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Safeguarding Task Force

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11 September 2020

Dear Ms Vincent and Dr Caudrey,

### **Safeguarding Task Force – feedback on July report**

I am writing this submission in my capacities as South Australia’s Guardian for Children and Young People, Child and Young Person’s Visitor, and Training Centre Visitor (collectively referred to as the Office of the Guardian for Children and Young People, or OGCYP).

The Guardian is appointed to advocate for and promote the rights and best interests of children and young people under the guardianship of the Chief Executive of the Department for Child Protection (DCP). The Child and Young Person’s Visitor is appointed to visit and inspect DCP residential care homes. The Training Centre Visitor promotes and protects the interests and rights of children and young people on remand or sentenced to detention in Kurlana Tapa Youth Justice Centre (KTYJC).

These three roles are established under three separate Acts, each of which states that particular attention must be paid to the needs and circumstances of children and young people who have a physical, psychological or intellectual disability.<sup>1</sup>

In South Australia, it is estimated that approximately one third of those in care have a disability, and one study of the residents at Kurlana Tapa Youth Justice Centre indicated that nine out of ten residents assessed had a disability or disability-related needs.<sup>2</sup> There is significant overlap between my roles of Guardian, Child and Young Person’s Visitor, and Training Centre Visitor as children and young people in care

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<sup>1</sup> s 26(2)(b) *Children and Young People (Oversight and Advocacy Bodies) Act 2016*; s 118(2)(b)(ii) *Children and Young People (Safety) Act 2017*; s 14(2)(b)(iii) *Youth Justice Administration Act 2016*.

<sup>2</sup> Department for Human Services (forthcoming 2020) *Disability Screening Assessment Project Report: Identification of Population Needs at the Adelaide Youth Training Centre (Kurlana Tapa)*. Adelaide, Australia: Youth Justice Assessment and Intervention Services.

account for approximately 40 per cent of all separate admissions to the Training Centre, with most coming from residential care facilities.<sup>3</sup>

My feedback on the Safeguarding Taskforce Report has limited comment on the contents of the report. Many of the safeguarding gaps identified do apply to those in care and/or youth detention, however I believe safeguarding gaps that require urgent attention for those under my mandate relate to basic standards of care and support.<sup>4</sup>

It is the experience of my office that staff within DCP and DHS are often not supported or equipped to navigate complex NDIS or other disability systems on behalf of those in their care. This can then result in already socially isolated and institutionalised children and young people leaving the care and/or youth justice systems with little support or skills to navigate adult life.

The attached addendum sets out my feedback as follows -

1. Some safeguards that exist for children and young people in care and/or detention who may have a disability, and how well they are working;
2. Comment on recommendations and learnings from previous reports and inquiries that applied to visiting programs;
3. The Child and Young Person's Visitor Scheme; and
4. The importance of visiting and advocacy in supporting children and young people to access and realise their human rights.

I also recommend that -

1. The Safeguarding Taskforce considers listing care leavers and those with experience in the youth justice system as priority groups for individual advocacy, and the Adult Safeguarding Scheme.
2. Consider mandatory notifications to the NDIS Commission for CARL notifications relating to disability service providers.
3. The Safeguarding Taskforce inquire into the quality and availability of disability care for those in youth detention, and those under the guardianship of the Chief Executive of the Department for Child Protection.

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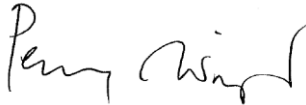
<sup>3</sup> Training Centre Visitor Annual Report 2018-19, p 9. More information relating to the experience of those in care who are also involved in the youth justice system can be found in the Guardian's report "*A PERFECT STORM? Dual status children and young people in South Australia's child protection and youth justice systems*". Available here: <http://www.gcyp.sa.gov.au/report-finds-children-in-care-overrepresented-in-youth-justice/>.

<sup>4</sup> More information about the experience of children and young people with a disability in care and/or detention can be found in our feedback to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, available here: <http://www.gcyp.sa.gov.au/wp-content/uploads/2020/07/2020-04-29-OGCYP-submission-Disability-Royal-Commission-final.pdf>.

