ms Gregory drew the matters to the attention of her colleague, Simone Hammond.135

Neither Ms Gregory nor Ms Hammond countenanced the notion that a carer might have sexually abused Rose. Ms Gregory wondered if Rose had been sexually abused by a relative. However, both carers ultimately favoured the conclusion that it was nappy rash, or that it was due to teething.136 Neither recorded their observations in the logbook, although another worker recorded that Rose’s genitals appeared red, or red and sore, on five separate occasions between March and May 2012.137

The Commission’s examination of the logbooks at Rose’s placement revealed a gap in time between the end of a logbook which was completed at 12.50pm on 7 April 2012 and the next book which began at 10.00pm that night.138 This is particularly noteworthy as McCoole was working a shift which coincided with the time at which the new logbook should have begun.139 The gap included the time following McCoole’s offending against Rose.

Logbooks are intended to give a continuous record of the events in the house, including how the children are being cared for and important observations about their wellbeing. However, it appears that no-one reviewed the logbook sufficiently closely to identify this gap of more than nine hours—another lost opportunity for the Agency to require an explanation from McCoole about his work practices.

ANNA, CAITLIN, CLAIRE AND GEORGIE PHAM
After McCoole completed his training as a Families SA youth worker in May 2012, he worked regular shifts at 14 R Road.140 This was a Nation Building house under the supervision of Mr Sterzl. At the time the Pham siblings, Anna (aged nine), Caitlin (aged eight), Claire (aged seven) and Georgie (aged five), resided in the house.

McCoole has not been convicted of any offence which identifies any of these children as a victim. However McCoole was convicted of an offence of indecent assault committed on 14 July 2012 against an unidentified victim. McCoole maintained he could not recall this particular incident, but the timing of the offence coincides with a shift McCoole worked with the Pham sisters, during which time he was alone with them.141 It can therefore be inferred from the evidence that one of the Pham sisters was the victim of that offence.

Families SA was aware of allegations that before coming into care the sisters had been sexually abused by their older brother.142 Nevertheless, their brother was permitted to stay overnight at the house as part of reunification efforts. On these occasions two workers were rostered to work the overnight shift, undertaking their duties so that they maintained constant supervision of the girls’ bedrooms.143

While in care, the Pham sisters exhibited high levels of sexualised behaviours. Workers tasked with caring for them were not well equipped to investigate or manage this behaviour. Wendy Harmston, a Families SA youth worker, understood that discussing these behaviours or comments with the girls was not encouraged. Workers were told to simply ignore the behaviour or divert the girls to something else.144

There were instances where the children’s conduct had the potential to raise concern about McCoole’s behaviour towards them, or general concerns about the levels of distress they were experiencing. For example, Ms Harmston observed Caitlin’s behaviour would escalate when McCoole came on shift including temper tantrums and yelling and screaming.145 Ms Harmston considered that recording these observations in a logbook would be inappropriate because it was available for all staff members to inspect.146

Two particular instances should have resulted in action by staff.
CASE STUDY 5 SHANNON McCooLe—
KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

Night shifts at 14 R Road were staffed exclusively by nannySA workers. Ms V regularly worked these shifts alone. She recalled a night shift when Anna woke up and asked her who was working in the morning. On being told that it was ‘Shannon’, Anna responded that she did not like Shannon ‘because he is a paedophile’. Ms V was confident that Anna understood the meaning of the word paedophile, and she replied to Anna saying ‘that’s not very nice’. Anna replied ‘well he is’.146

The following morning Ms V spoke to the Families SA worker on the morning shift. She was assured that workers were aware that Anna called McCoole a paedophile and that the statement had been recorded in the logbook and reported to senior staff. On that basis, Ms V herself did not make a logbook entry.147 Her reluctance to do so was due, at least in part, to the power imbalance between agency and Families SA workers, and a consequent reluctance to report matters that reflected poorly on Families SA staff. She appreciated her obligation to notify CARL about Anna’s statement, but did not do so because she had been assured by the Families SA worker that they were aware of the matter.148

Families SA worker Graham Curyer had observed Anna to regularly use the word ‘paedophile’ as a term of general abuse, in circumstances when she was in an agitated state. However, Ms V said that had not been her experience and Anna had not been in an agitated state when she had made the allegation.149

nannySA worker Ms K was also engaged at 14 R Road predominantly on night shifts. On one occasion, after McCoole finished a shift, Ms K overheard Caitlin and Claire talking to each other in the bedroom they shared. Claire said ‘everyone sounds scared. I can’t sleep, what if he comes back in here’, to which Caitlin responded ‘if he puts his dick in my mouth again I’ll bite it off’. Ms K entered the room and assured the girls she was there and everyone was safe. She did not specifically raise the comments with the children, believing that if such matters needed to be discussed that should occur at Child Protection Services (CPS), which offered a specialist service.150

Ms K believed she recorded the incident in a logbook and prepared a separate incident report. However, no such documents were located in records produced to the Commission, although an incident report may not have come within the terms of the summons issued by the Commission if it had not been uploaded to the C3MS database.151

Ms K thought the comments she overheard referred to the abuse allegations that had been made about the Pham’s older brother. She did not receive any feedback about what she recorded in the logbook or the incident report. She did not follow up the matter as she had previously experienced a resistance from Families SA staff to her asking questions. Under questioning, Ms K accepted that what she had heard obliged her to have made a report to CARL.152

CHELSEA FLOROS

Chelsea Floros was removed from her mother’s care following her admission to hospital with injuries consistent with a serious assault. She required special attention. She was underweight and developmentally delayed.

Her first placement was in commercial care at 11 L Street, a placement staffed by nannySA workers and overseen by Families SA seniors and supervisors. Siblings, unrelated to Chelsea, aged two and three years were also placed at the house.

In approximately February 2013, two year old Chelsea was moved to 57 C Street, a transitional accommodation house staffed by Families SA workers, with two teenagers. The teenagers had irregular school habits, were often hyperactive and used inappropriate language. None of the five Families SA staff at 57 C Street had experience working with very young children; only one had the experience of caring for her own children.153 They received a small amount of training but remained, in one worker’s opinion at least, ill-equipped for the task. The house had no bathtub and Chelsea was bathed in a tub on the shower floor:154

Managing the needs of the teenagers, as well as Chelsea’s high needs, became increasingly difficult, but over time staff numbers were reduced from double-handed shifts to a single worker rostered to care for the three children.155

McCoole worked at least one shift with Chelsea in September 2012 at 11 L Street. He may have worked another shift in August 2012, but Families SA records are in conflict in this regard. McCoole worked regular shifts with Chelsea at 57 C Street.156 McCoole subsequently pleaded guilty to the persistent sexual exploitation of Chelsea. He offended against her at both premises.157

On many occasions during her time in care, and after her placement in foster care, Chelsea demonstrated behaviours which were indicative of trauma.

On one occasion at 11 L Street Chelsea became distressed during a nappy change, thrashing around and screaming ‘no’, while covering her genital area with both hands. Ms K observed this behaviour and said she called for her colleague Ms L to come into the room. Ms K recalled preparing an incident report and discussing the behaviour with a senior. However, the relevant logbooks have no record of the incident and no incident report was produced to the Commission. If the report was not
Two relevant observations were recorded in the logbook. On 5 September 2012 a worker noted Chelsea was excessively interested in her genitals and appeared to be trying to masturbate.104 On 7 September 2012 Ms K observed that when Chelsea was lying down waiting to be dressed after her bath, she appeared distressed and behaved in an unusual manner, crying ‘don’t daddy, don’t daddy’. These observations were both recorded in the observation log as late entries on 9 October 2012.105

These entries were sent by OPS4 senior youth worker Lincoln Rogers to Chelsea’s caseworker Pamela Watson.106 Ms Watson assumed the behaviours originated in the trauma of physical abuse suffered by Chelsea before she entered care. It did not occur to Ms Watson that Chelsea was at risk of sexual abuse in care nor was she concerned about the adequacy of her care. No action was taken to investigate or address the behaviours or distress being exhibited.107

Chelsea’s unusual behaviours continued after her move to 57 C Street. She was observed playing violently with her doll, sometimes touching its genitals in an apparently sexualised way. On one occasion a carer noticed Chelsea’s genitals were very red, which she thought was unusual because Chelsea was no longer in nappies.108

Ms O, a Families SA youth worker, was aware from regular discussions at staff meetings that Chelsea had been playing aggressively with her doll. On 22 April 2013 during a day shift Ms O came across Chelsea with her pants down poking the feet of her doll either close to or into her vagina. Ms O was concerned about the incident and recorded her observations in the logbook.109

A second Families SA worker observed similar behaviour from Chelsea. That worker had received no training in how to deal with sexualised behaviours in a child as young as Chelsea. He spoke with Ms O. She told him she had seen something similar and had ‘handed it on’, indicating that she had made senior staff aware of it.110

Weekly summary updates were prepared as a mechanism by which significant information was passed to a child’s caseworker. Ms O’s observations of Chelsea’s play were included in a weekly update. However her observations were reported as Chelsea poking the dolls feet towards rather than into her vagina.111

Ms O was concerned about the significance of what she had seen and wanted Chelsea reviewed by a psychologist. She was concerned about the origin of the behaviour, as she was not aware of any history of Chelsea being sexually abused. She spoke about her concerns directly with Marc Beltman, Chelsea’s new caseworker.112 In due course Mr Beltman told Ms O that he had spoken with a psychologist about the behaviours she had observed. Mr Beltman told Ms O that the psychologist considered them not inappropriate for a child of Chelsea’s age.113

In May 2013, a foster care placement was secured for Chelsea with Mr and Mrs W. They were new foster parents, originally interested in providing a child with long-term care. They agreed to foster Chelsea on the basis that it was possible she might need long-term care if reunification efforts with her mother were unsuccessful. Mr and Mrs W cared for Chelsea between May and December 2013. She was then transitioned to the long-term care of a family member interstate.

Mr and Mrs W were not given any information about Chelsea’s history of sexualised behaviours114 but almost immediately they were challenged by this conduct. On coming into Mr and Mrs W’s care Chelsea’s toilet training regressed slightly, and she returned to wearing nappies for a period of time. Chelsea would become upset during nappy changes, often repeating the words ‘Shannon do pat pat’ accompanied by moving her hands to her genital area before Mrs W applied nappy cream. On occasion Chelsea became quite insistent when Mrs W did not apply the cream. Sometimes Chelsea mentioned ‘Charlie’ in this context. Mrs W said she redirected the behaviour and after a few weeks it subsided.115

Mrs W told Mr Beltman about this behaviour early in the placement, including reporting Chelsea’s reference to the names ‘Shannon’ and ‘Charlie’. Mr Beltman told Ms W that it was likely the names were associated with someone Chelsea knew from being in care or from other experiences in her past. Mrs W felt her concerns had not been taken seriously. She said she also told Mr Beltman that Chelsea frequently experienced night terrors during which she also mentioned the name Shannon.116

Mr and Mrs W were helped by a foster care support worker Ms X, who consistently advised Mr and Mrs W to report the behaviours they observed to Mr Beltman.117 Chelsea continued to talk about ‘Shannon’. On one occasion Mrs W told her support worker that Chelsea had been mentioning ‘Shannon’ at odd times. One morning while Chelsea was watching morning television with Mrs W she said ‘[w]ho put your pee-pee on Shannon’s pee-pee?’ followed by ‘Shannon’s pee-pee right there!’118 Although Mrs W believed she would have reported this incident to Mr Beltman, he had neither recollection nor a note of it.119

CASE STUDY 5: SHANNON MCCOLEE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT
As the placement progressed, Mr and Mrs W and their support worker Ms X continued to ask for psychological input to support their care of Chelsea. Mr Beltman was not receptive to this suggestion, on the basis that Chelsea was too young to benefit from psychological therapy. Ms X disagreed and believed there were psychologists capable of helping the family to better support Chelsea.

**The lack of attention given to Chelsea’s behaviours**

Mr Beltman told the Commission that while Chelsea was in residential care no issues had come to his attention that caused him to be concerned that she had been sexually abused. Although a young child masturbating to soothe themselves could suggest sexual abuse, Mr Beltman concluded that this behaviour was also consistent with physical abuse, which was evident in Chelsea’s history, and he did not investigate the matter further.

Mr Beltman said he was unaware that the previous caseworker, Ms Watson, had been told about Chelsea’s distress during nappy changes while in residential care. He had failed to read the relevant C3MS records when familiarising himself with Chelsea’s history.

Ms O told the Commission that she reported her observations of Chelsea’s sexualised behaviours directly to Mr Beltman. Mr Beltman accepted that she may have done so, but he had no memory of it. He remained of the view that her behaviours could be attributed to sexual or physical abuse. This is contrary to the evidence of Dr Sarah Mares, an experienced specialist infant, child and family psychiatrist, who expressed the opinion that a child of Chelsea’s age inserting objects into her vagina amounted to a ‘specific indication of probable sexual abuse and should raise a high level of concern’.

Mr Beltman claimed that he consulted a number of experienced practitioners, including his supervisor, a principal social worker and Child Protection Services, to obtain advice about Chelsea’s behaviour generally. He said notes of these consultations should be recorded on C3MS, but they were not located by the Commission. A failure to record such details makes it impossible for subsequent caseworkers to fully understand a child’s complete history. It is not possible for the Commission to determine whether the consultations ever occurred.

Mr Beltman acknowledged receiving advice from Mr and Mrs W about their concerns but he could not recall the specific detail. Although he asserted that he recorded such information when he could, no such records were located on C3MS.

Mr Beltman followed up Chelsea’s reference to the name ‘Shannon’ by contacting the house where she had previously resided. He was told that ‘Shannon’ was the name of a worker who had been previously employed there. Mr Beltman did not give the reason for his enquiry as he was concerned about confidentiality. He finally assumed that Chelsea’s use of the name ‘Shannon’ was associated with a good memory and that she had enjoyed a level of trust with that person.

No therapeutic support was provided to assist Mr and Mrs W to manage Chelsea’s behaviours. Mr Beltman considered that these issues did not need to be addressed until Chelsea was in a long-term placement. He agreed that this attitude effectively placed Chelsea’s needs on hold.

**NICKY SCHULTZ**

In September 2013, McCooole undertook some shifts at 14 R Road, after his return to work from suspension for the investigation of a care concern (discussed later). A group of five siblings by the name of Schultz, aged between two and 15 years, resided in the house.

McCooole was not charged with any offences relating to these children. In the course of the investigation that followed McCooole’s arrest, Nicky Schultz, aged seven, disclosed that McCooole had touched her indecently but her disclosure lacked specific detail.

Louise Purton, an acting senior youth worker who supervised the house at 14 R Road, noticed that Nicky showed a clear dislike for McCooole. On one occasion Ms Purton observed Nicky screaming, crying, and kicking in anticipation of McCooole putting her to bed. Her behaviours were so heightened that Ms Purton intervened and asked another worker to put Nicky to bed.

**JAYDEN CONTI**

In January 2014 McCooole began working regular shifts at 10 S Street with Jayden, who was seven years old. For some time, Jayden was the only child in the placement, partly due to his difficult behaviours.

A chart on the wall had photographs of the staff on it, so Jayden would know who was caring for him on the various shifts. More than once, Jayden removed the photograph of McCooole from the chart. He said he did so because McCooole did not smile properly. The only photographs that Jayden ever removed from the chart were those of McCooole.

In the early stages of the placement, Jayden exhibited protective sleeping and bathing habits. He preferred to sleep under rather than on top of his bed, and would often bathe with his clothes on. Advice from a clinical psychologist supported workers permitting Jayden to sleep and bathe as he pleased as long as he was safe. Most workers were happy with this approach.
However, McCoole had his own ideas. He believed that children’s behaviours should be as normal as possible. Whenever he oversaw Jayden’s bedtime routine he insisted that Jayden sleep on top of his bed rather than underneath. On occasion, this caused Jayden’s behaviours to escalate. 147

Jayden’s difficult behaviours extended to a habit of drawing pictures of penises around the house, on paper, on walls and on furniture. Jayden was unable to explain why he did this.

On one occasion Families SA worker Ms B found an image of two penises that Jayden had drawn on the wall of his bedroom. She said these appeared different from his other drawings. One penis was larger than the other. It had an angry face and appeared to be ejaculating. The other had a sad face. Ms B asked Jayden what was coming out of the angry faced penis and he said it was ‘just piss’. Ms B logged this observation for it to be passed on to Jayden’s psychologist. 148 She also photographed the images and spoke with Jayden’s caseworker about them. 149

However, Ms B was advised not to ask Jayden about these behaviours because she was not a psychologist. 190 This behaviour eventually stopped by about late April 2014. At that stage, McCoole had moved to another house.

BROOKE ANDERSON

Between March and June 2014 McCoole worked at 6 S Street where he cared for 13 year old Brooke Anderson. In the same street was a second Families SA residential care house. That made it convenient for workers at both premises to help each other when the need arose.

On 12 April 2014, Ms C was working at the other S Street house when she received a telephone call from McCoole. He was upset and told Ms C that Brooke had called him a paedophile. McCoole asked Ms C to come to the house to support him. When Ms C arrived, McCoole told her that he had had an altercation with Brooke. Brooke had gone to the bathroom and he became worried that she was intending to self-harm. He said he jangled his keys to warn Brooke that he was going to enter the bathroom, and when he went in he found Brooke sitting on the toilet with her underpants down. 191

Ms C then spoke to Brooke about the matter. Brooke told Ms C that contrary to McCoole’s version of events, he had entered the bathroom without warning. Brooke again called McCoole a paedophile. 192 Brooke appeared calm, but when Ms C indicated that she was going to leave, her behaviour escalated again. Brooke attempted to assault McCoole and she was physically restrained. Robert Griffin, a senior youth worker, then arrived at the house. McCoole told Mr Griffin that he had knocked on the bathroom door and called out to warn Brooke before entering. This was different to the version he had given Ms C. Mr Griffin also spoke with Brooke. She insisted that McCoole entered unannounced and she was naked from the waist down. 193

Mr Griffin accepted McCoole’s version of events. He did so on the basis that McCoole was the adult and he believed that youth workers recruited to Families SA underwent a rigorous selection process and were bound by a code of ethics. He was aware that Brooke had a history of self-harming and dishonesty and that led him to doubt her account. 194

Because Brooke had been physically restrained, McCoole was obliged to complete a critical incident report. 195 This report presented a version of events which was inconsistent with Ms C’s own observations as well as McCoole’s account to Ms C. It was also inconsistent with the version of events relayed by Brooke, as given to Ms C. Brooke’s version was not recorded in any way in the report, contrary to the requirements of regulation 14(3) of the Family and Community Services Regulations 2009.

Notwithstanding serious deficits in the report Katherine Decoster, the supervisor tasked with reviewing and approving the report, endorsed it, noting that the incident was well managed. 196 At the time Ms Decoster was unaware of the requirement set out in the regulations to record the child’s account of events. In addition, no process existed for McCoole’s report of the incident to be shown to Ms C, as a witness to events, nor to allow her to record any disagreement she had with the version given by McCoole.

SUPERVISION OF MCCOOLE

Throughout McCoole’s employment with OSHC, nannySA and Families SA, aspects of his conduct and behaviour indicated an employee whose performance was substandard. Specific incidents should have raised serious questions about McCoole’s suitability to work with children in care and, in particular, whether children were at risk of harm in his care.

A series of events occurred while McCoole was working in Families SA houses, the most serious of which is the care concern relating to Mikayla Bates, discussed later in this case study.
The evidence before the Commission showed that McCoole was an unpopular worker. Very few other workers wanted to work with him and he was not well liked. Some workers thought that his bed and bath time routines took too long. They noticed that he preferred to do those things alone, and he usually refused help. He was described as arrogant, dominant and overconfident. He was not considered a team player and many colleagues questioned the appropriateness of his approach to youth work. On some occasions, McCoole’s conduct was considered positively offensive to people who worked with him.

THE R-RATED MOVIE

In late 2012, McCoole was working at 14 R Road caring for the Pham sisters. On occasion, carers would bring in movies from home for the girls to watch. There was a particular occasion when McCoole brought a computer hard drive to the house, which he said contained some movies suitable for the girls. He advised others in the house that they were also welcome to use it. It is not clear from the evidence how long the hard drive was at the house, but it appeared that it had been there previously and the children could have accessed it.

When some carers went to access the movies on this hard drive, they discovered that in addition to children’s movies, there was a folder which contained movies which were not G-rated. Among these movies was one entitled Young people fucking, which was R-rated. The carers were especially alarmed by the title as ‘young people’ is a term commonly used to refer to children in care.

Mr Norman was the supervisor of the house at this time. He was told about the movie on the hard drive and he asked Mr Rogers, the senior on shift, to go to the house to investigate. Mr Rogers then retrieved the hard drive. He said there were a number of children’s movies on the hard drive, but in a subfolder labelled ‘personal files’ he located the movie, Young people fucking. He watched the first few minutes of the movie. That portion did not depict any sexual acts. The movie was rated R (restricted to viewers over the age of 18), but Mr Rogers considered that subject matter should not be accessible by young people. He confiscated the hard drive and left it on Mr Norman’s desk at the administration building. He detailed what he knew about the nature of the movie in a document addressed to Mr Norman.

Mr Rogers’ assessment of the movie should be considered in the context of features of the movie overall:

- it depicted five separate couples performing various sexual acts with one another;
- some sexual acts involved the use of sexual aids;
- a third person was depicted observing some of the sexual acts; and
- it was in English and would not require subtitles if broadcast on Australian television.

Mr Rogers told the Commission that he advised Mr Norman that he had only looked at the first couple of minutes of the movie. Mr Norman said he was not sure whether Mr Rogers had watched the whole movie but he said that he had checked an Internet database and that suggested to him that the movie was a comedy, similar in style to the film American pie. Mr Norman assumed the movie might contain some sexually explicit content but relied on Mr Rogers’ assurance it was ‘not of any nefarious nature’. It did not occur to Mr Norman that might be something concerning about a person bringing a movie with that particular title into a house in which care was being provided for young children.

The topic was raised in a supervision session on 8 January 2013 with McCoole. The Commission is unable to determine which of the senior staff made the decision to address the matter in this way. Mr Norman and Darren Calvert (acting in the Nation Building supervisor role at the time) both denied responsibility. Mr Norman thought that this response was adequate and in line with protocol. Mr Calvert knew of no policy, protocol or procedure which would guide a response to such events. Mr Calvert could provide no insight into why a discussion in supervision was an adequate response.

Mr Calvert and Mr Rogers conducted the supervision session and the resulting notes record:

**The title was an MA-rated movie, not pornography.**

Lincoln viewed the movie and confirmed this to be true. Darren discussed that either way, any movies of that subject matter should not be accessible by [young people]

**Shannon stated that this was an oversight and that it shouldn’t have happened, and will not again.**

The note incorrectly records the movie as MA-rated.

Mr Calvert’s main concern was that personal material had been brought into a residential care house. He went so far as to assert in evidence that the content of the movie was irrelevant because there was no evidence that any of the children had watched the movie. This misses the point in two respects: first, McCoole spent periods of...
time alone with the children and there is no suggestion that anyone asked the children if they had seen the movie; and secondly, it fails to consider that bringing such a movie into the house might be indicative of an intention to use the sexualised images in the process of grooming a child or young person.

McCoole’s assertion that the incident was an oversight was not questioned, and he was not asked to elaborate on the circumstances. Mr Calvert accepted McCoole’s claim without conducting any probing or critical examination.

Mr Norman responded to the incident by sending an email to all southern area Nation Building staff advising that no personal hard drives were to be brought into the houses.

GEORGIE PHAM

McCoole worked with the Pham sisters when Georgie, the youngest, was between five and six years old. McCoole appeared to have a better relationship with Georgie than with her sisters. His approach to her was softer and gentler than with the others, and Georgie responded by cuddling McCoole and sitting on his lap.

Every Friday night the sisters were permitted to watch a movie with the workers on shift. On two or three occasions during such movie nights, Corinne Hams, a Families SA worker, observed Georgie sitting on McCoole’s lap for extended periods of time. Ms Hams considered this inappropriate, particularly as there was information that the girls had been sexually abused before coming into care. Ms Hams was also concerned because Georgie did not behave the same way towards other male workers. Ms Hams told both McCoole and Georgie that Georgie should sit beside McCoole and not on his lap. Nevertheless, the behaviour recurred the following week, and Ms Hams reported her concerns to Mr Norman.

Ms Hams was not told whether McCoole was spoken to about this behaviour. A meeting was held with all six staff members which included a general conversation about the children’s behaviours. The outcome of the meeting was that Mr Norman introduced a ‘no touch policy’ that applied to all workers working with the Pham children.

Ms Hams was aware through other staff that Anna Pham had referred to McCoole as ‘Mr Paedophile’. Ms Hams understood Mr Norman’s decision to stop all physical contact was made both because McCoole was allowing Georgie to sit on his lap and because McCoole was referred to as Mr Paedophile.

Mr Norman disputed that the policy had been introduced as a result of the conduct of McCoole. Initially, he said that he put the no touch policy in place because workers, in particular males, would often worry about allegations being made against them and they would prefer not to physically touch the children. To avoid children having a preference for certain workers on account of differences in their care approach, Mr Norman said he decided to enforce a policy under which no worker would be allowed to physically touch the children.

