2018

PARLIAMENTARY STANDING COMMITTEE OF PUBLIC ACCOUNTS

Report of the Auditor-General

Special Care Packages for Children in Out of Home Care

January 2018

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15 January 2018

The Hon Ivan Dean MLC
Chairman
Parliamentary Standing Committee of Public Accounts
Parliament House
HOBART

Dear Chairman

REPORT OF THE AUDITOR-GENERAL

Special Care Packages for Children in Out of Home Care

This report has been prepared consequent to an initial audit assessment conducted under section 25 of the *Audit Act 2008*, following your request that I consider undertaking a performance audit into compliance and service delivery of Out of Home Care provided to children in State care.

The objective of this initial assessment was to determine whether the delivery of Special Care Packages for children and young people through non-government provider arrangements warranted a full performance audit and, if so, the timing of that audit.

Yours sincerely

Rod Whitehead
Auditor-General

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EXECUTIVE SUMMARY

INTRODUCTION

A referral from the Parliamentary Standing Committee of Public Accounts (PAC) to undertake a performance audit into compliance and service delivery of Out of Home Care (OOHC) provided to children in State care was received by the Tasmanian Audit Office (the Office) on 3 August 2017. Under Section 25 of the *Audit Act 2008*, the Auditor-General may carry out any audit that PAC requests.

The PAC's referral was accepted for assessment by the Auditor-General and an assessor appointed on 31 August 2017. The assessment was conducted between 1 September 2017 and 10 November 2017.

The Auditor-General has determined that a report from the initial audit assessment be presented to PAC.

BACKGROUND TO REQUEST

The request from PAC was precipitated by concern expressed by a member of the PAC regarding the care of children in State care within Tasmania. This concern arose from matters raised in the ABC's 4 Corners "Broken Homes" program (the Program) that aired on 14 November 2016. The Program alleged private sector residential care providers were profiteering and not meeting their duty of care responsibilities.

The Program highlighted alarming situations for young people in OOHC across multiple States, including Tasmania. In Tasmania, a provider, Industry Education Networking Pty Ltd trading as Safe Pathways (Safe Pathways), was identified as allegedly running its residential care on a limited budget with inadequate placement of children into suitable accommodation, as well as deficiencies in staff recruitment, training, briefing and provision of required therapeutic care, such as counselling, for children under a Special Care Package (SCP).

At the date of preparation of this report, the Program was still available at: http://www.abc.net.au/4corners/broken-homes-promo/8012404.

PURPOSE OF THE INITIAL AUDIT ASSESSMENT

The purpose of the initial audit assessment was to determine the:

- established or stated audit or review requirements for OOHC service providers
- nature, timeliness and number of specific checks or audits undertaken
- outcomes of those checks/audits including number of reports made
- actions taken when reports were made.

In addition, the audit assessment was to look at payments made to external providers for OOHC SCPs.

These criteria are in line with those requested by PAC.

INITIAL AUDIT ASSESSMENT APPROACH

Our approach to the initial audit assessment included:

- examination of documents relevant to establishment of a Register of Approved Providers (the register) for SCPs for OOHC
- examination of previous reviews of OOHC SCPs and Safe Pathways
- analysis of the Department of Health and Human Services' (DHHS) responses to the above reviews
- interviews with relevant staff in:
    - DHHS Child and Youth Services (CYS)
    - DHHS Finance and Budget
    - DHHS Internal Audit
    - the Commissioner for Children and Young People (CCYP)[1]
- addressing matters specifically identified as detailed in the purpose of the initial audit assessment.

1. Interviews were held with then Commissioner Morrissey and relevant staff from his Office. Interim Commissioner Clements has provided comment on this report.

SUMMARY OF AUDIT ASSESSMENT FINDINGS

As noted by DHHS, regardless of the period of time children spend in OOHC services, the number of children currently in, and entering, OOHC is higher than the number of quality caring households and placements available and unless the numbers of children entering and remaining in care reduces substantially, this is not likely to change.[2]

DHHS undertook a major review of OOHC in 2014, resulting in a series of reforms. These included the agreement to implement the *National Standards for Out of Home Care*[3] (National Standards) and the introduction of SCPs. In 2015, a register to deliver SCPs was established through a Request for Proposals Process (RFP), with six providers selected. One of the selected providers was Safe Pathways.

Concerns were documented by the RFP selection panel about Safe Pathways' ability to deliver, given no current on the ground presence in Tasmania. In addition, a referee for Safe Pathways, while mostly positive about the provider, commented that DHHS should give attention to Safe Pathways' *'compliance with monitoring requirements'* and ensuring that all their staff have *'working with children checks'*.

In July 2017, a DHHS internal review of Safe Pathways:

- raised a number of administrative non-compliance matters including:
    - failing to obtain valid working with vulnerable people registration for all staff
    - poor staff recruitment and induction practices
    - inadequate staff training and support
    - case management and documentation matters
    - adequacy of complaints management processes
- concluded that, while there was *'…limited evidence the six children received care that was aligned to their therapeutic plans'*, no children in the care of Safe Pathways were harmed
- recommended the agreement with Safe Pathways be terminated.

The agreement with Safe Pathways was subsequently terminated on the grounds that working with vulnerable people registration was not obtained for all staff.

The review also found that DHHS could improve a number of its practices, including:

- monitoring of providers
- complaints processes
- child support officer and carer interactions
- governance of funding agreements.

