



Commissioner for Children and Young People  
Western Australia

# DISCONNECTED, UNPROTECTED:

What happened to the  
best interest of the child?



# ACKNOWLEDGEMENTS

## Acknowledgement of children and young people

I acknowledge the challenges faced by children and young people who have had, or may have contact with, the Child Protection system. I acknowledge the continued significant overrepresentation of Aboriginal children in out-of-home care in Western Australia.

## Acknowledgement of Country

I proudly acknowledge and pay respect to the Traditional Custodians of the lands, skies and water across Western Australia and acknowledge the Whadjuk people of the Noongar nation upon whose lands my office is located. I recognise the continuing connection to culture, families and communities of all Aboriginal peoples. Together, my team and I, also pay our respects to Elders, past and present and to the emerging young leaders. We recognise the knowledge, insights and capabilities of Aboriginal peoples, and pay respect to Aboriginal ways of knowing, being and doing.

## Language

For the purposes of this report, the term Aboriginal encompasses Western Australia's diverse language groups and also recognises Torres Strait Islanders who live in Western Australia. The use of the term Aboriginal in this way is not intended to imply equivalence between Aboriginal and Torres Strait Islander cultures, although similarities do exist.

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## Definition of children and young people

There are varying definitions for what defines a child or young person, including aged-based approaches. The Australian Bureau of Statistics collates data into five-year age categories to align more closely with developmental stages of adolescence.

The United Nations Conventions on the Rights of Children states that 'a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier'. The United Nations defines youth as those aged 15 to 24 years.

For the purposes of this Report, the definition of 'children and young people' is contained within the *Commissioner for Children and Young People Act 2006 (WA)*, which refers to people under 18 years of age as children and young people.

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# COMMISSIONER'S FOREWORD



Protection of our children and young people is a whole-of-community responsibility. They rely on adults to support them, guide them and provide safety. There are so many people in our communities in Western Australia (WA) who do this every day, from the passionate and dedicated staff working in the systems supporting our children, to the amazing families, extended families and other individuals who provide Kinship Care and Foster Care, and to those working within the community services and Aboriginal Community Controlled Organisation sectors.

Yet, we still have thousands of children and young people who do not experience safety, protection or the support of families and communities. Our systems are under-resourced, focused on crisis response rather than early intervention and support, and overwhelmed by the magnitude of the challenges in supporting children and young people.

During the first four years of my term as Commissioner for Children and Young People (WA), a significant proportion of queries and complaints to my office has been related to the child protection portfolio. While my legislation does not enable me to investigate individual complaints, I am able to review trends in complaints. Given that we are not the complaints agency, it is particularly difficult to identify specific trends.

Due to the number of concerns raised (where we have provided guidance and advice to the complainant on how to proceed and follow complaints processes), I was of the firm belief that I should review the policies, practices and procedures in the child protection system.

On 25 March 2025, I advised the Minister for Child Protection and the Director-General of the Department of Communities that I would undertake an Inquiry into the

processes, policies and practice related to children placed into the Kath French Secure Care Centre (KFSCC). The focus was on children and young people with three or more admissions into KFSCC during the period 1 January 2020 to 1 January 2025 inclusive. Specifically, I decided to review these against the Objects and Principles of the *Children and Community Services Act 2004 (WA)* and the Nine Dimensions of Care used by the Department of Communities (DoC) when planning for children in out-of-home care (OOHC).

Arguably, the Kath French Secure Care Centre (KFSCC) provides support to those children and young people in OOHC with the highest, and most complex, needs. The DoC subsequently identified 19 children and young people who met this criterion. This is not an Inquiry into KFSCC, rather it is a review of the actions taken for the children and young people in the sample from when they entered the OOHC system.

I acknowledge the sample size of 19 does not enable the data to be extrapolated across the child protection system more broadly. It is not a representative sample. However, the reason for focusing on those with multiple entries into KFSCC was because these children and young people are, arguably, some of the most vulnerable in the system.

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We requested direct access to both Asist and Objective systems; however, we were advised this was not possible due to confidentiality provisions relating to the identity of potential mandatory reporters. Instead, case files were made available to our office electronically. However, in many cases, we often were unable to locate information and made subsequent requests to the Department. As an example, we did not generally receive copies of Child Safety Investigation Outcome reports; copies of reports for Court; care arrangement transition meetings and planning notes, limiting our understanding of the reasons for bringing a child into the OOHC system. In February 2026, we determined it was not feasible to continue to seek documentation for each child and we would proceed to preparing the report based on information provided to that point.

This Inquiry was undertaken in accordance with Functions outlined in the *Commissioner for Children and Young People Act 2006* (WA), Part 3, section 19, clauses:

- (c) to promote and **monitor** the wellbeing of children and young people generally
- (f) to **initiate and conduct inquiries into any matter**, including any written law or any practice, procedure or service, affecting the wellbeing of children and young people
- (g) to **monitor and review** written laws, draft laws, policies, practices and services affecting the wellbeing of children and young people.

We note considerable work has been undertaken in relation to working in partnership with the Aboriginal Community Controlled Organisation sector. There has been additional resourcing provided within the child protection system to recruit Child Safety Officers. There has also been additional funding allocated to prevention, early intervention and family support services; however, there is a critical and

urgent need to expand this funding and service offering across the state. It is also necessary to transition successful pilot programs to the core business and fund them accordingly rather than continuing the current approach of extending the pilot's term in two to three locations. Outcomes for children to be safe, supported and healthy sometimes appear to be a long way off for the more than 5,000 children in OOHC.

Unfortunately, for many of the children in OOHC, including those removed from their families before the age of 2 years, they are not being provided with positive experiences, safety or nurturing. For the majority of the sample group, their rights are not being upheld, their voices are not being heard and their best interests do not appear to be leading decision-making processes.

I urge the Government to use the findings and recommendations from this Inquiry to improve life outcomes for all children and young people in WA, with a particular focus on building a system that provides early intervention, prevention and support, so we can help families nurture and support their children to live healthy, happy and safe lives.

I thank the Department of Communities for their co-operation with this Inquiry.

I also thank the team at the office of the Commissioner for Children and Young People for their commitment to this important Inquiry and the work they undertook to ensure the voices of children and young people continue to be elevated in matters directly affecting their safety, health and wellbeing.

Dr Jacqueline McGowan-Jones  
**Commissioner for Children and  
Young People (WA)**

# EXECUTIVE SUMMARY

**This Inquiry has resulted in 50 findings and 56 recommendations designed to assist the Department of Communities (DoC) and the Western Australian Government to take action to improve the outcomes for children and young people in the out-of-home care (OOHC) system.**

They relate specifically to an assessment of the actions taken following the removal of a child from their family, against the Objects and Principles of the *Children and Community Services Act 2004* (WA) (the CCS Act) and the Nine Dimensions of Care used by the DoC to guide decision making and planning for children in OOHC.

The Inquiry analysed the experiences of a sample of 19 children and young people identified by the DoC as meeting specific selection criteria. The provided sample was used to assess the ability of the DoC to meet its statutory obligations for a cohort acknowledged as the most vulnerable, which more broadly reflects the ability of the out of home care system to achieve core functions for those most in need of support. The multiple system failures identified relate specifically to the 19 children and young people and while this number should not be used to suggest whole of system failures, it is indicative of a system that has not been able to comprehensively support some of the most vulnerable children and young people in their care.