Mr Norman recalled that Ms Hams reported her concern that Georgie would consistently sit on McCoole’s lap. However, he understood that those concerns related to Georgie’s affection towards males generally, including himself, which made him feel uncomfortable. He did not understand that Ms Hams thought that McCoole was treating Georgie’s affection inappropriately. The Commission prefers Ms Hams’ version of events and is satisfied that McCoole’s specific behaviour was drawn to Mr Norman’s attention by Ms Hams.

ANNA PHAM

Families SA youth workers are trained in non-violent crisis intervention (NVCI). This training includes teaching workers how to restrain a child if it is necessary as a last resort. Any restraint should be performed calmly and should not harm the child or cause pain.

On 17 February 2013 McCoole, Ms Harmston and trainee Ms U took the Pham sisters shopping. The girls had some pocket money and wanted to look around to find something to buy. Nine year old Anna selected something that cost more than the money she had. She had more money in a savings account, but required permission from a senior worker to access this, and they were not contactable while the girls were at the shops. Anna became upset about not being able to buy anything and her behaviour escalated as the group returned to the vehicle. Ms Harmston placed Anna in the vehicle but was not able to secure her seatbelt.

McCoole intervened. He took hold of Anna and restrained her outside the vehicle. Anna was tiny, slight and had ‘no body weight’. Ms U could hear Anna screaming. She felt the incident was going on for too long so she exited the car. McCoole was speaking loudly and gruffly to Anna, telling her he would not let her go until she calmed down. He was kneeling behind her, with her back against his stomach and her legs spread out on the ground. The hold was not consistent with NVCI practices. Each time McCoole spoke, Anna’s behaviour got worse.

Ms U considered that McCoole’s response was unnecessary. He could easily have escorted her to the van. She thought the restraint of Anna was an exercise in aggression and power. McCoole subsequently completed the requisite critical incident report. Once again, aspects of McCoole’s report were inconsistent with the observations of other workers present, and it painted McCoole’s behaviour in a less serious light. The report again failed to record any account from the child.
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However, Mr Sterzl considered and approved the report, commenting ‘this situation was handled well by the staff team involved’.221

JAYDEN CONTI
Jayden Conti (whose circumstances have been discussed earlier) sometimes threatened to harm himself and the staff working with him. Jayden was a small child. When necessary he would allow workers to restrain him using an NVCI hold. He generally responded to restraint by sitting and verbally abusing staff, and it was not necessary to hold him very firmly. Often while being held, Jayden would ask to go to the toilet. Sometimes this appeared to be his way of asking to be let go. Usually at that point workers would end the restraint and Jayden would go calmly.224

Other workers observed occasions when McCoole would restrain Jayden quite forcefully. On 12 February 2014 Jayden had been sent to his bedroom after becoming agitated in the course of a conversation. He was throwing things at Ms B, one of his workers. Ms B stood in the doorway to his room and was speaking to him to calm him down. McCoole pushed Ms B out the way and placed Jayden into a restraint.225 Jayden yelled a couple of times that he was going to ‘piss himself’ and he complained that McCoole was hurting him. McCoole continued to hold Jayden until Ms B intervened and said ‘[t]hat’s enough’. She said she thought it had reached a point at which it had gone on for too long and it was inappropriate. McCoole initially ignored Ms B but he ended the restraint not long after.226

McCoole completed a critical incident report. He recorded:

Staff put Jayden in the NVCP/PCI position to keep him safe from hitting his head again. Staff (Ms B) enters the room as support and to observe. Jayden begins crying and telling staff he is going to wet himself but is still elevated. Jayden tells staff (Shannon) they are hurting him. Staff tell Jayden they are barely holding his arms, this is observed by the second staff member.227

[Emphasis added]

McCoole’s assertion that he was ‘barely holding Jayden’s arms’ is inconsistent with Ms B’s observations. Ms B was not asked to endorse the contents of the report. She believed that she could not read such a report until after it was approved by management. Jayden’s view or account of the incident was not obtained.228

Neither the logbook entry nor the critical incident report records Ms B’s request to McCoole to stop the restraint. Ms B explained that senior staff had issued an instruction not to log conversations or concerns which related to other staff members.229 The logs and reports are thus not necessarily a complete or accurate record of a child’s experiences, and incomplete accounts could protect staff members whose actions require examination.

Ms B recalled that she spoke to a supervisor or a senior, possibly Daniel Knight, about the incident. She explained that the hold went wrong and she did not agree with it.230 Mr Knight could not recall this specifically, but he did recall Ms B telling him about a restraint that involved McCoole moving or shoving her out of the way. Mr Knight did not recall speaking to McCoole about the matter. Ms Decoster subsequently approved the report prepared by McCoole, commenting ‘[s]taff managed the incident well ... Staff also made sure Jayden understood the reasons as to why they need to hold him and keep him safe’.231

Ms Decoster said she would have investigated the incident further if she had been aware that Ms B had a different version of events from McCoole, in particular that Ms B did not agree that McCoole was barely holding Jayden’s arms or that she had felt the restraint went on too long.232

The report included a reference by Jayden to a complaint that staff were hurting him during the restraint. Nevertheless, Ms Decoster’s approval of the report indicated her belief that the incident had been managed well. She did not investigate the matter further or try to ascertain why Jayden complained that he had been hurt. She resolved the inconsistency between McCoole’s assertion that he was ‘barely holding his arms’ and Jayden’s complaint by accepting unquestioningly that McCoole was telling the truth.233

MOLLY COLLINS, WILLIAM AND JENNA MOORE
From late August 2012 to February 2013, McCoole, as a Families SA employee, undertook shifts at 9 T Avenue. In October 2012, 11 year old Molly Collins was placed in Families SA employee, undertook shifts at 9 T Avenue. In October 2012, 11 year old Molly Collins was placed in Families SA employee, undertook shifts at 9 T Avenue.

On New Year’s Day 2013, nannySA worker Wendy Dennis and McCoole took the three children to the beach.235 Twice during the excursion Ms Dennis observed McCoole interacting with Jenna and Molly in what she considered to be an inappropriate manner. On one occasion he held the girls inappropriately while lifting them up and throwing them in the water. Later he swam into deeper water with both girls hanging onto him around his neck. Ms Dennis did not feel comfortable with what she observed but did not report her concerns to anyone.236

NICKY SCHULTZ
Friday, 13 September 2013, was McCoole’s second shift back from suspension after the Mikayla Bates care concern. nannySA worker, Ms Hammond, and McCoole took some of the Schultz siblings to a play café.237 Ms Hammond observed that McCoole was taking photographs on his personal mobile phone of seven year
old Nicky, wearing a skirt, when she was coming down a slippery dip. He was possibly also taking photos of two year old Lachlan. When Ms Hammond approached McCoole he put his mobile phone away, saying, ‘I will upload those later’.

Photographing children in care on a personal mobile telephone was, and is, prohibited. House cameras were available for staff to record the experiences of children. At times staff did use their own devices, but some, at least, believed that prior permission from a supervisor was needed for that to occur.

The visit to the café was recorded in the logbook, but not the taking of photographs. Ms Hammond was aware of the Mikayla Bates care concern and did not want to alert McCoole to her concerns about him. A day or two later, Ms Hammond telephoned Mr Sterzl and reported her concerns. She asked Mr Sterzl to check the house computer for the photographs.

She subsequently saw Mr Sterzl using the computer, but did not know if he checked for the photographs. Ms Hammond was never advised whether Mr Sterzl located the photographs nor of the outcome of her report.

During a regular senior staff meeting, Ms Purton, a senior youth worker, became aware that a concern had been raised about McCoole taking photographs on his personal device. In response to this issue, a formal email was sent to all staff to remind them that such a practice was prohibited.

Manager Ms Lamont told the Commission she thought that at some stage she had been made aware that McCoole had taken photos of children in care on his personal device. She said the play café occasion sounded familiar, although she was unable to recall with precision when that had occurred or when she had been told about it. Ms Lamont assumed the supervisor would have met with McCoole to discuss the issue but there is no evidence that any such meeting ever took place.

During shift handovers at 14 R Road Ms K heard McCoole describe the Pham girls as ‘nothing but fucking cunts’. Ms K asked McCoole not to use such language. On other occasions McCoole was heard to refer to children as ‘little shits’, ‘bitches’ and an ‘idiot’.

He referred to a 12 year old child with autism as a ‘real der’. At one mealtime he was disparaging and critical of the same child, aggressively telling the child to ‘[s] top being a pig. Stop eating like that’. When Mr Curyer, another worker in the house, challenged his approach, McCoole said the child ‘deserved it. The kid’s a pig. No-one’s going to show him. He needs to be shown. He can’t keep doing that.’ McCoole ignored advice that his approach to the child was demeaning and unhelpful.

APPROACHES TO YOUTH WORK
Children in residential care are faced with workers who care for children in a variety of ways. Their care ranges from a therapeutic nurturing and supportive approach to a highly rule-focused strict and consequence-oriented one. As a result, workers’ personal views at times prevail over the appropriate evidence-based approach for children with trauma-related backgrounds.

MCCOOLE’S MILITANT APPROACH
McCoole’s approach towards discipline was at the more extreme end of the rule-based approach. He demonstrated little flexibility or preparedness to back down, and unwillingness to negotiate with children or alter his rules.

McCoole’s approach was variously described as strict, militant, regimented, authoritative, dictatorial, dominant and controlling. Some children were fearful of McCoole and complied with his directions because of this. Some children would respond when McCoole pointed at them, without him needing to speak.

He:
• used his loud voice, size and physicality to get his point across and intimidate children;
• was willing to shout at children from different rooms of the house;
• was prepared to regain control over children by physically moving them; and
• had children do household chores in his place.

In the circumstances it is understandable that some workers were surprised that McCoole was working with children.
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PERSONALITY ISSUES

Although some of McCoole’s peers thought his work practices could not be faulted, most considered aspects of his behaviour so disagreeable or offensive that they struggled to work with him. McCoole created disharmony. Some staff actively avoided him and would leave shift handovers early to avoid interacting with him.

Comments by McCoole’s colleagues included:

- he was arrogant, bombastic, opinionated, obnoxious and dominating;
- he spoke about being better than other staff members;
- he told colleagues he was getting looked after by management and management had sent him to fix teams or houses;
- he critiqued staff members in a negative way to other workers and highlighted the faults of other workers to senior staff;
- he took credit for other people’s work and presented issues that had been addressed by them as his personal achievements or efforts; and
- he was willing to argue his point in team meetings.

However, this was in stark contrast to McCooles’s behaviour towards senior staff. He was known to ‘suck up’ to seniors. Ms Hams suggested McCooles’s approach to her was not as confronting as with other workers because he knew she had occupied leadership roles. Mr Rogers was aware from the time McCooles was a nannySA employee that he was eager to please and would ‘brown nose’ senior staff. McCooles would go out of his way to impress males and get on the side of the men working in residential care.

GENDER AND RACIAL BIAS

Many female workers found McCooles challenging. He was described as chauvinistic, demeaning and was said to often put women down. He held strong ideas about male and female roles and what were appropriate tasks for male or female workers. On occasion, McCooles shared his views about gender roles in front of children.

Ms B worked with McCooles in the care of Jayden Conti. Because Jayden had some challenging behaviours, one staff member would always sit in the rear of the car with him when it was necessary to transport him anywhere. McCooles insisted that he should always be the one to drive the vehicle and Ms B was always relegated to the back with Jayden. McCooles repeatedly commented to Ms B that they looked like a Muslim family. When she was away from the children, Ms B told McCooles his comments were not appropriate.

However, McCooles persisted with inappropriate remarks. Ms B expressed her frustration to senior youth worker, Mr Knight. Mr Knight thought that McCooles should not make Ms B feel uncomfortable in the workplace, and he sent an email to his supervisor, Ms Decoster, explaining the issue. He took no further action.

According to Ms B, the following day Ms Decoster rang her to enquire if she was all right. Ms Decoster assured Ms B that McCooles’s conduct was unacceptable. Ms Decoster asked Ms B if she wanted to make a formal complaint or if she wanted the matter taken to human resources. Ms B said she told Ms Decoster she simply wanted her complaint noted in case the conduct continued in the future. However, there is no record of this complaint in McCooles’s supervision file.

Ms Decoster denied in evidence that she had been made aware of Ms B’s concerns about McCooles and she could not recall a conversation with Ms B where she enquired about her welfare. However, the evidence of Ms B and Mr Knight is to be preferred on this topic. The Commission is satisfied that Ms Decoster was made aware of McCooles’s gender and racially offensive conduct but did nothing about it.

A PROBLEM PERFORMER

The Nation Building senior youth workers and supervisor were aware of the discontent and instability McCooles was causing within months of him becoming a Families SA employee. Mr Norman spoke to colleagues in the workplace of McCooles as a problem worker who was loud, opinionated and ‘rustling feathers’. Mr Norman was dismissive of a suggestion by Mr G, a senior youth worker, that Mr Norman would have to ‘pull [McCooles] up’.

Mr Rogers was aware that McCooles was not well-liked and that the consequent disharmony was affecting the functioning of teams. McCooles was moved between houses frequently. It is likely that his workplace performance and inability to work effectively as a part of a team were responsible, at least in part, for some of his moves.

Senior staff went so far as to enquire of some youth workers whether they would be prepared to work with McCooles. Christina Manderson was asked by Mr Sterzl whether she would work with McCooles at 14 R Road. She said she regarded McCooles as bombastic and arrogant but she told Mr Sterzl that as a professional she would work with him. Ms Manderson had worked in residential care for at least four years and had not ever been given this choice about any other worker. Ms Hams also agreed to be partnered with McCooles as everyone else had refused to work with him.
Mr Sterzl described McCoole as having a loud, robust personality which could ‘rub people the wrong way’. Mr Sterzl knew other workers had raised issues about McCoole’s interpersonal skills. Consistent with Mr Rogers’ evidence, Mr Sterzl described moving McCoole from location to location to try ‘to find a match’ of staff members who could work together, although he later confined this comment to the period when McCoole returned to work from suspension.240

LACK OF RESPONSE TO COMPLAINTS
Although a number of workers raised both formal and informal complaints about McCoole, little effort was made to deal with them.241 Over time, dislike for McCoole grew in the workforce, peaking just before his arrest.242

In March 2014, four separate complaints were made by female staff members to senior youth worker Mr Knight and supervisor Ms Decoster. The complaint by Ms B about McCoole’s persistent inappropriate remarks was one of the four complaints.

On 3 March 2014 youth worker Karen Roberts sent an email to seniors Mr Knight, Mr Griffin and Linda McLaren, and to Ms Decoster, raising concerns about an impending move of McCoole to the house at 6 S Street.243 Ms Roberts raised a number of concerns which included the need for consistency of staff and her knowledge of McCoole, which suggested he would be a poor fit for the children in the house. She said that one child had already expressed a fear about McCoole coming to work in the house.244 The events which followed this complaint are discussed later in this case study.

On 8 May 2013, another worker, Ms C, emailed Mr Knight, setting out a series of concerns about McCoole’s conduct. She told Mr Knight that this was the first time that she had ever made such a complaint and it was out of character for her to do so. Ms C could not recall ever receiving a response to that complaint.245

Youth worker Sharyn Ball also complained about McCoole’s conduct towards her. She felt that he belittled her both in the house and in public. Mr Knight became aware of Ms Ball’s feelings through one of her colleagues, because Ms Ball did not want to make a formal report. Mr Knight viewed it as unprofessional to make a complaint and then not follow it up officially. He considered that a complaint had to be reduced to writing to make it official.246

Mr Knight responded to these concerns by having an informal conversation with McCoole in which he advised him there were some issues with the way he was speaking to people.247

On 10 April 2014 Ms Decoster called a supervision meeting with McCoole, attended also by Mr Knight. None of the concerns raised by the female workers were addressed at this meeting.248 Although Mr Knight thought the concerns required attention he deferred to Ms Decoster’s approach to the meeting.249 This meeting is discussed further below.

Following this meeting, Mr Knight did not make any enquiry with any of the workers as to whether the issues with McCoole persisted.250 Against this background, it is understandable that some staff viewed McCoole as ‘bulletproof’.251 Despite the constant challenges and difficulties McCoole caused in team environments, senior staff consistently failed to address his workplace conduct.252

SUPERVISION
On 8 January 2013, Mr Calvert conducted a supervision session with McCoole. This concerned three incidents that reflected poorly on McCoole. One was the discovery of the Young people fucking movie discussed earlier. The second related to events which had led to William Moore being badly sunburnt on a trip to the beach on New Year’s Day 2013 and the third was an occasion when McCoole attended a residential care house outside of work hours without permission.253

As to this last incident, Mr Rogers had given permission for McCoole to visit 10 L Street to say goodbye to the Mason siblings who were leaving residential care to move to home-based care. However, McCoole did not attend the house on the agreed day while he was on shift. Rather, he attended on another day without warning when he was not working. The clear rule was that staff were not permitted to attend houses when not on shift.254

The supervision notes include the following topics of discussion:

• The negative effect of McCoole’s visit on the children, which drew attention to the transition. A team decision had been made not to mention the transition, to avoid the children stewing on it.
• That McCoole had failed to ask for permission to attend on the day he did and had he sought such permission it would not have been granted.

McCoole acknowledged his decision had been poor, and agreed that he would go through the proper channels in the future. In relation to accumulated concerns, McCoole claimed that he had been ‘off his game’ recently and suggested supervision ‘was the motivation he needed to kick back into gear’.255
The supervision notes also recorded that ‘the need for staff to reduce the amount of gossip and rumour in the workplace, as it promotes disharmony amongst teams’ was also raised with McCoole. Mr Calvert said it was necessary to raise these matters with McCoole to ‘achieve harmony, trust and compliance within teams’ and because McCoole had the ‘emotional IQ of a peanut ... he just didn’t get the message ... he wasn’t the most endearing person’. Mr Calvert did not regard these emotional deficiencies as unique. Mr Calvert asserted there was very little effort put into achieving harmonious teams, and they:

constantly get sent people that have not fitted in somewhere else or not suitable to the teams or the workplaces. There was very little effort put into harmonious teams in the business.297

Approximately five months into his employment with Families SA, it was obvious McCoole’s performance as a residential care worker was unsatisfactory.298 McCoole was placed on fortnightly half-hour supervision sessions to be conducted by Mr Norman for an indefinite period. Mr Norman said this was to get McCoole ‘back on track’, not to keep a closer eye on him.299

Two supervision sessions, approximately three weeks apart, were conducted by Mr Norman in January and February 2013.300

Goals identified for McCoole during the session on 30 January 2013 were:

To improve on appropriate use of voice control

Attempt to try a few different methods of getting an idea heard and accepted by team mates, in the least offensive way as possible.301

Mr Sterzl explained that these were performance issues identified for McCoole. McCoole had an inability to appreciate the impact of his potentially intimidating voice in a residential care environment, and senior staff were addressing the issue by trying to get him to use a softer voice.302

This issue persisted at the 20 February 2013 supervision session although some improvement was noted.303 Mr Norman suggested that from his observations of McCoole from outside the formal supervisions, McCoole’s work habits appeared to be improving.304

The next supervision session was scheduled for 4 March 2013.305 However, on 25 February 2013 McCoole was moved from Nation Building to the transitional accommodation program.306 These programs were separately managed. Ms Decoster became McCoole’s supervisor but she did not consult written supervision records which were available to her.307

The fortnightly supervision sessions ended. Some 13 months later, on 10 April 2014, McCoole had his first and only supervision session with Ms Decoster and Mr Knight. This is the supervision referred to earlier which followed the four complaints raised by female workers about McCoole.308

Ms Decoster initially said in evidence that the complaints she had received from Ms C and Ms Ball about McCoole’s communication skills were not discussed at the meeting. She stated that it was not her intention to do this and the issues were not discussed. She gave this evidence after referring to notes that were taken at the time.309

However, Ms Decoster changed her story when she was referred to a statement which she had given to police in November 2014. She asserted, consistent with that statement, that these complaints had been discussed at the meeting and she could not explain why that conversation was not reflected in any way in the supervision session notes. She remained adamant that performance issues in the context of the complaints had been discussed.310

Mr Knight was also in attendance at this supervision session and he in fact took the notes. Consistent with the notes and Ms Decoster’s original evidence, Mr Knight said that concerns raised by the staff members had not been addressed with McCoole. He was certain that all the feedback given to McCoole during the supervision was positive.311

A number of workers described a mistrust of Ms Decoster as a supervisor, regarding her as having misrepresented the truth on occasions.312 Workers complained that Ms Decoster would deny saying things that she had said and would claim not to know about issues that had clearly been brought to her attention. On occasions, when confronted by workers about these issues, Ms Decoster would claim not to remember, or that she was unwell.

Ms Decoster was an unsatisfactory witness in the case study. At times her evidence was contradictory and difficult to follow. Under close questioning about failures of her management of McCoole she claimed to be unwell but when given the opportunity to explain her problem, said that she was exhausted and the questioning was difficult emotionally. The Commission rejects Ms Decoster’s evidence about speaking to McCoole about his performance and finds that no such conversation ever occurred.

The supervision of McCoole by senior staff in Nation Building and transitional accommodation was as inconsistent as it was ineffectual. It was characterised by a constant lack of response to legitimate workplace concerns. In that environment it is not surprising that the most blatant red flag to McCoole’s activities failed to provoke the response that was so desperately needed.
THE MIKAYLA BATES CARE CONCERN

In June 2013, nannySA worker, Ms H, lodged a care concern about McCoole's conduct towards six year old Mikayla Bates. This event occurred in the period during which McCoole was offending against children in care. Appropriate action on this care concern would not have prevented most of McCoole's offending, but it gave Families SA the best opportunity to enquire into his conduct and potentially remove him from the workforce.

The investigation of this care concern brings together important issues about the capacity of the organisation to protect children against child sexual offending. It demonstrates the importance of:

- maintaining a high level of knowledge in the workforce of child sexual abuse and behavioural indicators of abuse;
- clear policies, procedures and practices which must be enforced in practice; and
- maintaining and critically examining comprehensive records of both employee and child behaviour to properly address the needs of children in rotational care environments.

It also highlights the negative effect of poor organisational culture and the influence individual staff can have on the efficacy of processes such as investigating care concerns.

On 23 May 2013 McCoole started a series of shifts through nannySA at 10 L Street, a Nation Building house. Mikayla Bates, her seven year old brother Levi and an older, unrelated child, had recently been placed at the house. 313

Ms H had not worked with McCoole before this placement. An afternoon shift on 3 June 2013 was only the fourth occasion they had worked together. That evening McCoole initiated bath time with Mikayla and Levi. While bathing the children McCoole twice approached Ms H as she prepared dinner. He commented that he found it funny that the children would freely expose themselves while bathing and become shy when they got out of the bath. The second comment related directly to Mikayla. He said ‘[i]t’s funny how Mikayla lays in the bath exposing herself to me but when she gets out she’ll cover herself with a towel and say “Ooh don’t look at me”.’ Ms H said she felt uneasy about these comments by McCoole with respect to Mikayla’s behaviour. 314

The evening of 5 June 2013

On 5 June 2013 Ms H worked an afternoon shift with McCoole. McCoole initiated bath time and Ms H prepared dinner. McCoole made similar comments to those he made two nights earlier. 316

After dinner, they were watching television. McCoole began tickling Mikayla around her stomach and ribs. Mikayla appeared to happily engage with McCoole. McCoole then withdrew his attention. He said to Mikayla ‘get off me’ and told her not to touch him with dirty hands, which appeared to make Mikayla feel shame and confusion. McCoole restarted tickling Mikayla in a pattern of alternating lavishing and then withdrawing his attention. Ms H recognised this conduct as potentially indicative of grooming. 314

At bedtime, Ms H went with Levi to his bedroom and started reading a story to him while McCoole did the same with Mikayla. Mikayla’s bedroom was close to Levi’s. While reading, Ms H heard a noise which sounded like a heavy object or body lying on Mikayla’s bed. McCoole called out to Ms H that the beds were not big enough. McCoole’s voice then lowered to a whisper and Ms H heard the word ‘tickle’. Mikayla sounded as if she was trying to laugh, but was uncomfortable. Ms H heard Mikayla say ‘[s]top, don’t, don’t tickle me there’. Ms H did not hear a response from McCoole. 317

Ms H felt something was not right and moved to quietly enter Mikayla’s bedroom. However, as she left Levi’s room, Levi yelled out loudly, ‘hey, what about a hug?’ By the time Ms H reached Mikayla’s room, McCoole was on his way out. He pushed past her, walking down the hallway towards the office. 318

Ms H entered the bedroom and saw Mikayla on all-fours on her bed, positioned on top of the bedding. She was staring wide eyed at the doorway and appeared to be in shock. No lights were on. Ms H told Mikayla it was time to get under the blankets and tried to pull the blankets from under Mikayla, but she did not move. Mikayla then said, ‘my bottom hurts’. Ms H asked her why and Mikayla only repeated the words. 319

Ms H then heard McCoole coming back towards Mikayla’s room. Mikayla moved under the blanket and pulled it up to her nose. As Mikayla lay down, Ms H again asked why her bottom hurt. 320

McCoole entered the bedroom. He pushed past Ms H and stood between her and Mikayla. 321 McCoole placed a bracelet on Mikayla’s tailbone, saying ‘I’ve got this for you Mikayla’. 321 McCoole shepherded Ms H from the room, remaining close to her as she returned to Levi’s room to give him a hug goodnight. He remained immediately behind her as she walked down the hallway. When Ms H paused at the entrance to Mikayla’s room, McCoole pushed her until she moved towards the office. 323

Ms H did not record her observations of McCoole’s behaviour in the logbook. She described being in shock and not knowing how to record what she had observed. 324
Ms H believed McCoole was not rostered to work the following day.226

MIKAYLA’S BEHAVIOUR THE FOLLOWING NIGHT
On the afternoon shift the following day, 6 June 2013, Josie Dimond worked with McCoole at 10 L Street. McCoole spent time alone with Levi and Mikayla during the shift.216

As Ms Dimond was putting Mikayla to bed, Mikayla reached out and tickled Ms Dimond under her arm, asking ‘[d]oes this tickle?’ She repeated the tickling on Ms Dimond’s neck. She then reached her hand out towards Ms Dimond’s crotch and attempted to tickle her, asking ‘[h]ow about there?’ Ms Dimond told Mikayla to stop and spoke to her about appropriate behaviour.227

Ms Dimond concluded that Mikayla was simply being inquisitive. In those circumstances she did not believe it was necessary to record her observations in the logbook.228

On the following two evenings Mikayla demonstrated aggravated or upset behaviour at bedtime.229

MIKAYLA’S DENIAL
On 7 June Ms H worked the morning shift with McCoole.230 While in the car with Mikayla on the way to school, Ms H asked Mikayla if her bottom still hurt. Mikayla scowled, put her head down and responded ‘I never said that’ in a growl. Ms H repeated the question and Mikayla repeated her denial.231

The same day, Ms H returned to the house to work an afternoon shift with Ms Dimond. Ms Dimond told Ms H about Mikayla trying to tickle her crotch the previous night. Ms H then shared some of her observations of McCoole’s behaviour on the evening of 5 June. Ms H asked Ms Dimond to log Mikayla’s tickling behaviour. Ms Dimond made a late logbook entry.232

FIRST ATTEMPT TO NOTIFY THE CHILD ABUSE REPORT LINE
Ms H said she had spent 6 June gathering her thoughts. She felt she had interrupted McCoole while he was washing Mikayla and was processing her observations. She found the concept of a person who worked in child protection being a paedophile inherently shocking.233

Ms H refrained from discussing her observations with anyone as she feared she would not be believed. She had not found the seniors approachable when it came to less serious concerns, let alone a situation of this apparent magnitude. She was also aware of the experiences of a colleague who had reported observations about a Families SA senior and was subsequently falsely accused of misconduct. All of these matters contributed to Ms H not reporting her observations immediately.234

On 8 June Ms H was unwell and did not work. However, she felt she had a duty to decide what to do and she contacted a friend who was studying law for advice. Following that advice, Ms H made notes of her observations. Ms H had also been giving thought to her obligations as a mandated notifier. By 8 June 2013 she had fixed in her mind the significance of her observations and decided to report her concerns to CARL. She first attempted to contact CARL on the evening of 8 June 2013 but abandoned the call after being left 45 minutes on hold.235

LEE NORMAN’S RESPONSE
On 9 June 2013 Ms H spoke with senior youth worker, Mr Norman. The following matters were raised with him:236

• McCoole had made comments about Mikayla exposing herself to him in the bath. Mr Norman told Ms H she probably did not need to come to him with these concerns. He said they sounded ‘like Shannonisms’ and she could have taken this up with McCoole.
• Ms H described her observations of McCoole’s behaviour in Mikayla’s bedroom. When she reported that she thought McCoole had lain on the bed, Mr Norman said he often did this himself with the children.
• She described her observations within Mikayla’s bedroom, including Mikayla’s position and that she had complained her bottom hurt.

