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

WITNESS STATEMENT OF RACHEL MARNI HALES

I, Rachel Marni Hales of [redacted] in the State of Tasmania, Operations Manager, and [redacted] 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.

2. I make this statement on the basis that its contents can be made public. I am happy for the Commission to use its contents as evidence or in the final report.

3. I make this statement on behalf of Baptcare. I am not in any way speaking on behalf of the Department of Communities Tasmania (**Department**).

BACKGROUND

4. I am employed by Baptcare which is a non-governmental agency which provides Family and Community Services, Mental Health services, National Disability Insurance Scheme (**NDIS**) Disability Support services, and Aged Care services.

5. One of the roles of Baptcare is to operate and manage the Department's Strong Families, Safe Kids Advice and Referral Line (**ARL**), alongside Mission Australia and Department employees.

6. My role in the ARL at the time of this statement is Acting Operations Manager and my responsibilities are to oversee Baptcare's Family and Community Services programs for Tasmania. My substantive role is NGO Manager for the ARL, overseeing the non-government teams in partnership with the ARL Manager.

7. Attached to this statement and marked **RH-1** is a copy of my curriculum vitae.

THE PURPOSE OF THE ARL

8. I understand that the purpose of the ARL is to provide one intake system for all concerns about a child's wellbeing and safety. The primary function of ARL is to ensure children and families are provided with the right support to meet their needs, and that relevant matters are reported to the right people such as Child Safety Services (CSS) and police. One of the aims of the ARL is to ensure that only suitable matters are referred to CSS and all other matters are dealt with in

the community through early intervention. The ARL service is available to all Tasmanians who have concerns about children, including health and teaching professionals. When someone contacts the ARL, a conversation is opened – this language has replaced the previous term of "notification." The "notifier" is called the initial contact.

9. The advice service provided by the ARL, is designed to give advice to people that may have concerns but do not know what to do. Usually, our advice will be about the person's obligations as a prescribed person under the *Children Young Persons and Their Families Act 1997* (Tas) for the purpose of mandatory reporting (if applicable), how to open a new conversation with the ARL, what happens when a contact is made into ARL, and what supports are available to the family they are contacting about. The aim of the advice is to ensure the person calling has the skills to take the next steps in terms of opening a conversation with ARL or supporting the family at a community level.

10. Our referral service is provided to people who contact ARL with concerns about a child's safety and wellbeing that can be managed through referral to a universal support such as Family Support, or that require a referral to CSS or police for further investigation.

11. Upon receiving a contact, the ARL worker obtains the name of the initial contact, their role with the child or family, and details about the child and their family. They also obtain detail of what the concern is and what the initial contact would like to have happen. The ARL staff will then decide whether to refer the matter to another organisation (including Child Safety Services), support service, work with the family short term to determine the right next steps or close the matter. The decision is based on the type of concern and the immediate risk to the child. This process is discussed in more detail below.

THE STRUCTURE OF ARL

12. The Department is responsible for managing and operating the ARL. However, the ARL workforce is made up of Baptcare, Mission Australia and Department staff. The ARL consists of ARL workers who respond to incoming contacts about families, Practice Leaders, Practice Managers, and a state-wide team of Liaison Officers composed of NGO and Department staff.

13. The ARL workers and leaders are based in Hobart and are responsible for operating the phone line and responding to online contacts. There are six ARL teams. Each team consists of approximately six ARL workers and one Practice Leader. Of these six teams, one is made up of Baptcare staff, one is Mission Australia staff and the remaining four are Department staff. Above the Practice Leaders are Practice Managers who are the clinical leads. Practice Managers are Department staff, and each Practice Manager is responsible for two teams. They report to a Principal Practice Manager who sits within the Department but not exclusively with ARL. The NGO Manager oversees the Baptcare and Mission Australia ARL workers, Practice Leaders, and Community Liaison Officers, and overseeing the entire ARL is the State-wide Manager who is from the Department. Baptcare and Mission Australia Operations Managers sit on the Senior Managers Operations Group and meet bi-monthly with the State-wide Manager, NGO Manager, Principle Practice Manager, and Director of Child Safety Services to discuss high level operational matters.