I acknowledge the work of the staff within the DoC who support children and young people – their commitment to improving the lives of children and young people is commendable. It is equally important to acknowledge that many do not have the time, resources, skills or experience required to fully embed the Objects and Principles of the legislation into their work.

The role of Foster, Kinship and Family Carers is crucial in providing the support and care required for children in the OOHC system. I thank these carers for their commitment.

Evidence consistently shows that home environments provide greater safety than other care arrangements, including Therapeutic Residential Care. Concerningly, throughout this Inquiry there appeared to be many instances where Foster, Kinship and Family Carers were not given sufficient information and support to enable them to meet the needs of vulnerable children with complex needs. In fact, in some cases, it almost seemed that once they were placed (especially with Kinship and Family Carers), the DoC ceased to follow procedures and protocols to ensure that the carer's support needs were met or that the needs of the child had been supported. This included ceasing funding for health care, education, leisure and recreation. There is often an unreasonable financial burden placed on carers. These costs must be met by the legal guardian if we are to build a sustainable Foster, Kinship and Family Care system.

A review of publicly available child protection practice frameworks, policies and standards, demonstrates an opportunity to better align these to the Objects and Principles of the CCS Act.

Promoting the wellbeing of children, families and communities while encouraging and supporting parents, families and communities in carrying out this role are primary objectives within the CCS Act. The Inquiry found that the focus is often at the crisis end of the system – which is arguably the most expensive in terms of outcomes for children – rather than on the supports and services providing early intervention to prevent bringing a child into OOHC.

Please be assured that I am focused on the overall safety and wellbeing of the child and there will always be occasions when urgent action is required to protect against abuse. OOHC will always be required; however, it must be a better place not just a different place, noting this is not a requirement under the legislation. Rather, I see this as a moral imperative. The majority of the cases reviewed were unclear about the specific reasons for coming into care or the severity of the issue. For example, “can’t adequately give care”. Such reasons would appear, on the surface, to indicate that better planning for a child before bringing them into care would improve the likelihood of stability of care arrangements.

The principles outlined in the CCS Act highlight that decision making must be in the ‘best interests of the child’, and that the preferred way of safeguarding and promoting a child’s wellbeing is to support the child’s parents, family and community in the care of the child. The Act is also clear that intervention action should only be taken in circumstances where there is no other reasonable way to safeguard and promote the child’s wellbeing.

Unfortunately, the Inquiry was unable to provide information demonstrating that these principles are being consistently upheld.

A review of the cases of the 19 children, the majority of whom entered OOHC as babies or toddlers, demonstrated a failure to meet the key principles outlined in the CCS Act relating to achieving continuity and stability in living relationships; preserving *and enhancing* the child’s relationships with family; preserving *and enhancing* the child’s connection with culture and traditions of the child’s family and community; and the provision of support to a child to participate in decision-making processes.

The Annual Care Plans reviewed showed significant deficiencies in each of the Nine Dimensions of Care used by the DoC to guide

planning for children once they have entered OOHC. These are detailed further within the Report. Alarming, in one case where it was determined that the child’s behavioural needs could not be met, they were reunified with family, despite the child having previously been identified as experiencing Family and Domestic Violence, and the DoC advised that such violence “appeared to be well managed”. Nonetheless, there was no evidence in the file to support this presumption.

It is with grave concern that I noted many instances in which a child was made responsible for achieving their own outcomes, or decisions were made by the DoC based on a flawed approach to addressing the needs of the whole of the child. For example, determining education was not a priority due to behavioural complexities, rather than seeking options such as one-to-one tutoring.

It is important to consider what action the DoC might take if a birth parent was not providing education and medical care, and whether this would potentially result in a child being removed from the family and placed into OOHC. If the legal guardian is the DoC and they too are not meeting the child’s basic needs, what happens to the child?

I encourage the Government to ensure that when a child is removed from their immediate family, they receive quality support and experiences aligned with the Objects and Principles of the CCS Act and the Nine Dimensions of Care and to commit to a whole-of-system approach to changes in child protection practice.

Further, I strongly recommend the Government embrace the opportunities for real and meaningful change in the protection of our most valuable resource in Western Australia – our children – and commit to acting on our findings and recommendations. I also urge the Government to consider these recommendations as part of the review of the CCS Act in 2027.

# FINDINGS AND RECOMMENDATIONS

**We encourage legislative and government bodies to consider the following findings and recommendations from this Inquiry in the upcoming statutory review scheduled for 2027.**

Overall, we found the Department of Communities (DoC) unable to demonstrate the ability to reliably fulfil the 'best interests of the child' under the Objects and Principles of the *Children and Community Services Act 2004 (WA)* (the CCS Act) or the Nine Dimensions of Care. All 19 children and young people in the sample were harmed, disadvantaged or not afforded meaningful supports and opportunities to develop or heal.

The focus of arranging care for these 19 children and young people appeared to be on where to place a child rather than what was in the best interest of the child. We identified a pattern of inconsistent case management, which led to inaccurate reporting and incomplete information, resulting in unsafe decision making and unstable care arrangements. Tailored resources and independent oversight are required to support the DoC in meeting its core obligations of providing safety, stability, healing, and reunification to children and young people in out-of-home care (OOHC).

We also found most case notes and care plans spoke of actions to be taken, plans to be developed, discussions to take place and referrals to be made. However, there was minimal evidence of the follow-up or outcome of these intended actions.

Rather, we observed a culture of 'copy & paste' across plans, reports, notes and forms. There were also blank templates,

inaccuracies in client information and missing documentation reflecting poor recordkeeping that does not meet the legislative requirements for confidentiality or recorded decision making.

In one case, we were unable to establish a chronological history of the child's contact with the DoC prior to coming into care or their experience while in OOHC from the available documents. This highlights the problematic nature of the systems used, and the difficulty in distilling key credible, evidenced case histories and decision making beyond a Child Safety Investigation report.

In meeting the needs of children in OOHC, the DoC's trauma informed responses should include mechanisms for holding significant trauma history (including grief and loss) at the forefront of all relevant care planning documents for the child. It was evident that the extent to which this is undertaken by Case Managers and managed through case supervision by Team Leaders is insufficient and inconsistent. It is crucial that all information pertaining to a child be regularly reviewed and updated. This knowledge must be shared throughout the child's OOHC journey.

The findings and recommendations arising from this Inquiry focus on four key areas. Nonetheless, critical action is required to ensure that we provide children with care protection from harm and stable environments that will support them to

flourish and thrive in their future. The four key areas of focus, prioritised in no particular order, are:

- Identified gaps in the CCS Act.
- Alignment of practice to the Objects and Principles of the CCS Act.
- Practice gaps in relation to the Nine Dimensions of Care.
- General recommendations related to improving systems, services, support and cross government action.

An additional recommendation relating to the development of the new Client Management System is included. Funding to ensure the uploading of current files to the new system is critical.

Improving outcomes for our most vulnerable children will not be achieved by another ‘trial’ or ‘pilot’ project; nor will it be achieved by incremental actions on areas of concern. Real and meaningful change will only occur within an overarching framework that funds

early intervention, prevention and support services as key components of practice approaches and frameworks, with a focus on supporting families and communities to care for their children. We must uphold the rights of children as outlined in the United Nations Convention on the Rights of the Child (UN CRC).