Overall, the report contained nine recommendations covering:

- mandatory training for OOHC staff
- improved reporting between providers and DHHS
- creation of reference groups to help guide responses to issues facing the sector.

Other reviews undertaken by WLF Accounting & Advisory (WLF) and DHHS Internal Audit included detailed financial acquittals of each SCP managed by Safe Pathways and a review of each of the other providers on the register. The financial acquittal of each SCP managed by Safe Pathways resulted in a return of $842 903 of funds underspent by Safe Pathways on children in its care under SCPs. The reviews also identified SCP acquittals were not provided to DHHS due to the providers not setting up their systems to allow for acquittal by individual child/package of care.

In January 2017, the CCYP released a report following increased concern that Tasmania was the only jurisdiction in Australia that had not as yet established standards or other accountability mechanisms for the OOHC sector.[4] There were seven recommendations from the report which were intended to constructively offer a number of strategies and practical steps to improve outcomes for children in OOHC. The Tasmanian Government has accepted all seven recommendations and work on implementing them is now underway.

2. *'Positioning Statement: Response to Examinations and Investigations under section 23 of the Audit Act 2008 – Out of Home Care'*, DHHS, Office of the Deputy Secretary Children
3. *An outline of National Standards for out-of-home care*, Commonwealth Government 2011
4. This document can be found at: *http://www.childcomm.tas.gov.au/wp-content/uploads/2017/01/Children-and-Young-People-in-Out-of-Home-Care-in-Tasmania-Report-WEB.pdf*

DHHS has commenced addressing the issues raised in the Safe Pathways internal review. DHHS has developed and publicly released its Strategic Plan for Out of Home Care in Tasmania 2017-2019 and has also developed an Implementation Plan that specifies the tangible activities and deliverables against the Strategic Plan.

CONCLUSION FROM INITIAL AUDIT ASSESSMENT

Based on the evidence obtained during the course of our initial assessment, we concluded:

- there have already been a significant number of reviews on OOHC SCPs to date
- problems are known to DHHS and a performance audit at this point in time is unlikely to uncover new information
- DHHS has outlined a plan to make improvements which, if implemented properly, address the recommendations made across the various reviews
- DHHS be afforded time to implement planned reforms, with consideration of commencing a performance audit in 2018-19.

SUBMISSIONS AND COMMENTS RECEIVED

This report was provided to the Minister for Human Services, the Secretary of DHHS, and other persons who, in the opinion of the Auditor-General, had a special interest in the report, with a request for submissions or comments. Responses, or a fair summary of them, are included in Appendix One.

LEGISLATIVE CONTEXT

LEGISLATIVE FRAMEWORK

Child safety in Tasmania is mandated by the *Children, Young Persons and Their Families Act 1997* (the Act), the object of which is to:

1. … provide for the care and protection of children in a manner that –
    a. maximises a child's best interests; and
    b. recognises that a child's family is the preferred environment for his or her care and upbringing; and
    c. recognises that the responsibility for the protection of a child rests primarily with the child's parents and family.

Part 7 of the Act deals with 'Children under guardianship or in custody of secretary' and section 69 sets out the 'Powers and duties of Secretary in relation to children under guardianship or in custody of Secretary generally':

1. Subject to this Act, the Secretary may provide for the care of a child who is under the guardianship, or in the custody, of the Secretary under this Act or any other enactment in any one or more of the following ways –
    a. by placing the child, or permitting the child to remain, in the care of a guardian of the child or a member of the child's family;
    b. by placing the child in the care of any person or any body of persons, corporate or unincorporate, the Secretary considers suitable;
    c. by giving such directions as to the care of the child in the place in which the child resides as the Secretary considers appropriate;
    d. by making arrangements for the education of the child;
    e. by making arrangements (including admission to hospital) for the medical or dental examination or treatment of the child or for such other professional examination or treatment as may be necessary or desirable;
    f. by making such other provision for the care of the child (including financial assistance) as the Secretary considers appropriate.
2. In making provision for the care of a child, the Secretary must –
    a. consider the best interests of the child to be the paramount consideration; and
    b. have regard to the principles set out in Part 1A ; and
    c. make provision for the physical, intellectual, psychological and emotional development of the child; and
    d. have regard to the desirability of securing stable living arrangements for the child.
3. Unless the Secretary considers that it would not be in the best interests of a child to do so, the Secretary must –
    a. notify the guardians of the child about where the child is placed and the circumstances of the child as soon as reasonably practicable after the child is placed in the custody of the Secretary; and
    b. keep the guardians of the child informed about where the child is placed and how the child is being cared for.

CHILD SAFETY SERVICES

DHHS has a primary responsibility to deliver statutory child protection services in accordance with the Act. Child Safety Services (CSS) is within the CYS division, under the Deputy Secretary, Children.

CSS's activities, through its regionally-based teams of child safety officers (CSOs), include:

- receiving and responding to reports of concerns for a child's welfare
- undertaking investigations and assessments
- where necessary, seeking Court Orders which may place a child under the guardianship of the Secretary for a specified period
- making arrangements for placing a child in OOHC where required and ongoing case management.

Statutory OOHC responses are required where children and young people need to be protected from physical abuse, sexual abuse, emotional abuse, neglect or family violence.