Please contact my Senior Policy Officer, Jessica Flynn, on 8226 8570 or at [jessica.flynn@gcyp.sa.gov.au](mailto:jessica.flynn@gcyp.sa.gov.au), if you require any further information about, or wish to discuss, this feedback.

As is commonly my practice, it is my intention to publish an edited version of this submission on my office's website. Please contact Ms Flynn by 21 September 2020 if you have any concerns about this.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Penny Wright', written in a cursive style.

**Penny Wright**  
**Guardian | Child and Young Person's Visitor | Training Centre Visitor**  
**Office of the Guardian for Children and Young People**

## **Safeguarding Task Force – feedback on July report**

**from Penny Wright, Guardian for Children and Young People, Child and Young Person’s Visitor, and Training Centre Visitor**

**September 2020**

This feedback focusses on safeguarding mechanisms for those in care and/or those in youth detention.

Psychological distress alters cognition, emotions, behaviour, and physical responses. Trauma-related behaviours which are challenging but which do not meet the criteria of a disability for NDIS purposes are common amongst this cohort. My office is aware of children and young people in the care of the state who are shifted between the health, mental health, and disability care systems due to the inability of the systems to develop a comprehensive, child centred response rather than one that responds to the needs of various systems.

While children and young people are in care and/or youth detention, the relevant government department is their corporate parent and is therefore responsible for ensuring that a child or young person’s needs are being met.

Much of this feedback about safeguarding can apply to all children and young people within my mandate, but the failures in safeguarding are amplified for those with a disability, especially those living in residential care. Due to the high rates of disability within populations in care and/or youth detention, it is assumed that general safeguarding issues also apply to those with disabilities.

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### **1.1 Safeguarding for those in care**

Society expects that when children and young people are removed from their families by the child protection system they are then placed in an environment where they can receive the care and support they need to thrive. This is the reality for many of the children and young people in care in South Australia but for a very vulnerable cohort, this is not the case.

Some safeguarding gaps for those in care (both generally, and with a disability) are as follows -

- Outcomes of reports to the Child Abuse Report Line and care concerns are generally unknown to the person who made the notification, which can then lead them to believe that “something is being done” when it may in fact not be the case. DCP data for 2018-19 shows that only 37 per cent of reported notifications were screened-in.<sup>5</sup> I am concerned that these safeguards for screening in and out seem to be set by resourcing capacities, rather than the nature of the concern, and the impact on the child. I am also concerned that the threshold required to investigate care concerns or incidents is much higher than the community may expect.
- Opacity in the systems relating to complaints and information sharing are undermining safeguarding efforts and responsiveness.

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<sup>5</sup> Reported notifications that meet the child protection threshold for further Department for Child Protection assessment and response as defined by policy and regulations. More data available here <https://www.childprotection.sa.gov.au/department/reporting-and-statistics>

- All aspects of my office’s work demonstrate that too often there is no allocated DCP worker, or no worker regularly visiting a child or young person in care.
- I understand that ongoing diagnosis, assessment and identification of disabilities or related needs are not *guaranteed* for those in care.
- Applications for NDIS assessments or packages are too often left too late, which results in care leavers having to navigate the NDIS system alone or with limited supports.
- There is a lack of disability-specific placements for those in care. GCYP Advocates hear too often about children and young people who are placed with carers who are not equipped or adequately supported to provide quality care. This would be unacceptable for adults and it is not acceptable for children and young people.
- Regular visits to disability-specific residential care houses are a critical component of safeguarding. GCYP Advocates do not have the capacity to fulfil this function, and we are not aware of any other oversight being provided.
- We believe that the risk of peer-related sexual abuse is not managed consistently well by DCP. Children with disabilities are vulnerable when placed with children who exhibit harmful sexualised behaviours (who may also have a disability) but a shortage of placement options means that this occurs too frequently. This is a significant safeguarding gap that needs to be reviewed and addressed by the Department.