We must resource the system to ensure that children are cared for and are not disconnected and unprotected.

## Findings and Recommendations

### Outstanding Gaps in the CCS Act

While the *Children and Community Services Amendment Act 2021 (WA)* (CCS Amendment Act) addressed several of the concerns raised by academics, advocacy bodies and government agencies, several significant recommendations were not adopted resulting in enduring gaps in legislation.

| Findings                                                                                                                                                                                                                                                                                                                                       | Recommendations                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1. Ambiguous Definitions:</b> The CCS Act still lacks clear definitions of critical concepts such as ‘needs’, ‘responsibility’, ‘attitude’, ‘psychological harm’, ‘emotional abuse’, ‘neglect’ and ‘maltreatment’. This creates substantial discretionary scope for decision-makers and may undermine consistency and community confidence. | 1. Ensure that this is addressed and included in the legislation as part of the planned 2027 review of the CCS Act.                                                                                                                              |
| <b>2. Limited Recognition of Disability:</b> Although disability considerations were strengthened, the CCS Act still inadequately addresses developmental disabilities, trauma-related impairments and long-term psychological impacts of abuse and neglect.                                                                                   | 2. Ensure that this is addressed and included in the legislation as part of the planned 2027 review of the CCS Act.<br>3. Embed the United Nations Conventions on the Rights of People with Disabilities into the CCS Act when reviewed in 2027. |

| Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Recommendations                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>3. Absent Aboriginal and Torres Strait Islander Placement Oversight:</b> While Aboriginal participation rights were increased, the CCS Act does not establish Aboriginal-controlled oversight mechanisms; require Aboriginal-led decision making to be the primary decision-making model; fully implement the prevention, partnership and connection elements of the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP); or allow for a moratorium on long-term or permanent (Special Guardianship) orders for Aboriginal children.</p>                                                                                                                                                                                    | <p>4. Ensure that the findings and recommendations are addressed, resolved and included in the legislation as part of the planned 2027 review of the CCS Act.</p> <p>5. Embed the Declaration on the Rights of Indigenous Peoples into the CCS Act when reviewed in 2027.</p>                                        |
| <p><b>4. Limited Leaving Care and Transition Planning:</b> There remains limited statutory obligations safeguarding young people transitioning out of care, with insufficient recognition of their ongoing best interests after leaving the child protection system.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <p>6. Ensure that this is addressed and included in the legislation as part of the planned 2027 review of the CCS Act.</p>                                                                                                                                                                                           |
| <p><b>5. No Recognition of International Human Rights Frameworks:</b> Although influenced by the UN CRC, the CCS Act does not formally recognise it as a guiding legislative framework.</p> <p><b>6. The evolution of the CCS Act:</b> The CCS Act reflects a gradual shift from a protection-focused model towards a rights-based, culturally responsive OOHC framework. The 2021 amendments substantially strengthened child participation, Aboriginal self-determination, family connection and the primacy of the child's best interests. However, significant issues remain, particularly around definitional clarity, Aboriginal-led decision making, disability recognition, oversight mechanisms and support for young people leaving OOHC.</p> | <p>7. Introduce a Child Rights Act in WA, which should align to the UN CRC and the Optional Protocols, and ensure that this includes matters such as minimum standards and indicators for child protection and youth justice and detention.</p> <p>8. Embed compliance with the UN CRC into the CCS Act in 2027.</p> |
| <p><b>7. Focus on removal of children:</b> The CCS Act should focus on compliance with the object of encouraging and supporting parents, families and communities in carrying out the role of safeguarding and promoting the wellbeing of children, rather than the removal of children.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <p>9. Ensure that Earlier Intervention and Family Support is available to all families who come to the attention of the DoC, not just to Aboriginal families or those working towards reunification, to prevent children coming into OOHC.</p>                                                                       |

## Findings and Recommendations

### Misalignment with the Objects and Principles of the CCS Act

| Objects and Principles                                                                                                                                                               | Findings                                                                                                                                                                  | Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>To encourage and support parents, families and communities in safeguarding and promoting the wellbeing of children, including safely managing the behaviour of their children</b> | 1. No evidence of intervention action or provision of supports and services to prevent the child being taken into OOHC.                                                   | 1. Government invest in holistic approaches to support families in caring for their children, focusing on early intervention, support and social services and preventing children being removed from their families.<br><br>2. The DoC is funded to provide intensive, early supports to children, including grief, loss and trauma counselling, and to provide support to carers to meet the needs of children in their care. |
| <b>Provide for the protection and care of children in circumstances where their parents have not given, or are unlikely or unable to give, that protection and care</b>              | 2. While children have been removed where parents have not given protection and care, evidence for all children demonstrates the DoC has not achieved these goals either. | 3. Undertake a comprehensive audit of outcomes for all children in OOHC and make necessary changes to policies, practices and approaches to address deficiencies.                                                                                                                                                                                                                                                              |

| Objects and Principles                                            | Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Paramount consideration is the best interests of the child</b> | <p>3. No evidence of a formal assessment against each of the domains of 'best interests' as defined in the CCS Act.</p> <p>4. Significant evidence of placement instability, disconnection from family, and lack of attention to child's physical, emotional, educational and cultural needs.</p> <p>5. DoC is unable to demonstrate an ability to reliably evidence fulfillment of the 'best interests of the child' for any of the Nine Dimensions of Care.</p> | <p>4. Review the documentation used to make decisions regarding children deemed at risk and ensure holistic analysis against the principles outlined in the CCS Act.</p> <p>5. Decision-making templates and policies to be updated to ensure alignment with the Objects and Principles of the CCS Act, enabling staff to fully assess options and approaches for each child or young person.</p> <p>6. Review approaches for removal of a child, including pre-planning, to focus on identifying suitable care arrangements prior to removal (whenever possible, noting some children are at significant, immediate risk).</p> <p>7. Develop a robust, evidenced-informed 'scale' of risk for each concern area to enable staff to make decisions based on the potential for immediate harm. (Note: the focus is to determine whether immediate removal will result in an improved outcome and not multiple placements in a short timeframe, adding to attachment disorders and trauma.)</p> |

| Objects and Principles                      | Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Principle of child participation</b>     | <p>6. Lack of evidence that children are provided with the required information, as outlined in the CCS Act, to participate in the decision-making process.</p> <p>7. Insufficient opportunities provided to children and young people to express their opinions during decision making.</p> <p>8. Inconsistent integration of the tools designed to facilitate participation, and partial evidence of responsive consultation.</p> <p>9. Majority of decisions made did not evidence input from, or consultation with, the children or young people they impacted.</p> | <p>8. Develop age-appropriate materials, in a variety of languages (including Aboriginal English and Kriol), to provide to children about their rights and the processes followed by the DoC.</p> <p>9. Develop and embed into the Annual Care Plan template a proceduralised framework for using tools that capture the views of children and young people, actioning required follow-up, and recording the process of consultation, input and outcome.</p> <p>10. Once a new specific framework has been developed, train all staff in responsive use of tools for engaging children and young people in conversations across all Nine Dimensions of Care and where children or young people demonstrate cognitive, language and cultural differences.</p> |
| <b>Principle of community participation</b> | <p>10. Lack of evidence to demonstrate the intent of the principle being applied consistently and for all decision-making processes.</p> <p>11. Aboriginal Services and Practice Framework is 10 years old and appears to be still in use.</p> <p>12. The Multicultural Plan 2021–2023 included development of a Culturally and Linguistically Diverse (CaLD) Services Framework by end 2023.</p>                                                                                                                                                                       | <p>11. Undertake comprehensive systemic reviews of the Aboriginal Services and Practice Framework and the CaLD Services Framework, including specific, individualised approaches for differing cultures to ensure alignment to the Objects and Principles of the CCS Act. This must be done in consultation with peak bodies, community representatives, service users and children and their families.</p>                                                                                                                                                                                                                                                                                                                                                  |

