Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

WITNESS STATEMENT OF STEPHEN JOHN KINMOND OAM

I, Stephen John Kinmond OAM of [redacted] in the State of New South Wales, Chief Executive Officer of Association of Children's Welfare Agencies, do solemnly and sincerely declare that:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND AND QUALIFICATIONS

2. I am currently the Chief Executive Officer (CEO) of the Association of Children's Welfare Agencies (**ACWA**), a leading non-government peak body for the NSW child and family sector. ACWA works closely with our members, other community service sector peaks, and a broad range of government and non-government stakeholders, to bring about reform that will achieve better outcomes for children, young people families and communities, particularly those who are most vulnerable. Moreover, ACWA also delivers training that is focused on strengthening the skills and capacity of the child and family sector workforce to deliver quality services to children, young people, and families in need.

3. Prior to my appointment as the CEO of the ACWA, I was the NSW Community & Disability Services Commissioner and NSW Deputy Ombudsman (Human Services) for 15 years. Before that, I was the NSW Assistant Ombudsman (Police) for eight years. During my time at the NSW Ombudsman, I was involved with:

   (a) handling complaints about government and non-government community and disability services;

   (b) reviewing the deaths of people with disability and children;

   (c) providing oversight to agencies to appropriately respond to reportable incidents involving people with disability in supported accommodation and allegations of child abuse made against 'employees'; and

   (d) reviewing and promoting improvements in community and disability services.

4. I have close to 30 years of investigative experience and have also worked as a solicitor and run my own consultancy practice.

5. I have the following qualifications:

(a)	Bachelor of Arts	(University of NSW)
(b)	Diploma of Education	(Sydney Teachers College)
(c)	Diploma of Criminology	(Sydney University)
(d)	Bachelor of Laws	(University of NSW)
(e)	Diploma of Legal Practice	(College of Law)

6. Attached to this statement marked **SK-1** is a copy of my curriculum vitae.

REPORTABLE CONDUCT SCHEME IN NSW

7. In May 1999, a reportable conduct scheme was established in NSW (**NSW Scheme**) pursuant to Part 3A of the *Ombudsman Act 1974* (NSW). The NSW Ombudsman (**Ombudsman**) was responsible for overseeing the handling of child abuse and neglect allegations that were made against employees of more than 7,000 government and non-government agencies. In this respect, it was charged with both responding directly to allegations of abuse, but also providing monitoring and oversight of investigations carried out by a designated government or non-government agency.

8. From 1 March 2020, the NSW Scheme has been administered by the Office of the Children's Guardian (**OCG**) under the *Children's Guardian Act 2019* (NSW). I had advocated for this change to assist in centralising safeguarding initiatives.

9. In this statement, my references to the NSW Scheme mean the scheme as administered by the Ombudsman, unless otherwise stated.

10. In 2010, I was appointed to lead the Employment-Related Child Protection Division (**ERCPD**) which had responsibility over the NSW Scheme.

11. The Ombudsman made a number of submissions to the Royal Commission into Institutional Responses to Child Sexual Abuse (**National Royal Commission**) in relation to the NSW Scheme and reportable conduct schemes more generally. I refer to and adopt two of these submissions:

    (a) attached to my statement and marked **SK-2** is part of the Ombudsman's Statement to the National Royal Commission which

broadly sets out the Ombudsman's role in the reportable conduct scheme as it operated at the time, including our approach to information sharing and disclosure.

(b) attached to my statement and marked **SK-3** is a copy of the Ombudsman's response to Consultation Paper on best practice principles in responding to complaints of child sexual abuse in institutional contexts dated 6 May 2016. This response broadly sets out the Ombudsman's role in the reportable conduct scheme as it operated at the time, as well as its education and training role.

12. In my view, any integrity body must have strong institutional independence, as well as powers and resourcing sufficient to carry out their statutory functions. Without powers and resourcing, then the aims of an integrity body are likely to go largely unrealised.