Many children in OOHC can be safely and sustainably reunited with their families when their families receive appropriate supports and interventions and may spend only relatively short periods of time in OOHC. Others may need to be in OOHC for the longer term to ensure they are safe and well and to help them recover from their experiences of trauma, abuse and neglect.

OOHC REFORMS

DHHS undertook a major review of OOHC in 2014, resulting in a series of reforms.

Tasmania, along with all States and Territories, agreed to implement the National Standards. The National Standards focus on those *"children and young people whose care arrangements have been ordered by the Court, where the parental responsibility for the child or young person has been transferred to the Minister/Chief Executive."* [5]

The National Standards are designed to improve the outcomes and experiences for children and young people by focusing on the key areas within care that directly influence positive outcomes. These are:

- health
- education
- care planning
- connection to family
- culture and community
- transition from care
- training and support for carers
- belonging and identity
- safety, stability and security.

The National Standards also align with the aims of the CCYP.

DHHS advised that the National Standards will be implemented in 2018-19.

5. The system varies slightly state by state but, in this context, the Secretary of DHHS is taken to be the Chief Executive.

OUT OF HOME CARE MODEL

Service response

The model for the OOHC system places the child and their individual needs at the centre of all care-based decisions. The service response is designed to:

- provide a safe, nurturing environment for children and young people who can no longer remain at home
- provide an appropriate range of placement types and specialist programs to better meet the needs of different children and young people
- recognise carers who play a significant role in a child or young person's life and who may be volunteers or employees with a range of qualifications, skills and training for their role
- recognise the importance of stability planning (permanency options) in the development of children and young people
- provide robust placement matching and coordination components that minimise the potential for placement breakdown, and
- provide consistent high quality responses to children's needs.

DHHS advised the OOHC system is under pressure whereby demand for quality placements exceeds capacity.

The Office undertook a performance audit of '*Children in out-of-home care*' in September 2011. Data at that time revealed that the total number of children in OOHC was 893 in June 2010, compared with 576 in 2005. DHHS Internal Audit undertook a review in November 2016 on '*Visiting children in Out of Home Care*' which quoted the total population of such children sitting in the Child Protection system as 1082. Thus, the number of children in OOHC in Tasmania is growing.

DHHS further advised that regardless of the period of time children spend in OOHC services, the number of children currently in, and entering, OOHC is higher than the number of quality caring households and placements available and unless the numbers of children entering and remaining in care reduces substantially, this is not likely to change.

This highlights DHHS's situation in facing increasing demand with limited placements in an economic environment that confronts increases in costs each year.

Duration and type of OOHC placements

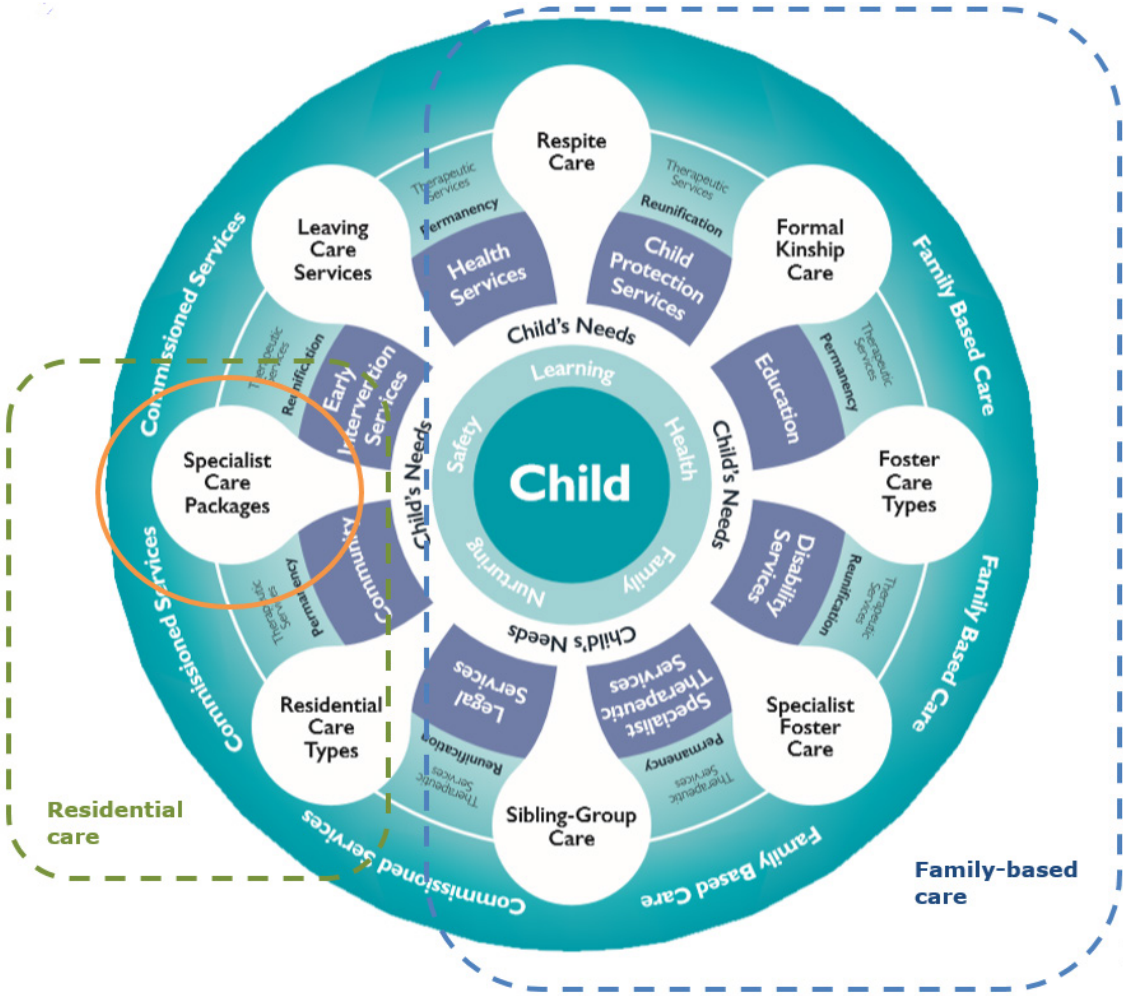
The current OOHC service system in Tasmania recognises two categories of care types applicable to children – family based care and residential care.