## **1.2 Safeguarding for those in youth detention**

Almost all residents in youth detention have a disability or disability-related need. Approximately one-third of South Australia’s youth justice detention population are children and young people in care. The prevalence of disability and those in care in the youth detention population could be a symptom of multiple system safeguarding failures.

- Entry processes into KTYJC do not guarantee assessment for, or identification of disabilities. It is the experience of the Training Centre Visitor Unit that the system does not appear to adapt its processes to meet the needs of individual children and young people with disabilities.
- KTYJC has a case management team that ensures all residents have case plans that are tailored to their disability-related needs but there can be a disconnect between what is recorded in case plans by social workers and how this is implemented by operational staff in the day to day operations of KTYJC. This situation is exacerbated by the fact that the design of the KTYJC physical infrastructure does not reflect to the prevalence of disability within the population and it is by no means a therapeutic environment.
- The recent onsite presence of Youth Justice Assessment and Intervention Services (which enabled access to occupational therapists and psychological and speech services) has resulted in some early improvements in disability assessment and support.

- Staff training around disability has been proposed, and is pending. It is proposed to improve the ability of staff to recognise, understand and respond appropriately to disability related behaviours.
- The proposed development of KTYJC's complaint system seeks to ensure an accessible, transparent, and responsive process. This needs serious development and possible independent involvement to ensure it is a trusted, effective, and usable system.
- There has been some liaison between the NDIS and Youth Justice at a strategy level to improve the response for children and young people in custody. Youth Justice Assessment and Intervention Services are also seeking to build their capacity to assess and/or detect disability on admission. Outcomes associated with these initiatives are still unclear.
- There are unmonitored phone lines for detainees to contact lawyers or TCV. These are working as far as we know and contribute towards safeguarding practices.
- I believe that KTYJC's operating model appears to assume detainees do not have a disability, whereas a recent study found that 9 out of 10 who were assessed had a disability or disability-related need. Further issues relating to disability can be found in The TCV's report *Great Responsibility: Report on the 2019 Pilot Inspection of the Adelaide Youth Training Centre (Kurlana Tapa Youth Justice Centre)*.<sup>6</sup>

### **1.3 Safeguarding for Aboriginal children and young people**

Aboriginal children and young people with a disability who are in care and/or youth detention may be some of South Australia's most vulnerable and marginalised people. Ongoing and meaningful engagement with Aboriginal communities must be initiated by systems to continuously improve safeguarding mechanisms for Aboriginal children and young people. Visiting schemes and other oversight bodies must also strive to employ, using targeted recruitment, an appropriate number of Aboriginal staff who have expertise about the care needs of children and young people with a disability.

### **1.4 The role of the Office of the Guardian for Children and Young People**

The OGCYP is a safeguarding mechanism for those in care and/or youth detention. The OGCYP provides independent oversight of the child protection and youth detention systems, with almost 4,500 children and young people in care, and approximately 300 individuals entering youth detention each year. Because the population of KTYJC generally fluctuates between 20 and 40 individuals at a time, the TCV is better able to see and meet with every detainee during fortnightly visits. This is not the case for the Guardian's Advocacy Team, and the 4,500 children and young people in care across the state, in placement arrangements ranging from foster and kinship care to residential care and independent living.

The South Australian Government has a statutory responsibility as corporate parent for children and young people in care and/or detention. These children and young people have rights as young citizens to have

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<sup>6</sup> Available here: <<http://www.gcyp.sa.gov.au/wp-content/uploads/2020/07/TCVU-inspection-report-2020-web.pdf>>.

their practical and developmental needs met in the light of international human rights covenants and in domestic law and policy.

I have long considered the need for an inquiry into children and young people in care with disability. Historically, the issues for this cohort have been prevalent and are often a source of concern in individual advocacy. Significant concerns were also raised as part of the Child and Young Person's Visitor Scheme, and the establishment of the Training Centre Visitor Unit has also confirmed problems with the care, treatment, and control of those with disabilities at KTYJC.

