OmbudsmanSA

STATEMENT ON INVESTIGATION

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Outcome of Ombudsman investigation into the actions of Families SA / the Department for Child Protection – alleged failure to protect young people from sexual exploitation

The Ombudsman has concluded a lengthy own initiative investigation concerning the actions of Families SA and the Department for Child Protection (collectively, **the agency**) in responding to concerns about the activities of an alleged sexual perpetrator.

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

1. Alleged failure to ensure the care and protection of two girls

The Ombudsman first became aware of the allegations on receiving a handwritten letter from a prisoner. This letter raised allegations against the agency and a range of private individuals, traversing events said to have taken place over the better part of a decade.

It was apparent from the tone and construction of the letter that the issues raised in the complaint were the source of profound distress to the prisoner.

A consistent theme running through the prisoner's letter was the alleged failure of the agency to take appropriate action to protect a succession of children from an individual, Peter,[1] alleged by the prisoner to be a known sexual perpetrator.

The prisoner alleged that the agency failed to take appropriate action in the past to protect two girls, Kate and Emma, from Peter. Both Kate and Emma are now adults with children of their own.

The prisoner submitted that the agency was aware that Peter was involved in sexual activity with both Kate and Emma during a period in which Peter was acting *in loco parentis* to the two girls. The prisoner submitted that both girls were under the age of consent at this time and, notwithstanding allegations of sexual abuse coming to the agency's attention, Kate and Emma were permitted to remain in Peter's care.

In the course of responding to preliminary enquiries by the Ombudsman, the agency acknowledged that Peter had previously acted as an informal guardian to Kate and Emma.

[1] Pseudonyms have been assigned to the parties.

The agency informed the Ombudsman that it had an extensive history of involvement with Kate and Emma; including more than 50 intakes concerning their care and protection as children and, subsequently, a number of intakes concerning the care and protection of their children.

The agency also acknowledged receiving notifications in the past which alleged that both Kate and Emma were being sexually abused by Peter while in his care.

In the course of reviewing the agency's records, the Ombudsman determined that the agency also received notifications alleging that Peter had sexually abused three other girls.

None of the allegations concerning Peter were substantiated by the agency at the relevant time.

The Ombudsman observed that it was apparent from the agency's records that, notwithstanding the regular notifications concerning the family, the agency possessed little actual knowledge of Kate and Emma's living arrangements at the time it first began receiving notifications about Peter.

The Ombudsman observed that this situation did not improve following the first intake concerning Peter. The Ombudsman noted that subsequent records within the agency's files evidenced continued confusion as to Peter's relationship with the family and the precise living arrangements of both girls.

The Ombudsman observed that at no stage during the girls' childhood did the agency ever:

- enter and inspect Peter's property
- interview the children's mother concerning the allegations about Peter
- sight the child the subject of the notification
- interview Kate or Emma concerning the allegations about Peter
- interview any of the notifiers or known informants
- interview any of the other alleged victims
- interview Peter or Peter's partner in a formal setting
- interview Kate in light of subsequent allegations concerning Emma.

The Ombudsman opined that the agency's lack of knowledge of the girls' precise circumstances appeared to result from the agency's tendency to shift responsibility for investigating the allegations to SA Police. The Ombudsman remarked that, while there was nothing improper in the agency referring notifications raising allegations of criminal offending to SA Police, this act alone did not absolve the agency from conducting a thorough assessment into each child's circumstances.

The Ombudsman observed that in each case where an intake concerning Peter was closed without substantiation, there remained a range of risk factors readily apparent that required further engagement by the agency. The Ombudsman noted that in each case, when the agency was informed that SA Police were not pursuing a charge, a strategy discussion should have been convened to discuss alternative methods of engagement and intervention. The Ombudsman opined that, lack of substantiation aside, the information before the agency about Peter clearly merited ongoing, proactive monitoring in some form.

In his final report, the Ombudsman summarised the errors made by the agency as follows:

1. **Failure to properly assess and investigate intakes raising serious child protection concerns**
    - Intakes were in each case closed in circumstances where the agency itself had made little to no enquiries into the circumstances of the child.
    - The agency misclassified notifications meriting an immediate agency response.
    - The agency routinely failed to interview key witnesses or otherwise satisfy itself that key witnesses had been interviewed by SA Police.
    - The agency routinely failed to seek or obtain key information from SA Police.
2. **Failure to consider statutory powers and factors unique to the child protection jurisdiction**
    - The agency failed to consider the breadth of remedies available under the Children's Protection Act.
    - The agency failed to consider or assess each intake in light of the lesser standard of proof and relaxed rules of evidence applicable under the Children's Protection Act.
    - The agency failed to contemplate intervention in the absence of Police prosecution of Peter.
3. **Failure to adopt a holistic approach to the notifications concerning Peter**
    - The agency failed to properly assess and investigate the notifications concerning Emma in light of earlier notifications concerning Kate and the other alleged victims.
    - The agency failed to reassess earlier allegations concerning Kate in light of subsequent notifications concerning Emma and the other alleged victims
    - The agency failed to appropriately consolidate information concerning Peter so as to build a case for statutory intervention.

The Ombudsman concluded that the agency's response to the notifications concerning Peter was unreasonable within the meaning of section 25(1)(b) of the *Ombudsman Act 1972*.