13. In my experience, an effective reportable conduct scheme, as an example of a particular kind of integrity body needs to have some or all of the following features:

(a) direct electronic access to critical risk information held by the relevant authorities and regulators. In the case of NSW, that meant the NSW Police Force (**COPS database**); Family and Community Services **(KiDS database**) and the OCG (**Carers Register**) (discussed in paragraph 16, below);

(b) robust legislation which provides for the transfer of information between agencies that have responsibilities relating to the safety, welfare or well-being of children and young people. In NSW, this was provided through by the information exchange provisions in Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (**CYP Act**) (discussed in paragraphs 19 to 21, below);

(c) a mechanism for a 'Notification of Concern' function, permitting an 'interim bar' to be sought in respect of an employee where there is a 'real and appreciable risk to the safety of children during the course of an investigation', similar to the mechanism contained in Schedule 1, Clause 2A of the *Child Protection (Working with Children) Act 2012* (**WWC Act**) (discussed in paragraphs 22 to 25, below); and

(d) a process for 'Class or kind' determinations, which permit specific entities that have been assessed as having proper investigative structures in place, to not have to notify the Ombudsman of certain less serious matters. However, their handling of these matters could still be the subject of Ombudsman oversight and audit, if the Ombudsman deemed this necessary (discussed in paragraphs 27 to 29, below).

14. In addition, it is important to consistently assess and evaluate the operation of oversight bodies and to that end, it is important that a mechanism is put in place to capture data about the kinds of complaints or referrals that are received, what sectors they are in, and the outcomes from significant actions taken (including investigative action). In my view, strong data collection is also an important tool to inform risk-based regulation.

15. I have described below, at a high level, the way in which these features were included in the NSW context.

Direct access to databases

16. There are a range of agencies tasked with investigating different aspects of conduct that relate to children, or to people who have contact with children. In the NSW context, the Ombudsman had direct access to COPS and KiDS databases, and the Carers Register.

17. In my experience, the Ombudsman's access to these databases enabled us to gain critical insights into risks relating to individuals that were the subject of allegations, that would not otherwise have been known to us.

18. Another benefit of direct access to these databases was that it enabled the Ombudsman to identify intra and inter agency practice weaknesses - for example, where agencies did not proactively share information. This allowed us to take action to ensure that critical risk related information was shared in individual cases, as well as recommending, and/or providing, additional training or support for those agencies and sectors where we had identified weaknesses in their intra or inter agency sharing practice.

Information exchange

19. The NSW Scheme had the benefit of Chapter 16A of the CYP Act, which provides significant scope for the Ombudsman and other prescribed bodies to proactively share risk-related information to promote the safety, welfare, and wellbeing of children.

20. The existence of a legislative power to permit the exchange of information operated (among other things) to overcome agencies concerns about breaching individuals' "privacy" and allowed the Ombudsman to provide information to the Carer's Register to assist the Children's Guardian in developing profiles of individuals who potentially posed a risk to children. In this regard, information was routinely provided by my office to the OCG under Chapter 16A to inform its administration of the Working with Children's Check (**WWCC**) system.

21. Further, the Ombudsman regularly referred matters to the police for investigation, some of which resulted in further investigation and prosecution.

Notification of concerns

22. Another important feature of the NSW Scheme was the ability for the Ombudsman to make a 'notification of concern' to the Children's Guardian under Schedule 1, Clause 2A of WWC Act.

23. We were able to make a notification of concern to the Children's Guardian if we formed the view, arising from the receipt of information in the course of exercising our functions, that "*on a risk assessment by the Children's Guardian, the Children's Guardian may be satisfied that the person poses a risk to the safety of children*". The Children's Guardian was then responsible for considering and applying that information having regard to their statutory obligations – including deciding whether to permit certain persons to engage in work with children.

24. It is important to note that this clause was not limited to matters arising from the exercise of our functions under Part 3A. If sufficient concerns arose from information which we received from exercising any of our wide-ranging functions, we could refer the matter to the Children's Guardian.

25. I took the view that an Ombudsman's Office should err on the side of disclosure, given the importance of ensuring the Office of the Children's Guardian was provided with relevant risk related information to carry out their functions. My approach was always to think about what the community's views would be on a failure to act in a particular situation, including failing to provide information that indicated an individual may pose a risk to children. I find this to be a simple but helpful test.