Mr Norman told Ms H he would email Mr Sterzl as he (Mr Norman) was going on leave. He appeared to be drafting an email.

Mr Norman told Ms H that nannySA staff often made accusations about other workers and did not want them to know. Ms H indicated she had no issue with McCoole knowing she made the report.

Mr Norman said he would talk to McCoole about it. He told Ms H he had often talked to McCoole in the past about pulling his head in and McCoole was often targeted because of his weight and loud voice. He told Ms H not to worry about reporting the matter to nannySA as he would take care of it.

Ms H made notes of this conversation. She felt her concerns were downplayed and dismissed by Mr Norman.

On 10 June Ms H again spoke with Mr Norman. She told Mr Norman she was going to report the incident to nannySA, as it was her obligation to do so as a nannySA staff member. During this conversation, Mr Norman denied having previously told Ms H he would report the concern to nannySA.237

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In evidence Mr Norman gave an account of this conversation that differed substantially from that given by Ms H. In particular, he denied being informed that Ms H had found Mikayla on her hand and knees and that Mikayla had complained that her bottom hurt. Mr Norman said that Ms H told him no more than that she had read a logbook entry for the day recording that Mikayla had a sore or red bottom, that she had seen McCoole leave Mikayla's bedroom to get a drink of water and had felt intimidated by McCoole. Mr Norman reported Ms H as saying that she had 'joined the dots together and I know something happened in that bedroom ... I just know something happened. Call it women's intuition.'

There is no evidence in the logbooks of Mikayla complaining of a sore bottom during the relevant time period. Ms H made contemporaneous notes of the conversation with Mr Norman. She understood that it was significant and would have repercussions. The totality of the evidence supports the conclusion that Mr Norman did not consider the matter especially serious, and placed little weight on the account given by Ms H. The Commission accepts Ms H's account of the events and her subsequent conversation with Mr Norman in their entirety.

INITIAL ACTIONS
On 11 June, Ms H contacted Ms McKenna at nannySA to report her observations. On advice from Ms McKenna, Ms H immediately made a notification to CARL.

Ms McKenna contacted supervisor Mr Sterzl about Ms H's report. It appeared to Ms McKenna she was giving Mr Sterzl information he had not heard before. Mr Sterzl gave Ms McKenna advice about contacting McCoole, who was on leave. He mentioned the possibility of McCoole attending a meeting with them both on his return from leave.

The Commission finds that Mr Sterzl learnt of the allegations from Ms McKenna. His immediate response was to plan to meet with McCoole to discuss the allegations, even though he had not received any information about the reported conduct. This is denied by Mr Sterzl, who asserted that he only intended the discussion to be a general conversation, that he was already aware of the care concern, and believed a CARL notification had already been made. Mr Sterzl's account is in conflict with his subsequent conduct and the evidence of other witnesses.

At about midday on 11 June Ms H received a telephone call from Mr Sterzl. Ms H provided an account of the events she had witnessed. She told Mr Sterzl that she had already made a CARL notification. He responded with a deep sigh, leading Ms H to feel that she had acted incorrectly. During this conversation Mr Sterzl advised Ms H that she could take back the allegations. Ms H reiterated that she stood by everything she had said.

Mr Sterzl maintained in evidence that he would not have suggested that Ms H could take a CARL report back. However, in all the circumstances, his account on this topic is rejected. The Commission accepts Ms H's account of the conversation.

On about 12 or 13 June 2013 Ms McKenna telephoned McCoole and advised him he was stood down. She scheduled a meeting with him for 19 June 2013. She advised Mr Norman and Mr Sterzl of the meeting by email, although this meeting did not eventuate as a result of the ongoing investigation.

THE CARE CONCERN
Ms H's CARL notification was referred to the Care Concern Investigations Unit (CCIU—which investigated complaints related to children in care) for a category determination. On 12 June 2013, Catherine Harman, then manager of CCIU, allocated the care concern to Ms Lamont, and Don Williams. Mr Williams was a supervisor in the directorate whose work included responding to care concerns. Ms Harman was responsible for allocating a category to the care concern but had not yet made the decision.

The interagency code of practice: Investigation of Suspected Child Abuse or Neglect defines three categories of care concern and the responses expected from agencies for each: minor, moderate and serious. Minor care concerns ‘are minor breaches of accepted care standards that pose a minor risk to the safety and wellbeing of the child/young person’. They are managed jointly by the contracting agency/alternative care service provider and Families SA in a general practice case management process. Serious care concerns are ‘serious breaches of accepted care standards where the child is expected to be in immediate danger or has already suffered serious harm or is at significant risk of serious harm as a result of the carer, staff member or volunteer’s actions’. An investigatory response by a CCIU investigator is required and a strategy discussion, attended by various agencies involved with the child and person under investigation, must be held.

On 13 June 2013, Ms Harman determined the care concern as minor. She made the determination despite Mr Williams raising concerns in an email about the allegations, which he felt indicated grooming and required a proper investigation.
Ms Lamont informed Ms Harman by email that she intended to meet with McCoole and make a decision as to whether he would receive further shifts with Families SA. The email said this appeared unlikely. As McCoole was a casual employee, Ms Lamont was contemplating whether there was an option not to provide him with further shifts. In response to this email, Ms Harman indicated she would need to report the matter to SAPOL, although she doubted anything would occur. She told Ms Lamont she might assess the care concern as minor as Ms Lamont was ‘well on to it’ and could liaise with nannySA. The classification could be reconsidered if SAPOL took action. Ms Harman could not assist the Commission with what she meant by this comment.

Ms Harman understood the allegations reported by Ms H related to a potential sexual assault. She agreed that, generally speaking, it would not be appropriate to deal with an allegation of sexual assault against a child in the manner contemplated for minor care concerns.

The consequence of this determination was the assignment of responsibility for the response to the local office, the directorate and nannySA. In explaining why she determined the care concern was minor, given sexual allegations were involved and the minor determination would divert responsibility away from CCIU, Ms Harman said that she had confidence in the ability of the local office to respond to allegations involving sexual offending.

On 14 June an email was sent notifying representatives of the directorate, Aberfoyle Park local office, nannySA and SAPOL of the ‘minor’ designation. It attached a copy of the care concern referral (Ms H’s CARL notification).

Detective Sergeant Bernadette Martin of SAPOL South Coast Family Violence Section considered the matter in consultation with Detective Senior Sergeant Noel McLean of the SAPOL Sexual Crimes Investigation Branch. They received the care concern referral and Ms H’s typed notes. Det Sgt Martin determined there was insufficient information to justify a criminal investigation at that stage. Det Sgt Martin accepted that it was possible to draw an inference that a criminal offence had occurred, but she maintained that there was insufficient evidence to support a prosecution. Both officers agreed that if further information was identified, the matter could be referred back to SAPOL.

On 19 June Det S/Sgt McLean advised Brett Dixon from the Department’s Special Investigations Unit (SIU—which investigated serious misconduct alleged against departmental employees) by email that SAPOL would not investigate the matter, that inappropriate behaviour only was indicated, and that the matter could be reviewed if further information arose.

SHANE STERZL’S INFLUENCE
Linda Hurley, manager of Aberfoyle Park office, allocated responsibility for the care concern to Melissa Rowley. Ms Rowley was the supervisor of Toni Jezeph, who was the allocated social worker for Mikayla and Levi. Ms Jezeph was on leave when the local office received the care concern referral.

On 14 June 2013, before the receipt of the care concern referral, Mr Sterzl and Ms Rowley had a telephone conversation about the care concern. Mr Sterzl requested a social worker attend 10 L Street to interview Mikayla. Mr Sterzl told the Commission he was unaware that Ms Lamont was asking SAPOL to consider the care concern. He agreed it was probably not his role to ask Ms Rowley to arrange for Mikayla to be interviewed, particularly in circumstances where the referral had not even been received. Mr Sterzl pointed to a lack of understanding of the process and a desire to ensure everything was followed up as his reason for making this request. Mr Sterzl said it did not cross his mind that having Mikayla interviewed at this stage might interfere with a police investigation.

Although Ms Lamont could not recall if she asked Mr Sterzl to organise for Mikayla to be interviewed she felt it was too soon for that to occur, particularly if SAPOL were to become involved. She regarded that task, in any event, as the responsibility of the case manager (social worker).

Ms Rowley considered that during their conversation Mr Sterzl was attempting to influence how seriously she viewed the care concern by minimising its seriousness and shaping her perception of McCoole and Ms H. She said Mr Sterzl told her:

- he hoped the social worker and Mikayla could have their conversation before McCoole returned to work on 19 June (Ms Rowley understood Mr Sterzl intended to return McCoole to shifts at that point);
- no concerns had previously been raised about McCoole;
- he had spoken with Ms H and she explained she needed time to think about whether she was right about what she had observed, accounting for the week delay in her report; and
- neither Mikayla nor Levi had said anything and there had been no change in Mikayla’s behaviour or indicators which suggested she had been abused.

Mr Sterzl did not recall whether he made a number of these comments. He denied saying no previous concerns had been raised about McCoole. His evidence as to when he became aware of the earlier complaints about McCoole was unclear, but he ultimately asserted that he may not have been aware of the issues at the time of the care concern. He said that the length of
time McCoole was off the floor was not his concern. He denied minimising the seriousness of the care concern in conversation with Ms Rowley.

The Commission accepts Ms Rowley's account of the conversation. Mr Sterzl made a series of comments that he either knew to be inaccurate or failed to check the accuracy of, including:

- how long Ms H had delayed her report;
- any uncertainty of Ms H about her observations;
- there had been no relevant changes in Mikayla's behaviour; and
- no concerns had previously been raised about McCoole.

As a result of this conversation with Mr Sterzl, Ms Rowley did not view the care concern as being overly serious.237 The Commission considers that the comments were made by Mr Sterzl with the intention of minimising the seriousness of the allegations. He succeeded in doing so, at least until Ms Rowley was provided with the written care concern document.

Mr Sterzl's conversation with Ms Rowley is the start of a pattern of conduct by him directed at undermining Ms H. Mr Sterzl's conduct, as described by a number of witnesses, demonstrated an attitude of questioning the veracity of Ms H's account. Mr Sterzl maintained his improper attitude towards Ms H even after the care concern had been resolved.

TONI JEZEPH'S INTERVIEW WITH MIKAYLA

After Ms Rowley read the care concern referral she believed that an unhealthy interest in Mikayla had been identified, which required investigation.238 Ms Rowley assumed SAPOL and Child Protection Services (CPS) had already declined to interview Mikayla because the matter had been allocated a minor determination.239 She did not believe any of the social workers in her team had the expertise to conduct an inquiry into a potential sexual assault.240

Ms Hurley decided to send Ms Jezeph to interview Mikayla. Ms Rowley did not initially support this approach, but she ultimately agreed.241

When Ms Jezeph returned from leave on 17 June 2013, she was asked by Ms Rowley to go to 10 L Street and speak with Mikayla.242 Ms Rowley said she advised Ms Jezeph to speak to Mikayla in a formal way and in a private setting.243 Ms Jezeph did not follow up arrangements which had been made for her to be accompanied by Ms Wallis, a more experienced social worker.244 Ms Jezeph said that this was because she viewed Ms Wallis as more of a hindrance than a support.

Ms Jezeph had no experience conducting forensic interviews with children to investigate allegations of abuse. She had limited experience in responding to care concerns. She was not aware of the principles guiding interviewing in the Interagency Code of Practice.245

Ms Rowley said she gave Ms Jezeph the care concern referral and made her aware the interview was part of a care concern investigation.246 Ms Jezeph said that she was not advised the notification was a care concern but her evidence is rejected on this point. Her own notes demonstrate that she was aware of this fact.247 The Commission also accepts the evidence of Ms Rowley in preference to that of Ms Jezeph on the point that she provided Ms Jezeph with some limited advice as to how to conduct the interview with Mikayla.

Before speaking with Mikayla, Ms Jezeph had received information that led her to believe the care concern was not being taken seriously. Ms Rowley advised her that workers at the house had said there was nothing in the care concern. Ms Jezeph was also told the notifier had delayed reporting her observations for a week. However, Ms Jezeph could not recall whether she received this information from Ms Rowley or Mr Sterzl.248

Ms Jezeph advised Mr Sterzl that she would be attending to interview Mikayla. She said Mr Sterzl told her he did not think there was much in the care concern. He said it resulted from a personality clash and by reference to Ms H said, ‘basically she’s a fucking bitch anyway, she wanted the job and Shannon got it’.249 He also told her McCoole was pretty loud, that some people did not know how to take him and “there is no way he would do that”.250

Mr Sterzl recalled a telephone call with Ms Jezeph, but could not recall the exact conversation. He doubted that he referred to the personality clash in those terms. He denied referring to Ms H as a fucking bitch or that he asserted McCoole would not act in the way alleged.251

Ms Jezeph's account of this conversation is preferred to that of Mr Sterzl. Ms Jezeph advised Ms Rowley of Mr Sterzl’s comments. Ms Rowley told Ms Jezeph that, if anyone knew McCoole, they would.252

Ms Jezeph was frank about the impact this conversation had on her own views.253 Although she thought the circumstances described by Ms H indicated a possible sexual assault, she was confused because the suggestion of concoction had been raised.254 A professional investigation would not have had placed weight on comments of this type.
CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

On 18 June 2013 at 3.45pm Ms Jezeph attended 10 L Street and spoke with Mikayla.231 The circumstances of the discussion and method of questioning were not conducive to providing Mikayla with the best opportunity to disclose any concerns she may have had. The discussion took place in an open living area with multiple distractions. Mikayla’s brother and workers were close by and one of the workers participated in the conversation. Mikayla had a telephone conversation with her father, and she was also playing a computer game.276 It was inappropriate for Mikayla to be interviewed where carers were present. Mikayla may also have anticipated the return of McCoole at any time.

The method adopted to interview Mikayla was a significant departure from best practice. The questions posed were so broad that they failed to focus Mikayla’s attention on what had occurred at bedtime on 5 June. They did not give her sufficient guidance as to what Ms Jezeph wanted to discuss with her.

During the interview, Mikayla mentioned McCoole by name in response to a question about whether any of the carers at the house made her feel uncomfortable. Mikayla said that McCoole had told her she could have dessert at any time, but then she couldn’t. Ms Jezeph, unaware of the potential significance of this statement responded with ‘oh well, these things happen’, and did not pursue the matter.277

Ms Jezeph’s response may well have indicated to Mikayla that Ms Jezeph was not interested in anything she might have had to say about McCoole. Ms Jezeph was unconcerned about McCoole in this context. She did not think that Mikayla might have been throwing out McCoole’s name to her to test her reaction and to possibly follow it up. She failed to record in her notes that McCoole was the person to whom Mikayla referred.278 Ms Jezeph said she had been told not to record the name in her notes. This decision meant that those who later assessed this discussion were unaware of the potential relevance of the reference to McCoole.

Following the interview, Ms Jezeph spoke to some of the carers in the office. Their evidence establishes that Ms Jezeph conveyed that she did not think Mikayla had said anything of note during the interview. Their evidence also establishes that they were told that Ms H was the notifier who raised the allegations and were advised of their content. Ms Jezeph asked whether it was normal for Ms H to have interpersonal issues and whether she had a vendetta against McCoole. Ms Dimond mentioned to Ms Jezeph her own recent experience when she had withheld dessert after Mikayla had behaved badly at dinner time, which Mikayla had not mentioned in the same context.279 This information should have brought the importance of Mikayla’s reference to McCoole in this context into greater prominence.

It is not possible to determine whether it was Ms Jezeph who shared information about the allegations and Mr H’s identity. It may have been Mr Rogers who did so. Whoever it was, those matters should not have been discussed in that environment.

RESPONSE TO THE INTERVIEW

Ms Jezeph was not aware of the incident in which Mikayla tickled Ms Dimond on 6 June or Mikayla’s subsequent distressed behaviour at bedtimes. Ms Jezeph relied on C3MS weekly updates to inform her of Mikayla’s behaviours, rather than checking the logbooks. The relevant weekly update of these matters was not uploaded until after Ms Jezeph had made her assessment that the allegations were not proven.241 Ms Jezeph’s conclusion was accepted by the local office without question, despite concerns being held about Ms Jezeph’s capacity to interview Mikayla. Following the uploading of the care concern, the local office’s position was that Nation Building staff were responsible for deciding what action to take.241

Ms Jezeph spoke to Mr Norman about the allegations. He told her that Ms H was ‘a bitch’ and sang McCoole’s praises. He suggested that Ms H had a motive to lie, and that there was ‘no way that McCoole would do that [sexually assault a child]’. Mr Norman denied making those statements, but the Commission rejects those denials.242

Mikayla’s father was not advised of the care concern by Families SA as Ms Rowley believed that ‘natural justice’ principles did not allow it.251

Ms Lamont met with Ms H on 20 June 2013 to discuss the allegations. Ms Lamont found Ms H to be credible.244 After the meeting, Ms H contacted Ms Lamont and advised her of Ms Dimond’s late logbook entry which recorded the tickling incident.

Ms Lamont had initially been of the view that the matter required investigation rather than case management and she continued to advocate with Ms Harman for this to occur. Ms Harman agreed to call a strategy meeting to discuss how the care concern would progress after Ms Lamont drew her attention to the late logbook entry.242

In the meantime, Mr Williams emailed Mr Dixon of SIU asking whether they would conduct an investigation.244

THE 2 JULY 2013 STRATEGY MEETING

On 2 July 2013 a strategy meeting was held, attended by Ms Harman, Ms Lamont, Ms Hurley, Ms McKenna and Ms R of the Department’s Human Resources Misconduct and Incapacity Unit (HR-MIU).245 The interface between SIU, CCIU and the HR-MIU was poorly defined. HR-MIU provided a human resources advice function to managers and a liaison point for employees where performance
issues arose, which were not sufficiently serious to require an investigative response from CCIU or SIU. Any action by HR-MIU would await the resolution of investigations being conducted by CCIU or SIU.

Ms Harman indicated that she was not prepared to change the category of the care concern. She considered that, without a disclosure from Mikayla, there was insufficient evidence to proceed to an investigation. 280

The meeting resolved that further action should be taken to determine if any further evidence could be obtained. The steps to be taken were to:

- make an attempt to have Mikayla formally interviewed;
- provide the late logbook entry to SAPOL with a request that they review their decision not to investigate; and
- have Ms R of the HR-MIU speak with the manager of SIU about a skilled investigator interviewing McCoole (SIU had not decided whether it would investigate at that time).

Both Ms Lamont and Ms McKenna were advised by Ms R to refrain from interviewing McCoole while these actions were being completed. 281 Some of the attendees, including Ms Harman, viewed a response that focused on the delivery of training to McCoole as appropriate, rather than any more serious action. 282 Ms McKenna was pushing for speedy action to be taken to resolve the care concern. She viewed her role as including acting as an advocate for McCoole. 283

Following the meeting there was confusion as to which documents would be sent to SAPOL and by whom. 284

On 3 July 2013 Ms Harman forwarded Ms H’s typed notes to Det S/Sgt McLean. However, SAPOL had already received this material and advised that it did not change their decision. 284

SAPOL did not ever receive the logbook entry. 285 It is unnecessary to determine why, but it is clear that the intention at the meeting was that it should be sent. SAPOL was thus not given information that both SAPOL officers agreed was relevant, and which Det S/Sgt McLean felt would have led him to the view that an investigation should proceed.

REFERRAL TO CHILD PROTECTION SERVICES
On 5 July 2013 Ms Jezeph made a request to CPS for a forensic interview with Mikayla. 286 CPS was given information on the progress of the investigation and told that SAPOL would not investigate. CPS also received a copy of the logbook entry. 287

A properly conducted forensic interview gives a child the best opportunity to disclose. 288 Forensic interviews are conducted by a CPS interviewer with a SAPOL officer and senior CPS employee present in a separate room. It is unusual for CPS to conduct an interview without SAPOL involvement. 289 A prosecution resulting from an interview undertaken in the absence of a police officer to verify any transcript produced for court purposes, may face evidentiary difficulties. 290 CPS would not conduct a forensic interview without SAPOL present. However, if CPS disagreed with SAPOL’s position not to investigate, it remained open to CPS to call for a strategy meeting and advocate for their position. 291

Cate Braham considered the referral to CPS. She said that a decision not to interview Mikayla was made by Sue Macdonald, the CPS Director, on the basis that the available information did not merit a forensic interview. 292 Ms Braham advised the local office, Ms Lamont and Ms Hurley by email that a forensic interview would not be conducted. She cautioned against other staff interviewing Mikayla, a prospect that had been contemplated. 293

In evidence, Ms Macdonald accepted she had made that decision although she had no memory of it and she was quite frank in indicating that she now held a contrary view. She explained that the decision would have been made in the context of a particularly chaotic environment at CPS at that time. Ms Macdonald’s willingness to accept responsibility for the decision reflects a principled and conscientious approach. However, it is unnecessary to attribute this decision to any particular individual. If the matter unfolded in the way described by Ms Braham, Ms Macdonald’s decision does not show a deficit in her skill or judgement, rather it was a decision made in particular circumstances, on the day in question.

Ms Macdonald expressed the opinion in evidence that the content of the notification was concerning and would justify the conduct of a forensic interview or, at least as a first step, an interview with the child’s care giver. It is not a precondition to a forensic interview that a child has made a disclosure. In some instances, a series of observed circumstances might be sufficient to justify a forensic assessment or interview.

REFERRAL TO SPECIAL INVESTIGATION UNIT AND HR MISCONDUCT AND INCAPACITY UNIT
SIIU was responsible for the conduct of investigations into serious misconduct alleged against departmental employees. SIIU and CCIU operated concurrently, with CCIU investigating only complaints that related to children in care. Despite CCIU declining to investigate this care concern, it remained open for SIIU to conduct an investigation into any alleged worker misconduct. 294
SIU, like CCIU, operated a system of categories which dictated the response to allegations of misconduct. Again, the allegations in this case were allocated the lowest category, category C—matters such as minor breaches of duty of care, being absent without proper cause or failing to comply with management directions.