Within these care types it is recognised that placements are temporary rather than an end-point - that is, the placement is one possible option for care until reunification with their parents or permanency options are considered appropriate. The duration of care can therefore comprise:

- Short-term care for children while their family situation is assessed. The length of the stay can be from a few nights through to twelve months. At the end of short-term care the child may be reunified with their family or they may remain in care. Depending on the situation, carers who started caring for a child on a short-term basis may decide to offer long-term care.
- Long-term care for children who cannot return to live with their families and who need a stable, supportive placement in which they can live until the circumstances of their families change or they turn 18 years of age.
- Respite care for children for short periods of time on a regular basis, for example, one weekend a month. It provides families, including carers, a break from caring. Whenever possible, respite carers make a commitment of twelve months so that children can establish a regular routine and get to know the families with whom they usually stay.

Figure One illustrates the spectrum of care types available for children and young people in care.

Figure One – Care model for the new OOHC system



Source: adapted from 'Out of Home Care Reform in Tasmania', Children and Youth Services, 2014

Family based care is the preferred service model for OOHC and includes kinship care, foster care and supported family based care.

Residential care is provided to children or young people who have challenging behaviours or high support needs that cannot be addressed in a less intensive environment, that is, where home based care placements are not suitable.

Children requiring residential care support have been assessed as requiring specific, intensive or professional support because their needs are too complex to be managed in a home based environment with volunteer carers.

The aim of a residential care program is to provide young people with an appropriate and contained environment in which their behaviour can be managed and modified. The end goal of residential care is to reunify the young person with their family or transition them to a home based care placement.

SPECIAL CARE PACKAGES

INTRODUCTION OF SCPS

SCPs were a key part of the OOHC reforms launched by DHHS in June 2014. They are the most intensive care type and are designed to provide specific supports to children that are not available through other care options.

SCPs are delivered through individualised packages of support to a small number of children or young people on a 24-hour basis by paid support workers in a family-like home (for example, rented accommodation) where additional specialist support services or therapeutic interventions may also be provided for the child, the care team and to maintain placement stability.

From a funding perspective, SCPs represent a shift from block funding supplemented by invoicing to activity based funding for services provided under an approved provider arrangement by non-government providers.

As at 6 November 2017, 68 Tasmanian children were under SCPs but DHHS advised this number has been as high as 90 children in the previous 12 months, as changes in individual circumstances drive amendments to case and care plans.

SCP PROVIDERS

As part of the 2014 reforms to OOHC, DHHS established the register to deliver SCPs. A RFP process for the provision of SCPs closed on 19 June 2015. Potential providers were assessed by DHHS using the following criteria:

- ability to provide services that are consistent with service requirements
- experience and/or capacity to provide out of home care services
- experience in establishing and maintaining collaborative relationships with key stakeholders to deliver services
- sound organisational governance and financial structure
- ability to recruit and maintain suitable staff and provide for their continuing professional development
- value for money.

While we did not review the RFP process, we noted there was adequate documentation of the decision-making process and probity advice.

Funding agreements were negotiated with successful respondents in October 2015 and service provision commenced in November 2015. The six successful providers were:

- Australian Childhood Foundation (therapeutic services only)
- Key Assets
- Kennerley (younger clients only)
- Life Without Barriers
- Optia (later known as Oak Tasmania and now known as Possability)
- Safe Pathways.

SAFE PATHWAYS

Safe Pathways was admitted to the register in November 2015. Safe Pathways is a for-profit provider that operates in Northern Queensland and the Northern Territory but did not then have a presence in Tasmania. The first Tasmanian child was put under its care on 26 February 2016.

RFP documentation to establish the register revealed that the selection panel raised concerns, during the deliberation process, about Safe Pathways' ability to deliver, given it had no current on the ground presence in Tasmania. Safe Pathways assured the panel at interview that any time lag in getting people recruited for Tasmania would be supplemented by existing staff from interstate.

In addition, a referee for Safe Pathways, while mostly positive about the provider, commented that DHHS should give attention to Safe Pathways' *'compliance with monitoring requirements'* and ensuring that their staff have *'working with children checks'*.

A review of Safe Pathways, which was initiated by DHHS prior to the Program and finalised in July 2017, found that valid working with vulnerable people registration had not been obtained for all staff. The agreement with Safe Pathways was then terminated on this basis and the provider was, in effect, removed from the register.