## Findings and Recommendations

### Misalignment with the Nine Dimensions of Care

| Dimension     | Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Safety</b> | <ol style="list-style-type: none"> <li>Persistent safety concerns <i>while in care</i> including: <ul style="list-style-type: none"> <li>sexual vulnerability and exploitation</li> <li>physical and emotional abuse</li> <li>absconding</li> <li>unstable living arrangements</li> <li>inconsistent case management</li> <li>unsafe reunification</li> <li>unclear child placement principle decision making</li> <li>pre-emptive admissions to Secure Care</li> <li>children with diagnosed mental health conditions contained at Secure Care</li> <li>reasons for cessation of a placement were not recorded within the documents provided.</li> </ul> </li> </ol> | <ol style="list-style-type: none"> <li>Revise policies and processes for the response to and management of sexual assault and exploitation to ensure transparent reporting of outcomes throughout case documentation, in line with mandatory reporting obligations and trauma informed support.</li> <li>Embed ongoing Family and Domestic Violence training in case supervision, covering effective interviewing, assessment and monitoring of alleged perpetrators, and linking to perpetrator accountability service referral pathways.</li> <li>Conduct an audit of screening and vetting processes for carers and DoC staff to ensure that the methods are suitably comprehensive and periodically reviewed.</li> <li>Re-establish reunification teams at all DoC hubs.</li> <li>Designate Kath French Secure Care Centre (KFSCC) as a mental health facility to ensure necessary oversight and protection in relation to rights, advocacy and support for children and young people with mental health conditions.</li> <li>Embed the Mental Health Advocacy Service within KFSCC.</li> </ol> |

| Dimension               | Findings                                                                                                                                                                                                                                                                                                                                                                                                                              | Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Care Arrangement</b> | <p>2. The identification of care arrangements often occurs after the removal of a child, resulting in multiple care arrangements, lack of ability to identify potential Family Carers or no assessment of the needs of the child (e.g. trauma counselling, disability supports).</p> <p>3. Changes, and the decisions made resulting in changes, are often not clearly identified in Annual Care Plans or Quarterly Care Reports.</p> | <p>7. Embed static historical data pertaining to care arrangements, judicial orders, kinship details and mandated assessments within OOHC planning and reporting templates, including a prompt to clarify the accuracy of the information before submission.</p> <p>8. DoC to embed mandatory mechanisms within Annual Care Plans and Quarterly Care Reports to track changes, decisions and outcomes.</p> <p>9. DoC to revoke current policy allowing for non-submission of any care plans or reports.</p> |
| <b>Health</b>           | <p>4. In many cases there was insufficient information included in the documents provided to evidence that required health assessments were undertaken.</p> <p>5. Where health assessments were completed, identification of actions required and taken were often not evident.</p>                                                                                                                                                   | <p>10. Embed an audit process, to be undertaken by the Advocate for Children in OOHC, into practice and review of Annual Care Plans and Quarterly Care Reports, with a focus on ensuring that health assessment and planning is undertaken. Audit process to include a review of actions undertaken in response to the plans, and cases where action does not appear to have occurred.</p>                                                                                                                  |

| Dimension                                    | Findings                                                                                                                                                                                                                            | Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Education</b>                             | <p>6. Consistent missed opportunities for meaningful engagement in education and vocation resulting from a de-prioritisation of learning, reflecting an ignorance of its role as a significant aspect of childhood development.</p> | <p>11. Develop a centralised process between the DoC and the Department of Education to offer, arrange and monitor educational funding arrangements.</p> <p>12. Support alternative education options, including home learning and tutoring, with appropriate resourcing for Education Officers and Case Workers to work with the complex needs of children in OOHC.</p> <p>13. Revise conceptualisation of children's non-school attendance in line with trauma informed and 'school can't' theoretical perspectives, incorporating early intervention responses to waning school participation where there is history of adversity.</p> <p>14. Consider the impact of a placement change that will also necessitate a change in school and the requirement for a plan to support continuity of relationships from previous schools, including support to develop new social, community and education networks.</p> |
| <b>Emotional &amp; Behavioural Wellbeing</b> | <p>7. There was a pattern of reactive and punitive responses to significant dysregulation and risk taking without evidence that appropriate steps were taken to support the navigation of traumatic life crises.</p>                | <p>15. Implement a formal mechanism for monitoring and evaluating the section 22 amendments of the CCS Amendment Act, with a focus on effective inter-agency collaboration and compliance in escalating matters that are not given timely priority.</p> <p>16. DoC and Western Australian Police (WAPOL) to establish a co-located response to calls from OOHC staff and carers to ensure that attending officers are child and youth trauma informed specialists, allowing for planned, proceduralised management and consistently supported long-term outcomes.</p> <p>17. Develop a centralised system that categorises and rates the severity of crisis incidents, linked to staged responses across agencies.</p>                                                                                                                                                                                               |

| Dimension                                | Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Social &amp; Family Relationships</b> | <p>8. Both barriers to and missed opportunities for social and family connection, negatively impact the social and emotional wellbeing of the child.</p> <p>9. Development, maintenance and support of safe and healthy relationships that foster connection and belonging that can endure beyond OOHC remains a significant gap in ensuring the best interests and wellbeing of children in care.</p>                                                                                                                                                                                                                                                                                                                                                                                                           | <p>18. Develop a statewide network, including Aboriginal and Torres Strait Islander and CaLD community members, to follow up the identification of family connections and facilitate contact between relatives and individuals in OOHC.</p>                                                                                                                                                                                                                                                                                             |
| <b>Identity &amp; Culture</b>            | <p>10. Exploration of sexual, cultural and religious identities were not actively supported.</p> <p>11. Cultural Support Plans were completed sparingly.</p> <p>12. Where a CaLD background was identified, meaningful exploration of practices, needs, values or connections was not evidenced.</p> <p>13. There was an identified variance in the consistency and meaningfulness of Aboriginal Practice Leader (APL) consults.</p> <p>14. DoC was not responsive to self-identification of Aboriginality.</p> <p>15. The majority of children had no reported information on religious interests or practices and no evidence that religious identity was directly explored.</p> <p>16. Insufficient opportunities provided to children and young people to express their opinions during decision making.</p> | <p>19. Review current policies that require the completion of Genograms and Cultural Support Plans and redesign practice to incorporate both activities into initial efforts to identify Kinship and/or Family Carers and later efforts to develop a child's identity.</p> <p>20. Form a community advisory committee consisting of both CaLD and Aboriginal representatives and conduct an audit of the policies and practices that are currently intended to fulfil the requirements of sections 8, 12, 13 and 14 of the CCS Act.</p> |