This decision was made in the face of the allegations potentially sitting within the contemplation of categories relating to serious misconduct. Category A* includes any complaint of a potential criminal offence of sexual contact or behaviour or the sexual abuse of a child. Category A includes other potential criminal offences and other serious or significant breaches of duty of care.612

The category decision was made at a meeting attended by Ms R, the HR-MIU employee allocated to the matter, and Ms R’s manager Julie Lawson Hall on 19 July 2013. Ms R and Ms N, SIU manager, held different views about the appropriate categorisation. It is unclear precisely what occurred at the meeting or the role of Ms Lawson Hall in the decision. However, it is likely that the category decision was made, if not solely, then principally by Ms N.613

It is significant that Ms N in evidence remained of the view that the category determination was correct. She believed that the responsibility to investigate concerns about a child in care lay with CCIU. As SAPOL and CCIU had declined to investigate, she concluded that SIU was unable to deal with any suspicion of sexual assault within the allegations. As such, the threshold test to conduct a category A or A* inquiry was not met.614

The category decision had a significant impact on disposition of the matter. SIU did not conduct investigations into Category C matters. Such matters were referred to the HR-MIU.615 With CCIU and now SIU declining to investigate, it fell to the directorate, in conjunction with nannySA, to conduct any necessary inquiry. It was Ms R’s role, as the allocated HR-MIU case manager, to help and advise the directorate and fulfil the HR functions.616

Ms R intended to write a letter to McCoole setting out the allegations and requesting a response from him. Using a similar rationale to Ms N, she took the view that only disciplinary issues could now be addressed in the Department’s response. Allegations which supported sexual assault could not be considered.617

NANNYSA

Ms McKenna had refrained from meeting with McCoole because of the initial advice from Families SA that any nannySA interview with McCoole had to await their action. While Ms McKenna was on leave, Mr Sterzl maintained contact with Peter Emmerton, chief executive officer of nannySA. Following a continuing pattern, Mr Sterzl made comments to Mr Emmerton which demonstrated his view that the allegations probably had little substance.618

McCoole maintained regular contact with Ms McKenna during his suspension. Over time he became increasingly angry and threatened legal action against nannySA. This contributed to Ms McKenna’s anxiety about the care concern. She felt under increasing pressure, to the extent that she asked Mr Emmerton to take over conduct of the care concern.

On 22 July 2013 Ms R informed Ms McKenna that SIU would not conduct an investigation. The Commission accepts Ms McKenna’s evidence that Ms R also informed her that nannySA could now conduct an interview with McCoole. 612

On 23 July 2013 Ms McKenna and Maree McCulloch, operations manager of Bubble ‘n’ Squeak (another business arm of Hessel), interviewed McCoole.

The purpose of the interview, as perceived by Ms McKenna, was for McCoole to have an opportunity to answer the allegations. She did not view it as an investigation into a sexual assault. Ms McKenna considered it would enable her to assess whether nannySA was content to put McCoole back to work and whether he needed direction or retraining.617

Ms McKenna viewed the allegations surrounding McCoole’s conduct in the bedroom as the area of concern. She agreed it could be inferred that McCoole had tickled Mikayla where she was not comfortable and it was possible something had happened in relation to Mikayla’s bottom. However, Ms McKenna felt there may have been innocent explanations for what had been observed. For example, she thought the comment by Mikayla that her bottom was sore could have been attributable to a medical condition such as worms or constipation.617

Ms McKenna was not concerned about McCoole’s comments about children exposing themselves in the bath, as they were not made repeatedly. She interpreted the allegations of lavishing and withdrawing attention in the tickling game as akin to a brother treating a sister unkindly and not indicative of grooming.617

Ms McKenna approached the interview by reading the allegations to McCoole and allowing him to respond. Any questioning of McCoole was limited to one or two questions.618

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Ms McKenna had refrained from meeting with McCoole because of the initial advice from Families SA that any nannySA interview with McCoole had to await their action.
Ms McCulloch’s sole involvement in the interview was acting as scribe.614

Immediately on completion of the interview, Ms McKenna advised McCoole she was satisfied with his responses and the allegations appeared to be unfounded. She regarded McCoole’s responses as credible and thought that Ms H’s concerns had resulted from a misunderstanding. In hindsight, Ms McKenna accepted the interview process was inadequate as she did not probe into the areas where McCoole failed to provide an explanation, and she did not investigate further the possibility of a ‘misunderstanding’ with Ms H.615

On 24 July 2013, Ms McKenna emailed Ms Lamont advising her that she was ‘fully satisfied’ with the explanations given by McCoole at interview. By this, Ms McKenna meant that she was satisfied the care concern was not substantiated in view of the principle that a person is innocent until proven guilty, although she did not include that qualification in her communication with Ms Lamont.616

Ms McKenna completed the interview with McCoole shortly before her last day of work with nannySA. She wanted to finalise nannySA’s position on the care concern so someone else would not be left with a ‘mess’ to deal with. She denied that this influenced the way she dealt with the matter, and that accepting McCoole’s account was the tidiest outcome. She also asserted she had ‘not really’ resolved the matter in this way to avoid legal action. Rather, she tried to follow due process after an already long delay.617

CARE CONCERN CLOSURE RECOMMENDATION
On 9 August 2013, Mr Williams uploaded a case closure recommendation onto C3MS. The recommendation noted that618:

• He made general denials of the comments about the children bathing and saying ‘oh, don’t look at me’.
• He denied tickling Mikayla and said it was ‘gentle poking’ while watching TV. He asserted the behaviour may have given the impression of lavishing and withdrawing attention because he only did this during ‘ad’ breaks. Ms McKenna thought this was a possible explanation, but agreed she could have checked its accuracy with Ms H.
• Ms McKenna thought McCoole made a general denial that he had been whispering in the bedroom.
• McCoole gave no explanation why Mikayla was on her hands and knees or why she said her bottom hurt. Ms McKenna did not recall if she specifically put this to him. At the time Ms McKenna did not think it significant that McCoole failed to address these topics.

The care concern was closed by Ms Hurley on 13 August 2013. The Commission accepts that she was acting as scribe.619

In making this recommendation Mr Williams intended to advise the local office that the directorate had completed its actions and to prompt a response from, or review by, that office. Whether the office would have done so is questionable given Ms Rowley’s belief that the local office’s involvement in the care concern had ended following completion of the interview with Mikayla.620

Mr Williams relied on information he received from Ms Lamont and C3MS to prepare the recommendation.621 Mr Williams’ summary was inaccurate in a number of respects and omitted relevant information which was available on C3MS. In particular, the summary failed to reflect a C3MS entry of Ms Harman relating to the 2 July meeting which referred to the logbook entry. Mr Williams assumed, incorrectly, that SIU would investigate as Mr Dixon had not responded to the contrary to Mr Williams’ email of 24 June.622 Furthermore, the recommendation was made before the directorate completed its inquiry; McCoole had not been interviewed by the directorate, as Ms Lamont intended.

The care concern was closed by Ms Hurley on 13 August 2013.623

ACCEPTANCE OF NANNYSA INTERVIEW BY FAMILIES SA
McCoole was never sent a letter by HR–MIU. Ms R did not send it herself. She said she asked Kristin Kuehn, who assumed conduct of the matter when she went on leave in August, to do so. Ms Kuehn did not send it. Ms Kuehn in evidence did not recall being asked to send the letter, but other evidence supports Ms R’s account that she was asked to do so.624 The Commission accepts that she was asked to send the letter.
Ms Lamont had deferred her interview of McCoole until the letter had been sent. Ms R informing Ms McKenna that McCoole could be interviewed by nannySA, combined with the failure to send the letter, meant that the directorate had not conducted its own inquiry before the nannySA interview.

Ms Kuehn received notes of nannySA’s interview with McCoole. On 20 August she recommended to Ms Lamont that she should accept the opinion of nannySA, that the concerns were unsubstantiated. She wrote:

> it may be best to progress this matter by acknowledging the content and outcomes of the interview and confirming performance expectations with Mr McCoole. This may need include a refresher in standard operating procedures.

This rationale is internally inconsistent; if it was accepted that the allegations were unfounded, it is difficult to see why retraining was required.

Ms Kuehn attributed her recommendation that Families SA accept nannySA’s interview and judgement to an erroneous belief that McCoole was solely a nannySA employee. She was unable to explain why she suggested the outcome of the interview should be accepted when McCoole had not been required to provide an explanation for some of the alleged conduct.

Ms Lamont remained concerned about the qualifications of the interviewer and felt that the interview did not contain enough information from McCoole about the events to form a basis for her assessment. However, faced with an absence of support for ongoing action, and with nannySA indicating its satisfaction that the allegations were unsubstantiated, ‘it just died’.

Ms Lamont met with McCoole and Mr Sterzl on 22 August 2013. The purpose of the meeting was a performance management discussion with McCoole. They discussed additional training, the need for McCoole to develop a better understanding of the dynamics of abuse and that he needed to stop tickling children. In the meeting McCoole denied the allegations and that he had any gaps in his understanding about sexual offending.

THE DIRECTORATE’S RESPONSE

Ms Lamont held lingering concerns about placing McCoole back to work with vulnerable children on single-handed shifts. She wanted McCoole monitored for the safety of the children with whom he worked. McCoole’s return to work was on the proviso he only work on double-handed shifts for one to two months. Ms Lamont was reassured by her understanding that double-handed shifts would ensure McCoole would always be monitored by the presence of a second staff member. Ms Lamont’s decision to return McCoole to work was also influenced by staff shortages in the directorate. A staff freeze was placing pressure on the workforce: it had reached a stage where filling shifts required day-to-day crisis management.

McCoole’s casual employment contract with Families SA expired on 23 August 2013, the day following the performance management discussion. Ms Lamont thought that she was obliged to renew the contract as all staff on short-term contracts had been informed their contracts would be renewed. She spoke with the directorate’s business manager and understood there were no grounds to refuse to extend McCoole’s contract.

In contrast, Ms R thought that Families SA was not obliged to give McCoole work. He was employed on a casual basis, so she thought there was no impediment to Families SA not giving him shifts and, at the end of his casual employment contract, no obligation to offer him a further contract. Ms R said she advised Ms Lamont of her view.

It is not possible to resolve the inconsistency between the two witnesses on this issue.

At 10 L Street, a new policy was put in place prohibiting all carers from sitting on children’s beds while reading stories. A sign to this effect was displayed and the policy was discussed at a staff meeting.

CONVERSATIONS WITH MS H

On 17 August 2013, Ms H had a conversation with Mr Norman in which she sought an update on the status of the investigation. Mr Norman advised Ms H that McCoole would be cleared and he would go back to work with their full support. Ms H felt Mr Norman was justifying the behaviour of McCoole and dismissing her concerns. When she said that she had no reason to falsify anything, Mr Norman responded ‘yeah, but we don’t know you’. He said she could be trying to set McCoole up and was in any event just ‘putting dot points together anyway’. He questioned her observations and belittled her opinions. Part of the conversation was overheard by another nannySA worker.

Mr Norman’s account of the conversation contrasts greatly with that of Ms H. He paints her as aggressive and unprofessional, pushing for more to be done in the investigation as she had heard McCoole was returning to work. He shared this account of the conversation in an email sent on 20 August to Mr Sterzl, Mr Calvert and Mr Rogers. He concluded the email saying:

> Ms H’s willingness to condemn a fellow worker simply based on her feelings and the connecting of imaginary dots is quite dangerous and professionally intolerable. I made this very clear throughout her conversation.
Notwithstanding the content of the email sent by Mr Norman, Ms H’s account of the conversation is accepted, and Mr Norman’s rejected.

Soon after this email was sent, Ms H became aware that McCoole was returning to work when Mr Norman made a phone call in her presence, asking McCoole to pick up some shifts. Although Mr Norman denied in evidence that this call was deliberately staged to emphasise to Ms H his loyalty to McCoole, the Commission is satisfied on the weight of the evidence that the call was placed with that intention.

MCCOOLE’S RETURN TO WORK
McCoole returned to regular shifts with Families SA on 13 September 2013.437 In addition to restrictions requiring him to work double-handed shifts, McCoole was not permitted to work at 10 L Street.

The restrictions in place on McCoole’s work were not explained consistently to Nation Building seniors, nor were operational staff made aware of any restrictions on his conduct. The perception that McCoole had been ‘cleared’ of the allegations arose, and was the position on his conduct. The perception that McCoole had been allowed to be alone with children, in direct conflict with Ms Lamont’s intent.

Purton, who was asked to monitor his first shift back to work. She was told that McCoole was allowed to be alone with children, in direct conflict with Ms Lamont’s intent.439

The manager had stipulated a double-handed shift requirement for a period of one to two months. The restriction should have been enforced with such rigour that no member of the senior staff group could have had any doubt as to the required working arrangements or the outcome of the care concern.

McCoole was then placed on shift with Mr Curyer at 9 T Avenue. Soon after, Mr Curyer ceased work for a period of time and McCoole took over his position. As there were insufficient Families SA employees, McCoole worked single-handed shifts. It is unclear precisely when this occurred, but it was likely before the end of the one to two month period specified by Ms Lamont. Even during the period that McCoole was working double-handed shifts he would have been alone with children from time to time.440

The response of the workforce to McCoole’s return to work was not positive. Some workers objected to him moving to houses at which they worked.441

Mr Curyer and other workers were consulted about their willingness to work with McCoole, a circumstance so rare as to be notable.442 Ms Lamont was advised of a complaint by one worker, but otherwise was not informed at that time of other complaints, such as the report of McCoole photographing Nicky Schultz on his mobile telephone, during the period he was supposed to be supervised.443

MCCOOLE’S PROMOTION
Between 18 and 26 January 2014, McCoole was appointed to the position of acting senior for six shifts on the recommendation of Mr Norman, who at the time was acting in Mr Sterzl’s position.444 Mr Norman said McCoole had demonstrated an interest in an acting position, and that he decided to give him the opportunity. Mr Norman explained he was attempting to replace a male senior with another male. He wanted to keep the gender balance to promote consistency for the children. He took this position despite the fact all the other seniors in the section were male.

Mr G, another senior youth worker, said he had a conversation with Mr Norman in which Mr Norman warned him about Ms H. In this conversation Mr Norman said he placed McCoole in the acting position in response to Ms H and her friends calling McCoole a ‘pedo’.445 Mr Norman denied making this comment but his denial is rejected.

Mr Norman’s explanation for his decision to promote McCoole also cannot be accepted. Consistent with Mr Norman’s comments to Mr G, the Commission is satisfied that Mr Norman did not base his decision solely on a consideration of merits. He was motivated, at least in part, by a desire to demonstrate his loyalty and show the women he thought had acted improperly towards McCoole, that McCoole’s professional standing would not be affected by their actions.

SHANE STERZL AND LEE NORMAN’S BEHAVIOUR
Mr Sterzl and Mr Norman continued to publicly express their poor opinions of Ms H following the resolution of the care concern. The conduct extended to attempting to influence the views of other employees towards her.

Towards the end of 2013 Ms H applied for and was offered a position with Families SA working in residential care houses. She was to be deployed in a group of houses managed separately to Nation Building and transitional accommodation. Mr Sterzl on two occasions made derogatory comments about Ms H’s work capacity and intellect. The first was in Ms H’s presence. On learning that she had been accepted to a position with Families SA he said ‘how did someone like you get through?’. He did not appear to be joking. He subsequently reiterated his point to Ms Hammond, saying ‘she’s got rocks in her head, that one’. On the second occasion Mr Norman belittled Ms H’s intelligence in the presence of Ms Hammond and Mr Rogers.446 Mr Sterzl denied making any of the comments.447 The Commission is satisfied that the comments were made.
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Ms Hammond was given the impression that Ms H was a laughing stock among the seniors. She did not appear to receive any support from nannySA, nor from Families SA seniors or supervisors during the care concern process. Ms Hammond observed that Ms H appeared distressed and affected physically by the stress of the process.411

When Ms H began work with Families SA she was allocated to a group of houses which were managed separately to Nation Building and transitional accommodation. Mr G, Paula Elliott and Mr P were seniors in that area. While they were discussing Ms H joining their section, Mr Norman approached them and advised them to watch out for Ms H as ‘she’s trouble’ and was ‘going around accusing good workers of being pedos’. Mr P concluded that Mr Norman’s view of Ms H was quite negative.412 Mr Norman denied having ever spoken with Mr P about this topic and did not recall this discussion. Mr G recalls that at a later time, after McCoole’s arrest, Mr Norman referred to Ms H and those supportive of her as ‘a bunch of scorned old women’.413

Later in 2014, Mr Norman told Ms D, an acting supervisor in the Seaford area, that he did not really want Ms H to return to Nation Building houses as she was a troublemaker and could not be trusted.414

Ms S, another worker, overheard a telephone call between Mr Sterzl and a person she believed to be Mr Norman in which Mr Sterzl described Ms H as a troublemaker and could not be trusted.415

After McCoole’s arrest was made public, a meeting of the 10 L Street team was called. Mr Norman conducted the meeting. When asked by Ms Dimond what staff should do if they had information they felt may add to the case, Mr Norman cautioned them against assuming who had been arrested, as that may risk the investigation. He asserted they should not ring a police hotline.416

In evidence, Mr Norman said he did not recall this specific team meeting. He said he was psychologically injured by the discovery of what had occurred and his memory of the days and weeks thereafter was scant. Ms Dimond’s evidence is accepted on these matters.

Mr G recalled receiving a text message from Mr Norman after McCoole’s arrest. The message contained a link to an Advertiser article which referred to McCoole being promoted. Mr G said Mr Norman wanted him to ‘suss out’ whether Ms H had leaked the information.417 Mr Norman does not recall sending such a text message and expressed a view that Ms H and Mr G may have colluded to concoct evidence against him. The Commission rejects Mr Norman’s evidence on this topic.

Mr Sterzl and Mr Norman were both unsatisfactory witnesses whose evidence on most issues was not credible. There is a substantial body of credible evidence that they continuously undermined Ms H, both during and after the Mikayla Bates care concern.

ORGANISATIONAL CULTURE
The events discussed in the context of the Mikayla Bates care concern should be viewed in the wider background of the organisational culture in Families SA southern residential care area. Throughout McCoole’s employment, red flags were ignored and discounted. The ineptness of the response by senior staff to McCoole’s workplace performance, and the apparent condoning of his conduct, can be properly understood only as part of the prevailing culture.

The organisational culture provided an arena where the interests of employees and agendas of individuals overshadowed the need to act in the best interests of the children in care.

Nicole Stasiak, current Director of Residential Care, reflected on what she had come to understand about the cultural issues following the arrest of McCoole. She reported hearing about senior staff trying to shut down staff members debriefing. Ms Stasiak described pockets of close-knit groups within which incidents or issues would remain confined. Staff were told the only option available to them to report concerns was to the next ranking person. The culture was dysfunctional and not healthy or supportive.

Ms Stasiak had become aware of some staff being promoted through being ‘tapped’, without training in leadership or support to develop the necessary skills. In her opinion, knowledge of legislation, and of departmental policies and processes, was limited, and understanding of the differing roles of youth workers and social workers was lacking.418

The reflections of Ms Stasiak echo many of the experiences of the organisation’s culture described in evidence to the Commission.

THE STATUS OF COMMERCIAL CARERS
Commercial carers employed by agencies such as nannySA are permitted to care for vulnerable children who are in care. They often do this on shifts alone with multiple children and without supervision or oversight. This is an immense responsibility and places unparalleled trust in commercial carers. Yet, in many respects, Families SA staff treated them as inferior.
Commercial carers are given unconstrained access to children in care, but are limited in their access to information about those children. In a sense, information about the children was, at times, guarded more closely than the children themselves. The training offered to commercial carers is scant compared to that expected of Families SA employees.

Indifferent attitudes to nannySA workers permeated the senior staff level. Ms K described the approach to nannySA workers under senior Mr Calvert as ‘[w]e were on a need-to-know basis and we didn’t need to know’. Mr Calvert would not respond to matters escalated to him by nannySA workers. Ms Hammond described Mr Calvert’s attitude towards her as being one of disregard.

For Mr Calvert’s part he told the Commission he had no views about the quality of commercial carers. While at one time he was keen to support them, his approach changed because of the complexities of supervising staff not employed by the government. Mr Calvert considered it was not possible to have the same expectations of commercial carers as Families SA staff. Despite these views, he maintained he did not see agency staff as having a different role or status to Families SA workers. He disputed the comments made about his conduct towards commercial carers.

The view commercial carers had of their status in the workplace was relevant to how they responded to their observations of McCoole’s conduct. For example, nannySA worker Ms V did not log Anna Pham calling McCoole a paedophile in part because Families SA workers made her feel as though they were ‘higher up’, even though they did the same work.

Supervisors, in consultation with seniors, have the power to determine which agency staff are given shifts. Remaining in favour with the senior staff is therefore important. Ms Hammond said this dependence on Families SA to receive shifts meant many nannySA workers were reluctant to log or report incidents. Ms Hammond was not alone in her perception.

In the absence of collaborative and respectful working relationships, it is difficult to see how the care given to children can be the best possible standard. Unbalanced and unsupportive relationships challenge the organisation’s ability to focus on the wellbeing and protection of children in its care.

THE SOCIAL WORKER–YOUTH WORKER DIVIDE

On 1 January 2013, while cared for by McCoole and Ms Dennis on an excursion to the beach, William Moore was badly sunburnt. Ms Gregory, who cared for William that night, described the sunburn as ‘bad enough for the child to be screaming all night’.

William’s social worker Mirjana Vidovic was advised of the incident. She sought more information and, in consultation with her acting supervisor and manager, gave the matter close consideration to ensure that it met written criteria before raising the matter as a care concern on 9 January.

Ms Vidovic was allocated to manage the relevant response. On 23 January, Ms Vidovic and her acting supervisor met with a senior youth worker and acting supervisor Mr Calvert to discuss the care concern. The relevance of this meeting is unrelated to the response to the care concern; Mr Calvert had taken steps to address the care concern which Ms Vidovic considered adequately dealt with the issues. The relevance is in Mr Calvert telling Ms Vidovic in the meeting that the care concern should not have been raised. He expressed the view that the more care concerns that are raised about a particular youth worker, the more unfavourable it looks.

Ms Vidovic was clear the relevant policy supported the incident being raised as a care concern, and explained that to Mr Calvert. Mr Calvert did not consider the youth workers had failed to meet the necessary standard of care as the sunburn did not require hospital treatment. In his view, the social workers were ‘setting a standard that most parents could not meet’. He thought if such a line was taken, staff would decide not to take children to such activities, which was more negligent than the occasional incident that arose. Ms Vidovic understood Mr Calvert’s position was that if workers adhered to all practices, children would not be able to do anything at all.

The response to this care concern is indicative of tensions between those Families SA staff delegated to be the legal guardians of children in care and those youth workers tasked with providing day-to-day care to the children. Delegated legal responsibility for a child in care sits with social work practitioners in local offices, not the directorate. If the social worker ultimately responsible for the child considers there has been a failure to meet a sufficient standard of care, questioning that view gives the appearance of the worker’s interests being prioritised over the child’s interests.

THE CONDUCT OF DARREN CALVERT AND HIS EVIDENCE BEFORE THE COMMISSION

Mr Calvert asserted that Ms Vidovic was ‘playing it safe’, and ‘made a judgement from an office that was based around her career as opposed to the outcomes for the kids’. Mr Calvert suggested rules provided staff with guidance only and that their application was discretionary.
The Commission’s ability to foresee the significant criticisms Mr Calvert would level against Ms Vidovic in evidence was limited because he did not provide a statement before giving evidence. Mr Calvert was given that opportunity but declined it when told that the Commission would not inform him in advance of exactly what the Commission wanted to know.477

Consequently, Ms Vidovic did not have an opportunity to respond to the allegations which emerged for the first time during Mr Calvert’s evidence.

However, the Commission does not accept Mr Calvert’s assertions in relation to Ms Vidovic’s reasons for raising the care concern.

It is appropriate at this point to comment on Mr Calvert’s evidence in general. His responses in evidence were dominated by an assertion that he did not recall events and circumstances. These purported memory gaps were not the result of medical impairment or psychological issues. Importantly, giving Mr Calvert the opportunity to refer to documents during his evidence did little to assist his memory.488

Mr Calvert and Mr Norman worked together for 10 years and were close friends.489 Following Mr Norman’s evidence, but before Mr Calvert gave evidence, the two of them discussed Mr Norman’s evidence. Mr Norman told Mr Calvert the questions he had been asked in evidence. Remarkably, when giving evidence less than 24 hours later, Mr Calvert claimed he could not recall any of them discussed Mr Norman’s evidence. Mr Norman evidence, but before Mr Calvert gave evidence, the two

Despite understanding that he was summoned to give evidence in relation to McCoole, and that McCoole was the focus of this inquiry, Mr Calvert made no effort to gather his thoughts about his involvement with McCoole. His casual attitude bordered on contemptuous. He implied that the Commission was to blame for his faulty memory because the Commission had not advised him in advance of the questions he would be asked.490

Mr Calvert did not try to assist the Commission, nor answer any questions to the best of his memory and ability, despite his extensive involvement in significant aspects of McCoole’s employment with Families SA.

LOGGING A COLLEAGUE’S NAME

Evidence surrounding the recording and logging practices of workers calls into question the robustness of information-gathering processes in residential care environments. Practices did not appear to be entirely consistent, but the prevailing view was that observations that reflected negatively on another worker should not be recorded in logbooks.492

Families SA worker Ms C said she received a clear instruction through training that when recording observations about another worker in a negative light the other worker should not be named.473

nannySA worker Ms Hammond logged a disclosure, including the name ‘Darren’, made to her by one of the Schultz children regarding Mr Calvert’s conduct.494 Within days the logbook containing the entry was removed from 14 R Road and a directive was issued by Mr Sterzl that the names of other workers were not to be mentioned in logbooks. Rather they were to be generically described as ‘youth worker’ or ‘yw’.