14. The ARL have 12 Community Liaison Officers that sit at the leadership level, across Baptcare, Mission Australia and Department. They are co-located at regional offices across Tasmania, five in Hobart, three in Launceston, two in Devonport, and two in Burnie. They offer face to face services and are the contact for referrals to regional family support services. The Liaison Officers also provide community education. Their involvement with the family is usually short term and they are used to attend home visits where this is required to gather further information, or a family are more comfortable speaking with someone face to face.

15. In addition to the Community Liaison Officers, the ARL also has a Family Violence Liaison Officer, a specialist Youth Liaison Officer, three Regional Hospital Liaison Officers and three Aboriginal Liaison Officers.

TRAINING AND PROCEDURES

16. The Baptcare staff must have a minimum qualification of a bachelor's degree in social work, psychology or equivalent Diploma that includes case management and case practice units and supervised practical work placements in a relevant field to be considered for a role with the ARL. This is the same for Mission Australia and Department staff.

17. Once recruited, all staff (regardless of employer) are required to sign confidentiality and privacy documentation to allow them to work within the government setting. They undertake induction, training, and supervision. This process takes several months. The training involves modules training and face to face training and includes specific training on the ARL model, and frameworks such as the Tasmanian Risk Framework and risk assessment, and Signs of Safety. This face-to-face training runs for 10 – 15 days and is delivered at different times of the year. Induction includes the new employee shadowing an experienced Worker for the first 4 weeks, then the new employee is put on the phones with supervision by a senior ARL Worker or their Practice Leader for the first few calls. The layout of the open plan office means that in each "pod" area there is a spread of new workers, experienced workers, Practice Leaders and Practice Managers which supports practice monitoring and development and allows for "live supervision" by Practice Leaders with their staff when they are taking calls.

18. All staff are provided the same package of induction and training materials when they commence, regardless of whether they are employed by Baptcare, Mission Australia or the Department. The training modules provided to each of the Workers as part of their induction have already been provided to the Commission by the Department.

19. All staff are regularly reviewed during their probation period and their progress monitored over a period of three to six months.

20. Practice Leaders provide their staff ongoing fortnightly supervision, part of which is to review each staff member's outstanding matters and assess what needs to be prioritised. Practice Managers also provide continual professional development training to ensure that the best practices are being used by all staff.

21. All staff must comply with the various Departmental policies, procedures, manuals, and other practice guidance when receiving a report, assessing a report, dealing with families, notifying other organisations, and referring matters, including:

    (a) Recording and responding to new contacts about the safety and wellbeing of children.

(b) Managing Contact to the Advice and Referral Line

(c) Reporting Concerns about Safety and Wellbeing of Children and Young People

(d) Risk and Safety Assessment

(e) Other Policies and Procedures as deemed appropriate

INFORMATION SYSTEMS

22. All contacts into the ARL are logged in our Children's Advice and Referral Digital Interface (**CARDI**) system. This is the information system used by ARL. We record the initial contact's details, the child, and family's details (if known) and a summary of concerns. The CARDI entry allows us to record an overview of the conversation in the summary box and what is referred to as the three boxes, which are based on the Signs of Safety framework: what are the concerns, what is working well and what does the reporter think needs to happen next. CARDI also has a section for case notes, but the details page with the three boxes is a live document that is updated as the conversation progresses, and at closure gives a full overview of the conversation. These entries are saved and are retrievable should further concerns be raised about the child later.

23. We also record any referrals made, and case notes will contain any communications had with families, professionals, schools, other services involved with the family and child and with the reporter.

24. If there is no identified risk to a child and a matter only requires referral to a universal service or the provision of advice all the information remains in the CARDI system. If a referral is made to CSS the information will move to the Child Protection Information System (**CPIS**) system, which is the CSS specific system. ARL would also transfer a matter to CPIS and work on it in this system in situations where there is evidence of actual abuse or risk of abuse to a child.