| Dimension                       | Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Recommendations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Recreation &amp; Leisure</b> | 17. Limited evidence of meaningful attempts to ascertain children's needs or engage them in community activities.                                                                                                                                                                                                                                                                                                                                                                                                               | <p>21. Actively pursue consistent and meaningful social activities focused on recreation and leisure within the community and involving prosocial peers for children in OOHC.</p> <p>22. Provide financial and case support to carers (all care types) to enable the pursuit of leisure and recreation activities, including allocation of funding to support these.</p>                                                                                                                                        |
| <b>Legal &amp; Financial</b>    | <p>18. Minimal recorded evidence of advocacy or support with financial literacy.</p> <p>19. Young people referred for guardianship with reasoning inconsistently recorded and limited evidence of supports put in place.</p> <p>20. The assessment of potential legal claims appeared to be a 'tick box' exercise that was superficially noted as part of the leaving care planning process.</p> <p>21. Limited evidence in case documentation that legal advocacy or representation was provided for criminal proceedings.</p> | <p>23. Remove any requirement to wait until age 15 to engage in the development of financial literacy skills and review whether the currently offered services address all aspects of understanding and managing financial decision making.</p> <p>24. Embed leaving care and post support care teams in every DoC hub.</p> <p>25. Review arrangements and timelines for referral for guardianship post care, ensuring that arrangements include an individualised assessment undertaken prior to referral.</p> |

## Recommendations

### Improving Systems, Services, Support and Cross Government Action

| Findings                                                                                                                                                                                                                                                                                                                             | Recommendations                                                                                                                                                                                                                                                                                                                                                    | Responsibility                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 1. Multiple systems in use to record matters relating to a child, with significant information currently held in a variety of systems, and places (e.g. a carer's file may have information not recorded on the child's file). It is noted the DoC has received funding to update their systems and this went to tender in mid-2026. | <ol style="list-style-type: none"> <li>1. Ensure the Client Management System enables all information to be held in one place that is relevant to each child in care, including sibling files, parent files and carer files.</li> <li>2. Ensure the DoC is funded to enable a full and comprehensive uploading of current, active files to the new CMS.</li> </ol> | <p>Department of Communities<br/>Department of Treasury<br/>Office of Digital Government</p> |
| 2. Inaccuracy and incompleteness in case documentation, including lack of timeframes to complete proposed actions; inconsistent reporting of follow-up on actions; minimal review of child circumstances information; 'tick box' approach to some of the Nine Dimensions of Care.                                                    | <ol style="list-style-type: none"> <li>3. Development and implement a comprehensive training program (preferably online) with fulsome instructions on how to complete required documentation such as Annual Care Plans and Quarterly Care Reports, and how to action items such as Hospital Discharge Summaries and KFSCC Discharge Summaries.</li> </ol>          | <p>Department of Communities<br/>Office of Digital Government</p>                            |
| 3. Children provide information on their needs, wants, preferences and concerns through Viewpoint and discussions with carers and care team; however, these are often noted but not actioned despite a clear legislative mandate to do so.                                                                                           | <ol style="list-style-type: none"> <li>4. Develop processes for reviewing and actioning information provided by children through discussions, Viewpoint surveys and other age-appropriate mechanisms.</li> <li>5. Embed the process as a key component of planning and review to ensure that the child's voice actively informs decision making.</li> </ol>        | <p>Department of Communities</p>                                                             |
| 4. Case and care practices often appear to be improved reactively, in response to an incident, complaint or escalation.                                                                                                                                                                                                              | <ol style="list-style-type: none"> <li>6. Undertake a continuous improvement process, ensuring random audits of files to identify opportunities for improvements in policies and practices.</li> </ol>                                                                                                                                                             | <p>Department of Communities</p>                                                             |

| Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Recommendations                                                                                                                                                                                                                                                            | Responsibility                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| 5. Health planning is ad-hoc, often in reaction to a crisis, and follow-up planning is infrequent.                                                                                                                                                                                                                                                                                                                                                                                                          | 7. Endorse the Health Navigator Pilot Program, funding expansion to include mental health and to cover all DoC districts.                                                                                                                                                  | Department of Health<br>Department of Treasury<br>Department of Communities                                     |
| 6. Cross-agency action for children in OOHC is often reactive and does not enable a focus on the holistic needs of the child. As the state is the 'legal guardian' of the child, the state has a responsibility to ensure that they bring the resources of all agencies together to effectively support the health and wellbeing of the child.                                                                                                                                                              | 8. Design and implement shared systems across the DoC, Department of Health, Department of Justice, WAPOL and Department of Education that include universal referral forms, mechanisms for data collation and a process for monitoring the outcomes for children in OOHC. | Department of Education,<br>Department of Communities<br>Department of Health<br>Department of Justice<br>WAPOL |
| 6. There is no independent advocate for children in OOHC. There is one advocate employed by the DoC and this has not changed since 2006. In 2006, there were 2,220 children in OOHC; by 2026, this number had increased to 5,189 children.                                                                                                                                                                                                                                                                  | 9. Increase the number of Advocates to one per DoC district to ensure that all children have access to advice, support and advocacy.<br>10. Advocates to undertake regular reviews of child case files to identify areas for action.                                       | Department of Communities<br>Department of Treasury                                                             |
| 8. Legislated oversight for OOHC facilities lacks independence, investigative powers, transparency and resources to evaluate whether Therapeutic Residential Care facilities and KFSCC operate consistently with the rights and wellbeing of children.<br>9. Current section 125 Assessor approaches do not appear to embed the voice of the child as a critical component of assessment.<br>10. Section 125 processes appear to focus on compliance with processes rather than the wellbeing of the child. | 11. Enact legislative reform to expand oversight mechanisms for OOHC to cover all aspects of providing care and enhance existing mechanisms, including the section 125 model, when reviewing the CCS Act in 2027.                                                          | Department of Communities                                                                                       |

# CHILD PROTECTION ASSESSMENT FRAMEWORK

The CCS Act was introduced to create a child protection framework centred on promoting children's wellbeing and recognising the primary role of families and communities in raising children. The CCS Act was heavily influenced by the Gordon Inquiry, the UN CRC and growing concerns regarding the overrepresentation of Aboriginal children in OOHC. Over time, criticism from academics, advocacy bodies, government reviews and the Commissioner for Children and Young People led to substantial amendments in 2021.

## Sections Governing OOHC

The Objects of the CCS Act are detailed in section 6 and include the Object 'to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely or unable to give, that protection and care'.

The provision of protection and care relates to OOHC under the DoC.

## General Principles Relating to Children and Young People (Sections 7-10)

The foundational OOHC principle is outlined in section 7 of the CCS Act, which establishes that the best interests of the child are paramount when exercising powers under that Act.

Section 8 of the CCS Act provides guidance in determining what is in the **best interests of the child**, and requires the following matters be taken into account:

- (a) The need to protect the child from harm.
- (b) The capacity of the child's parents to protect the child from harm.
- (c) The capacity of the child's parents, or of any other person, to provide for the child's needs.
- (d) The nature of the child's relationships with the child's parents, siblings and other members of the child's family and with other people who are significant in the child's life.
- (e) The attitude to the child, and to parental responsibility, demonstrated by the child's parents.
- (f) Any wishes or views expressed by the child, having regard to the child's age and level of understanding in determining the weight to be given to those wishes or views.
- (g) The importance of continuity and stability in the child's living arrangements and the likely effect on the child of disruption of those living arrangements, including separation from –
  - (i) the child's parents
  - (ii) a sibling or other member of the child's family
  - (iii) a carer or other person (including a child) with whom the child is, or has recently been, living
  - (iv) other people who are significant in the child's life.