Mr Sterzl’s evidence did not help the Commission understand the reason for this practice.

Various reasons were given for the recording practices. Most related to concerns about access to the recorded information by the worker concerned or a wider audience, including by non-government organisations. Clear instructions were given that notes must be factual, and may not contain matters of opinion. The view that the logbook was a legal document was also put forward.495

Some staff indicated that rather than recording negative observations they would either report the matter to a senior staff member or get advice about what to record. This view was supported by manager Ms Lamont. This practice gives workers a process to follow but does not necessarily clarify recording practices. In the absence of clear guidance, or an alternative mechanism for recording negative observations, it is possible that concerning matters may never be documented.496

The line between factual observations and opinions is not always easy to draw. Staff may be left uncertain as to whether they should record a significant event because they do not understand the distinction. Further, it is unclear why a staff member considered capable of caring for vulnerable children should be discouraged from recording a relevant opinion. For example, recording that a restraint continued for three minutes and was unnecessarily protracted (facts and opinion), is much more informative and child focused than merely recording the restraint lasted three minutes (factual).

THE BARRIERS TO COMPLAINING

A significant enabler of McCoole’s workplace conduct, both criminal and performance related, was the unwillingness of staff to raise concerns or complaints. The reasons are numerous and varied, and include:

- concerns about job security;
- the perception of an impenetrable alliance of senior staff members;
• senior staff confusing debriefing with gossiping, having the effect of stamping out the reporting of, or response to, genuine concerns;
• well-founded beliefs that complaints would not be addressed appropriately, leading to a sense of futility;
• the puzzling fixation of senior staff on employing a mediation process; and
• senior staff misidentifying workplace conduct issues as personality issues not deserving of their consideration.

Job security
McCoole’s conduct took place in a climate where Families SA workers were being employed on short-term contracts, sometimes as brief as one month. Fear that their contracts would not be renewed affected the workers’ preparedness to raise issues and concerns with senior staff.479

Lack of job security not only plagued workers at the OPS3 youth worker level. As an OPS4, Mr Rogers was regarded as being sympathetic to the concerns and challenges faced by staff. However, he was also on contract for a period of time. He told youth worker Ms Pinos he ‘felt as though his hands were tied’ and he would be able to ‘speak his mind’ once he was made ongoing. Mr Rogers did not accept being on a contract made it difficult for him to deal with complaints, but acknowledged he was ‘not going to rock the boat too much’ while trying to establish himself in the role.479

Social connections
‘The boys club’ became a shorthand term used by many workers to refer to a block of relationships between senior male staff that diminished workers’ willingness to raise concerns. Manager Ms Harman knew staff spoke of ‘the alleged’ boys club. Other senior staff members were aware at least of very tight relationships, if not the perception of the club.460

Ms Lamont was aware Mr Sterzl had a very tight team with his seniors, in particular Mr Norman, Mr Calvert and Mr Rogers. She said she was not aware of the extent of any social relationships between them. Ms Lamont did agree that it is not good for staff to think they cannot penetrate a group of senior staff if they have a complaint to make.461

While Mr Calvert was aware some youth workers referred to some senior staff as being in a boys club, he did not know if he was included in the group. Other seniors, including Mr Norman, Mr Knight, Scott Reed and David Hehir raised the topic with him on several occasions. He dismissed it as uninteresting, commenting ‘I’ve got nothing to say on it.’461 Mr Calvert was clearly not concerned with the perceptions of the workers he was overseeing. Similarly, Mr Norman’s concern was centred on his view that workers were making sexist remarks by referring to the boys club. He pointed out there was not a club; they were males put together by management.

Mr Norman, Mr Calvert and Mr Knight were all considered central figures in the boys club.461 The precise ‘membership’ of the club beyond this is unclear, as is the nature of the relationships between its members. It is unnecessary to make any determination about this matter. What is significant is the perception of a tight circle of relationships between a number of senior male staff members, which was too hard to penetrate and which was a barrier to raising complaints. A perception of relationships between senior staff members being ‘incestuous’ is not a sign of a healthy organisation.461

Debriefing vs gossiping
From the perspective of OPS3 staff members, discussing matters with colleagues is considered an important support mechanism to cope with the challenging and complex environment in which they work:

• staff are very close and we talk a lot and often, if you have a bad shift, you need to debrief with somebody, so a fellow staff member, either one that works in your house or works in another house, we confide in each other.461

However, many senior staff in the southern residential care area expressed concern that workers gossiping with their peers was prevalent and detrimental.

Ms H considered she was entitled to debrief with selected colleagues about her experiences, at the time of the care concern relating to Mikayla Bates. However, Mr Norman took the view ‘this gossip will inevitably garner snowballing weight against [McCoole’s] name and professional working relationships will be damaged’.464

Mr Norman made the point in evidence to the Commission that ‘gossip is very dangerous in our field’.467 However, his objectivity on this topic must be considered in the context of his belief that he, too, had been unfairly targeted by gossip and was, at the time of giving evidence, suspended from Families SA in relation to allegations of criminal conduct. Subsequent to Mr Norman giving evidence, he pleaded guilty to two offences committed in the course of his employment. The behaviour concerned theft of prescription medication from a child in care.

In Mr Norman’s view:

the unfortunate part about our business is gossip and once one person says something about another person it spreads like cancer which is something that we tried really really hard to stop from happening ... there started to be gossip about Shannon.468

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Mr Norman described gossip as including informal chats between people. If a staff member was to debrief with another colleague about their difficult experiences with McCoole, in Mr Norman’s view this would be considered gossip and could be perceived as a breach of the public sector code of ethics:

because basically you’re passing on personal opinion to a colleague on the same level as you that’s very negative in nature and if everybody did that about everybody then no-one in the work environment would essentially get along.603

Mr Norman was clear: ethically, the only option a person had was to debrief with a senior staff member and this position applied across the public sector. He explained the code of ethics allowed a staff member to debrief with their senior or supervisor as that is the ‘conflict resolution chain’.603

While Mr Norman disagreed he had spoken to Mr G about McCoole being a problem performer, he suggested seniors, because they are at management level, could debrief with each other and discuss workers. They were not restricted like youth workers who could ethically only debrief with someone more senior.

Ms Decoster considered there was a ‘very big difference’ between gossiping and debriefing. She explained that if a staff member needed to debrief about something they needed to go to ‘the right person’, their senior as a first point of call, or their supervisor or a manager. She regarded it as inappropriate for a staff member to discuss with a colleague difficulties they have experienced with another staff member, because the reputation of the other person could be tarnished.

Ms Decoster initially suggested that if she needed to debrief she would always speak with her manager and maintained she had never talked with a friend about something that had annoyed her at work. Ms Decoster soon retreated from this position conceding she had also spoken with colleagues at her own level. She then conceded it was not inappropriate for staff members to speak with their colleagues and debrief.

Ms Decoster was anxious to suppress a culture of staff discussing their grievances and concerns. As a conduit between Ms Decoster and the OPS3 staff, it was apparent Mr Knight agreed with this approach. Mr Knight’s evidence gave a clear illustration of why such a stance endangers a supportive and healthy reporting environment.

When Ms Ball raised her concerns with Mr Knight about McCoole, but did not want to pursue a formal complaint, Mr Knight said that Ms Ball ‘just wanted to debrief’. Mr Knight felt that sometimes the term ‘debrief’ is used instead of gossip. Mr Knight explained that a cultural issue existed where staff would gossip between themselves but would not want to pursue formal avenues. Ms Decoster encouraged complaints being recorded in writing. 617

Even though youth workers raised concerns about McCoole’s workplace conduct they were never addressed. As they were not put in writing it can be inferred they were dismissed as gossip and not worthy of a response.

Gossip is an organisational culture issue that remains of concern to manager Ms Harman. When a youth worker raised third party issues with her, Ms Harman told the staff member gossip was ‘rife’.617 While Ms Harman did not dismiss the possible cause of gossip as the existence of barriers to formally reporting concerns; she suggested it might also be related to staff working in isolation, on differing shifts and the relay of information being delayed. Ms Harman recognised the need to balance the deterrence of gossip with bringing important or useful information to the attention of senior staff.617

**Complaint resolution processes**

An expectation had developed among seniors that complaints raised by workers about other employees should be dealt with by face-to-face meetings in which workers voiced their complaints. This approach was referred to as ‘mediation’, although there is no evidence that any independent or qualified mediator was involved.

Various reasons were given for the practice, including a belief that natural justice principles gave a person the right to face their accuser and defend oneself; to allow the senior to ascertain the truth of the situation, or because it was a ‘no win’ situation for the senior.618

These reasons demonstrate a misunderstanding, or sheer disregard, for an appropriate complaint resolution processes. Fundamentally, mediation is not an appropriate tool to be used to ascertain the truth of a worker’s assertion. There will always be relatively minor workplace issues able to be dealt with by a senior member working together with staff but the evidence suggests that efforts were made to employ mediation in inappropriate circumstances.

Such a process could prevent genuine concerns or grievances about a worker coming to the attention of the person’s manager, because the worker is not willing to participate in the ‘mediation’ process.

The Commission observed examples of the latter in complaints received about Mr Norman. On three occasions workers complained about his conduct to Mr Sterzl and Ms Harman. In some instances the complaints related to serious concerns about workplace performance. In each case the complaints were not
pursued by the worker, or by the directorate, because workers did not want to participate in the ‘mediation’ process.

The practice served also to deter workers from even raising concerns, as they were not prepared to participate in the process.446

Particularly where there is a concern about anonymity, where concerns are serious in nature and require further enquiry, or where there is a power imbalance, such as a complaint about a more senior worker, mediation is an inappropriate method to resolve a complaint.

Losing faith in the grievance process

Many staff considered raising concerns and complaints to be an exercise in futility. This was particularly so for staff working under Ms Decoster in the southern transitional accommodation area.

One experienced youth worker spent significant time as a union representative, a role in which she made complaints about seniors, supervisors and managers. After seeing complaints go unaddressed, she lost faith in the process.446 Ms O, a youth worker with 10 years’ experience, described not trusting her supervisor Ms Decoster and this lessened her willingness to raise concerns. This was a consensus across the team of youth workers.497

Ms Decoster’s conduct and management style caused many of the staff she supervised to lose faith in the grievance procedure. She would respond to concerns or grievances brought to her attention by suggesting, for example, that the staff member raising the complaint was not coping or by giving the staff member an ‘opportunity’—the transfer of the complaining staff member to a different house. The reputation of staff who complained could be damaged, for instance, by being labelled as a person who could not be trusted. Staff were left questioning the efficacy of raising grievances as they felt they risked being punished for so doing.498

In mid-2012, with the support of union representatives, a majority of staff in Ms Decoster’s area met with manager Ms Lamont to raise longstanding grievances about her conduct. At the meeting, Ms Lamont discussed moving Ms Decoster to another area as an option. This did not happen. Ms Decoster was placed on a performance development plan, but her conduct did not improve. In fact, staff thought it became worse.499 This is not surprising given Ms Decoster viewed the concerns raised as unfounded.500 In the absence of their grievances being addressed ‘[e]veryone had lost faith in the system, in the grievance procedure. And in management’.501

Treatment of staff who complain

Ms Roberts raised a complaint about McCoole coming to work at 6 S Street following his return to work after his suspension. This was one of the four complaints raised by female youth workers which led Ms Decoster to arrange a supervision session with McCoole in April 2014.

The complaint was based on concern that McCoole’s presence would be detrimental to the team because of his personality traits. Ms Roberts also said a child at the placement expressed fears on learning McCoole was coming to the house. Her concerns were set out in an email to Ms Decoster and seniors. Unfortunately, it was phrased in rather emotional terms.502 Ms Roberts forwarded the email to other team members to keep them informed of events.502 Ms Roberts also emailed the child’s therapists about the child’s concerns without naming McCoole.

At the time of receiving the email Ms Decoster was not aware of the Mikayla Bates care concern but was aware of the complaints of the other female workers. Mr Knight had also raised his own concerns about McCoole moving to the house. He, too, thought McCoole might be a poor fit. His concerns did not change the situation. Ms Decoster informed him the decision had already been made.504

On 12 March Ms Decoster and Mr Knight met with Ms Roberts. It might be anticipated that the meeting would deal with Ms Roberts’ concerns about McCoole, but it failed to do so. Instead Ms Decoster focused her attention during the meeting on raising a litany of criticisms of Ms Roberts’ conduct which were founded on Ms Decoster’s incorrect understanding of both the facts and appropriate workplace practices.

For instance, she cautioned Ms Roberts for sending the email to the child’s therapist. This and other emails were said to be inappropriate use of a government communication medium which denied McCoole natural justice, as they published information relating to McCoole to which he could not respond. Ms Decoster told Ms Roberts this would reflect poorly on her professional reputation. The criticisms were made despite the email not identifying McCoole by name.

In addition to Ms Decoster’s unfounded criticism of Ms Roberts’ conduct, she criticised Ms Roberts for raising concerns by email, a curious position given her focus in other instances on complaints being documented in writing.505
The conduct of the meeting was also procedurally unfair. Ms Decoster advised Ms Roberts at the outset that the meeting was not intended to be a performance management session, yet then went on to treat it as such, advising Ms Roberts at the end that she would receive a formal letter. Further, despite noting that Ms Roberts was struggling during the meeting she continued to raise her unjustified set of complaints over a period of four hours.

Ms Roberts was offered the ‘opportunity’ to move houses at the meeting’s close. This was not so much an opportunity as a punishment for Ms Roberts’ perceived poor conduct.

Ms Decoster’s evidence about the conduct of this meeting and her purpose in holding it was internally conflicted and not substantiated by the meeting minutes and evidence of other participants. Her assertion that she did not raise Ms Roberts’ concerns about McCoole in interview because of advice received by the Human Resources section is not accepted. The weight of the evidence supports the conclusion that Ms Decoster never intended to raise these matters with Ms Roberts. Ms Decoster’s sole purpose of the meeting was to performance manage Ms Roberts.

Ms Roberts said she felt targeted in the meeting. This reaction is understandable. The conduct of Ms Decoster in this meeting, if known to other workers, would cause legitimate concern about the effect on their careers of raising legitimate workplace concerns. Such conduct has the effect of suppressing communication between supervisors and workers about the true state of play in the workplace.

The issues raised by Ms Roberts’ email relating to McCoole were not addressed by Ms Decoster at any later point, either with McCoole, or by making broader enquiries about his conduct in the workplace, by accessing information available to her in his supervision file or by enquiring into the circumstances of the Mikayla Bates care concern. However, she had been made aware of the care concern’s existence by Ms Roberts’ email.

Less than a fortnight later Ms Decoster contacted McCoole and asked him to attend 10 S Street and obtain a mobile phone on which Jayden Conti had taken pictures of his own erect penis. She asked McCoole to email the images to a social worker. Other workers at 10 S Street (where McCoole was not employed at the time) could have helped Ms Decoster with this task.

The decision to entrust McCoole with such responsibility, unsupervised, is indicative of the lack of regard Ms Decoster had to any of the complaints and information available to her about McCoole’s workplace conduct.

**Observations**

The organisation, and the individuals working in it, failed to respond to red flags at a number of stages. Information that should have been actioned was not actioned, reports of concerning behaviour were not made or not adequately actioned, and the behavioural communications of children in care were ignored. Had the various red flags been tracked and viewed together, or investigated in a more cohesive and comprehensive way, McCoole’s behaviour would have received greater scrutiny.

Many features that render an institutional environment vulnerable to infiltration by adults who offend against children were present in the directorate during the period McCoole was engaged to care for children.

Deficits in individual and organisational practice were identified in each of the organisations through which McCoole accessed children, in:

- recruitment and training;
- barriers to recognising and reporting red flags;
- the weight given to understanding children’s experiences in care; and
- the response to the Mikayla Bates care concern.

**Recruitment and Training**

It is clear from the evidence about recruitment and training in OSHC, nannySA and Families SA that recruiting and retaining appropriate staff to care for children presents substantial challenges. None of the relevant roles offered by the three organisations required any formal qualifications in child development, child care or youth work. Staff of each agency raised concerns that the workers they hired were sometimes not adequately skilled for the work they were required to do.

**Recruitment and Supervision at the Out-of-School Hours Care Service**

Although OSHC had policies which required a formal merit-based recruitment process, the evidence demonstrates that, at least for casual staff, those processes were not applied. Rather, the informal process for applicants to the casual pool applied little rigour to selection. At times, even this informal process was abandoned when applicants were known to current employees.
Viewed objectively McCoole appeared a suitable candidate for casual employment at OSHC. The evidence indicates that the selection process did depart from the norm. Unlike the usual practice, Ms E played no role in the assessment of McCoole as an employee. This was of particular concern as McCoole’s friend, Ms A, conducted the recruitment.

There is nothing unusual or improper per se about employing a staff member with whom there is a personal relationship. However, in such circumstances the relationship should be acknowledged and the recruitment should follow a formal process, and be conducted by a person independent of the relationship with the applicant.

After engaging McCoole, Ms A should have acknowledged the relationship and put in place supervision structures that guarded against her personal relationship with McCoole affecting her objective assessment of his work and conduct.

In addition to Ms E’s generalised concerns about McCoole’s suitability, a number of matters were brought to Ms A’s attention which should have caused alarm about his professionalism and attitude to working with children. They included inappropriate comments about children, inappropriate physical contact with children and sharing images of children in state care with other staff.

McCoole’s unattractive personality clearly obfuscated real concerns held by his colleagues. Ms A dismissed concerns expressed by Ms E with the observation McCoole had a tendency to ‘babble’. His clashes with another senior worker were put down to personality differences rather than a deficit in McCoole’s interpersonal skills. Ms A’s level of faith in McCoole’s conduct was so great that, on being notified that he had been suspended from Families SA, she made no effort to obtain more information or detail about the circumstances, nor did she make a firm decision not to engage him at OSHC. She accepted McCoole’s statement that the matter was cleared and he was able to return to work.

It cannot be said that any single incident brought to Ms A’s attention called for a decision to no longer employ McCoole at OSHC. However, their accumulated effect should have at least raised in Ms A’s mind the question of McCoole’s ongoing suitability to work with children. They justified far greater vigilance and oversight of his professional conduct than occurred.

Ms A’s personal relationship with McCoole clouded her judgement of his professional conduct and influenced her management of him. It is unlikely that she would have exhibited the same leniency towards a less familiar staff member about whom others had such strong views.

It is appropriate to take account of the fact this was Ms A’s first management position and she did not have a great deal of experience in the performance management of staff. The supervision of McCoole in those circumstances was particularly problematic and allowed an unjustified tolerance of unprofessional behaviour. The attention paid to supervision and performance management was inadequate and the perspectives of other workers on McCoole and his work standards were not considered.

In a highly casualised workforce, the same behavioural standards and professionalism should be expected of both casual and full-time staff. In environments where the wellbeing of children is at stake, it is critical that performance standards are clearly set, and consistently and rigorously enforced, for all staff.

RECRUITMENT TO NANNYSA AND SUBSEQUENT TRAINING

On 7 December 2010, Ms A gave a reference to nannySA which described McCoole’s work performance in glowing terms. Ms A had been working at OSHC service for just under 12 months. Ms A was not yet aware of concerns about McCoole’s behaviour.

nannySA’s selection process for hiring emergency care workers did not reflect the complexity of work, or level of trust, required of those applicants ultimately engaged. The standards applied were not rigorous. The interviewer had no particular experience in the emergency care worker role herself and no selection criteria for rating applicants’ answers against. The skills and knowledge expected of an applicant to the position were not identified, and no psychometric testing was required.

Ms T told the Commission the pressure to hire sufficient workers to satisfy nannySA’s contractual obligations with Families SA at times led to applicants being hired when she was not entirely comfortable with their level of experience.
Recruiting and training staff to the emergency care worker role carried a number of challenges. The work available through nannySA was casual and no particular level of work or income could be guaranteed from week to week. The work was highly specialised and challenging, and required a level of skill and knowledge beyond that expected of a worker with experience caring for children in other environments. Workers in the casual pool could register with other agencies or apply to work directly with Families SA. The resultant lack of stability and consistency in the workforce made it difficult to justify a substantial investment in pre-service training for staff appointed to the casual pool.

Although McCoole had no experience or formal training in caring for infants and preschoolers when he started work with nannySA, he was tasked to work with very young children after only a four-and-a-half hour course in infant care and nutrition. A course of that length is unlikely to equip a worker with the knowledge they would need to care for infants in an emergency or residential care environment. Ms Cole, Managing Director of Hessel, having reviewed the documents, agreed that McCoole was not well suited to work caring for infants.112

Ms Cole also agreed nannySA did not have the expertise in-house to manage children with complex trauma needs. In the absence of rigorous training and overarching principles of care operating in emergency and residential care homes, workers were left to draw on their own experience and knowledge of caring for children. Houses where teams of workers were left to make decisions without the structure of a clear line of authority showed inconsistent standards and approaches to care.

CONTRACTUAL ARRANGEMENTS GOVERNING THE ENGAGEMENT OF COMMERCIAL CARERS

The contractual arrangements governing the terms of engagement of commercial carers were premised on them being used in short-term interim arrangements. They were also based on a ratio of one worker to one child, and on certain restrictions on the hours and shifts worked. However, the evidence supports the conclusion that the use of agency staff grew and changed beyond the model contemplated in the contractual agreements without proper planning. Children in emergency care placements were remaining beyond what could properly be described as ‘generally unplanned and requiring an immediate response’.113 Workers engaged through the agency became, in effect, long-term carers for some children.

By the time agency staff began to be engaged in Nation Building and transitional accommodation houses, staff to child ratios were set at one staff member to three children as the norm and, beyond providing care, staff were also responsible for household chores such as shopping and cleaning. Children in these placements were not considered to be in ‘interim emergency’ arrangements.

The move to using agency staff in this more extended style of care required reconsideration of the training and conditions set out in the contractual arrangements. No such consideration was given. Day-to-day arrangements for engaging commercial carers grew unplanned without the oversight and clarity of a contractual agreement that accurately reflected operational practice.

After Families SA introduced senior youth workers and supervisors to oversee Nation Building houses, there was no planning or documentation about the division of supervisory responsibilities. Confusion naturally followed about responsibility for supervision and professional development of agency staff engaged to provide ongoing care for children in these houses.

RECRUITMENT INTO FAMILIES SA

By 2010 there was a clear acknowledgment of the need to build an appropriately qualified and trained workforce to match the growth in the residential care sector. The need was urgent to arrest the growing use of agency staff to cover workforce deficits and to invest in developing a Families SA workforce which could offer higher standards of care, and a greater level of supervision and oversight, at a more modest cost.

Recruitment processes in the directorate originated when recruitment was intended to maintain, rather than increase, the workforce. The processes had been reviewed and considered regularly by senior Families SA staff. In particular, frequent discussions mentioned the need for an organisational psychologist in the process and the suitability of the AIFP testing for the recruitment of youth workers to care for vulnerable children. In the absence of a suitable alternative the organisation had determined to continue to use the AIFP test.114

Three major barriers stood in the way of efficiently recruiting the necessary numbers of quality staff to the residential care sector:

1. availability of the requisite numbers of suitable candidates in the job market;
2. quality of the job on offer, in remuneration, conditions and stability of employment; and
3. knowledge, expertise and recruitment tools for helping decision making by selection panels.
These difficulties were magnified when demand for staff escalated. Pressure to fill positions and reduce reliance on agency staff was felt throughout the directorate, including by the recruitment coordinator Mr F.

At the same time, the nature of the work was changing. Children in residential care included younger children and infants who needed a workforce with different expertise and knowledge. Historically, residential care workers were hired and trained to work with older children. Some existing workers felt they were not qualified to care for infants and young children and did not consider this the role for which they were hired.

This shift required a re-evaluation of the recruitment processes and criteria being applied. No consideration was apparent of whether the AIFP testing was a suitable assessment tool for workers caring for very young children. Also apparently not considered was whether residential care worker positions could be separated into specialists in early and later years care.

Mr Waterford favoured the development of a higher level of expertise in the residential care workforce. Families SA’s capacity to implement this change was challenged by the disparate nature of the role. Mr Waterford observed:

> For a cohort within this population the level of trauma that they had experienced I think necessitated a higher level of expertise. The challenge in this space is that a lot of the work is cleaning, cooking, bottom wiping, and getting the right mix of operationally classified staff and professionally classified staff is vexed.

Residential care workers were hired to either an OPS2 or OPS3 position. Advertised positions attracted a large number of applicants, but only a low number were ultimately appointed. When McCoole was first hired, 19 applicants were interviewed from 104 applications. Of those 19, 12 were appointed to the casual OPS3 pool and three to the casual OPS2 pool.

Between 2010 and 2013, Families SA was unable to offer ongoing positions. Any vacancies were filled on short-term contracts. Even after Families SA received approval to hire new staff there was a three-year cap on the positions offered because of the requirement to test the capacity of the non-government market to take over the Nation Building area of residential care. The fact that positions on offer were not ongoing had an impact on the quality of applicants.