USE OF PROVIDERS NOT ON THE REGISTER

DHHS currently uses, on a case-by-case basis, providers that are not on the register. The reasons cited for this include:

- some children were already under the care of other providers and DHHS did not want to provide undue disruption to the child (continuity of service)
- the demand for placements is greater than the capacity of the approved providers to deliver
- providers used had an existing relationship with DHHS (their ability to deliver the service was known).

Other providers advised by DHHS include; Devonfield, Mosaic, Total Support Services and North West Residential. Some providers participated in the 2015 RFP process, but were not successful. No conclusions have been drawn from this information and we have not reviewed the capacity of any providers to deliver the services under the SCPs.

PAYMENTS TO SCP PROVIDERS

An analysis of payments to SCP providers was undertaken by DHHS's Budget and Finance area for 2015–16 and 2016-17. Table One shows amounts paid to all providers for the delivery of SCPs.

Table One – Payments to SCP providers

Provider	2015-16	2016-17	2016-17 adjusted
Australian Childhood Foundation [i]	-	213 300	213 300
Brahminy Group	169 880	-	-
CatholicCare	-	188 600	188 600
Devonfield	1 915 011	1 451 707	1 451 707
Kennerley [i]	225 889	669 659	669 659
Key Assets [i]	88 491	909 867	909 867
Langford	68 869	-	-
Life Without Barriers [i]	3 502 196	5 320 530	5 320 530
Many Colours 1 Direction	341 620	631 803	631 803
Mosaic	112 725	651 879	651 879
Multicap	347 881	494 385	494 385
Nexus Inc	-	16 053	16 053
North West Residential Support Services	532 897	419 158	419 158
Possability (Optia and Oak) [i]	1 910 688	7 715 255	7 715 255
Safe Pathways [ii]	160 510	1 842 633	999 730
Star	61 647	-	-
Total Support Services	-	133 527	133 527
Veranto	116 259	-	-
Total	**9 554 563**	**20 658 356**	**19 815 453**

i. Provider is currently on the register

ii. Provider has been removed from the register.

Payments to SCP providers reflect an estimate of the cost of services required by a young person at the time of assessment. The frequency that support services are provided to young people may, at times, need to vary and this may have a material impact on actual expenditure. As a result, an acquittal process was a requirement of funding agreements. However, a June 2017 review conducted by WLF noted that the language used in funding agreements led SCP providers to assume that funds provided for the agreed services were not subject to acquittal.

The amount shown as paid to Safe Pathways in 2016-17 represents the initial payments paid. An amount of $842 903 was recouped from Safe Pathways in May 2017 following a review of services provided under the SCPs. The amount repaid represents the return of funds not expended on the provision of services in line with contractual arrangements.

Amounts shown in Table One for 2015-16 are representative of a part-year only, as the register was not implemented until November 2015 (although some payments were made to individual providers on a case-by-case basis pre-register which are included in Table One.).

Financial acquittals for all other providers are now due to DHHS for review to determine whether any other SCP funds paid in advance also require repayment.

REVIEW OF SCP PROVIDERS

According to DHHS's internal review of Safe Pathways[6], discussed in further detail below, the first complaint regarding Safe Pathways was received by DHHS on 6 May 2016. The complaint was made by an employee alleging, among other things, no or minimal training of staff and no relevant recruitment clearances (e.g. working with vulnerable people registration, medical competency certificates or referee checks).

From August 2016 to November 2016, multiple other serious complaints involving six different children under Safe Pathway's care were received by DHHS. Consequently, DHHS wrote to Safe Pathways on 24 October 2016 notifying them of their intention to undertake a review.

After the review commenced, further complaints were received by DHHS.

On 14 November 2016, ABC's 4 Corners "Broken Homes" program aired nationally. Following the Program, the terms of reference for the Review were extended to include analysis of the financial arrangements put in place by Safe Pathways to support children in its care.[7] In addition, questions were asked in Parliament relating to the performance of Safe Pathways and the safety of children under their care. On 22 November 2016, the CCYP wrote to the Minister about his concerns. The Minister confirmed that children were being removed from the care of Safe Pathways on 2 December 2016 and the last child was removed by the end of the 2016 calendar year. The impacted children were transferred into the care of other SCP providers with Possability providing the greatest assistance.

As concerns around Safe Pathways became evident, DHHS instigated a number of reviews and audits. Since November 2016, CYS and SCPs have been the subject of no less than 16 separate internal reviews. These have predominately focused on the quality of care and financial oversight provided by SCP service providers.

Table Two summarises the SCP reviews and audits that have been undertaken and completed since November 2016.

6. Quality Improvement and Workforce Development, 12 July 2017.
7. Hansard, House of Assembly, Wednesday, 16 November 2016.

Table Two – SCP reviews and audits

Completed	Review or audit	Undertaken by
February 2017	Safe Pathways Review – SCP Numbers 1-10 (10 individual reports)	WLF
February 2017	Safe Pathways Review – Summary of all SCPs	WLF
March 2017	Safe Pathways Review – Final Report	WLF
May 2017	OOHC – Special Care Packages	DHHS Internal Audit
June 2017	SCPs – Other Providers Review Final Report	WLF
July 2017	Safe Pathways Review (discussed further below)	DHHS Quality Improvement and Workforce Development
July 2017	SCPs – Financial Oversight	DHHS Internal Audit

DHHS INITIATED SAFE PATHWAYS REVIEW

DHHS initiated its planning for the Safe Pathways review prior to the airing of the ABC 4 Corners program and it commenced shortly thereafter. The review was finalised in July 2017 (although work had commenced on some of the recommendations before this date).