- (h) The need for the child to develop and maintain contact with the child's parents, siblings and other members of the child's family and with other people who are significant in the child's life.
- (i) The child's age, maturity, sex, sexuality, background and language.
- (j) The child's cultural, ethnic and religious identity (including the need for cultural support to develop and maintain a connection with the culture and traditions of the child's family or community).
- (k) The child's physical, emotional, intellectual, spiritual and developmental needs.
- (la) The child's educational needs.
- (l) Any other relevant characteristics of the child.
- (m) The likely effect on the child of any change in the child's circumstances.
- (gb) Placement planning should prioritise carers who can support the child's ongoing relationships with family and significant people.
- (i) Decisions about a child should align with the child's cultural, ethnic and religious values and traditions;

### **Child safety, protection and wellbeing**

- (c) Every child must be cared for and protected from harm.
- (d) Every child should live in an environment free from violence.
- (e) Every child should have stable, secure and safe relationships and living arrangements.
- (ea) Every child should be treated as a valued member of society with respect for their dignity and privacy.

### **Stability and continuity of care**

- (f) Intervention should occur only when no other reasonable option exists to safeguard and promote the child's wellbeing.
- (g) Planning for a child in care should begin promptly to support long-term stability and consider reunification with parents as early as possible.
- (ga) Planning should aim to ensure continuity and stability in the child's living arrangements.
- (h) Decisions about a child should be made promptly, considering the child's age, characteristics, circumstances and needs to minimise harm caused by delay.

Section 9 of the CCS Act outlines further principles to be observed when performing any function under the CCS Act and are summarised as follows:

### **Family, community and cultural connection**

- (a) Parents, family and community hold the primary responsibility for safeguarding and promoting a child's wellbeing.
- (b) Supporting a child's parents, family and community is the preferred way to protect and promote the child's wellbeing.
- (ga) Planning should preserve and strengthen the child's relationships with family and significant people, unless this conflicts with the child's safety or needs.
- (gb) Prioritise placing the child with siblings and family members where safe and appropriate.

**Participation, communication and informed decision making**

- (ia) Decisions about a child with disability must account for potential discrimination or difficulties and support full and effective participation in society.
- (j) Parents and significant people in the child's life should be supported to participate in major decision-making processes.
- (k) Parents and significant people should receive clear and understandable information about major decisions, the reasons for them, and any available complaint or review processes.
- (l) Interpreters or appropriate support persons should be provided to assist people who have difficulty understanding or communicating in English or whose disability affects their ability to understand, participate or express their views.

Section 10 requires the involvement of a child in any significant decision-making process through the provision of adequate information in a manner and language that the child can understand. A child must be afforded the opportunity to understand the decisions being made and be provided with assistance to express their wishes and views, including the right to complain or request revision of decisions.

**Aboriginal and Torres Strait Islander Child Placement Principles (Sections 11-14)**

The provisions of the ATSICPP are particularly significant given the disproportionate representation of Aboriginal children in OOH. Unfortunately, the CCS Act does not include specific reference to all five elements of the ATSICPP. The principles covered in sections 11 to 14 of the CCS Act are specific to Aboriginal children and are to be considered in addition to those outlined in sections 7 to 10.

**Child Placement Principle (section 12)**

This section outlines the placement hierarchy element of the ATSICPP. Any decision about placement arrangement must be in accordance with the following order of priority:

- (a) Placement with a member of the child's family.
- (b) Placement with a person who is an Aboriginal person or Torres Strait Islander in the child's community in accordance with local customary practice.
- (c) Placement with a person who is an Aboriginal person or Torres Strait Islander who lives in close proximity to the child's community.
- (d) Placement with either a person who is an Aboriginal person or Torres Strait Islander or a person who is not an Aboriginal person or Torres Strait Islander but who lives in close proximity to the child's community and is responsive to the cultural support needs of the child and is willing and able to encourage and support the child to develop and maintain a connection with the culture and traditions of the child's family or community.

- (e) Placement with a person who is not an Aboriginal person or Torres Strait Islander but who is responsive to the cultural support needs of the child and is willing and able to encourage and support the child to develop and maintain a connection with the culture and traditions of the child's family or community.

### **Principle of Self-determination (section 13)**

Aboriginal and Torres Strait Islander people have the right to participate in the protection and care of their children with as much self-determination as possible.

### **Principle of Community Participation (section 14)**

This section broadly encapsulates the participation element of the ATSICPP.

- (1) A family, community or representative organisation of Aboriginal people or Torres Strait Islanders must be given, where appropriate, an opportunity and assistance to participate in decision-making processes that are likely to have a significant impact on the life of a child who is a member of, or represented by, the group, community or organisation.
- (2) Consideration must be given to the wishes and views of the child, taking into account the maturity and understanding of the child and the child's parents about the participation of a family, community or organisation.

In addition to these principles, section 81 requires consultation with Aboriginal or Torres Strait Islander people, organisations or agencies with relevant knowledge of the child before placement decisions are made. This provision aims to ensure culturally informed decision making and preserve family and community connections.

## **Evolution Through Legislative Review**

Numerous reviews have identified deficiencies in the original CCS Act, particularly regarding OOHC decision making and Aboriginal and Torres Strait Islander child protection.

### **Increased Incorporation of Aboriginal Ways**

Advocacy organisations, including SNAICC, the Western Australian Commissioner for Children and Young People, the Child and Family Wellbeing Association of Western Australia and the Youth Affairs Council of Western Australia, sought integration of specific OOHC considerations that aligned with Aboriginal familial structures and cultural ways, including:

- full legislative implementation of all five elements of the ATSICPP (prevention, partnership, participation, placement and connection)
- stronger consultation obligations
- family-led decision-making processes
- greater Aboriginal self-determination
- stronger obligations to maintain cultural connections
- greater evidentiary requirements before long-term or permanent removal orders.

A significant proportion of the changes introduced by the CCS Amendment Act aimed to enhance the cultural responsiveness and inclusion of OOHC. Specific alterations made included:

- Incorporating some of the ATSICPP provisions as a required placement process rather than a discretionary consideration and strengthening consultation requirements through the insertion of section 22A, which included Aboriginal and Torres Strait Islander

representatives and groups in inter-agency collaborations on best interests of the child; replacement of section 81 to include consultation before placement of an Aboriginal child or Torres Strait Islander child; and insertion of sections 89A and 89C to include the development of Cultural Support Plans in consultation with Aboriginal and Torres Strait Islander representatives and groups.

- Introducing broader definitions of family and community.
- Transforming community participation and self-determination into rights-based obligations.
- Increased emphasis on sibling placement, family connection, cultural identity and long-term stability.

### **Increased Child Participation and Rights**

This was requested through stronger recognition of children's rights, greater involvement of children in care and leaving-care planning, stronger language requiring participation rather than merely encouraging it and recognition of children as valued citizens.