There was evidence that less suitable applicants were appointed to the casual pool because of a perception that the skills required for that work differed from full-time positions. The casual workforce was seen as being available to fill short-term gaps in the roster. The workers could be of a lower standard because they were not being asked to provide long-term ongoing care to children. When Ms Stasiak took on the role as Director she formed the view, against the background of demand for staff, that appointing some applicants to a casual pool allowed the directorate to closely examine their work performance with a view to determining whether they were suitable for ongoing work. Some applicants were already working in Families SA houses through agencies, and appointment to the casual pool gave Families SA an opportunity to more closely train, supervise and assess their work than might otherwise have been the case.

The difficulty with this approach is that once staff were appointed to the casual pool, even on a short-term contractual basis, their performance was not regularly reviewed. Rather, the view was taken that casual staff were entitled to have their contracts renewed unless some performance issue was identified.

**THE SELECTION PROCESS**

In 2012 recruitment of youth workers was coordinated in the directorate by the recruitment coordinator. Mr F had minimal recruitment experience, no formal training in the area and little expert support available to him. He inherited a recruitment process that he understood had the imprimatur of senior members of Families SA staff. It was not within his power to depart from the process.

Selection panels were assembled solely from people working in the field and contained no human resources or psychological expertise. No panel members had qualifications or training that would permit them to adequately interpret the results of the psychometric tests used. McCoole was hired to the Families SA casual pool on his first application under this method.

Mr Waterford acknowledged the danger in continuing to use an unsatisfactory psychometric test as good candidates might be excluded. He thought the best approach, in all the circumstances, was to ensure issues raised by the testing were carefully explored at interview. He agreed the organisation’s ability to do this depended on the skill and experience of the selection panel. At the time of McCoole’s appointment, the selection panel did not have the skill or knowledge to use the AIFP test results in the nuanced way contemplated by Mr Waterford.
CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

Insight into the value of psychological expertise was obtained from the evidence of departmental organisational psychologist Dr Jane Richards, who reviewed McCoole’s AIFP results after his arrest. Dr Richards explained the accumulation of items of concern identified in the AIFP battery of tests:

*all that I can get from here is there is a profile of a person that would be a risk to us, possibly a risk in not caring adequately for children ... possibly some depression/anxiety, but certainly someone who is unconventional, who resists being directed, who improvises, who is disorganised. So from those things, loner, socially isolated is also a concern. So I’d be looking at this instrument, the results of that, with his resume, and then trying to piece things together. So now I think he’d be screened out, but if he went to psychological interview he’d definitely be screened out by then.*

Even without the assistance of an expert psychologist, the AIFP test made it clear that advancing McCoole should be done only with extreme caution. Mr F did not give this warning the weight it deserved because of concerns about his own ability to interpret the test and, in particular, the potential he may be unfairly excluding worthy candidates on the basis of the test results. The weight placed by Mr F on the test results was influenced by his perception that the test was not designed for recruiting residential care youth workers.

It was unusual, but not unheard of, to advance candidates who had been assessed as ‘Caution—High Risk’ by the AIFP testing. In the selection processes led by Mr F the AIFP test was used solely to screen out unsuitable applicants. Once candidates were advanced past this stage, even if that occurred against the recommendation of the AIFP results, the results played no continuing role.

The residential care worker position was unique. It attracted high numbers of unqualified applicants who were heavily scrutinised during recruitment. This scrutiny was essential, given the position of trust staff were placed in and the risk associated with placing such vulnerable children into the care of a worker who turned out to be unsuitable. The risk was especially great in an environment where single-handed shifts were still common and where the chances of abuse being detected were remote. The challenges of recruiting to a position of this kind demanded a skilled recruitment panel with the capacity to use the results of the AIFP test in a way that informed recruitment to this specialised staff group.

The use of a selection panel of youth workers, led by a more experienced worker, but inexperienced recruiter, positioned this important task too low in the organisational structure. Recruitment of the vast number of workers required to staff the Nation Building houses, and take over emergency care, required a carefully planned recruitment process with clearly identified selection criteria reflecting the changing demographic of children in residential care.

The high levels of responsibility placed on residential care workers, and the potential for abuse of the trust placed in them, required the character of potential applicants to be carefully assessed. A number of concerns existed about the suitability of the AIFP test to deliver this assessment. Even putting those concerns aside, the AIFP test was not properly used. The selection panel’s lack of training and knowledge about the test meant the available information was not properly scrutinised and interpreted.

Mr F made a poor decision to ignore the clear warning of the AIFP test. However, his decision cannot be divorced from the organisational setting in which it was made. That is, Mr F was given no relevant training and no support from a suitably qualified psychologist or human resources specialist. All these factors contributed to the red flag of the AIFP test results being ignored.

The AIFP test at no time claimed to determine if a candidate was at risk of abusing children. The warning that McCoole was ‘high risk’ did not identify such a risk. There is no validated, reliable psychological test that reveals a person’s risk of abusing children. People who sexually abuse children are such a heterogeneous population that it is difficult to identify, by reference to a reliable constellation of features, a heightened risk to children. Further, as most sexual offences against children are not committed by paedophiles, excluding paedophiles from a particular environment would not necessarily protect children.

The future for Families SA includes a continued need to place children in residential care environments and thus the need to develop and give effect to appropriate recruitment practices.

Excluding unsuitable candidates from entering the residential care workforce at the recruitment stage is critical. Recruitment processes present the best opportunity to rigorously examine aspects of an applicant’s psychological profile.

Appropriately focused and interpreted psychometric testing should help Families SA identify applicants who for various reasons would be unsuitable workers in residential care environments. It is unlikely that such testing would be able to recognise with any precision or reliability a tendency to offend against children in care. However, residential care should be staffed with psychologically resilient staff. Testing of candidates for psychological features which ensure they are the best fit for the environment is critical to the development of a robust and reliable workforce.
A robust recruitment process must include the checking of references and reports from previous employers, including speaking personally with the referee and asking specific, direct questions about the applicant’s interaction with children. Concerns are rarely committed to writing in a formal referee report, but personal contact and asking targeted questions are more likely to uncover information that helps the process. There remains value in verbal communications being accompanied by the formality of a written response to targeted questions.

Following the arrest of McCoole, and identification of the deficits in the process by which he was recruited, substantial changes have been made to recruitment processes. The AIFP tests are no longer used for youth worker recruitment. Current psychological assessment practices are discussed in Chapter 12. They are more rigorous and should continue.

TRAINING INVESTMENT
The evidence establishes a deficit of well-trained suitable workers in the child care industry. More specifically, working with children in state care carries with it challenges and complexities well beyond those faced by child care workers or nanny staff working in a traditional family environment.

In these circumstances it is difficult to justify the lack of formal qualifications required at the entry level for work as an emergency care worker with nannySA or a youth worker with Families SA. However, imposing a requirement for a formal qualification would affect recruitment in two ways:

• It would exclude candidates who lack formal qualifications but nevertheless have the skills and life experience to make them excellent youth workers; and
• It would narrow the potential field of candidates even further, and might lead to insufficient numbers of staff being available.

The answer to this dilemma lies in an increase in the intensity of in-house, pre-employment and ongoing training requirements for new workers. New Families SA youth workers undertake a six-week induction and training course. They are then obliged to complete a certificate in youth work within the first 12 months of their employment. It is not clear whether there is any consequence to their ongoing employment if the qualification is not completed in the time stipulated.

A greater investment in training on the topic of child sexual abuse is also required. This is discussed below.

BARRIERS TO RECOGNISING AND REPORTING RED FLAGS
In the course of the evidence a number of themes emerged to explain why workers failed to report or take adequate action when they observed concerning behaviour from children and McCoole. These themes go beyond blaming individual failures and demand an examination of the system in which the individuals were working. Consideration must be given to:

• staff knowledge and training in recognising and responding to children with concerning behaviours;
• staff knowledge and training in recognising and responding to staff who behave in concerning ways;
• the clarity of reporting pathways for staff who become concerned about the behaviour of a colleague in the workplace;
• the degree of organisational interest in receiving information about concerns; and
• the lack of clarity about the policies and protocols governing interactions between workers and children in residential care, and lack of consistency in their enforcement.

KNOWLEDGE AND TRAINING—RECOGNISING AND RESPONDING TO CHILDREN WITH CONCERNING BEHAVIOURS
Psychiatrist Dr Sarah Mares assisted the Commission on the topic of the responses of children to sexual abuse. Dr Mares’ has a longstanding practice and academic focus on the impact of early adversity and therapeutic intervention with high-risk infants and young children and their families. Her evidence informed the Commission’s consideration of the significance of children’s behaviours.

In a number of instances, staff were ill-equipped to understand the significance of behaviours they observed. Children in residential care by definition have been exposed to abuse or neglect. Their care setting should not only provide safe day-to-day care, but a therapeutic environment in which to heal past trauma. Non-verbal children, in particular, rely on adults around them being attuned and sensitive to behavioural and emotional changes which may indicate distress from current or past abuse or neglect. Where a child’s behaviours indicate continued distress at their circumstances, serious questions need to be asked about the source of that distress. Staff in residential care facilities charged with understanding the experience of children in their care need to be especially curious, skilled and knowledgeable to overcome the fragmentation of information across workers and shifts.
CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

The most obvious and serious example of this barrier to reporting emerges from the various behavioural observations made of Chelsea Floros. According to Dr Mares, Chelsea demonstrated behaviours that should have raised a high level of concern about probable sexual abuse. Some of Chelsea’s comments, in the particular context, amounted to a disclosure and should have been investigated.327

Chelsea’s social workers were made aware of observations of her distress and other behavioural indicators. Her behaviours were dismissed as being attributable to events before Chelsea entered care. Mr Beltman was made aware of a range of concerning behaviours by staff in the residential care environment and by Chelsea’s foster parents. He was in the best position to accumulate the various pieces of information available to him.

Mr Beltman’s knowledge and experience was inadequate for the task of providing case management to an infant with these challenges. On his own admission, his management of her case was compromised by other work pressures. Mr Beltman attributed Chelsea’s behaviours to her pre-care experiences. He failed to consider the potential of current abuse, even though he knew there was no known history of sexual abuse in her past.

As a result, the accumulated force of the observations made was never properly understood.

On other occasions workers overheard children who had been exposed to McCoole making statements which should have raised serious questions about sexual abuse. Seven year old Paige Thomson was heard to make statements in her sleep possibly indicative of distress originating in sexual abuse. Caitlin and Claire Pham were overheard discussing matters which raised the same possibility. On each occasion the worker dismissed the potential seriousness of their observations by attributing the statements to previous abuse outside the residential care environment.

Neither worker countenanced the possibility the statements related to more contemporary events. On that basis the observations were not escalated or investigated, despite workers understanding their obligation to make a report to CARL.

Neither worker questioned the children about what they had said. The youth worker job and person specification anticipates that candidates will perform some counselling of the young people in their care.328 The two youth workers were ideally placed to discuss the statements with the children, having overheard them and being present at the relevant time. However, neither felt adequately trained or supported by the organisation to ask questions in a way that might put the statements in context or identify concerns that could be followed up. Ms Pinos said she had been trained not to speak with a child, but to pass information on through a senior youth worker.

In an organisational environment where workers are specifically prohibited from asking the most basic clarifying questions about disclosures of this kind, there is a danger that assumptions will fill the knowledge gap.

The same pattern was evident in the manner in which Anna Pham’s reference to McCoole as a paedophile was managed. Ms V accepted an assurance that Families SA staff were aware of Anna’s use of the term and took no further action.

When children make statements of this type there must be a prompt response. Workers must be empowered to enquire sensitively to explore the significance of such statements. Querying the meaning of a comment is not the same as gathering evidence when a disclosure of sexual abuse is made. That more complex and comprehensive task is one properly reserved for experts in CPS or SAPOL.

Jayden Conti was a boy with highly sexualised behaviours. The manner in which his behaviours were addressed highlights the themes observed for a number of children with whom McCoole came into contact.

Jayden’s constant drawing of penises was identified by Dr Mares as communicative, potentially a re-enactment of past trauma or behaving in a provocative way to attract attention against a background of neglect or being consistently ignored.329 Dr Mares considered someone should have asked Jayden about the meaning behind his drawings, rather than addressing the behaviour in isolation from the reasoning behind it.

Staff caring for Jayden day-to-day were given specific instructions not to deal with these behaviours because they did not have psychological qualifications. This practice again removes an opportunity to develop a natural conversation about a child’s behaviour in a timely way and in a comfortable setting.330

Jayden demonstrated specific reactions to McCoole, such as the removal of his photograph. There was no attempt to understand the reasoning for his behaviour or to escalate it to a psychologist to investigate it more expertly.

Other workers noticed certain children would avoid McCoole when he was on shift. As a matter of common sense, some children will have preferred workers, and workers who consistently enforce boundaries might be less likely to be favoured. However, where these reactions go beyond natural preferences, such as Ms Purton’s
observations of Nicky Schultz’s distress related to McCoole, there should be a discussion with the child about the meaning of the observations.

The potential significance of these isolated observations is easier to recognise when the events are viewed cumulatively, and with the benefit of hindsight. Without these advantages, each decision when considered in isolation is understandable, particularly in light of an organisational setting that discouraged any enquiry about the meaning of such behaviours.

In reforming residential care to reduce the risk of child sexual abuse it is necessary to make a substantial investment in increasing the workforce’s knowledge and confidence about trauma, sexualised behaviours, signs of distress and how to talk to children about their distress. Families SA also needs to reconsider the restrictions on information provided to workers, including commercial carers.

Therapeutic responses to difficult behaviours need some understanding of the communicative intent that sits behind the behaviours. Dr Mares observed that when children who have experienced trauma are in a safe situation, where they are given consistent and appropriate care, their behaviours should attenuate. Such an environment acknowledges the inappropriateness of what has happened to them in the past. If workers have a good knowledge of what has brought the child into care in the first place, they will be much better placed to assess the potential significance of behaviours they observe and to respond in an empathetic way.

Training workers to enable them to provide this standard of care, and giving them permission to refer to a child’s past trauma in the course of providing empathetic care, is critical to improving the chances of a child confiding in a worker when events are causing them continuing distress. Obviously this will always be subject to the specific advice of a mental health professional caring for a particular child.

The evidence establishes a need to increase knowledge in the residential care workforce, and more broadly within the Agency, in identifying and managing trauma-related behaviours, including behavioural indicators of sexual abuse. Such training must highlight barriers to complaining for children and young people. Dr Mares emphasised that training must be accompanied by allowing workers to discuss the application of theory to their day-to-day work and to review their learning by applied discussion. The evidence shows that some Families SA-approved training is delivered to nannySA workers by non-expert staff. Training must be delivered by experts in the field who are equipped to address questions and discuss the practical application of theory.213

In addition to training, Dr Mares emphasised the importance of quality professional supervision. Workers need an outlet to discuss difficult issues they are experiencing and to reflect on whether they have responded to those situations in the right way. The supervisor therefore must be knowledgeable and skilled in the area of child development and trauma. Supervision must transcend operational matters and the identification of performance deficits, and allow genuine reflection about the work.212 Such supervision should also address the traumatic nature of the work. Vicarious trauma can impair professional competence over time.213

In addition, supervision from providers external to the Agency should be available to workers to allow discussion of concerns about children or staff in the workplace. Supervisors who are not involved in daily management of the residential care environment could focus consideration on the child’s experience.

**KNOWLEDGE AND TRAINING—RECOGNISING AND RESPONDING TO CONCERNING BEHAVIOURS FROM STAFF**

It is apparent that awareness was low in the directorate of the vulnerability of children in care to be re-abused. Some witnesses simply did not consider the possibility of sexual abuse or demonstrated poor understanding of the dynamics of child sexual abuse. Others assumed the recruitment processes in place were robust enough to exclude child sex offenders.

When senior youth worker Mr Griffin was faced with an accusation made against McCoole by 13 year old Brooke Anderson, he dismissed Brooke’s version, in part because he trusted in the rigours of the selection process. He assumed that someone who had obtained work in a residential care environment could not be a child sex offender. He was not the only senior to hold this view.

The dynamics of grooming and the vulnerability of children in institutional settings to sexual abuse were also poorly understood. When McCoole was found to have brought the movie *Young people fucking* into a residential care house, the response was ill-conceived and inadequate. No senior staff member turned their mind to the grooming potential of a movie that contained strong sexual content. The focus of concern was on breach of policy surrounding the bringing of personal items to work, video piracy and breaches of copyright.234 The circumstances warranted close investigation, including specific and robust questioning of McCoole.
Potential grooming can be addressed by the enforcement of clear boundaries between adults and children in the care environment. Those boundaries signal what is and is not acceptable and set a clear standard against which conduct can be assessed. Caring for children with sexualised behaviours can be especially challenging. Training in how to establish boundaries and deal with sexualised behaviours is critical.\textsuperscript{131}

When Ms Hams raised a complaint with Mr Norman about McCool permitting Georgie Pham to sit on his lap, Mr Norman did not understand the complaint to be about McCool’s behaviour, rather that Georgie was indiscriminately physically affectionate towards male carers. He also failed to understand the significance of a worker’s failure to consistently enforce boundaries with a child with sexualised behaviours. Mr Norman’s introduction of an across the board no-touch policy did not address the concerning features of the complaint nor properly reflect the best interests of the Pham children.

Professor James Ogloff gave evidence to the Commission to assist in the consideration of issues related to the behaviour of child sex offenders. Professor Ogloff is a registered psychologist with endorsement in clinical and forensic psychology, and has a long research and practice interest in the psychology of sexual offenders. His evidence informed the Commission’s consideration of organisational aspects of preventing child sexual abuse.

Professor Ogloff told the Commission about his training of child protection staff in Victoria addressing the dynamics of child sexual abuse and the diverse characteristics of child sex offenders. The training identifies risk factors for sexual abuse and strategies for intervention.

Training of child protection staff is critical for dispelling widely held stereotypes of child sex offenders and the erroneous thinking that a paedophile is easily recognised. Front-line staff, especially residential care workers, need help to understand the complex dynamics of grooming. They need to openly discuss the challenges of distinguishing grooming with a sinister purpose from genuine engagement with children who need consistent loving relationships with adults in their lives. Such training must be carefully designed not to alarm, but to challenge stereotyped thinking and encourage workers to have an open mind about the risks to children in institutional environments.

THE CLARITY OF REPORTING PATHWAYS

The Commission heard consistent evidence that concerns were not reported because of a lack of certainty about reporting pathways. Handwritten logbooks were the primary method for recording observations in the residential care setting. They were necessarily accessible to all workers within the house and were thus an inappropriate place for recording confidential information. There was a high level of uncertainty about whether, and when, observations about the conduct of other workers should be recorded.

Workers gave a number of reasons why they did not record observations, for example:

- concern that the worker who was the subject of the observation would see the logbook record;
- general reluctance to log events that reflected poorly on workers; and
- belief that observations which were potentially critical of a worker should not be included in the logbook.

Where observations themselves are not included in logbooks the chance of important observations about the conduct of adults in the environment receiving any scrutiny or critical attention is lessened.

The other available pathway was to report the behaviour to a senior or a supervisor. Workers adopting this path had to have confidence their report would be taken seriously and actioned in some way, and confidence their own professional position would not be compromised by making the report. The reporting of concerns about McCool to senior staff was hampered by a belief that reports would not be taken seriously, as senior staff were perceived to be friends with McCool.

The lack of clarity around supervision responsibilities between nannySA and Families SA also lessened information sharing about commercial carers. The information obtained by nannySA from the anonymous call was not communicated in any form to Families SA. Even if it had been, Families SA was not responsible for the supervision of agency staff, and did not keep files in which accumulated concerns might be tracked. This was the case even for agency staff working directly with Families SA.

The potential for poor outcomes from unclear reporting and other pathways is discussed further below in the context of the Mikayla Bates care concern.

ORGANISATIONAL INTEREST IN RECEIVING INFORMATION ABOUT WORKER CONDUCT

The Commission received a great deal of evidence which described a hierarchical, conflict laden, toxic culture within southern residential care. It was a culture where complaints about a colleague’s ability to work in a team environment were easily dismissed as ‘personality issues’ irrelevant to work performance.

Some seniors and supervisors exhibited a preoccupation with official grievance procedures, the rights of the worker being complained about and the need to stamp out ‘gossip’. All contributed to an environment where
workers were reluctant to complain, knowing they would not be taken seriously, no action would be taken or their professional position would be compromised.

McCoole was almost universally disliked in his workplace. Senior youth worker Mr Calvert described McCoole as having the ‘emotional IQ of a peanut’. Alarmingly, Mr Calvert observed that poorly functioning teams in the residential care setting were not uncommon.

However, it is not apparent that seniors and supervisors actively took steps to address dysfunctional teams or dysfunctional individual employees. Team dynamics are not fixed by the relative strengths and weaknesses of the staff, but depend on strong leadership, clear expectations, and retraining or other measures for staff who consistently show themselves incapable of working as an effective team member.

McCoole’s personality deficits were well known, but his supervision file reveals that very few issues were ever raised with him. Senior staff members did not appear to consider that an inability to work harmoniously as part of a team was a performance issue that required consistent monitoring or action.

Even when supervisor Ms Decoster was alerted to McCoole’s frequent unappreciated racist and sexist jokes, these matters were not raised with him. Workers were told senior staff were not interested in hearing about personality issues and could act only if genuine work performance issues were raised.

The evidence suggests a focus on the processes relevant to raising grievances about workers, rather than creating an open workplace where grievances could be aired and dealt with. Senior staff were unprepared to act on complaints or information that were not ‘official’—a term that appeared to mean formal, in writing and accompanied by a willingness to be identified as the source of the information.

Concurrently, senior staff had a preoccupation with stamping out negative communication about other workers. The term ‘gossip’ was used to describe any communication between workers which contained negative observations about colleagues. Mr Norman held a particularly strong view about the potential for gossip to hinder a worker’s professional progress. He appeared to dismiss as gossip any information that came to him which conflicted with his own positive perception of McCoole.

Mr Norman went so far as to suggest to the Commission that debriefing with a colleague rather than a supervisor or senior about a difficult shift with a difficult co-worker would be a breach of the public sector code of ethics.

He and other senior staff took the position that any worker who wanted a complaint about a colleague to be acted on must be willing to engage in ‘mediation’ with the other employee. Given the power imbalance that might sometimes be present between seniors and youth workers, and the precarious position of commercial agency staff if reporting about Families SA staff, it is little wonder complaints were not made official and many observations did not reach the ears of anyone who could take action.

The strong emphasis on compliance with a formal process, and the strict hierarchical nature of that process, restricted the flow of important information to seniors and supervisors. An organisational malaise about the utility of reporting concerns and complaints developed. There was little confidence that information would be acted on, and if it was it would require the accuser to face the accused, regardless of the respective power of each party. Thus, information flow was suppressed and the organisation was unable to build a picture of accumulated concerning behaviours.

The toxic workplace culture is typified in the response of supervisor Ms Decoster to the complaint Ms Roberts made about McCoole. Ms Decoster’s reaction to the matters raised by Ms Roberts was unwarranted. Ms Robert’s email contained at its heart a number of legitimate child-centred concerns, yet Ms Decoster made no effort to consider the merits of the underlying issues raised. Instead she focused on her own inaccurate perception of inappropriate conduct on the part of Ms Roberts over the course of a four-hour meeting.

Ms Decoster claimed that a number of the matters she raised with Ms Roberts were issues on which she took advice from the Human Resources section. She was unable to provide the name of the consultant on whose advice she claimed to have relied. It is difficult to accept that any competent human resources consultant with all the relevant information would have given advice supportive of the action Ms Decoster took in the course of that meeting.

Ms Decoster advised Ms Roberts that if she remained concerned about working with McCoole she could move houses. This suggestion overlooked the need for continuity of staff for the children in care and minimised the significance of the relationships she would have built with those children. This proposal did not help Ms Roberts, as Ms Decoster claimed; it acted as a punishment for her conduct. Further it stands as an example of the manner in which supervisory staff failed to properly deal with (in this case, perceived) poor performance, or a staff member who was experiencing difficulties.
CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

The way Ms Roberts was treated, if known to other residential care workers, carried a strong message about the professional danger of raising concerns, especially outside the strongly enforced grievance pathway. It told workers that the priority of senior staff was the protection of workers’ rights and procedural niceties, rather than children’s rights and experiences.

Multiple complaints had, by this time, been raised about McCoole and over the course of more than two years nothing had been done to act on his behaviour. It appeared very clear that the organisation had little interest in hearing about McCoole’s continuing substandard performance.

POLICIES AND PROTOCOLS GOVERNING INTERACTIONS BETWEEN WORKERS AND CHILDREN IN RESIDENTIAL CARE

The conduct of workers in residential care settings is governed by a series of operating procedures and practice guides. The guide to Building and Maintaining Positive Relationships includes information about maintaining appropriate boundaries with children and young people.

The guide identifies examples of behaviour that would breach personal and professional boundaries. For physical contact, a boundary violation is described as including ‘unwarranted and/or inappropriate touching of a child or young person (personally or with objects)’. This gives very little guidance to workers about what level of physical contact with children is and is not acceptable; it doesn’t help workers who detect what they observe as problematic behaviour to identify with precision which workplace policy or process has been breached.

The ambiguity can be exploited by workers who consciously or subconsciously use physical playfulness to accustom a child to touch, for the purpose of sexual exploitation.

Introducing excessive prescription for acceptable levels and types of physical contact in a residential care environment can be counterproductive. Children in rotational care, especially young children, need physical affection and care that is as natural as possible. Removal of all forms of physical engagement with children in these environments is out of the question.