Due to the office's resourcing, the OGCYP has a very limited ability to conduct outreach and primarily relies on children and young people contacting the office via phone to speak to an advocate. This operational model presents significant barriers to those children in care who are too young to contact us or who may have communication or other disabilities that impede their ability to seek assistance.

In line with our resources, the office must prioritise the needs of children and young people who contact us directly for advocacy, with safety being the most common presenting issue.<sup>7</sup> It is notable that child protection legislation specifies that the safety of children and young people is paramount,<sup>8</sup> and there is a requirement that the GCYP and TCV be sufficiently resourced to carry out the requisite functions.<sup>9</sup>

The office is funded for staffing as below -

- Admin, Communications, Policy = 4 FTE
- Training Centre Visitor Unit = 2.4 FTE
- Advocacy Team = 5.0 FTE
- GCYP<sup>10</sup> = 1.0 FTE

Total = 12.4 FTE

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<sup>7</sup> p 21, Guardian for Children and Young People Annual Report 2018-2019.

<sup>8</sup> s 7, *Children and Young People (Safety) Act 2017*.

<sup>9</sup> s 24 *Children and Young People (Oversight and Advocacy Bodies) Act 2016*; s 13 *Youth Justice Administration Act 2016*.

<sup>10</sup> Penny Wright is GCYP, TCV, and CYPV. Only the GCYP role is funded with a salary. Neither the roles of TCV or CYPV are funded.

Advocacy is not the only function carried out by the GCYP, CYPV and TCV roles. The table of functions below sets out the functions which are legislatively required to be undertaken by my office.

**Table of functions for GCYP, CYPV, TCV**

	GCYP <sup>11</sup>	CYPV <sup>12</sup>	TCV <sup>13</sup>
Promote the best interests	✓	✓	✓
Act as an advocate	✓	✓	✓
Monitor circumstances	✓		
Provide advice to the Minister	✓	✓	✓
Inquire	✓	✓	✓
Conduct visits		✓	✓
Inspect		✓	✓
Communicate with residents		✓	
Investigate matters referred by the Minister	✓		✓

Currently, the GCYP is primarily conducting advocacy and monitoring activities, and has not had the resourcing to undertake an inquiry since 2016. The TCV is in a similar position of not being resourced to undertake inquiries, and the ability to undertake inspections every one or two years is currently under review. The entire CYPV role is unfunded and there are no functions being carried out.

This demonstrates significant gaps in the OGCYP's capacity to undertake safeguarding functions as required by statute.

The nature of the work of the Guardian's Advocacy Team indicates that the residential care system is causing unacceptable amounts of harm and distress to those living in that environment. We do not know how many children and young people with disabilities live in residential care, or where they are placed. We do not know the nature of disabilities experienced by children and young people living in residential care. It is unacceptable that the relevant oversight body is unable to ascertain this information. It is our understanding that DCP is unable to extract this information from their systems, which indicates they are also unable to conduct their own planning and initiate system-wide responses based on the needs of the care population.

Because of a lack of resourcing in DCP, they are unable to provide accurate and current data on children and young people in care with a disability. Despite my office having a requirement to focus on the needs

<sup>11</sup> Functions and powers of the Guardian are set out in section 26 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016*.

<sup>12</sup> Functions and powers of the Child and Young Person's Visitor are set out in section 118 of the *Children and Young People (Safety) Act 2017*.

<sup>13</sup> Functions of the Training Centre Visitor are set out in section 14 of the *Youth Justice Administration Act 2016*.



and experiences of those in care with a disability, we do not have capacity to find out this information ourselves, so there is no specific oversight for those with disabilities in care.

We know that children and young people living in residential care placements who have disabilities are being placed together with other children and young people with harmful sexual behaviours. Despite the risks associated with this, these placement matching problems do arise, and we hear of cases of peer on peer sexual abuse taking place as a result of co-habitation and limited capacity of staff to supervise to mitigate risk. We are not confident that medical procedures to prevent pregnancy for girls with disabilities in care are being handled in the best possible way. We believe that restrictive practices such as locking doors and windows of residential care properties occurs when it is considered to be a necessary policy for security reasons, but this practically means that residents are held securely, with staff having access to keys.