These requests were addressed in the CCS Amendment Act, which

- expressly recognised children as valued members of society
- expanded requirements for information sharing and participation in decision making
- included additional protections for children with disabilities and communication barriers.

### **Stronger Best Interest Provisions**

Stakeholders called for clearer obligations requiring compliance with best interest principles; expansion of protection from harm to include family violence; recognition of psychological wellbeing and developmental

needs; and greater consideration of children with disabilities.

The CCS Amendment Act sought to address these requests by inserting two new sections:

- Section 5A – requires all functions under the CCS Act to observe the Act's Objects and Principles.
- Section 7 – makes the best interests of a child a guiding requirement rather than a consideration.

### **Greater Accountability in Decision-Making**

Government reviews recommended that under the CCS Act, all decision-makers are required to demonstrate compliance with placement hierarchy requirements, explicitly prioritise reunification before long-term alternative care, and employ a broader application of the principles.

The amendments addressed some of these requests through:

- stronger planning obligations and support for family reunification where appropriate
- a requirement for cooperation across public authorities, non-government agencies and service providers to fulfil the best interests of children in care.

The evolution of the CCS Act reflects a gradual shift from a protection-focused model to a rights-based, culturally responsive OOH framework. The 2021 amendments substantially strengthened child participation, Aboriginal self-determination, family connection and the primacy of the child's best interests. However, significant issues remain, particularly regarding definitional clarity, Aboriginal-led decision making, disability recognition, oversight mechanisms and support for young people leaving care.

# PURPOSE OF THE INQUIRY

The child protection system can have a profound impact on children and young people, who are especially vulnerable to the harmful effects resulting from contact with the system. For this reason, child protection has been a priority area for the Commissioner for Children and Young People since the establishment of the office in 2007.

Section 28 of the CCS Act states that a child is in need of protection if:

- the child's parents are dead or incapacitated or if the child has suffered, or is likely to suffer, harm as a result of any one or more of the following – physical abuse, sexual abuse, emotional abuse or neglect
- the child's parents have not protected, or are unlikely or unable to protect the child from harm, or further harm, of that kind
- the child has suffered, or is likely to suffer, harm as a result of the child's parents being unable or unwilling to provide adequate care for the child, including provision of medical, therapeutic or other remedial treatment for the child.

If a child is taken into protection and care, the DoC has responsibility for the day-to-day care, welfare and development of the child, including responsibility for making decisions about any medical or dental examination, treatment or procedure in respect of the child.

The DoC determines and manages placement arrangements for the child, with the process governed by the CCS Act and supported by policy frameworks. According to the DoC, the types of long- and short-term care arrangements place emphasis on safety, stability and connection to family, culture and community.

There are multiple care arrangement types (see Table 1) and arguably placement within a family context, such as Family and Significant Other (Kinship) Care or Community Foster Care, provides the most valuable supports and environment for children to flourish and thrive. However, this relies on the carers being provided with the critical and necessary support to manage a child's grief, loss and trauma, medical and dental needs, educational requirements, emotional development, and recreation and leisure interests.

All other care arrangements are provided in a more institutionalised environment,\* with the potential exception of Respite Care or Emergency Care, which is only available in the metropolitan area.

The types of care arrangements outlined in Table 1 are accurate as at 22 August 2026 and were provided by the DoC. Over the past 15 years, there have been changes in the types of care arrangements; for example, previous arrangement types included Family Group Homes and Hostels.

It should be noted that 'self-selection' often means a child has absconded and is living with a person who may be unsafe, potentially providing drugs, sexually abusing the young person or encouraging them into crime.

\* Institutionalised care is comprehensive medical and personal support provided in a residential facility for individuals who cannot live independently.

While admission to hospital is considered a care arrangement, there is no definition that includes the use of hotels, caravan parks, chalets or staff caring for a child informally due to the unavailability of other options. This needs to be clarified in the definitions of care arrangement types.

**Table 1. Types of Care Arrangement**

| Type of Care Arrangements                          | Description                                                                                                                                                                                                                                                                        |
|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Long-term</b>                                   |                                                                                                                                                                                                                                                                                    |
| <b>Family and Significant Other (Kinship) Care</b> | For children and young people aged 0 to 17 years with low to complex needs unable to live with their own families for a time. Can be temporary or long-term. Carers are volunteers who are either related to, or have a pre-existing relationship with, the child or young person. |
| <b>Community Foster Care</b>                       | For children and young people aged 0 to 17 years with low to complex needs unable to live with their own families for a time. Can be temporary or long-term. Carers are volunteers who are typically not related or known to the child.                                            |
| <b>Community Foster Care – Other Residence</b>     | For children and young people aged 0 to 17 years with complex needs. Can be temporary or long term. Carers are a service provider employee.                                                                                                                                        |
| <b>Group Foster Care</b>                           | Group care for children and young people aged 7 to 17 years with low to moderate needs, with an emphasis on the provision of care arrangements for sibling groups. Care is usually provided at a ratio of one staff member to four children.                                       |
| <b>Therapeutic Residential Care</b>                | Group care provided by the DoC for children and young people with complex needs. Care is provided by employees on a rotating staff model at a ratio of two staff members to four children.                                                                                         |
| <b>Complex Care</b>                                | For children and young people with complex and extremely complex needs. Care is usually provided at a ratio of one staff member to one child.                                                                                                                                      |
| <b>Stepping Stones</b>                             | Intensive step-down therapeutic care for children and young people exiting Therapeutic Secure Care. Care is usually provided at a ratio of three staff members to two children.                                                                                                    |

| Type of Care Arrangements          | Description                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Time Limited</b>                |                                                                                                                                                                                                                                                                                                                                                  |
| <b>Emergency Care</b>              | For children and young people aged 0 to 17 years with low to complex needs who require emergency care outside work hours in the Perth metropolitan area. Care is provided by a volunteer Foster Carer in their own home.                                                                                                                         |
| <b>Temporary Care</b>              | Group care arrangements for children and young people aged 0 to 12 years with low to moderate needs that provide stability and maintain community connection for those without a stable care arrangement for a period of up to three months while a future care arrangement is identified.                                                       |
| <b>Short Break (Respite) Care</b>  | Temporary, short-term care arrangements for children and young people aged 0 to 17 years with low to complex needs with an approved Family, Significant Other, Community Foster Carer or care agency. Respite Care is designed to provide respite for a short period to the primary carer to support the sustainability of the care arrangement. |
| <b>At-Risk Youth Accommodation</b> | Emergency overnight accommodation for at-risk young people aged 14 to 17 years when no alternative suitable accommodation is available.                                                                                                                                                                                                          |
| <b>Therapeutic Secure Care</b>     | Short-term, intensive care for children and young people in care who pose an immediate and substantial risk to themselves or to others where there is no other suitable way to manage that risk and support the child or young person in receiving the care needed.                                                                              |
| <b>Other</b>                       |                                                                                                                                                                                                                                                                                                                                                  |
| <b>Living with Parents</b>         | When a child or young person is living with their biological parents, usually as part of a reunification process.                                                                                                                                                                                                                                |
| <b>Self-Selected Care</b>          | When a child or young person chooses not to stay with carers who have been assessed to care for them. Instead, they might choose to stay with friends, family members or acquaintances who have not been assessed or approved by the DoC.                                                                                                        |
| <b>Detention</b>                   | When a child or young person is held in custody or detention while awaiting a court appearance or trial, or where they have been found guilty of an offence.                                                                                                                                                                                     |
| <b>Hospital</b>                    | When a child is admitted to a hospital.                                                                                                                                                                                                                                                                                                          |

The number of children entering care in WA continues to rise at an alarming rate. Between 2019 and 2024, the number of Indigenous children in OOHC significantly increased, reflecting persistent overrepresentation in child protection systems across the nation (Quarterly Data Child Protection provided to CCYP). On 30 June 2026, in WA there were 5,189 children in care, of whom 3,139 (60.49%) were Aboriginal. The number of Aboriginal children in care aged 4 years and under was almost double that of non-Aboriginal children in the same age group.