Instead, greater specificity for considerations that might inform a decision about what are appropriate interactions would help consistent judgement by workers. Discussing and addressing the issue of boundaries regularly and openly at staff meetings would also support more candid engagement between staff about these challenges.

In a number of instances Mr Norman’s response to individual deviations from behavioural standards by McCoole was to impose blanket prohibitions that applied to all staff. He took this option rather than address McCoole’s behaviour at an individual level. For instance, he imposed a ‘no touch’ policy at 14 R Road with the Pham sisters which encouraged workers to use high fives and pats on the back and prohibited other forms of physical affection. Mr Norman explained he put the policy in place out of concern that staff were worried about excessive affection from Georgie Pham and a concern about nepotism. Mr Norman’s decision reflected concern for the comfort of workers, rather than the interests of the children.

A blanket ban on staff bringing movies to work followed McCoole bringing the Young people fucking movie to 14 R Road, and sitting or lying on beds was prohibited following the Mikayla Bates care concern.

Other policies were inconsistently applied throughout the directorate. For example, workers were prohibited from taking photographs of children on their personal devices. Staff at OSHC knew McCoole had photographs he had taken of children on his personal mobile telephone. When Mr Sterzl was informed, immediately after McCoole returned from suspension, he appears not to have dealt with the conduct in any way.

The few attempts to manage deficits in McCoole’s work performance through ‘supervision’ were inadequate. Senior staff had a narrow repertoire of performance management tools. Mr Calvert said the usual starting point for staff about whom there were concerns was fortnightly supervision sessions. The utility of that approach depends on listening to others in the work environment to identify whether the worker has modified and improved their behaviour. Even when fortnightly supervision was instituted, it was short lived and did not focus attention on monitoring McCoole or his skill development in the precise areas identified. McCoole was never placed on performance management or probation of any kind, nor required to attend for retraining.

A National Crime Agency (UK) thematic assessment on institutional child abuse (see Chapter 12) identified that inconsistently applied standards in care environments can normalise poor behaviour and breaches of rules. On at least two occasions the significance of McCoole’s behaviour, when brought to the attention of seniors, was dismissed as part of his idiosyncratic personality. When Ms A at OSHC was faced with staff reporting criticisms about McCoole, she dismissed them, saying he had a ‘tendency to babble’. Similarly when Mr Norman was told about McCoole’s statements referring to Mikayla Bates ‘exposing herself’ to him, he commented they sounded like ‘Shannonisms’ and did not need to be brought to his attention.
McCoole’s personality and his unpopularity with colleagues obscured the ability of senior staff to take legitimate complaints about his conduct seriously.

THE WEIGHT PLACED ON THE CHILD’S EXPERIENCE OF CARE

Children in institutions that do not value their voice or point of view, are especially vulnerable to exploitation and abuse. Some child sex offenders target children who, if they complain, are less likely to be believed by adults.

Children in residential care with a history of lying, and abuse. Some child sex offenders target children who, therefore less likely to be believed if they complain, are especially vulnerable. Further, offenders who hold a position of power in an institutional setting often take advantage of what is known as ‘positional grooming’—the assumption that their position in the organisation of itself brings with it an inherent level of trustworthiness.

Children in institutional care can become vulnerable when they are isolated from consistent caregivers who can listen to them and advocate on their behalf. Their vulnerability is exacerbated if the organisation does not have formal and informal mechanisms to ensure their experiences of care are heard and understood. In South Australia, the regulatory safeguards on the use of restraint in residential care facilities are an important formal mechanism for ensuring children’s perspectives are heard (see Chapter 12).

Given the breadth of circumstances in which it is permissible to use force under the Regulations, any use of force must be accompanied by strict requirements about its documentation, including the recording of a contemporaneous and independent account of the child’s point of view.

Residential care staff use a pro forma to comply with the regulatory requirements. Although the pro forma includes space to record the views of the child, the critical incident reports examined by the Commission did not record any such details.

The pro forma includes a field for recording the names of all witnesses to the relevant incident. The structure of the form gives the impression the version put forward is common to all witnesses to the incident. A worker who has physically restrained a child can complete the critical incident report and forward it to senior staff without seeking input or approval from other staff present. As there appears to be systemic disregard for the child’s account, this leaves the person whose conduct is under scrutiny entirely responsible for authoring the version to be examined.

Three critical incident reports authored by McCoole were examined by the Commission. In two of the incidents (Jayden Conti and Anna Pham) other workers expressed concerns about the manner in which McCoole performed the restraint and regarded his actions as excessive. In the third (Brooke Anderson), careful consideration of the child’s version of events was called for to examine the propriety of McCoole’s actions leading to the critical events. In each instance the staff identified by McCoole as witnesses to the incidents would not have endorsed the reports as an accurate record of their observations, had they been asked. In all reports McCoole’s ability to deal with the situation was praised.

In the report describing his restraint, Jayden was recorded as complaining McCoole was hurting him. That information reached the attention of supervisor Ms Decoster. If NVCI techniques are correctly applied a child should never experience pain. In Ms Decoster’s assessment of the report, no weight was placed on Jayden’s complaint of pain, the only reference to his experience. No follow-up enquiry was conducted. Instead, Ms Decoster recorded her satisfaction that the incident was managed well.

Families SA systemically failed to comply with the regulatory safeguards on the use of force. The total failure to record the child’s perspective in the manner required by regulation evidences a low level of interest in the child’s experience. On two occasions when a child’s version reached the attention of senior members of staff (Brooke and Jayden), it was either assumed to be untrue, or simply ignored.

While children who have experienced abuse and neglect may well have developed unhelpful behavioural habits such as lying, it is dangerous to automatically prefer the voice of adults over children where versions collide. Formal and informal mechanisms to enable children to have their versions heard and respected improve the chances that a child will share their experiences. They also act as a deterrent to would be offenders who know that the potential victim is surrounded by well-informed adults who are keen to listen to, and understand, what the child has to say.

A PERFECT STORM: THE MIKAYLA BATES CARE CONCERN

It is difficult to fathom the concurrence of poor decisions and lack of action which culminated in McCoole’s return to work, in circumstances where his supervisor took the view he had been ‘declared innocent’. The series of decisions that followed nannySA worker Ms H’s initial report of her observations of McCoole’s conduct towards Mikayla Bates focused on McCoole’s rights, reasons why Ms H might have fabricated the allegation or misinterpreted her observations, and adherence to process and policy. At no stage was clear focus drawn to the high level of vulnerability of a six year old child in care. Mikayla’s biological father, who retained a close and continuing interest in her welfare, was not informed about the allegations. This denied Mikayla the one person who might have advocated strongly on her behalf.
A state framework, in existence in 2013, brings together the respective investigative expertise of CPS, SAPOL and Families SA. The Interagency Code of Practice establishes a robust system for agencies to offer a coordinated approach to suspected child abuse. If the system had functioned in the way it was designed to, the disastrous failures outlined and discussed below may well have been avoided.

The response to Ms H’s notification to CARL was thwarted by the categorisation of the information as a minor care concern. The notification desperately required an inter-agency investigative response from a team of skilled and experienced investigators and practitioners. Instead the categorisation attracted a hybrid investigation/case management response, conducted by ill-equipped and misguided practitioners.

The following significant aspects of the mismanagement of the care concern were a result (directly or indirectly) of the initial categorisation:

- No inter-agency strategy or initial planning meeting was held to coordinate and guide the response.
- CCiu staff with investigative skill were not involved in the management of the matter.
- Investigative tasks were allocated to staff at the local office who lacked the experience and skills to conduct a highly specialised interview of the child.
- The matter fell to be addressed collaboratively between the local office, the directorate and nannySA. It was inappropriate for the matter to be cooperatively managed.
- The positioning of the investigation at this level allowed seniors and supervisors from the directorate to influence the conduct of the investigation in an inappropriate manner.

THE BARRIERS TO REPORTING CONTEMPLATED BY MS H

Ms H’s capacity to recognise cognitive distortions in the way McCoole spoke about Mikayla, and to identify inconsistent lavishing of attention through the tickling ‘game’, revealed a sophisticated understanding of the dynamics of child sexual abuse. Nevertheless, Ms H still grappled with the implications of reporting such a matter. She told the Commission:

To begin with I was working in child protection and the disbelief that someone who was in child protection was a paedophile was quite shocking. I had had conversations with seniors who were at the house and I did not find them to be approachable in situations much much less of concern than this and I had been working in the [nannySA] agency staffing arrangement for a period of time. It was a very clear understanding amongst agency workers that we were not given very much credit for our ability and there was an incident I heard of coming into work at the agency where an agency staff member was set up, falsely accused of something and then taken off the line. So there were many factors involved in why I didn’t present it in a more timely manner to my seniors.544

Ms H understood that as a Families SA employee McCoole was regarded as ‘one of ours’. She was well aware of the power imbalance and potential personal consequences of raising her concerns.

Ms H’s concerns were realised in the conduct of Mr Norman upon her initial report. Mr Norman’s response resorted to the grievance process, referring to McCoole’s language about Mikayla as a ‘Shannonism’ and indicating Ms H should have raised it with McCoole directly. His immediate reaction was to minimise the seriousness of the issue, influenced by his view that McCoole had a history of being ‘targeted’. Mr Norman proposed to speak to McCoole, not about the possibility he had sexually assaulted a child, but about ‘pulling his head in’.549

It was necessary for Ms H assert her understanding of the seriousness of the matter and the way it should be dealt with. Ms H was left with the impression that Mr Norman felt she was overreacting.550

Mr Norman’s response revealed he did not understand the seriousness of the allegation nor the process that should be followed to properly investigate it. Mr Norman genuinely thought it would be possible to address the issue simply by speaking to McCoole without raising a formal care concern.

Ms H also spoke with the supervisor Mr Sterzl. His response to being told Ms H had notified CARL demonstrated his displeasure that the formal complaint had been made and the chance to deal with it quietly within the directorate was lost. Alarmingly, during the course of his conversation with Ms H, Mr Sterzl suggested that the actions Ms H had taken to formalise the matter could be undone.

The residential care practice guide, Understanding and Responding to Abuse and Neglect, instructs workers who become aware of an allegation of abuse or neglect made by a child against a staff member. They require the worker to:

Inform your supervisor immediately. You should contact your supervisor or manager immediately before you make a notification or document the allegation. Your supervisor should be able to direct you as to what is the most appropriate response. It is your supervisor’s role to balance the needs and safety of the child or young person and the accused staff member and they will advise you of what action to take next and how to document the incident.541 [Emphasis in original]
This advice creates an expectation that youth workers will permit senior staff to manage the response to allegations. Further, it implies that workers are obliged to act in accordance with the directions of senior staff, who will be considering the rights of the accused worker when determining how to act, rather than in accordance with their own conscience, training and knowledge. The advice insinuates it would not be improper for senior staff to require a worker to document allegations in a particular way or refrain from reporting matters.

If the approach taken by Mr Norman and Mr Sterzl is representative of the attitude of seniors and supervisors in the directorate to allegations of this kind, the advice in the practice guide is exceptionally dangerous.

THE MINOR CATEGORISATION AND DEMARCATION OF RESPONSIBILITIES BETWEEN CCIU AND SIU

When a notification to CARL alleges abuse of a child not in the care of the Minister, the investigation is conducted in accordance with the Interagency Code of Practice. An initial strategy meeting must be held and usually guides the respective actions of the relevant agencies. For children in care, the process is different. A strategy meeting is not mandated, but in response to most serious care concerns, an initial planning meeting does occur. At these meetings all relevant agencies discuss the matter and prepare a joint response. Initial planning meetings are potentially a powerful tool for bringing parties together, sharing information and planning a coordinated response. An initial planning meeting was exactly what was required to plan an appropriate response to Ms H’s information.

It is difficult to justify the characterisation of the concerns raised in the report as ‘minor’. Ms Harman was unable to identify any circumstances in which a disclosure of sexual abuse of a child in care should be so categorised (apart from historical allegations that had already been addressed). Circumstances are unlikely to arise where the response prescribed for a minor care concern, which focused on supervision, development and training by discussion-based processes, is appropriate for an allegation of sexual abuse.

Ms Harman conceded in hindsight that the accumulation of circumstances made it possible to infer that Mikayla had been sexually assaulted and that the minor categorisation was inappropriate. She agreed that, in the absence of a specific disclosure from Mikayla, it was even more critical that a careful investigation occur, because those with the power to protect Mikayla were unable to consider her account of what had happened.

The categorisation was a gross error which persisted, even in the face of Ms Lamont agitating for a reclassification. It is most likely that Ms Harman was influenced by her understanding, from Ms Lamont’s email, that McCoole was an agency worker and was unlikely to receive any further shifts. However, this does not explain why the categorisation persisted after it became clear McCoole was also employed by Families SA.

Ms Harman held the view that, if SAPOL determined an investigation was warranted, CCIU’s approach might change. This shows a misunderstanding of the differing focus and questions for the two investigatory bodies. Misconduct investigations have a different standard of proof and investigative powers to criminal investigations. They are potentially less constrained by procedures. A misconduct inquiry had greater capacity to achieve an outcome, such as McCoole’s exit from the workforce, without the greater restraints imposed on a criminal investigation.

The evidence disclosed a persistent and incorrect view among departmental staff involved in care concerns that on SAPOL declining to undertake a criminal investigation, the allegation of a sexual assault could not be considered in any internal investigation. Ms N, the manager of SIU, believed that the decision by SAPOL not to investigate meant that SIU had to divorce any suspicion of sexual misconduct from its consideration of the allegations, leaving only practice concerns.

The evidence given by Ms N on this topic was, at times, difficult to follow. She appeared to take the view that responsibility for investigating sexual assault allegations sat with CCIU because the child was in care. That is, depending on the care status of the child, the investigation of employee misconduct would be approached in a different way.

Any potential for SIU to properly investigate the matter was precluded by the ‘category C’ classification. Category C was reserved for minor instances of misconduct, such as being absent without cause or failing to comply with a manager’s directions. Category A encompassed serious or significant breaches of duty of care and category A* actually contemplated incidents of sexual contact or behaviour or sexual abuse of a child. It is difficult to see how the evidence available to Ms N could properly be described as falling into category C rather than category A.

At the time the respective functions of CCIU and SIU were not clear. No document existed governing their respective responsibilities and little planning had been devoted to integrating the two investigatory bodies. Their independent operation was not the best use of the Department’s resources.
SIU’s determination that misconduct of a Families SA employee should be approached differently to that of any other departmental employee, particularly where allegations of sexual misconduct are involved, defies logic. The most rigorous and efficient investigative processes should be applied. This approach, and the separate functioning of the two bodies, meant that more robust investigatory systems were not brought to bear on resolving Mikayla’s care concern.

Once both investigative units disavowed responsibility, the directorate’s Ms Lamont was left to deal with the care concern without the help of investigative expertise or an interagency cooperative approach. Her management of the matter was supported only by advice from the Department’s Human Resources section. The directorate’s response was stymied by lack of planned action by the Human Resources section. The failure to send the letter of allegations to McCoole, and corresponding poor advice by Ms R to Ms McKenna, saw McCoole interviewed by nannySA while Ms Lamont’s response stood on hold, awaiting action from the Human Resources section.

The final involvement of Ms Kuehn of the Human Resources section, who was asked to take responsibility for the section’s response when Ms R went on leave, lacked even the most basic understanding of McCoole’s employment relationship with the Department. She incorrectly assumed that McCoole was engaged solely as a nannySA employee, and took the position that Families SA should be persuaded in its own decision making by nannySA’s opinion about McCoole’s return to work. Even with that misunderstanding, it is difficult to understand how an experienced human resources consultant could consider that nannySA’s actions had adequately addressed the concerns raised and, without a more convincing explanation from McCoole, that a ‘refresher in standard operating procedures’ might be adequate to address the concerns.¹⁴⁶

These actions were, in effect, the final nail in the coffin of any attempt to resolve the issues in a robust way. As the investigation experts in the Department refused to apply their expertise, less qualified staff were left to manage the matter with inadequate knowledge and skill. The deficiencies of the eventual investigation need to be viewed against the background that those with the knowledge and expertise to do better had not.

The relevant events were witnessed by three people: Mikayla, McCoole and Ms H. The Department did not interview either of the adults; and the ‘interview’ with Mikayla could hardly be characterised as a serious attempt to obtain her story. It is astonishing that an investigation into potential child sexual abuse could be finalised without taking such important basic steps. The obvious steps of comprehensively checking logbooks, investigating Mikayla’s behaviour in the days after 5 June with workers, and examining McCoole’s supervision records for any similar conduct, were never taken.

Of course the investigation stalled, when the Department failed to recognise the need for, or undertake, basic investigatory processes and to consider its own information.

**THE CONDUCT OF SAPOL AND CPS**

The care concern documentation was referred to SAPOL at an early stage. It is significant SAPOL was never given the logbook entry evidencing Mikayla’s sexualised behaviours towards Ms Dimond. Both Det S/Sgt McLean and Det Sgt Martin considered this information relevant to their decision. Det S/Sgt McLean thought it would have changed his opinion.¹⁴¹

To conduct a criminal investigation, Det Sgt Martin required sufficient information to be satisfied that a criminal offence may have been committed.¹⁴² She did not believe that the accumulated circumstances observed by Ms H, and the inferences that could be drawn from them, reached the standard to justify a criminal investigation. She accepted that an inference that a sexual assault had occurred in the bedroom could be drawn, but was concerned that such an inference was ‘speculative’.¹⁴² She put SAPOL’s position as: ‘We’re not saying that the door’s closed. What we’re saying is perhaps Families SA need to do some further inquiries or collate further information’.¹⁴²

Det S/Sgt McLean took a similar approach. He believed the information given to the police revealed an employee with an unhealthy sexual interest in children. He felt heightened concern that McCoole had the intent to do something, but there was insufficient evidence of actual offending. According to Det S/Sgt McLean, a report of such observations by a parent would justify a conversation with the parent to draw out more information on which an investigation might be based. He considered that the communication back to Families SA, indicating it would be reviewed if further information arose, was the equivalent of such a conversation.¹⁴⁵

The information available to SAPOL suggested more than grooming. Contrary to the opinions expressed by the two SAPOL officers, there was sufficient evidence to draw an inference, which was not speculative or fanciful, that a vulnerable child in rotational care had been sexually assaulted. A caring and attentive parent who made the same observations would be unlikely to accept it was insufficient to justify an investigation. A caring parent would pursue the matter to advocate for the safety and best interests of their child. Mikayla did not have the benefit of any such advocacy.
SAPOL’s decision not to investigate was used by CCIU and SIU in a way SAPOL could not possibly have anticipated. Each agency that could have applied its expertise to conduct a proper forensic investigation believed it was the task of another. Responsibility for the care concern was shifted between different parts of the one organisation until it reached those with the least capacity, qualification and authority to respond appropriately.

CPS offers a unique forensic investigative service. For six year old Mikayla, they were the agency with the expertise to give her the best chance to disclose what had happened. Her disclosure would not only have contributed to a potential prosecution, it would have also secured a greater level of safety for Mikayla and other children in the residential care environment. A prompt referral to enable Mikayla to be interviewed as soon as possible after the relevant events was critical. The referral of the matter to the local office in preference to an inter-agency strategy meeting or initial planning meeting meant CPS received its referral on 5 July 2013, more than two weeks after the relevant events.

Ms Macdonald, an experienced and knowledgeable social worker, was Director of CPS at that time. She conceded in her evidence that she did not know how the decision came to be made not to accept the referral. She thought the information available would justify, at the very least, an interview with the care giver to understand more about the child and their experience. Ms Macdonald considered if the care giver spoken to was also the notifier, both perspectives could be obtained in a single interview.646

The overwhelming conclusion from all the circumstances is that an initial planning meeting, attended by CCIU, SIU, SAPOL and CPS was critical to the proper handling of this difficult matter. The matter was complex because it sat outside the norm. An insight into Mikayla’s experience relied on being able to properly and carefully analyse the accumulation of suspicious circumstances. McCooe’s statements and behaviour in the lead up to the critical events had significance to the dynamics of sexual abuse and the distortions that can be part of a sex offender’s cognitive processes when thinking about children and sexuality. The matter needed experts from all the agencies to remind one another what they knew about these issues. An investigation plan which took advantage of the best that each of the agencies had to offer was essential. Further, to avoid assumptions being made of the best that each of the agencies had to offer was also secured a greater level of safety for Mikayla and the other children in the residential care environment. Allocation to the local office brought about an oversight. If SAPOL had become involved, the interview should await advice from SAPOL. This was a serious oversight. If SAPOL had become involved, the interview performed by Ms Jezeph could have compromised the criminal investigation.

Allocation to the local office allowed seniors and supervisors in the directorate to exercise their influence over the process by sharing their own conclusions and impressions as to the veracity of the information being investigated.

Senior staff within the directorate did not wait for advice that SAPOL was not prepared to undertake a criminal investigation. Mr Sterzl’s initiation of the process led to Ms Jezeph interviewing Mikayla on 18 June 2013, the day before SAPOL informed the Department it did not want to conduct a criminal investigation. The email that advised all parties about the ‘minor’ determination, sent on 14 June 2013, did not make clear that any action should await advice from SAPOL. This was a serious oversight. If SAPOL had become involved, the interview performed by Ms Jezeph could have compromised the criminal investigation.

Allocation to the local office brought about an ‘investigation’ conducted by staff with no skills or experience in forensic interviewing and who did not appreciate or understand the sensitivities that might prevent Mikayla from disclosing, if she had experiences to share.

Ms Macdonald made the important point it was not only the outcome of the strategy or initial planning meeting that was of significance to the quality of an investigation, but also the process of engagement:

they give people an opportunity to learn from a matter that they might not know because … something that’s written is sometimes quite different when it’s spoken to … quite often in strategy discussions police will have additional information, Families SA might have additional information, sometimes it’s in the questions that are asked that the information becomes richer … it is … agencies genuinely engaging with each other to look at what’s the possible pathway here.647

THE ‘INVESTIGATION’ CONDUCTED BY THE LOCAL OFFICE AND THE DIRECTORATE

The care concern was referred to the local office for a case management response. Given the concern in question arose in the residential care environment, the response was to be planned in conjunction with the directorate. A less appropriate example than such a care concern being dealt with by a ‘case management response’ is difficult to imagine.

Allocation to the local office allowed seniors and supervisors in the directorate to exercise their influence over the process by sharing their own conclusions and impressions as to the veracity of the information being investigated.

Senior staff within the directorate did not wait for advice that SAPOL was not prepared to undertake a criminal investigation. Mr Sterzl’s initiation of the process led to Ms Jezeph interviewing Mikayla on 18 June 2013, the day before SAPOL informed the Department it did not want to conduct a criminal investigation. The email that advised all parties about the ‘minor’ determination, sent on 14 June 2013, did not make clear that any action should await advice from SAPOL. This was a serious oversight. If SAPOL had become involved, the interview performed by Ms Jezeph could have compromised the criminal investigation.

Allocation to the local office brought about an ‘investigation’ conducted by staff with no skills or experience in forensic interviewing and who did not appreciate or understand the sensitivities that might prevent Mikayla from disclosing, if she had experiences to share.

Ms Macdonald referred to the following matters which guide expert forensic interviews of children and which do not appear to have been factored into the local office’s management of the matter648:

• Whether a child will disclose does not depend on whether they have an otherwise open and outgoing personality.
• Sexual abuse can be particularly difficult for children to disclose as they have a sense of the secrecy surrounding it.
• If a child is not certain whether the person responsible for the abuse might come back to the house to provide care, they may be especially reluctant to disclose.
• A child is not necessarily more likely to disclose to someone with whom they have an existing relationship. They may well not talk about sexual abuse if they are uncertain about whether it is the right thing to do.
• A child may not feel comfortable disclosing when the interview is held in the same environment in which the abuse occurred.

A number of features of the interview undertaken by Ms Jezeph were also identified by Ms Macdonald as being relevant:

• Questions which direct a child to occasions they have felt ‘uncomfortable’ or whether they are ‘happy living here’ are potentially unhelpful because of the lack of clarity in the meaning behind ‘uncomfortable’. Rather than using confusing generalities, a proper forensic interview would gain insight into the child’s world, understanding the way the child’s day is structured and experienced, and employing the language the child might use. A trained interviewer is able to reach an appropriate balance between avoiding leading questions and enabling the child to understand what the interviewer is interested in talking about.
• Children sometimes, in advance of making a disclosure, throw out information to test whether they are being listened to and the potential reaction of the listener to the information they are considering sharing. If the child is not listened to at this point, or if disapproval is indicated, they may well choose not to disclose the abuse.
• Interviewing Mikayla in a residential care house might be problematic as she might be uncertain when McCoole was returning, indeed, whether he was about to walk in the door.
• Interviewing Mikayla in the presence of other residential care workers is likely to be distracting and might discourage disclosure, given the potential association of those staff with McCoole.

It is clear the ‘interview’ conducted by Ms Jezeph was poorly conceived and executed. Mikayla was not given the best chance to understand what the adults charged with caring for her were interested in talking with her about. The idea Mikayla would necessarily disclose abuse to someone she knew, in an informal but familiar environment, was contrary to expert knowledge about children and the factors that prevent disclosure of sexual abuse.

Ms Jezeph, a social worker, had neither the training nor the experience to conduct the interview in the skilled way that was required. The assistance Ms Jezeph received from more senior staff at the local office was in part ignored by her and in part insufficient to equip her to undertake the task at the requisite standard.