26. Notifications of concern triggered a risk assessment by the Children's Guardian in relation to whether the relevant individual poses a risk to children for the purposes of their suitability to work with children. Through our work in assisting the Guardian to exercise this function, we helped the Guardian in identifying individuals of concern whose histories would not have otherwise been identified by the WWCC processes.

Class or kind determinations

27. It was my observation that over time, many of the agencies we oversaw increased their competency in handling reportable allegations. This meant that they became accustomed to the kinds of matters which were reported, and the way in which they ought to be investigated. As a result, the Ombudsman was able to develop a more streamlined, outcome-focussed approach to the oversight of agencies' investigations.

28. One part of the more streamlined approach was to enter into individual agency and sector-wide class and kind determinations which exempted agencies from having to notify us of less serious forms of alleged reportable conduct. These determinations were based on the agency / sectors having demonstrated their ability to appropriately respond to reportable allegations. Determinations of this kind were called "class or kind" determinations. However, organisations and sectors about which such determinations were made remained subject to review and audit by my office, and a determination could be revoked at any time.

29. The benefit of "class or kind" determination is to substantially reduce the volume of notifications received each year, allowing us to concentrate our efforts on improving our analysis of, and response to, serious reportable conduct matters through:

(a) repositioning our strategic focus towards more active monitoring of more serious, higher risk allegations;

(b) increasing the proportion of investigators who were appointed to senior roles in our ERCPD; and

(c) increasing the level of practical support and scrutiny that we were able to provide to agencies responding to allegations of serious reportable conduct.

In summary, effective oversight of a reportable conduct scheme not only requires the oversight body to respond appropriately to individual notifications, it also requires the oversight body to be active in educating agencies to set up systems and processes that are consistent with best practice in this area of work (including in relation to agencies' identification of matters, reporting and investigative processes, and in connection with their capacity to proactively identifying and respond to risks).

Additional features of reportable conduct schemes

30. I support the recommendations of the National Royal Commission in relation to the implementation of reportable conduct schemes in all jurisdictions.

31. In my experience, in addition to the structural features of a reportable conduct scheme set out above, there are a number of additional factors which I consider contribute to the success of the scheme. I have set out below what I consider to be some of the most significant factors..

Proactive oversight

32. The oversight body of a reportable conduct scheme ought to be independent of government and of the institutions whose operations it monitors.

33. In practical terms, the oversight body must scrutinise agencies' systems through proactive oversight and ongoing monitoring of reportable conduct matters. This means that in addition to responding to notifications, it ought to be active in educating agencies to set up systems and processes that are consistent with best practice in this area, including in relation to identifying, consistently reporting, and taking proactive steps in relation to responding to risks.

34. For example, if a particular agency or sector has demonstrated low reporting rates, it is important for the oversight body to take timely action. Indeed, for the NSW Scheme, the Ombudsman's ability to undertake auditing activities was a critical function in assisting an agency to improve its systems and practices for providing safe environments for children in its care. Audits could be carried out randomly, or where an individual case necessitated a broader examination of an agency's practices, and where there appeared to be a need based on statistics coming out of a particular sector. In terms of exercising its functions, comprehensive data collection and analysis is important to the exercise of the oversight role.

Information sharing and access to databases

35. It is important for the oversight body to take an active role in ensuring that relevant information is shared with appropriate parties and acted on accordingly. In my view, there is no point in having a reportable conduct scheme if the oversight body does not share the information with other agencies or bodies that need to receive it. The oversight body must bring agencies together and ensure that critical information is provided, understood, and actioned.

36. Where there are issues involving an individual, or important issues pertaining to the quality of service of an agency, the oversight body needs to ensure that this information is provided to those who need to know about it.

37. However, the information sharing process needs to be simple. The oversight body should not have to refer to a decision-making tree in order to determine whether it can exchange information with other entities. It needs to have broad information sharing powers.

38. Further, these information sharing powers must be supplemented by direct access to databases of police departments, community services and child protection agencies in order for the oversight body to obtain a holistic understanding of the prevailing risks in particular matters and to better inform the assessment of any action that may be required.