Locking children and young people inside occurs. Depriving children and young people of their liberty potentially breaches their human rights and, where detention occurs, residential care homes would come within the purview of inspections as part of Australia's ratification of the Optional Protocol to the Convention Against Torture.

## **2. Recommendations and learnings from previous reports and inquiries that applied to visiting programs**

The Safeguarding Taskforce would be familiar with the various reports, inquiries and royal commissions that have recommended oversight and visiting functions for vulnerable people in our community.

As discussed in the Safeguarding Report, allowing visiting programs to enter private residences is a fine ethical line to tread and is generally considered invasive, inappropriate, and a breach of human rights. This may become more convoluted when children and young people in care and under the guardianship of the state are placed in private homes that have been assessed by DCP as safe. Many of these children and young people have limited contact with child protection workers so safeguarding may rely, much of the time, on teachers or other members of the community raising concerns about a child or young person's care.

OGCYP works with the police, public prosecution and DCP investigations units to ensure that children involved in investigations of sexual abuse in care have an advocate and that investigations are conducted in a timely manner. This process ('R20') was established in response to recommendations 20 and 24 from the Mullighan Inquiry in 2008,<sup>14</sup> which had concluded that allegations of sexual abuse of children and young people in care, and their investigation, should be monitored and coordinated. Our own data shows that sexual abuse allegations arising from residential and commercial care environments are significantly overrepresented.<sup>15</sup>

There is a possible safeguarding gap for those in care who are placed in private homes and poor safeguarding for those in residential care.

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<sup>14</sup> Pp 23-24, E Mullighan, Children in State Care Commission of Inquiry  
<<https://www.childabuseroyalcommission.gov.au/sites/default/files/WEB.0198.001.0001.pdf>>.

<sup>15</sup> pp 25-26 Guardian for Children and Young People Annual Report 2018-2019.

### 3. The Child and Young Person's Visitor Scheme (CYPVS)

The Law Society's feedback on the *Disability Inclusion (Community Visitor Scheme) Amendment Bill 2020* raises important issues about the validity of state-based visiting programs entering properties operated by registered NDIS providers. This may have implications for the Child and Young Person's Visitor Scheme if it is ultimately funded. I am not aware whether there are children and young people in care living in any properties operated by NDIS providers.

This raises two implications –

- 1) are those in care with complex disabilities receiving the specialist disability care they require?  
and
- 2) what jurisdictional issues may arise for oversight of those in the care of DCP if they are living in federally funded NDIS care facilities?

During the CYPVS's two year trial (2017-2019), increased pressure was placed on the government to close some of DCP's large residential care units, which have capacity to house up to 12 children and young people (numbers have been capped at six). DCP cannot report on where those in its care with disabilities live, but staff of the CYPVS reported high rates of disability amongst those living in residential care.

Observations of the CYPVS staff that relate to the safeguarding and quality of care of children and young people with disabilities living in residential care were reported back to DCP, and include -

- Issues with matching children to cohabit, involving the placement of vulnerable children and young people with disabilities with others who exhibit harmful sexual behaviours, and placement of those with violent disability-related behaviours leading to violence, aggression and bullying. My office believes this also increases the rate of police intervention and contributes to the overrepresentation of those in care in youth detention.
- Care staff had varying levels of understanding about NDIS services or disability generally. CYPVS staff reported challenges identifying and considering disability-related needs and services, which were compounded by regional location and access to DCP support services. Whilst some NDIS supports were sighted by CYPVS staff, there appeared to be poor uptake of NDIS supports, with some staff appearing to have limited knowledge of NDIS goals for those in their care.
- There appeared to be delays in identification of disabilities and NDIS assessment with one staff member telling the CYPVS -

*"we do the same as we do with all kids, they're all high needs... all disengaged, all operating at a similar level... [YP's intellectual disability] doesn't require us to treat her any differently."*

- Poor school attendance was widespread, limiting the supports and safeguarding opportunities with one young person stating -

*"I want to go to school but I'm not allowed! These kids here don't even get up to go to school and sleep all day long and I can't go!" (14 years old)*

- Some health issues were not addressed for residents including the prescription and possible mismanagement of psychostimulants, poor ear health and vision.
- Prevalence of SAPOL intervention and high rates of restraint (including with children under 10), high rates of those in residential care going missing from their placement which increases risk of predation by paedophiles and becoming victim to other crimes.
- Many staff have 12 months or less experience in a care environment, and report “not enough” training to respond to complex and diverse needs of children and young people with a disability.