THE RISK ASSESSMENT AND REFERRAL PROCESS

25. Any person in the community can open a conversation about a child through either the ARL phone line or the online form. The phone line operates Monday to Friday 8:30am to 5:00pm. If a person calls after hours, they will be put through to CSS After Hours service. If a person uses the online form out of

hours, it will be dealt with the next morning when the ARL services open. This means that if a person lodges their concern using the online form, it will be attended to when the office is open again.

26. Once a contact is made to the ARL, the ARL Worker will conduct an initial assessment in relation to wellbeing and safety of the child/children, guided by the Tasmanian Risk Framework (TRF), the Signs of Safety Framework, and the Tasmanian Wellbeing Framework. The CARDI details page is designed around components of the Signs of Safety Framework, with the three boxes outlining what the worries are, what is working well, and what needs to happen next. The TRF and Wellbeing Framework guide all decision making around whether there is current or future risk present for a child; these are not built into the CARDI system but are tools to inform decision making, available as part of ARL practice guidelines. The Wellbeing Domains are built into the referral form for Integrated Family Support Service, Youth Support, and Informal Kinship. If risk is identified and the matter is transferred into the CPIS system, here the TRF is built in and is completed in full before closure or referral to CSS.

27. The guiding framework at this initial assessment is the Tasmanian Risk Framework. As above, the TRF is built into the CPIS system. Once completed, a risk matrix is used to manually assign a risk rating based on risk factors, protective factors, and the probability of future risk. This is then reviewed by the Practice Leader before they authorise closure.

28. The Tasmanian Risk Framework, the Signs of Safety Framework, and the Tasmanian Wellbeing Framework have already been provided to the Commission by the Department. There are various policies, procedures and manuals that assist staff in using these frameworks to make an assessment.

29. An assessment of risk will usually be done in consultation with a Practice Leader, either during a call or following the call. However, an experienced ARL Worker will know whether there is evidence of risk and refer to the matter to the CSS by moving the report from the CARDI system to the CPIS system. In the CARDI system, evidence of risk is guided by the frameworks, and if a matter is transferred to CPIS a full initial assessment is completed using the built-in TRF. Risk is assessed in an ongoing manner as additional information is gained during the initial assessment (In CARDI). Risk is assessed more comprehensively in CPIS with CARDI used for wellbeing assessment only. If

the staff member's immediate Practice Leader is unavailable, they will ask another Practice Leader on the floor. A matter will be escalated to the Practice Manager if it is complex. We also have a process called Weekly Review Meeting where complex matters can be referred and discussed each week, chaired by either the State Manager or the NGO Manager and including representation from Practice Leaders, Practice Managers, and sometimes professionals who are working with the family. Examples of the kind of complexity that lead to escalation in this way include:

(a) Cases where there is incongruent information received from differing sources such as a family member reporting concerns for children but professional stakeholders who engage with the children regularly have limited or no concerns.

(b) Cases where there has been highlighted potential immediate risk and clear processes on next steps is required to ensure safety is maintained and an appropriate response is actioned effectively.

(c) Matters where there is a differing opinion on what the best next step may be.

30. The assessment of potential risk to the child which is carried out by the ARL worker in concert with the Practice Leader will determine what occurs with the report. If the risk is only applicable to one child in a family, they will be identified in the report as the subject child. If the risk is toward multiple or all children in the home, they will all be selected as a subject child. In a situation where there is a Person Believed Responsible who may pose risk to many children in the community, we would be assessing the known children and referring to police regarding those children and identifying the broader risk. Broadly speaking the possible outcomes are as follows:

(a) If, in the view of both the ARL worker and the Practice Leader, there is no risk to the child, or the call is for advice only, then the report will be closed straight away.

(b) If there appears to be some risk to the safety or wellbeing of a child, but it is not an immediate risk, the ARL Worker would review historical information on the family and gather further information from the family, professionals, schools, and services to determine the risk level

and need for further intervention or support. If, on consideration of this information it appears the family needs supports they will be referred to the appropriate universal service to meet their needs and the report closed. If this information shows actual or potential future risk that requires further assessment, or that the risk has escalated to an immediate risk the matter will be referred to CSS.