Ms Jezeph’s conclusion that the level of concern was ameliorated by Mikayla’s failure to disclose reflected an unsophisticated understanding of the dynamics of child sexual abuse and the barriers to disclosure. Her approach highlights the dangers of untrained staff undertaking such sensitive and specialist work. Ms Jezeph’s failure to understand the possible significance of Mikayla’s reference to McCoole (on the dessert issue), and the lack of interest demonstrated in her response, potentially shut down further discussion about the very topic she had been tasked to investigate. Ms Jezeph inadequately documented Mikayla’s comments about McCoole which prevented those who later relied on her record from identifying potentially significant statements.

Beyond the interview of Mikayla, no action was taken by directorate or local office staff to gather any evidence. As it turned out, Ms Dimond held information relevant to the matter, but did not understand its significance until she had a chance conversation with Ms H. Had Ms H not spoken about the matter with her colleague (which according to seniors and supervisors was prohibited) Ms Dimond’s observations may never have emerged. At no stage was there clarity about who should conduct any investigation beyond interviewing the child concerned.

Although the minor determination of the care concern dictated a collaborative case management approach between the directorate (tasked with supervision of the worker) and the local office (tasked with managing the wellbeing of the child), there was no documented guidance about how the two sections would manage an investigation. The system in place did not contemplate that a complex investigation would be managed collaboratively, because any such investigation should have been conducted by CCIU.

THE CONDUCT OF SHANE STERZL AND LEE NORMAN

Some observations about the effect of the conduct of Mr Norman and Mr Sterzl must be made.

Mr Sterzl maintained in evidence that at no time did he express a view about the strength of the allegations against McCoole. He described his approach as ‘neutral’ and that he did not even hold a private view about the strength of the allegations. The evidence of Ms Jezeph, Ms Rowley, Ms Lamont and Ms H is to the contrary. Their evidence demonstrates Mr Sterzl’s belief that the allegations were baseless and that he made various statements designed to convince others tasked with the investigation to adopt this view.
In particular, Mr Sterzl asserted to Ms Jezeph and Ms Rowley that Ms H had a motive to fabricate the allegations. Such claims were baseless and untrue. He told Ms Rowley that there were no previous concerns about McCoole, no behavioural changes observed in the children that would support the allegations and that the notifier had been uncertain about her observations causing her to delay her report. This information was also untrue.

Mr Sterzl informed his manager, Ms Lamont, that he regarded the allegations as originating in a personality clash between the notifier and McCoole, communicating a similar if more understated message. The allegation was baseless. However, Ms Lamont was not influenced in her approach by Mr Sterzl’s characterisation.

Mr Norman approached the allegations in the same way. He reinforced the message being promoted by Mr Sterzl when he spoke with Ms Jezeph after her interview with Mikayla.

In concluding she was satisfied that nothing had happened, Ms Jezeph said she was influenced by statements made by the people she considered knew McCoole best. She did not think there was an innocent explanation for what Ms H had reported, but accepted what she heard from others that Ms H had embellished her account or taken her observations out of context. Ms Jezeph said she ‘trusted what people told me’.

Mr Norman’s uncritical support of McCoole began before the care concern. The accuracy of the work report by Mr Norman on the initial Families SA application by McCoole is questionable. Mr Norman maintained it was an accurate reflection of his view of McCoole’s performance at the time, despite knowing the identified need for McCoole to work on his communication skills and voice control. Supervision records made by Mr Norman from after the work report contradict Mr Norman’s assertion that these issues had been dealt with by that time.

The conduct of Mr Sterzl and Mr Norman was unethical and improper. It was designed to influence the course of the investigation, and that succeeded. Their conduct evidenced an alarming willingness to disregard evidence of the sexual abuse of a child in the houses they were charged with supervising.

Mr Norman and Mr Sterzl drew on unfounded and incorrect assumptions about the notifier and McCoole. Neither exhibited any preparedness to investigate the truth of their statements with any rigour, even though their own experience, and the documents available to them, highlighted McCoole’s history of questionable workplace conduct and some concerning behavioural observations of Mikayla in the aftermath of the events. The Commission accepts that Mr Sterzl and Mr Norman genuinely held their beliefs, but neither had any reasonable factual basis on which to hold them.

Their conduct also affected the notifier Ms H. No-one in the official investigation gave her feedback or advice about the response to her report, thus neglecting to consider her significant contribution, and the need for her to be informed about what would follow (within appropriate confidentiality bounds). The disregard for her wellbeing is demonstrated by Ms H discovering McCoole was returning to the workforce when she ‘overheard’ Mr Norman’s phone call to McCoole, offering him shifts.

The conduct of these senior staff members contributed to the organisational culture of the southern residential care directorate where workers considering reporting matters held legitimate concerns for the professional consequences of so doing. For an organisation tasked with the care of vulnerable children in institutional settings, such a culture is dangerous in the extreme.

Seniors and supervisors must contribute to a healthy organisational culture by modelling appropriate behaviour. In one respect Mr Sterzl and Mr Norman were correct; prolific and malicious gossip within the workplace has the capacity to damage the reputation of a worker. Their conduct towards Ms H demonstrates this point.

Mr Norman made a number of statements to members of staff which denigrated Ms H and undermined her professional standing. He sent senior staff in southern Nation Building an email on 20 August 2013, which condemned Ms H’s continued advocacy against McCoole being cleared to return to work. Mr Norman’s campaign was waged in circumstances in which he had not ever taken the trouble to read Ms H’s complete account of what she had seen.
THE CONTRIBUTION OF NANNYA

At the relevant time, there was no written contract in place which included terms governing how nannySA staff would be supervised or managed when working in Nation Building or transitional accommodation facilities. However, previous and subsequent agreements did refer to the role to be played by nannySA in the management of care concerns.

The agreement which governed the relationship between Families SA and nannySA from 2008 to the end of 2011 limited nannySA’s role in care concerns or special investigations to support of the worker concerned. On 8 January 2015 a contract was entered into which outlined in greater detail the role to be played by nannySA. This agreement required the agency to ‘work in partnership with Families SA regarding care concerns and special investigations’ and ‘follow up allocated actions resulting from care concern and special investigation processes’. In each agreement unfettered power was vested in Families SA to require the agency not to engage certain personnel. That is, it was entirely within the power of Families SA to decline to have any particular agency staff member work in residential care or emergency facilities.

As the care concern was given a minor classification it was to be ‘dealt with jointly by the contracting agency/alternative care service provider and Families SA’. In contrast, commercial care agencies had no role to play in the management of serious care concerns.

The initial ‘minor’ classification created a situation in which nannySA was asked to contribute to an ‘investigation’ where there was a clear conflict of interest as a result of its own financial interest in returning McCoole to work, and where Ms McKenna was faced with concerns about potential litigation from McCoole. nannySA provided an informal advocacy role for McCoole during its dealings with him. Of itself, that was not inappropriate but it created a further potential conflict when the advocate was required to assume a role in the conduct of the investigation.

nannySA had no expertise or training in investigating sexual abuse or identifying problematic grooming behaviours. It was inappropriate to ask it to play any part in the response. Had the matter been properly classified as a serious care concern it would not have been placed in that position. An agency’s role in care concerns should be limited to circumstances that require only staff development and training to prevent recurrence.

The clumsy back and forth process that ensued between Families SA, the Department’s Human Resources section and nannySA arose from lack of clarity about the role of each in resolution of the matter. McCoole’s unusual employment circumstances appear to have flummoxed both agencies and stymied progress. When nannySA was finally given permission to interview McCoole it did so swiftly, uninhibited by the weight of process and procedural confusion that had stalled the Department.

However, the interview was inadequate. All it did was present the allegations to McCoole and ask him to respond. His responses were then accepted at face value. He was not pressed to answer the most concerning aspects of the observations—what happened in the bedroom to cause Mikayla to be on her hands and knees complaining her bottom hurt? Without testing McCoole’s explanations against the recorded observations of Ms H, or directly with Ms H, Ms McKenna’s opinion that there had been a misunderstanding was critically flawed.

The cognitive distortions, the hallmarks of grooming and the accumulation of disturbing circumstances about the events in the bedroom were lost on Ms McKenna. Following the interview, she was prepared to return McCoole to work caring for children in other parts of the nannySA business, notwithstanding her lingering doubt about his denials.

Ms McKenna’s interview focused too much on compliance with process and too little on child safety. It was conducted with a naïve optimism that the interview would finalise the matter neatly before she left her employment.

The investigation of alleged grooming and child sexual offences is a highly specialised field. Such investigations should be conducted only by staff with the highest level of expertise. It is highly unlikely those staff would be located in the private labour supply companies with whom Families SA contracts. It is not appropriate that investigations are conducted ‘collaboratively’ with staffing agencies. Agencies should be obliged to cooperate with investigations, but never collaborate.

MCCOOLE’S RETURN TO WORK

Faced with an entirely inadequate investigation and unhelpful advice from the human resources consultant Ms Kuehn, Ms Lamont, the manager, permitted McCoole to return to work. She did so despite understanding the seriousness of the allegations and having some lingering doubts about the veracity of his denials. She believed she could do nothing to prevent him returning to work in the absence of factual findings from a properly conducted investigation.

Notwithstanding the remaining concern about McCoole’s conduct, no clear process was adopted by Families SA to determine whether they could simply decline to renew McCoole’s contract. By the time he returned to work he had no written contract of engagement. There may have been a basis on which they could have declined to offer him a further contract. Ms Lamont thought she might have discussed the issue with a business manager in the
directorate, and considered there might be difficulties if McCoole’s contract was not renewed. They did not seek formal advice.

Ms Lamont’s decision to return McCoole to work was based on incomplete information and inadequate understanding in two areas. The first was McCoole’s full work history. In the course of evidence a number of matters identified as ‘red flags’ were put to Ms Lamont. She said that if she had been aware of these issues her level of concern about McCoole remaining in the directorate would have been elevated. No comprehensive picture of McCoole’s previous workplace conduct was available to Ms Lamont or other senior staff because recording of information about residential care workers was not systematic. Some information had not been recorded at all. Other information dealt with in supervision was not considered. The second misunderstanding was that Ms Lamont believed that, in directing that he work double-handed shifts, McCoole would not be left alone with children.

The circumstances of McCoole’s return to work were unsatisfactory. The supervision regime lacked clarity and was poorly communicated to the staff who were expected to supervise him. Carers working with McCoole were not advised why he was obliged to work double-handed shifts, nor that there was any requirement to ensure he was not left alone with children. There was no retraining nor any program of intensive supervision over a defined period of time. No review of McCoole’s progress after his return to work was scheduled or conducted. McCoole’s disregard for the rules in the residential care environment continued. Coming as it did after the care concern, McCoole’s photographing of Nicky Schultz on his personal device required a serious response.

If the message to the workplace about McCoole being ‘bulletproof’ was not plain enough following his return to work, it was made perfectly clear after his January 2014 elevation to the acting OPS4 senior youth worker position. At that time Mr Norman was acting in the OPS5 supervisor role and was responsible for the decision. McCoole was objectively an extremely poor candidate for the role, because of accumulating concerns about his work performance and poor teamwork, and the tension about his return to work following the care concern. In making this decision Mr Norman was clearly influenced by his disapproval of the actions of Ms H, and those who supported her, in speaking out against McCoole.

**FINAL COMMENTS**

Ms H’s notification of McCoole’s actions provided the best opportunity for Families SA to investigate McCooe and rigorously consider the risk he posed to children in the residential care context. The opportunity was squandered because the systems in place to respond to this exact situation were not used. Rather, those with decision-making responsibility made their decisions on considerations other than the paramountcy of the safety of the child.

Decision making failed to give weight to the extreme vulnerability of young children in rotational care environments, and the disastrous consequences of permitting a person who proved to be a child sex offender access to children in that environment. The system response also failed to have regard to the high risk posed by an adult who was engaged in behaviours that might precede child sex offences, in a residential care environment.

The underlying sense was that compliance with process was more important than understanding the child’s experience. As each part of the system shrank away from shouldering any responsibility for this difficult matter, the response was left in the hands of staff who were the least qualified to deliver it.

It is tempting to place blame at an individual level for each decision in the process which contributed to the disastrous outcome. For some individuals, the lack of judgement evident in their actions calls into question their capacity to continue in the important roles they have been assigned. That is not a matter for the Commission to resolve. What is more important are the lessons that can be learnt from both individual and system failures.

**CONCLUSION**

Workplaces that provide services to children must consciously and deliberately protect against the risk of child sexual abuse. In organisations such as Families SA, where intimate care is provided to particularly vulnerable children, all aspects of organisational practice and culture must come under routine, rigorous scrutiny, informed by an understanding of child sexual abuse, child sex offender behaviour and the effects of abuse on children.

It cannot be said definitively that at any one point in time McCoole’s offending could have been prevented. However, it can be said that the accumulation of all the deficiencies revealed in this case study culminated in a workplace that failed to properly protect children against the risk of child sexual abuse from within.
This situation developed in circumstances where the risk of abuse within institutional environments had long been part of the public consciousness, where a body of understanding had developed about preventative practices, and where warnings from within the organisation identified ongoing risk. Financial pressures restricted the capacity to change where needs were identified, and the unplanned advancement of residential care provision contributed to the situation. However, these matters are not solely responsible for what occurred.

Serious deficits within the child protection system permitted McCoole to begin employment at nannySA, and to offend at work over a period of about three-and-a-half years. At the time he started working with children, McCoole had a clearly developed sexual interest in children, and predatory motives towards them. The characteristics of McCoole’s offending, and his characteristics as an offender are particularly heinous. However, those working in environments which provide services to children require an understanding that McCoole’s activities only represent one form of offending. Systems must be capable of protecting against the variety of circumstances in which child sexual offenders offend. Restricting opportunities to offend can be the most effective means of achieving this result.

Recruitment processes for nannySA and Families SA failed to apply the degree of rigour required in services that care for vulnerable children and without any apparent consideration of the potential risk of engaging people who may offend. The positive reference from the OSHC Director was accepted on face value, without considering that OSHC’s supervision of McCoole’s conduct might not have been as rigorous as it should. Within Families SA, McCoole was engaged despite warnings in a psychometric test that recommended caution, and indicated McCoole posed a high risk as a potential employee, even though it did not disclose a potential for sexual abuse. Families SA systematically misused test results because recruitment teams were not given the capability to understand the tests they were supposed to interpret.

Screening of applicants at the recruitment stage is fallible. It is but one of many systems that organisations need to protect against child sexual offending. Deficits in the practices of nannySA and Families SA beyond recruitment also failed children in their care.

Some practices in staffing residential facilities failed to provide adequate supervision and support for staff, including high child to staff ratios, the use of single shifts, and lack of oversight of operational staff by supervisors. The genesis of some of these deficiencies was an absence of service agreements, or inadequate provision in such agreements between nannySA and Families SA.

Lack of consistency or an absence of clear practice and procedure in the following areas contributed to inadequate scrutiny of McCoole’s behaviour in the workplace and allowed him to continually stretch the boundaries of what was appropriate:

- an absence of a clear approach to youth work generally;
- lack of clarity on permissible and impermissible contact with children;
- lack of clarity on conduct permitted and not permitted within residential care facilities;
- inconsistent practices of reporting observations of inappropriate conduct by a co-worker, including whether they can be named in a logbook, whether reports must be in writing, and the means by which the directorate addressed staff disputes;
- inconsistent practices for recording observations of children in care, including the logging of observations, critical incident reports, notifications to CARL, and the appropriateness of contact by workers with caseworkers or treating therapists;
- inadequate understanding and attention to the need to record and consider what children say about their experiences, including in critical incident reports;
- inadequate supervision of staff, including the conduct of supervision sessions and ongoing performance management;
- inadequacies in the conduct of care concern investigations regarding an allegation of abuse of a child in care by a worker; and
- lack of guidance on decisions about the continued employment of workers whose conduct is found to be of concern.

Combined with these deficiencies, a toxic workplace culture in parts of southern residential care discouraged staff from raising their concerns about children and colleagues, and punished those who did step forward. The conduct of some staff was inappropriate to the point that their continuing suitability for employment should be reviewed. The Commission recommends that the conduct of Ms Decoster, Mr Norman and Mr Sterzl be considered by the Department in this regard.

An organisation such as Families SA must have the capacity to monitor the conduct of staff and children for indicators of child sexual abuse, and act as a protection against such conduct. The inadequate understanding of the dynamics of child sexual abuse, the nature and behaviour of sexual offenders and the effects of such abuse on children, on the part of workers, including senior staff and those involved in investigations, was observed throughout the case study. There was inattention to the possibility of McCoole committing or contemplating sexual offences against children, even
from those responsible for scrutinising his conduct. Comprehensive training of Families SA staff and nannySA staff on these topics is necessary.

Closely related to this knowledge is the ability of the organisation to record and consider information about children and workers. Structures that consolidate such knowledge across large organisations such as Families SA, where staff and children frequently move from place to place and where knowledge is held in multiple areas, are particularly important. Deficiencies were identified by the Commission in these systems. They were starkest in relation to commercial agency staff, who do not have access to Families SA data management systems, and whose conduct is subject to minimal oversight.

Ultimately, the lack of scrutiny which attends the recruitment and employment of agency staff, combined with training inadequate to equip them for their role, establishes that the engagement of agency staff to provide care to children in residential care facilities bears an added unacceptable risk to children, particularly where they are engaged on single-handed shifts.

Positive changes have begun in Families SA, but the problems identified in this case study are by no means resolved. Many high-risk factors remain, not least of which is that children are still cared for on single-handed shifts, commercial carers are still engaged in the care of those children and problems appear to persist with the organisational culture.
CASE STUDY 5 SHANNON McCOOLE—KEEPING CHILDREN SAFE IN THEIR ENVIRONMENT

NOTES

1 R v Shannon Grant McCoole (2015), DCCRM-15-64.
2 The primary school was run under the auspices of the Department for Education and Child Development (DECD). Although physically located at the primary school, the OSHC service was not governed by DECD. It was governed by the OSHC Advisory Committee, a subcommittee of the schools’ governing council.
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10 Oral evidence: Ms A; Ms E.
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23 ibid.
24 Oral evidence: Ms A.
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446 Oral evidence: Ms H; S Hammond.
448 Oral evidence: S Hammond.
449 Oral evidence: Mr G; Mr P.
450 Oral evidence: Mr G.
451 Oral evidence: Ms D.
452 Oral evidence: Ms S.
453 Oral evidence: J Dimond.
454 Oral evidence: Mr G.
455 Oral evidence: N Stasiak.
456 Oral evidence: Ms K.
457 Oral evidence: Ms K; S Hammond.
458 Oral evidence: Ms V.
459 Oral evidence: J Pinos.
460 Oral evidence: W Dennis; J Gregory.
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NOTES

463 Oral evidence: M Vidovic Slack.
464 Oral evidence: D Calvert.
465 ibid.
466 ibid.
467 ibid.
468 ibid.
469 Oral evidence: D Calvert; C Harman; L Norman.
470 Oral evidence: D Calvert.
471 ibid.
472 Oral evidence: Ms O.
473 Oral evidence: Ms C.
474 Oral evidence: S Hammond.
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476 Oral evidence: N Reedman; Ms C; C Hams; S Hammond.
477 Oral evidence: J Dimond; C Hams; Ms C; J Lamont; Ms O.
478 Oral evidence: J Pinos.
479 Oral evidence: J Pinos; L Rogers.
480 Oral evidence: Ms D; C Harman.
481 Oral evidence: J Lamont.
482 Oral evidence: D Calvert.
483 Oral evidence: Ms D; J Dimond; J Pinos; K Roberts.
484 Oral evidence: J Pinos.
485 Oral evidence: K Roberts.
488 ibid.
489 ibid.
490 ibid.
491 Oral evidence: D Knight.
492 Oral evidence: C Harman.
493 ibid.
494 Oral evidence: L Norman; S Sterzl; D Calvert.
495 Oral evidence: S Sterzl; Ms K; C Harman; J Pinos.
496 Oral evidence: Ms Y.
497 Oral evidence: Mr Z; Ms O; Ms Y.
498 Oral evidence: Ms D; K Decoster.
499 Oral evidence: Ms D; Ms Y; J Lamont.
500 Oral evidence: K Decoster.
501 Oral evidence: Ms D.
503 Oral evidence: K Roberts.
504 Oral evidence: D Knight.
505 Oral evidence: K Decoster.
508 Oral evidence: K Decoster.
509 ibid.
510 nannySA, reference check conducted by Ms T S McCooele.
511 Oral evidence: Ms T.
512 Oral evidence: T Cole.
513 DFC, Service agreement between Minister for Families and Communities and Hessell Pty Ltd (July 2008 – 31 December 2011), pp. 8–9. DFC, Service agreement between Minister for Families and Communities and Hessell Pty Ltd (January 2012 – March 2012), internal unpublished document, Schedule 1, no date, p. 3.
514 Oral evidence: D Waterford.
515 ibid.
516 Mr F, internal memorandum to D Shen, 11 April 2012.
517 Oral evidence: D Waterford; Mr F; N Stasiak.
518 Oral evidence: N Stasiak.
519 ibid.
520 Oral evidence: J Lamont.
521 Oral evidence: J Richards.
522 Oral evidence: Mr F.
523 ibid.
524 ibid.
526 Oral evidence: J Ogloff.
528 Families SA, Role description: Child and Youth Worker, p. 3.
529 Oral evidence: S Mares.
530 Oral evidence: Ms B.
531 Oral evidence: S Mares.
532 ibid.
534 Oral evidence: D Calvert; L Norman.
535 Oral evidence: J Ogloff.
536 Families SA, residential care operating procedures & residential care practice guides, internal unpublished document, no date.
538 ibid.
540 Oral evidence: Ms A.
541 Oral evidence: Ms H.
542 National Crime Agency (UK) The foundations of abuse, p. 16.
543 ibid.
Oral evidence: Ms G; Ms U; Ms B.

Oral evidence: K Decoster.

Oral evidence: K Decoster.

Oral evidence: S Sterzl.

Oral evidence: Ms H.

ibid.

ibid.

ibid.


Oral evidence: C Harman.

ibid.

ibid.

ibid.

ibid.

ibid.

ibid.

ibid.

K Kuehn, email to Julia Lamont, 20 August 2013.

Oral evidence: N McLean.

Oral evidence: B Martin.

ibid.

ibid.

Oral evidence: N McLean.


ibid.

ibid.

Oral evidence: J Lamont.


Families SA, Supervision notes—S McCoole, 30 January 2013, pp. 1-3.

Oral evidence: L Norman.

On 26 September 2013 a contract was signed which backdated arrangements to 1 October 2012.


DECD, Panel deed between the Minister for Education and Child Development and Hessel Care Foundation Ltd, Schedule 2, internal unpublished document, 8 January 2015, p. 6.


Oral evidence: D McKenna.

Oral evidence: J Lamont.

ibid.
<table>
<thead>
<tr>
<th>Abbr.</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AFSS</td>
<td>Aboriginal Family Support Services</td>
</tr>
<tr>
<td>AIFP</td>
<td>Australian Institute of Forensic Psychology</td>
</tr>
<tr>
<td>ATSICPP</td>
<td>Aboriginal and Torres Strait Islander Child Placement Principle</td>
</tr>
<tr>
<td>C3MS</td>
<td>Connected Client and Case Management System</td>
</tr>
<tr>
<td>CaFHS</td>
<td>Child and Family Health Service</td>
</tr>
<tr>
<td>CARL</td>
<td>Child Abuse Report Line</td>
</tr>
<tr>
<td>CCIU</td>
<td>Care Concern Investigations Unit</td>
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<tr>
<td>CPS</td>
<td>Child Protection Services</td>
</tr>
<tr>
<td>CRC</td>
<td>community residential care</td>
</tr>
<tr>
<td>DCP</td>
<td>Department for Child Protection [Western Australia]</td>
</tr>
<tr>
<td>DCSI</td>
<td>Department for Communities and Social Inclusion</td>
</tr>
<tr>
<td>DECD</td>
<td>Department for Education and Child Development</td>
</tr>
<tr>
<td>FMC</td>
<td>Flinders Medical Centre</td>
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<tr>
<td>FNR</td>
<td>Full Investigation Not Required</td>
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<tr>
<td>FTE</td>
<td>Full time equivalent</td>
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<tr>
<td>GCYP</td>
<td>Office of the Guardian for Children and Young People</td>
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<tr>
<td>HR-MIU</td>
<td>Human Resources Misconduct and Incapacity Unit</td>
</tr>
<tr>
<td>ITC</td>
<td>intensive therapeutic care</td>
</tr>
<tr>
<td>LWB</td>
<td>Life Without Barriers</td>
</tr>
<tr>
<td>MAS</td>
<td>Manager—administrative services</td>
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<tr>
<td>NCA</td>
<td>National Crime Agency [United Kingdom]</td>
</tr>
<tr>
<td>NOC</td>
<td>Notifier Only Concern</td>
</tr>
<tr>
<td>NVCI</td>
<td>non-violent crisis intervention</td>
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<tr>
<td>OPS</td>
<td>operational services</td>
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<td>OSHC</td>
<td>out-of-school-hours care</td>
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<td>PAC</td>
<td>principal Aboriginal consultant</td>
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<td>PSU</td>
<td>Placement Services Unit</td>
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<td>PSW</td>
<td>principal social worker</td>
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<td>RAN</td>
<td>Responding to Abuse and Neglect</td>
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<tr>
<td>SAPOL</td>
<td>South Australia Police</td>
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<tr>
<td>SIU</td>
<td>Special Investigations Unit</td>
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<tr>
<td>SSO</td>
<td>school services officer</td>
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