Intersection with other agencies

39. In addition to information sharing and access to databases, a reportable conduct scheme must provide mechanisms for greater interagency collaboration in relation to reportable conduct matters.

40. In the context of WWCC, I agree with the National Royal Commission's recommendation that the body dealing with WWCC must be informed by the reportable conduct scheme. Put simply, the effectiveness of the WWCC scheme relies in part, on the WWCC body being apprised of relevant information pertaining to various individual's suitability to work with children. On this issue, a well-functioning reportable conduct scheme will obtain very valuable information which needs to be known and assessed by the regulatory agency with responsibility for the working with children check scheme.

41. In my view, it is also advantageous for the oversight body to routinely engage with police in relation to significant reportable conduct matters. This is particularly important when reporting agencies are less experienced in handling reportable conduct and interacting with police, as the oversight body will be able to play an active role in facilitating police/agency contact and in briefing police on relevant holdings and possible avenues of inquiry.

42. For the NSW Scheme, the Ombudsman reached an agreement with the NSW Police Commissioner in 2009 on a set of Standard Operating Procedures (**SOPs**) which outlined the responsibilities of local police in providing practical support to agencies responding to allegations of reportable conduct.

43. In my view, SOPs ought to be established with police as part of a reportable conduct scheme. In addition to providing clarity around when and how information should be exchanged, it also promotes ongoing dialogue with the police force and an exchange of expertise and knowledge.

Capacity building functions

44. Reportable conduct schemes should provide for capacity building and practice development, through the provision of training, education, and guidance to agencies within the scheme. If this element is lacking, it will lead to low-quality reporting that can undermine the system.

45. While providing training is important, it is the day-to-day training that is critical. In this regard, the NSW Ombudsman employed a range of strategies to raise awareness and knowledge of the NSW Scheme, including:

    (a) holding regular meetings with agencies and sectors to discuss emerging issues;

    (b) hosting information forums for agencies that are part of the scheme; and

    (c) supporting agencies through direct engagement in both individual cases and related system issues.

46. My experience in the NSW Scheme has been that smaller agencies at times lacked the required depth of knowledge and expertise to handle serious reportable allegations. This made it more important for these agencies to have consistent training and monitoring to assist in raising their levels of knowledge and expertise.

Challenges for reportable conduct schemes

47. There are a number of challenges for reportable conduct schemes, including:

    (a) identifying the appropriate threshold for reportable conduct;

    (b) identifying the type of information that can be exchanged; and

    (c) bringing about the type of cultural change required to make a scheme effective.

The Threshold for Reportable Conduct

48. In the NSW Scheme, the obligation to report arises when an allegation is made which 'may' involve 'reportable conduct'. Reportable conduct was relevantly defined to include:

    (a) a sexual offence;

    (b) sexual misconduct;

    (c) ill-treatment of a child;

    (d) neglect of a child;

    (e) an assault against a child;

(f) an offence under s 43B (failure to protect) or s 316A (failure to report) of the *Crimes Act 1900* (NSW); and

(g) behaviour that causes significant emotional or psychological harm to a child.

49. Sexual misconduct includes grooming conduct in some circumstances and was a matter about which I took a broad and expansive view.

50. This approach recognises that we often do not know at the time when a matter first comes to light, whether it involves reportable conduct - therefore, the threshold for reporting is only if a matter *may* involve reportable conduct.

51. I believe it is important to recognise that the threshold for taking action must be different to the threshold required to sustain a finding in a criminal matter. This need to proactively identify and respond to risk is vital to ensuring that we can take appropriate risk management action for the safety of children.

52. Nevertheless, whether or not an allegation should be reported requires a thorough and well-informed assessment. Educating agencies in this area requires significant educative work, to ensure that non-trivial matters which align with the above categories are reported (and to avoid over reporting of matters that don't require independent scrutiny).