(c) If there is an immediate risk to the safety of a child, the matter will be referred to CSS within agreed timeframes. If there is any allegation that a crime may have been committed, a referral will also be made to Police. ARL do not need to substantiate a potential crime, they make these referrals based on the information that is presented.

31. The point at which a contact into ARL is referred to CSS depends on the immediacy of the risk, as assessed by the ARL worker and the Practice Leader. The risk will be assessed as priority 1, 2 or 3 within the Tasmanian Risk Framework. If the matter is a priority 1, defined by Child Safety as "a response is needed with 24 hours to secure safety and /or urgent liaison with other agencies such as police or health is required". The referral will be made by ARL to CSS on the same day, usually within hours. If it is assessed as priority 2, defined by Child Safety as "risk issues have been identified and a planned Child Safety Assessment should commence within 7 calendar days to establish the circumstances of the child and their family it will be referred from ARL to Child Safety within those timeframes. If the matter is assessed as a priority 3, defined by Child Safety as" identified risks to the child are not immediate, and a planned approach should be taken within 14 calendar days to respond to the concerns". It will be referred to CSS within 14 days. Practice Leaders must sign off on all referrals to CSS and police. Once referred there is a supported case handover between the ARL Worker, their Practice Leader, and the CSS regional Team Leader. CSS will then take responsibility for the report and what happens with it and ARL's involvement ceases. If a crime has been identified, a referral to police will also be made as part of the work done by ARL within the above timeframes.

32. The system does not alert staff when the timeframes are overdue, they are set and maintained as an agreed practice guideline which is adhered to by staff and Practice Leaders.

33. I believe that once ARL receive information relating to an allegation of a Person Believed Responsible (**PBR**) the case is transferred to the CPIS database. The CPIS database links to the Department of Justice data system to flag and inform requests for Working with Vulnerable Persons cards for the PBR.

34. The risk assessment done by the ARL is only an initial assessment to determine what should immediately happen to the report. It is not an assessment of whether the harm is substantiated. This type of assessment is carried out by the CSS later.

35. The ARL 'best practice' is to aim that all CARDI conversations are resolved within 2 weeks to ensure timely actions are completed and referred as appropriate. The Practice Leaders have oversight of their staff and what matters they have open. If matters remain open too long the Practice Leaders will consult with the staff member to ensure matters are appropriately referred and dealt with.

36. A matter is not finalised until the ARL worker has assessed the child is safe or the matter has been referred onto an appropriate service (e.g., Family Support, CSS or other). A matter cannot be closed until it has been reviewed by a Practice Leader. Best practice is that ARL will inform the initial contact person of what is happening, who is doing what and (if agreed), when the matter is closed. This is referred to as 'closing the loop' and happens at different parts of the process depending on preferences established with the initial contact in the initial call.

RESPONSE TO CHILD SEXUAL ABUSE IN AN INSTITUTIONAL SETTINGS

37. There should be no difference in process between a report of child sexual abuse in an institutional setting or a report of child sexual abuse outside an institutional setting.

38. If the ARL receives an allegation of child sexual abuse or harmful sexual behaviours occurring in an institutional setting, the Police will be notified and ARL will speak to the institution and determine who is best to speak to the family. The report would then go through the normal risk assessment process, focussing on the safety of the child. If it is determined it is likely actual abuse has occurred and/or there is immediate risk of abuse, the report will be referred to CSS. ARL does not substantiate abuse as such – this would sit with CSS

and police. If there is no immediate risk to the child and there is identified safety around the child, the ARL would close the report and the matter would be left to the institution and police to manage. Wherever there is a Person Believed Responsible, whether the matter is closed at ARL or referred on, this is recorded in CPIS.