The scope of the review was to examine and provide a report on the following:[8]

1. Review the complaints that have been raised in respect of Safe Pathways and provide a chronology of the complaints to date and the actions taken in response, with analysis as to whether the response adequately addresses the concerns.
2. Consider whether the services provided for each subject child are or were in alignment with the services and care outlined in the therapeutic plan for that child.
3. Review the compliance of Safe Pathways with its obligations under the funding agreement in relation to service provider obligations, records, reports and acquittals; skills and competencies of employees and volunteers; fit and proper staff; services and performance standards of the funding agreement; consumer outcomes; services and performance standards of the funding agreement; key performance indicators and also service specialist standards obligations.
4. Determine the ongoing capacity of Safe Pathways to deliver the range of services necessary and to the standard required for the provision of a special care package.
5. Consider whether child safety services fulfilled its case management responsibilities with respect to each of the subject children.
6. Make recommendations regarding any actions that should be taken to resolve or address issues identified within the review as they relate to the above terms of reference.

The completed report is not a public document due to the sensitive nature of the content within the report, focussing, in part, on the experiences of six children. As a result, our comments below summarise aspects of the review and report without specifically referencing the particular circumstances of staff or children.

The review found that Safe Pathways had a level of administrative non-compliance which included:

- failing to obtain valid working with vulnerable people registration for all staff
- poor staff recruitment and induction practices
- inadequate staff training and support
- case management and documentation matters
- adequacy of complaints management processes.

8. Hansard, House of Assembly, Wednesday, 16 November 2016.

DHHS concluded from the review that no children in the care of Safe Pathways were harmed, however concerns were raised that there was '…limited evidence the six children received care that was aligned to their therapeutic plans.'

The review also found that DHHS could improve a number of its practices, including:

- monitoring of providers
- complaints processes
- Child Support Officer and Carer interactions
- governance of funding agreements.

Overall, the report contained nine recommendations covering:

- mandatory training for out-of-home care staff
- improved reporting between providers and DHHS
- creation of reference groups to help guide responses to issues facing the sector
- termination of the agreement with Safe Pathways on the basis of multiple breaches.

DHHS is in the process of addressing the recommendations (and those from other reports), through the implementation of its Strategic Plan for Out of Home Care in Tasmania 2017-2019, discussed further below.

WLF REVIEWS

WLF was commissioned by DHHS's Budget and Finance unit to provide 'an independent report on the revenue and costs associated with each SCP' managed by Safe Pathways. Each SCP acquittal was reported separately, plus there was also a summary report of all SCPs. Some SCPs relate to one child and some to multiple children. All but one report showed substantial underspending by Safe Pathways, the net result being a repayment to DHHS of $842 903.

In their reports, WLF made a number of recommendations, based on their review of the SCPs. These included:

- that contract management processes within DHHS be strengthened to ensure compliance with the terms of the SCPs
- DHHS consider a process for documenting a child's belongings on transfer to and from special care
- that providers report monthly on activities and amounts expended directly on each child.

Further, WLF was asked to provide similar reports for the other providers on the register. DHHS Internal Audit conducted the review of Possability (using the same methodology) as WLF had a conflict in reviewing that provider.

Findings and recommendations for each provider centred on the ability to acquit funding for each individual package. In particular, provider finance and payroll systems did not allow the ability to allocate indirect staffing costs to individual children/package of care.

WLF also stated, *'language utilised under the SCP funding arrangements included 'quotes' to provide the services for the child and this language has contributed to the assumption that the funds provided were for the agreed services and were not subject to acquittals. This is despite the requirement for acquittal being included within the funding deed.'*

DHHS INTERNAL AUDIT

In its review, 'Special Care Packages – Financial Oversight', DHHS Internal Audit looked at progress towards implementation of the WLF and Internal Audit recommendations relating to controls for the management of funding external OOHC providers. They found that progress had been made, but two key issues remained ongoing:

- emergency placements raise the risk that placements are locked in at a high care level because there is not time to make a full assessment and opportunities to adjust the care level downward are not monitored
- the limited number of providers on the register increases the risk of a provider refusing to take a placement and therefore the financial exposure at finding a different placement at short notice.

OTHER OUT OF HOME CARE REVIEWS

OUTLINE OF REVIEWS

Other reports considered in our initial audit assessment are summarised in Table Three.

Table Three – Other reviews of OOHC

Completed	Review or audit	Undertaken by
September 2011	Children in OOHC audit	Tasmanian Audit Office
September 2014	Follow up of the September 2011 Children in OOHC audit	Tasmanian Audit Office
November 2016	Visiting Children in OOHC	DHHS Internal Audit
January 2017	Children and Young People in OOHC (discussed further below)	CCYP

TASMANIAN AUDIT OFFICE PERFORMANCE AUDIT

Our 2011 audit of Children in OOHC covered the OOHC lifecycle process from notification to DHHS through to reunification with family. It covered all types of OOHC (foster, kinship and residential).

