OmbudsmanSA

STATEMENT ON INVESTIGATION

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Outcome of Ombudsman investigation into the actions of Families SA / the Department for Child Protection – alleged failures in responding to disclosures of sexualised behaviour between young people in care

The Ombudsman has concluded a lengthy own initiative investigation concerning two siblings under long-term guardianship orders (**the siblings**) and the response of Families SA and the Department for Child Protection (collectively, **the agency**) to disclosures of sexualised behaviour between young people in residential care.

The circumstances at the centre of the investigation predominantly took place during the Families SA era; that is, prior to 2017.

The matter was first brought to the Ombudsman's attention by the Guardian for Children and Young People (**the Guardian**) who contacted the Ombudsman on behalf of the siblings. The Guardian held concerns about the agency's response to allegations of sexualised behaviour between numerous young people over a six month period where the siblings resided at a residential care unit. The ages of the siblings and young people concerned ranged between 9 years and 13 years. The Ombudsman undertook an own initiative investigation of the matter in order to consider issues wider than those raised by the Guardian.

In undertaking this investigation, the Ombudsman was mindful of the literature provided to him indicating a general acceptance by experts in the field of Child Protection that sexualised behaviour between young people can be classified with reference to different spectrums. Although the classification titles may differ, it appears to be accepted that particular defined forms of sexualised behaviour between young people are considered to be 'developmentally appropriate sexualised behaviour' whereas some behaviour may be considered to be 'problematic' or 'harmful' sexualised behaviour and even sexual abuse.

The Ombudsman was also mindful of the department's submission that children and young people in Out of Home Care often exhibit sexualised behaviour as a consequence of the abuse that they have suffered prior to their placement in Out of Home Care.

1. The agency's placement of the siblings in a residential care unit with another young person

Prior to the siblings' placement in a residential care unit, they were accommodated in a short-term commercial care placement where they received rotational care delivered by commercial care workers and resided with another young person.

The Guardian expressed concern that the agency was aware that incidents of sexualised behaviour had occurred between the three young people in the commercial care placement and the agency had still determined it appropriate to transfer the three young people to a residential care unit where they continued to reside together.

The agency was only able to provide limited records to the Ombudsman relating to the transfer and placement of the three young people. However, the agency's file illustrated that:

- numerous incidents of sexualised behaviour were recorded as having occurred between the three young people in commercial care
- several officers of the agency, including a Senior Clinical Psychologist, held concerns about the proposed placement of the three young people together in the residential care unit due to the sexualised behaviour
- regardless, the agency then placed the three young people together in the residential care unit
- although the agency attempted to implement some strategies to address sexualised behaviours, the strategies were ultimately unsuccessful and there was a recorded decline in the young people's overall behaviour.

The Ombudsman concluded that the placement of the siblings together with the other young person in the residential care unit was wrong within the meaning of the Ombudsman Act. The Ombudsman did so taking into account:

- the nature and number of incidents of sexualised behaviour recorded in the commercial care placement
- the professional concern expressed about the proposed placement of the young people together at the residential care unit
- the recorded decline of the young people's overall behaviour after their placement together at the residential care unit.

To remedy this error, the Ombudsman made several recommendations including:

- when particular young people have a known history of sexualised behaviour between them, they are not to be placed together (other than in the case of siblings when it is in their best interests to remain together), and the agency takes particular steps to address the sexualised behaviours and protect the young people
- when a young person with a known history of problematic or harmful sexualised behaviour is placed with any other young person, the agency must take particular steps to address those behaviours and protect the young people.

2. The agency's response to evidence of sexualised behavior between young people in a residential care unit

The Ombudsman identified thirty records of the agency relating to sexualised behaviour between numerous young people during the six months the siblings resided at the residential care unit. Some recorded disclosures and allegations made by the young people to the residential care staff, whereas others recorded the observations of staff.

Having considered the agency's files, the Ombudsman formed the view that the agency had, in several different areas, failed to respond appropriately to the apparent sexualised behaviour occurring in the residential care unit at the time.