39. If the ARL receives a report of child sexual abuse or harmful sexual behaviours in relation to a child in State care (Out of Home Care) the call is immediately transferred to the regional CSS office (preferably to the child's case worker). The ARL does not have any involvement in these reports. The regional CSS office are required to adhere to the MOU between Department of Communities and Tasmania Police and are therefore responsible for making a referral to police in this instance, as the key worker engaged with the family, therefore allowing for collaborative planning and management of risk more fluently. If the ARL receives a report for child sexual abuse for a child in Ashley Youth Detention Centre (who is not a current client of Child Safety) the ARL Worker would complete the Police Referral.

INFORMATION SHARING

40. The Department is responsible for the operation and management of the ARL. So, the information sharing protocols that apply to the Departmental staff also apply to Baptcare and Mission Australia staff.

41. However, the Baptcare and Mission Australia staff are currently refused access to information from other statutory bodies. For example, our staff do not have access to the Family Violence Management System (FVMS) held by Tasmania Police Service, the Safe at Home Information Management Systems (SIMS), or the national 'Connect for Safety' system. Information on these systems is needed to complete a comprehensive risk assessment of a child. The refusal to provide information can cause frustration and delay in dealing with matters. To work around this issue, Baptcare and Mission Australia staff must ask their Departmental colleagues to request the information for them. The information can be gathered in this way, but it does cause a delay in some instances.

42. I understand that the reason other statutory bodies are refusing Baptcare and Mission Australia staff access to information, is due to a misunderstanding of the ARL system and our role within it. They view NGO ARL staff as not having

the same role and privacy agreements as Department staff, when in fact we all undergo the same training and induction and undertake the same role, and NGO staff are contracted to do so by the Department. This may arise because, so far as I am aware, there is no other system like the ARL operating in any Australian jurisdiction. The ARL was designed and implemented as part of broader CSS reforms to improve outcomes for Tasmanian families and is based on a successful international model of service. It combined the old CSS intake service and the old Gateway Services run by Mission Australia and Baptcare. The benefits of having this central service with both Government and Non-Government staff is broader staff attraction and retention, shared knowledge and skills, clearer separation of the ARL from Child Safety Services which can encourage families to engage with us more readily, and a strengthened culture, In our three years of service we have seen a steady increase in contacts into the ARL, and a decrease in referrals to CSS due to earlier intervention for families and referrals to Universal supports. Those matters that are referred to CSS have high substantiation rates, demonstrating our assessments of what needs further investigation are correct.

WHAT COULD BE IMPROVED?

43. All statutory bodies need to provide access to information to ARL staff, regardless of whether the staff member is from the Department, Baptcare or Mission Australia. This may require educating statutory bodies of their obligations and the role of non-government bodies within the ARL system.

44. There needs to be a better understanding and use of the ARL service and mandatory reporting obligations. Our Community Liaison Officers provide community education, which usually includes information around what to expect when you call the ARL, how to handle the report, feedback loops, role of Community Liaison Officers and question time. Now produced and shown to me and marked **RH-2** is a copy of our current training presentation. Although this education is available, it appears that some institutions prefer to manage child risk internally and are not open to this education being provided or the associated changes in staff practice. The challenge is that institutions that don't engage with ARL are not easily identifiable due to their non-engagement with the service. If ARL Workers have concerns for a specific agency or institution, they will communicate this to the Liaison team (via the Liaison inbox) so there

is an awareness of the possible need of targeted community education. With the rise in NDIS providers across the state, this is another area of need, as there remains for General Practices (Doctors and other allied health professionals).

45. Although the ARL is managing its current resources, further investment would improve the service provided by the ARL, particularly as the number of reports is increasing. It would enable the service to continue the conversational style it has adopted. Long-term contracting of the NGO component of the service would also give staff stability and reduce the loss of skills.

46. A challenge we face with an increase in reports and complexity of reports, is that there is pressure on referral points. Although we may refer a child or family to a service there may be long wait times, particularly for children. This leads to a missed opportunity to respond promptly. Investment is needed in the wider family support and youth support sector, in homelessness, and in children's mental health supports. If these areas were better resourced, families would receive earlier intervention and prevent children entering institutional settings.

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

Declared at [redacted] in the State of Tasmania

on 29th April 2022

[redacted]

[Signature of witness]

[redacted]