The audit resulted in 21 recommendations. The 2014 follow-up audit reported that six of the 21 recommendations had been implemented fully and a further four were substantially implemented. Documentation (of decision making and of events) was identified as a significant issue.

DHHS INTERNAL AUDIT

DHHS Internal Audit undertook a review of 'Visiting Children in OOHC' in 2016, focussing on the work of CYS to ensure:

- visits are undertaken in accordance with policy and procedures
- safety risks are assessed and controlled
- recording of information, and recording of incidents, is timely, accurate and complete
- data in the Child Protection Information System is recorded consistently
- KPIs are in place and reported against.

Findings included some large gaps between visits to children in care and inconsistency, some delay and some inadequacy in the recording of information. The latter findings are consistent with those reported in the two of the Office's performance audit reports in 2011 and 2014.

REPORT BY THE COMMISIONER FOR CHILDREN AND YOUNG PEOPLE

In January 2017, the CCYP released a report following increasing concern that Tasmania was the only jurisdiction in Australia that had not as yet established Standards or other accountability mechanisms for the OOHC sector.

The recommendations from the report were:

1. Prioritise the development of a strategic plan and implementation plan for the OOHC reform. Ensure the strategic plan incorporates strong governance and oversight mechanisms.
2. More closely integrate the OOHC Reform and the Child Protection Service redesign, and provide the resourcing required for successful and ongoing implementation, including by providing dedicated funding for implementation teams.
3. Establish an independent expert oversight committee to provide assistance and guidance to those implementing the child protection and OOHC reforms, accompanied by robust reporting arrangements on progress.
4. Establish an ongoing consultative panel of young people who have had experience of the OOHC and child protection systems, and who are therefore well-placed to contribute directly to the reform processes.
5. Establish independent external oversight and monitoring of the OOHC system, including by providing the CCYP with six-monthly reports on compliance with Standards and other agreed indicators of the wellbeing of children and young people in the OOHC system in Tasmania.
6. Ensure that mechanisms are in place to seek out and listen to the individual voices of children and young people in the OOHC system, including:
    a. establishing a visiting program for individual children and young people in OOHC – which incorporates an individual advocacy component
    b. reviewing the CSS Policy on visiting children in OOHC and reporting publicly on compliance with it
    c. expediting the establishment of a Tribunal in Tasmania vested with jurisdiction that includes decisions made about children's wellbeing in OOHC.
7. The Tasmanian Government develop and adopt Standards for the provision of OOHC in Tasmania and provide regular reports on compliance with these Standards. Noting the work currently being undertaken on child wellbeing as part of the child protection redesign, the Tasmanian government also develop an outcomes framework specific to children and young people in OOHC in Tasmania.

The report recognised that DHHS had commenced work to reform the child protection system including the OOHC system in Tasmania. However, there were some differing views between the CCYP and DHHS on what 'independent' oversight means in the context of advocacy. However now, the new advocate proposed by DHHS is to be established under the Secretary which is consistent with the Western Australian model upon which the advocate role is based.

HOW HAS THE DEPARTMENT OF HEALTH AND HUMAN SERVICES RESPONDED?

OOHC IN TASMANIA STRATEGIC PLAN 2017-2019

DHHS has commenced addressing the issues raised in the Safe Pathways internal review. DHHS has developed and publicly released its 2017-2019 Strategic Plan for OOHC in Tasmania.

DHHS accepted the recommendations in the CCYP's *Children and Young People in Out of Home Care* report and aims for full compliance with the National Standards.

DHHS has also identified the following priorities:

Strategy 1 Leading an Accountable System

Putting mechanisms in place to oversee the delivery of a coordinated, integrated and accountable system where all partners are aware of their role and contribution.

Strategy 2 Defining and Delivering Quality Care

Defining the standard for high quality out of home care services and ensuring this standard is consistently delivered

Strategy 3 Building the Out of Home Care System

Building a system which delivers the right amount and the right type of care needed by children and young people who can't live at home.

Strategy 4 Delivering a Safe Out of Home Care System

Taking a preventive, proactive and participatory approach to keeping children and young people in our care safe.

Strategy 5 Improving Outcomes for Children and Young People in Out of Home Care

Improving outcomes for children and young people in out of home care by delivering services which meet their specific needs.

Source: http://www.dhhs.tas.gov.au/children/out_of_home_care_reform_in_tasmania/documents/strategic_plan_for_out_of_home_care_in_tasmania

IMPLEMENTATION PLAN 2017-18

Achievement of the 2017-2019 Strategic Plan for OOHC in Tasmania is supported with an internal Implementation Plan that specifies 48 operational activities and associated timeframes.

The Implementation Plan also assigns responsibility to a unit (or position), provides notes on the action, including progress to date, and cross-references the recommendations from other reviews (e.g. the CCYP report) that the action addresses. Notable operational activities are summarised in Table Four below.