The CYPVS visited 99 children. Of those, 32 children identified as having a disability (12 also identified as Aboriginal). CYPVS staff also observed there were children and young people who did not have a documented disability (as per DCP records) but in the opinion of CYPVS staff, were observed to have delayed development – including speech and language, and trauma related behaviours. For more detailed findings from the CYPVS, please refer to the Final Report on the Trial Child and Young Person’s Visiting Program.<sup>16</sup>

Everyone should be committed to a residential care system that supports the individual needs of those in its care and enables them to thrive in all aspects of their lives. We cannot be confident that this is the case for residential care in South Australia.

Residential care environments have been the focus of multiple expensive and damaging inquiries and reports. Inspection and monitoring of residential care facilities is recommended in the United Nations Guidelines for the Alternative Care of Children.<sup>17</sup> If the CYPVS is not funded, the high levels of risk inherent in these care environments remain and it is the children and young people who predominantly bear that risk.

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<sup>16</sup> Available here <<http://www.gcyp.sa.gov.au/wp-content/uploads/2020/02/2020-Final-report-on-Trial-Child-and-Young-Persons-Visiting-Program-de-identified.pdf>>.

<sup>17</sup> Resolution adopted by the General Assembly on 18 December 2009, A/RES/64/142.

#### **4. The importance of visiting and advocacy in supporting children and young people to access and realise their human rights**

The Oakden Report found that a lack of exercise of statutory powers of the Community Visitor Scheme for mental health treatment centres and state run disability facilities resulted in harms not being identified.<sup>18</sup> As an independent statutory officer, I am constantly concerned that I am not adequately resourced to undertake my statutory functions.

The safeguarding gaps identified in the Safeguarding Report highlight the particular issues with state and federal systems and responsibilities. When it comes to children and young people with a disability in the care of the state, either under child protection orders or in detention, those safeguarding gaps become even more pronounced. The current state of safeguarding gaps for children and young people in care and/or detention represents significant risks for the safety and wellbeing of those individuals, but also for their families, communities, and for government itself.

Oversight bodies play a critical role in safeguarding, and lower the risk held by governments who provide care to vulnerable people. However, in my roles of GCYP, TCV and CYPV, there is no explicit requirement that DCP, DHS or other agencies consider my advice or advocacy positions. Failing to take advice or act on recommendations places the risk back on government, as inaction indicates acceptance of risks identified.

Effective oversight and safeguarding lowers risk for vulnerable people, and also the risk faced by government. Oversight bodies can identify safeguarding gaps early and make recommendations about necessary policy or practice changes. Effective oversight increases the public's confidence in the transparency and decision-making of departments and governments. It also increases savings to the government (and ultimately the community) – harm caused by youth detention and child protection systems lead to poor, damaging and expensive outcomes for individuals but also repeated inquiries, reports, royal commissions, and costly ongoing litigation. Adequately resourcing independent safeguarding and oversight systems and ensuring resourcing and independence pays off.

Those who are kept out of sight should not be out of mind.

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<sup>18</sup> Oakden: A Shameful Chapter in South Australia's History, A Report By The Hon. Bruce Lander QC Independent Commissioner Against Corruption 28 February 2018, 8.11 Lack of exercise of statutory powers (p 193) <[https://icac.sa.gov.au/system/files/ICAC\\_Report\\_Oakden\\_0.pdf](https://icac.sa.gov.au/system/files/ICAC_Report_Oakden_0.pdf)>.