53. Where a body failed to carry out investigations appropriately, then the Ombudsman could require the head of the agency or any officer involved in the investigation, to provide such additional information as the Ombudsman considers necessary. If the Ombudsman concluded that the investigation carried out by the organisation was inadequate, the Ombudsman could report its findings, recommending that the conduct be reconsidered, and that appropriate action be taken. However, in the vast majority of cases, the Ombudsman did not need to resort to a formal report along these lines, because agencies under the reportable conduct scheme, were generally very willing to work cooperatively with the Ombudsman in addressing any shortcomings in their handling of a matter.

Exchange of information

54. In my view, an oversight body needs to carefully assess the information it gathers and form a view as to whether certain information should be exchanged to other bodies (these are described in the NSW legislation) consistent with promoting the safety, welfare, and wellbeing of a child (or class of children). There can be challenges in determining whether the information should be exchanged, including the need to carefully assess the nature and quality of the information on hand. In this regard, it is important that reportable conduct schemes should not involve the circulation of information beyond what is required and permitted under legislation. Good information practice also requires a cultural commitment to child protection - this is discussed below.

Cultural change

55. Reportable conduct schemes require institutions to be vigilant. To be effective, there must be strong cultural change across the entire system that is concerned with the provision of services to children. An oversight body needs to be proactive in utilising its powers and encourage a community of practice where every participant understands that they have a responsibility to take action. Apart from anything else, the oversight body must have the technical expertise and capability to administer the reportable conduct scheme.

56. There needs to be people at the agency level who can identify risks and are willing to pursue evidence until they are satisfied they have done the best they can do in light of the information available to them.

57. Agencies also have to believe that what they are doing is making a difference. This means that oversight body must actively be value-adding to the work being done by the agencies and reinforcing the significance of their role.

58. A significant barrier to an effective scheme is a cultural reluctance to report misconduct, or a fear of reprisals if a report is made. It is critical that people who engage with the reportable conduct scheme are protected from adverse action, and for the oversight body to take steps to actively identify any sign of potential reprisals. One way of doing this is by a public interest disclosure scheme – often referred to as whistle-blower protection. Such a scheme must be simple and accessible and have a high degree of certainty for the person coming forward that they will be protected.

59. In the NSW context, we undertook the following steps to overcome a cultural reluctance to report and exchange risk related information:

- we would often identify low reporting from our analysis of relevant data holdings;
- we would also identify a failure to report critical risk related information from our active oversight of particular cases;
- when we identified evidence suggesting poor practice in these areas, we worked with the involved agencies on developing strategies to enhance practice (including but not limited to directly participating in training the staff of these agencies regarding their reporting and/or information exchange obligations)
- we were also approached by agencies regarding their desire to ensure that their staff and relevant volunteers understood and complied with their reporting and/or information exchange responsibilities and we actively worked with them in response; and
- finally, through modelling proactive information exchange in our own practice, this sent a very clear message across the various sectors we worked with, of our 'collective responsibility' to share information, within and across agencies, to promote the safety, welfare, and wellbeing of children.

Dual function regulation

60. Following a decision by the Ombudsman in 2010 to integrate our ERCPD oversight and our community services monitoring and review role, we were able to better identify, and seek to address, a range of systems issues impacting on the broader child protection system.

61. I have a flexible view regarding the way a reportable conduct scheme could be introduced in Tasmania. If a reportable conduct scheme is established in Tasmania, there are a range of options which could be employed. It will be important for Tasmania to identify the option that will work best for its State.

62. This is linked to the issue of resourcing. One of the benefits of an oversight model like the reportable conduct scheme in NSW, is that it provides for both direct investigative action (and other types of direct interventions in individual cases), as well as also having strong systemic oversight and reform capabilities. On a related note, if the oversight body can assist involved organisations and sectors within its jurisdiction to put in place high quality investigative and monitoring processes, then it can substantially increase its overall effectiveness.

63. In the early years of a scheme, when a proactive approach is particularly important, it is necessary for the oversight body to be funded in a way that

permits it to engage proactively in the community, and to educate the organisations in its jurisdiction.

I make this solemn declaration under the *Oaths Act 2001* (Tas).

Declared at [redacted]
on 29 March 2022.

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Stephen John Kinmond

Before me

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[redacted]