Among other things, the Ombudsman noted that:

- as mandated notifiers, the residential care staff were required to formally report a reasonable suspicion of sexual abuse to the agency. Although it appears to be accepted that not all sexualised behaviour amounts to sexual abuse, the agency's policies required 'problem', 'concerning' and 'very concerning' sexualised behaviour to be reported but did not require 'age appropriate' sexualised behaviour to be reported. The differing definitions and reporting obligations quite possibly resulted in staff not reporting incidents of sexualised behaviour as they should have been. The Ombudsman formed the view that several of the thirty incidents were not reported by staff when the seriousness of the matters alleged indicate that they should have been.
- allegations concerning the abuse of young people in care and allegations that an appropriate standard of care has not been met, are referred to as 'Care Concerns'. At the relevant time, Care Concerns were assessed and investigated by the Care Concern Management Unit. The relevant manual of practice provided that repeated incidents of any kind should, at a minimum, have resulted in an inquiry and that incidents of sexualised behaviour between young people in residential care should have resulted in an investigation. The agency's file contained only two Care Concerns relating to the siblings' time in the residential care unit. One Care Concern related to allegations of very concerning sexualised behaviour. However, that Care Concern was as assessed in a manner that resulted in no investigation being undertaken when, in the Ombudsman's view, it should have been. The Ombudsman was of the view that, to the detriment of the young people's wellbeing, there was once again a lost opportunity for the agency to detect and investigate what appeared to be an ongoing problem of sexualised behaviour between the young people at the residential care unit.
- the Ombudsman noted inconsistencies with the agency's recording of incidents of sexualised behaviour between the young people and failures to record incidents in important documentation.

The Ombudsman considered that each of the agency's failures were at the expense of the young people's immediate and long term wellbeing. It appeared that, at the time, the agency had failed to properly recognise the impact such events have on a young person. The Ombudsman was of the view that the agency failed to provide the level of care and protection that should be provided to any child and concluded that the agency's response to sexualised behaviour between the young people at the residential care unit was unreasonable within the meaning of the Ombudsman Act.

The Ombudsman took into account that recommendations stemming from the Child Protection Systems Royal Commission addressed many of the issues identified in this investigation and the agency was already implementing changes. The Ombudsman sought the views of the agency and the Guardian as to what may assist the agency in further remedying the errors identified in this investigation. Consequently the Ombudsman recommended that:

- all incidents of sexualised behaviour that occur in residential care are to be reported to the social worker of each young person involved and any therapist working with the

young person. If relevant, the young person's Advocate from the Guardian's office should also be informed

- when incidents of problematic or harmful sexualised behaviour occur in residential care, the agency must consult with relevant therapists to identify therapeutic supports for the young people involved.

3. The agency's response to enquiries from the Guardian for Children and Young People

Following the siblings' time at the residential care unit, the Guardian was contacted by concerned individuals in relation to disclosures that had been made by the siblings about sexualised behaviour that had occurred during their six months at the residential care unit. The Guardian then commenced enquiries with the agency.

In contacting my Office, the Guardian expressed concern that, given the extent of the incidents that appeared to have occurred in the residential care unit and despite a protocol existing, the Guardian had not received any referrals relating to sexual abuse. The Guardian also expressed concern that the agency had failed to respond to particular enquiries made by the Guardian's office and, in other instances, there had been delays.

Given the Guardian's advocacy role for young people in care, it is mandatory that the Guardian be notified when a child in care makes a disclosure of sexual abuse. The Ombudsman had already identified issues with the agency's reporting of sexualised behaviour during the relevant time at the residential care unit and issues with the Care Concern Management Unit's assessment of the limited matters it had before it. The Ombudsman noted that, had more incidents been reported and assessed appropriately at the time, it may have resulted in matters being assessed as allegations of potential sexual abuse requiring a referral to the Guardian. However, on the information before him, the Ombudsman was unable to conclude that the agency failed to refer allegations of sexual abuse to the Guardian.

Regardless, the agency's files demonstrated that the agency had both failed to respond to particular enquiries made by the Guardian's office and that that there were delays in the agency responding in other instances. On this basis, the Ombudsman formed the view that the manner in which the agency responded to enquiries made by the Guardian was wrong within the meaning of the Ombudsman Act.

The Ombudsman did not consider it necessary to make a recommendation to remedy this error on the basis that relevant changes had already been implemented by the agency in response to recommendations stemming from the Child Protection Systems Royal Commission.

Outcome

The Department for Child Protection has accepted the Ombudsman's conclusions in this investigation.