Table Four – Implementation Plan notable activities

Planned Date	Activity
February 2018	Execute new funding agreements with specific requirements and obligations
March 2018	Implement a learning and development framework for staff and carers Implement a formal complaint mechanism across CYS Implement a Quality Improvement Framework for CSS Establish a Serious Events Review and Complaints Coordination Unit DHHS's Grants Unit to monitor funding provided for SCPs Employ a Child Advocate
June 2018	Develop a shared training calendar for staff from CSS and out of home care providers Develop and implement a community visitor's program to support children and young people in OOHC
October 2018	Update the CYS Practice Manual in regard to Child Protection Services

REVIEW AND IMPROVEMENT OF OOHC CONTROLS

DHHS advised it is reviewing and improving OOHC controls relating to:

- case management policies and procedures
- funding agreements specify services, performance targets and recourse for failure to deliver
- working with vulnerable people registration for carers under the *Working with Vulnerable People Act 2013*
- review of quality of care concerns with the aim of improving placement
- review of serious abuse or neglect concerns by a Senior Quality Practice Advisor
- an additional resource to monitor existing SCPs and placements (recruited May 2017).

DHHS INTERNAL AUDIT

DHHS Internal Audit has identified 10 potential reviews within CYS in its Audit Plan for 2017-19 to 2019-20, subject to resource availability and other audit priorities.

AUDIT ASSESSMENT OBSERVATIONS

In performing our audit assessment we made a number of additional observations which are summarised below:

1. Completed audits and reviews have identified:
    - instances of limited clinical surveillance and monitoring of services provided to children
    - large time lags between visits of CSOs and children in OOHC
    - varying standards for recording of case notes (regularity, ability to edit, level of detail)
    - case notes are not finalised in the records management system
    - regular reporting on compliance with frequency of visits identified in individual care plans is not in place.
2. There is no coordinated/centralised complaints management process for dealing with OOHC complaints. The Implementation Plan includes the establishment of a Complaints Coordination Unit which will address this point.
3. There are deficiencies in funding agreements with approved providers, although this has already been identified and action is being taken to rectify this by the end of December 2017.
4. The implementation of the 2017-2019 Strategic Plan for OOHC in Tasmania and accompanying Implementation Plan will require cultural change and the re-prioritisation and re-design of existing processes. Additional resourcing requirements may also need to be considered.

ACRONYMS AND ABBREVIATIONS

the Act	*Children, Young Persons and Their Families Act 1997*
CCYP	Commissioner for Children and Young People
Children	In the context of this report, a reference to 'children' should be taken as the inclusive term of 'children and young people'
Committee	Parliamentary Standing Committee of Public Accounts
CSO	Child Safety Officer (also generically referred to as a case worker or child protection worker)
CSS	Child Safety Services
CYS	Children and Youth Services
DHHS	Department of Health and Human Services
Minister	Minister for Human Services
National Standards	*An outline of National Standards for out-of-home care* (Commonwealth Government 2011)
OOHC	Out of Home Care
the Program	ABC's 4 Corners "Broken Homes" program
the register	Register of Approved Providers
RFP	Request for Proposal
Safe Pathways	Industry Education Networking Pty Ltd, trading as Safe Pathways
SCP	Special Care Package
Secretary	Secretary of the Department of Health and Human Services
the Office	Tasmanian Audit Office
WLF	WLF Accounting & Advisory

APPENDIX ONE: SUBMISSIONS AND COMMENTS RECEIVED

Submissions and comments that we receive are not subject to the audit, nor the evidentiary standards required in reaching an audit conclusion. Responsibility for the accuracy, fairness and balance of these comments rests solely with those who provided the response. However, views expressed were considered in reaching the summary of findings.

Submissions received are included in full below or incorporated into the report.

Secretary, DHHS and Minister for Human Services

The Secretary and Minister provided a combined response thanking the Auditor-General for the opportunity to comment on the report and suggested some minor wording clarifications to the report, which were accepted.

CCYP

The Interim Commissioner thanked the Auditor-General for the opportunity to comment on the report and suggested some minor wording clarifications to the report, which were accepted.

Safe Pathways

Safe Pathways acknowledges your office will present its report on the delivery of special care packages for children in out of home care to the Tasmanian Parliamentary Standing Committee of Public Accounts.

I appreciate the opportunity to comment on aspects of the report related to Safe Pathways and note the report may be made public through parliamentary processes.

I would like to reiterate our disappointment in the Department of Health and Human Services' (DHHS) decision to terminate our contract without us being afforded an opportunity to address their findings. Throughout the review process we frequently requested information regarding the specific nature of complaints and the Department's concerns about our operations. We failed to receive any formal advice or communication about the outcome of the report or the specific allegations against us.

The official Notice of Termination cited failure to appropriately adhere to the Registration to Work with Vulnerable People Act 2013. We were advised there were 'other grounds' that could be considered cause for termination with no further explanation.

The DHHS concerns referenced by your report (Page 2 and Page 14) have not previously been communicated in full to Safe Pathways. These include:

- failing to obtain valid working with vulnerable people registration for all staff
- poor staff recruitment and induction practices
- inadequate staff training and support
- case management and documentation matters
- adequacy of complaints management processes.

Similarly, we have no further detail regarding the nine recommendations (Page 3) and serious complaints received by DHHS (Page 14).

The DHHS confirmed that no children in the care of Safe Pathways were harmed (Page 2 and Page 14), and we remain committed to the safety and wellbeing of our staff and the young people in our care. We have responded to this situation with some immediate improvements to our administration processes, ensuring we have the appropriate oversight and checks in place. Over the longer term we are investing in new system infrastructure that will further strengthen our processes.

I am hopeful that any future government decisions will benefit Tasmanian families who need access to quality out of home care services.

Lynn Walker

CEO Safe Pathways