In respect of this issue, the Ombudsman made the following recommendations to the Department for Child Protection:

1.1 That the department take appropriate steps to develop or revise guidelines and associated materials applicable to the assessment and investigation of notifications under the *Children's Protection Act 1993* and the *Children and Young People (Safety) Act 2017* so as to provide that:

(a) absent reasonable cause, and wherever practicable, intakes should not be closed for lack of substantiation unless and until:

- the department has considered all aspects of the child and family's situation
- the department is satisfied that all key witnesses have been interviewed by the department or by agencies working in cooperation with the department

- the department has made reasonable endeavours to obtain and review any records of interview applicable to interviews conducted by agencies working in cooperation with the department
- the department has made final enquiries of all agencies working in cooperation with the department such that it is satisfied that all evidence obtained by those parties has been made available to the department and has been considered by the department
- the department has considered the allegations against all previous notifications and intakes relating to the child and family's situation and against all previous notifications and intakes relating to the alleged perpetrator.

(b) the investigation and response to intakes must be determined upon consideration of:

- the balance of probabilities
- the rules of evidence applicable under the *Children's Protection Act 1993* and/or the *Children and Young People (Safety) Act 2017* (as applicable)
- the specific remedies available to the department under the *Children's Protection Act 1993* and/or *the Children and Young People (Safety) Act 2017* (as applicable) and under other applicable statutory instruments.

(c) the failure to charge or prosecute an alleged offender shall not by itself constitute sufficient basis for closing an intake.

1.2 That the department take appropriate steps to ensure that, when reviewing closures, senior staff consider the criteria identified in recommendation 1, above.

1.3 That the department take appropriate steps to develop a protocol by which senior staff are to conduct a review of assessment in circumstances where multiple notifications concerning a particular child or family's circumstances are screened out in any two-year period.

2. Alleged ongoing failure to ensure the care and protection of two children

The Ombudsman also investigated the agency's assessment of the risk posed to two children currently in the care of Peter, identified in the Ombudsman's final report as 'Sarah' and 'Jacob'.

The agency acknowledged in its response to the Ombudsman's investigation that there was a high likelihood that Peter sexually abused Emma when she was a child.

The Ombudsman observed that this appeared to be the only reasonable conclusion on considering the nature and volume of the allegations made against Peter.

The Ombudsman opined that the likelihood that Peter sexually abused Kate and the other alleged victims was similarly high. The Ombudsman observed that there was a degree of symmetry between these allegations that could not be overlooked.

The Ombudsman noted that the agency appeared to take the view that the absence of any notifications alleging that Sarah or Jacob were at risk of sexual abuse by Peter indicated that Peter did not pose a risk to either child.

The Ombudsman remarked that, in other words, the agency had not meaningfully assessed or investigated the risk of sexual abuse to Sarah or Jacob because it had not received a notification raising this specific concern. The Ombudsman remarked that this appeared to be a major shortcoming of the incident-based system implemented by the agency.

The Ombudsman expressed the view that the agency's determination that Sarah and Jacob were not presently at risk of sexual abuse by Peter failed to adequately consider the past allegations of sexual abuse perpetrated by Peter against Kate, Emma and the other alleged victims.

The Ombudsman expressed the view that the agency's response to the allegations concerning Kate and Emma 'plainly failed the two girls'. The Ombudsman expressed concern that the agency appeared to be adopting a similar approach to its consideration of the risk posed to Sarah and Jacob, and that, absent a change in course, it appeared possible that Sarah and Jacob would also be failed by the system.

In his final report, the Ombudsman noted that following receipt of his provisional views, the agency appeared to have made efforts to engage with and monitor the family. The Ombudsman made the following recommendations relevant to this issue:

2.1 That the department continue to engage with the parents of Sarah and Jacob in a manner consistent with recent efforts.

2.2 That the department notify the Ombudsman at 11 March 2019 and again at 11 September 2019 of its interactions with the family, including the terms of any safety plan agreed with the parents.

3. Closure of intakes without action

The Ombudsman also investigated the agency's decision to close three specific intakes without taking any action.

The Ombudsman remarked that the proportion of intakes closed for such reasons each year was 'simply staggering'. The Ombudsman noted that the report of the Nyland Commission recommended that the department phase out its practice of closing intakes due to a lack of resources. The Ombudsman endorsed the Nyland Commission's concern regarding this practice. The Ombudsman opined that the practice was 'repugnant to the objects and spirit of the Children's Protection Act'.

The Ombudsman noted that each of the three intakes closed for such reasons in the present case raised serious and compelling child protection concerns and had been assessed as such by the agency. The Ombudsman remarked that in each case, the agency had no basis to conclude that the matters causing the child to be at risk were being adequately addressed so as to negate the need for a response.

The Ombudsman observed that by closing each intake without further action, the agency could not reasonably be said to have caused an assessment of, or investigation into, the circumstances of the child to be carried out in accordance with section 19(1) of the Children's Protection Act.

The Ombudsman expressed the view that by merely faxing one such intake to SA Police, the agency could not reasonably be said to have caused such an assessment or investigation into the circumstances of the child in accordance with section 19(1). The Ombudsman opined that even if this requirement was considered to encompass an assessment or investigation by SA Police, the agency had no information to suggest that SA Police took such action.

The Ombudsman concluded that the agency's closure of the three subject intakes was contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act. The Ombudsman recognised that the Nyland Commission recommended that the agency phase out its practice of closing intakes due to a lack of resources and accordingly did not make any recommendations in respect of the issue.

The Department for Child Protection has accepted the conclusions made by the Ombudsman's investigation.