Inquiry by the Auditor-General into Out of Home Care, Tasmania

2011 – 2012

Details

The Inquiry by the Auditor-General into Out of Home Care began in 20011 and reported in 2012. Its purpose was to find out whether out of home care offered effective child protection. The Auditor-General recommended better documentation, support and training of carers, and more planning for children and young people's transition out of state care.

The Report was entitled *Report of the Auditor General: Children in out of home care*. In the letter attached it, the Auditor-General described its purpose as to: 'express an opinion on the effectiveness of out-of-home care as an element of child protection'.

The Auditor-General found that the child protection system had implemented the cheaper recommendations of earlier reports but that the most 'costly and substantial' ones were delayed, probably until more funding was available. The Auditor-General commented:

> *We are usually reluctant to recommend specific funding on the grounds that an increase in one area inevitably results in a decrease in another. Such prioritisation is the province of government, not of auditors-general. Nevertheless it needs to be recognised that OoHC is an area in which a short-term saving can lead to much greater long-term social, health and financial costs. This is particularly relevant to the need to improve system access and support for carers.*

The Auditor-General found that although the child protection service did not deal with notifications of child neglect and abuse as quickly as their own timeframes required, it did address the most urgent ones on time. Children did not appear to be in danger because of delays.

The overwhelming criticism made by the Report was that child protection services kept poor records. This made it difficult to carry out the inquiry. At times, the Auditor-General could not tell whether deficiencies were due to lack of documentation or poor performance.

The Report focused on four main areas. These were: whether or not children were in the right placements; how well the child protection service managed carers; the active monitoring of placements; and the process for children's transition out of state care.

Regarding the placements, the Auditor-General found that it was impossible to tell whether or not there was a shortage of carers because, in an emergency, one was always found. However, this meant that children and carers were not properly matched. There was not enough documentation to show how many children were in multiple placements because of poor matching. In addition, there were not enough resources to train carers, children's physical, developmental, psychosocial, and mental health levels were not properly assessed, and case

files tended to deal with the present rather than the long-term needs of the child.

Child protection services did a good job of recruiting and assessing carers but did not give them enough support or training, for instance in therapeutic care. Carers had practical difficulties getting to training in managing 'challenging' behaviour. There were not enough support workers per carer, insufficient visits, and annual reviews did not get done routinely.

Child protection workers were supposed to visit children in out of home care every six weeks but none of the children's files had an up to date summary of the visits. Less than 50 percent of them showed that enough visits had been made.

The Auditor-General could not find enough documented evidence that the risk factors that led to children becoming state wards had been sufficiently addressed before they returned to their families. Case files did not contain care leaving plans that dealt with problems in housing or financial management.

In summary, the Attorney-General recommended that:

- Documentation and making use of that documentation in every area of the child protection system be improved. As a basis for this the Child Protection Information System needed to be fully implemented. It should include all placement documents in a readily accessible format, the details of carers so that better placements could be made, and a summary of visits to children's placements so that compliance could be monitored. The Report suggested that all children's case files contain a needs assessment. Care and case plans would be used to 'structure' visits. Afterwards, they should be updated promptly on the basis of the visit instead of 'using an unstructured narrative'.
- The child protection service ensure that carers received adequate information about particular children, that they were paid extra for undertaking training courses, and that new carers were recruited specifically to provide respite. The service should find ways of giving carers more support, and of making sure that their annual reviews were done and recorded in the Child Protection Information Service. There ought to be 'cool off facilities' and a therapeutic foster care program so that suitably trained foster carers could receive accreditation.
- When children left state care there needed to be completed care plans. There also needed to be documented evidence that risks had been addressed, and that, in the words of the report, 'the views of the child have been heard and a safe return home is achievable'. Every young person over the age of 15 ought to have an approved leaving care plan.

More info

Related Entries

Related Events

- Select Committee on Child Protection, Tasmania (2010 - 2011)

Related Organisations

- Department of Health and Human Services, State of Tasmania (1998 - 2018)
  The Department of Health and Human Services ran the child protection system.