Of the 5,189 children in care in June 2026, just under half (48.27%) were living with a family member, parent or former guardian (Quarterly Data Child Protection provided to CCYP). A further 1,670 children were in General Foster Care, representing almost one-third (32.18%) of all children in OOHC. There were a further 635 children in Therapeutic Residential Care, 61.25 per cent of whom were Aboriginal children. Concerningly, 340 children were in a 'self-selected arrangement' and 39 children were reported to be in 'other' living arrangements, raising significant concerns about their health and wellbeing.

In relation to Secure Care, for the period 1 January 2020 to 1 January 2025, there were 195 admissions across a total of 135 children and young people. Of these, a proportion (19) were admitted three or more times (DoC Correspondence). These children could be considered as some of the most vulnerable in the care and protection system.

Children who have contact with the child protection system in WA and are placed in a Secure Care arrangement face a range of concerns that impact their wellbeing, development and future opportunities.

The DoC states that Secure Care is a short-term, intensive, secure care arrangement for children who are experiencing significant risks to their safety, wellbeing or development, and whose needs cannot be safely managed through less restrictive interventions. It is used when a child presents with multiple and serious risk factors, such as persistent absconding, high-risk behaviours, harmful substance use, severe self-harming behaviours or association with unsafe individuals or environments. Admission is determined on a case-by-case basis, taking into account the child's age, developmental needs, circumstances and best interests, with the aim of providing immediate safety, assessment, stabilisation and intervention.

Secure Care arrangements are designed to cater for children with complex needs, the potential to harm themselves or others, or increased vulnerabilities. Many of these children have experienced, or been exposed to, extreme trauma, abuse or neglect, leading to mental health issues such as anxiety, depression and post-traumatic stress disorder (PTSD). Emotional and mental health challenges manifest as feelings of isolation and loneliness, and a lack of family support can worsen the child's emotional wellbeing. Inadequate access to appropriate and tailored mental health services or delayed interventions can exacerbate these challenges.

# SCOPE OF THE INQUIRY

The scope of the Inquiry was limited to an assessment of compliance with legislation, policies and frameworks in relation to 19 children and young people, with experience of multiple admissions into the Kath French Secure Care Centre (KFSCC), over a five-year period.

This included a review of the DoC case files from the time the child entered OOHC until the child was either reunified, aged out of care or became deceased. It is noted that the DoC was unable to provide direct access to their recordkeeping systems (ASSiST and Objective) and instead provided files through a secure network.

While the Inquiry was constrained to reviewing evidence relating only to children who entered Secure Care three or more times, it was not undertaken to make recommendations related to individuals. Rather, the Inquiry focused on identifying examples of quality case practice, opportunities for improvement and recommendations to improve outcomes for children in OOHC in WA.

The Inquiry did not consider:

- any siblings of the identified children who are also in contact with the child protection system
- post-leaving care arrangements
- an assessment of the quality of care placements and living arrangements.

# IMPLEMENTATION

Within the WA child protection system, the CCS Act is operationalised as the Nine Dimensions of Care (illustrated in Figure 1). The dimensions align with the broader WA child protection standards and wellbeing domains described in *Better Care, Better Services*, outlining the areas in which children's needs must be assessed and supported.



## 1. Safety

Focuses on ensuring that a child is physically safe, protected from harm and living in an environment where risks are actively identified and mitigated. It includes immediate safety planning, ongoing risk assessment and ensuring that carers understand and implement strategies to keep the child safe. WA's child protection system places a strong emphasis on assessing actual harm and ongoing risk, as reflected in its Child Safety Investigation processes. Beyond physical safety, this dimension also includes emotional safety by ensuring that the child feels secure, believed and supported. Trauma-informed practice is central, recognising that children in care often have histories of abuse, neglect or instability. Carers and practitioners work to create predictable routines, safe relationships and environments where the child's sense of security can be rebuilt.

## 2. Care Arrangement

Focuses on providing children with stable, predictable care arrangements. Long-term planning supports permanency through reunification, Foster Care or other pathways, including Special Guardianship Orders. WA's stability and connection framework outlines structured stages for planning, reviewing and achieving permanency. Care arrangement also includes preparing the child for future transitions, celebrating progress and ensuring continuity of relationships and support. Stability is considered foundational to healing from trauma and building a positive future.

## 3. Health

Covers the child's physical health, medical needs, nutrition, sleep, hygiene and developmental milestones. It ensures that children receive timely medical assessments, ongoing healthcare and support for any chronic conditions or disabilities. WA's care standards emphasise responding to the needs of children and young people, which includes meeting health needs consistently. Preventative health is also a focus, including regular check-ups, dental care, immunisations and healthy lifestyle habits. Carers and practitioners collaborate to ensure that the child's health information is up to date and that the child understands their own health needs in an age-appropriate way.

## 4. Education

Ensures that children have access to quality education, support for learning needs and encouragement to achieve their academic potential. Focus is on school attendance, engagement and addressing barriers such as learning difficulties or behavioural challenges. Education also involves fostering curiosity, celebrating achievements and helping the child develop aspirations for the future. Carers and practitioners collaborate with schools to ensure consistent communication and tailored support.

## 5. Social & Family Relationships

Focuses on maintaining and strengthening the child's relationships with family, siblings and significant others, wherever safe and appropriate. WA's case planning framework includes structured contact planning to support meaningful connections. Children are also helped to build healthy peer relationships and connections within their schools, clubs, cultural groups and neighbourhoods. Stable, supportive relationships are central to long-term wellbeing and are considered a key predictor of positive outcomes for children in care.

## 6. Recreation & Leisure

Focuses on ensuring that children have regular opportunities to participate in recreational and social activities of their choice. Children are supported in developing their sense of self, engaging with their community and fostering social connections through regular participation in activities of interest to them.

## 7. Emotional & Behavioural Wellbeing

Focuses on the child's mental health, emotional regulation, trauma recovery and sense of self. Many children entering care have experienced trauma, so therapeutic support is considered essential, whether through formal counselling or everyday relational healing. WA's therapeutic care approaches emphasise stability, connection and trauma-informed practice. This includes building resilience, supporting the child in expressing their feelings safely and helping them develop coping strategies. Carers play a key role in modelling emotional regulation and providing consistent, attuned responses that help the child feel understood and valued.

## 8. Identity & Culture

Ensures that children maintain a strong sense of identity, including cultural, familial, linguistic and community connections. For Aboriginal children, this includes alignment with culturally safe practices and adherence to ATSICPP. There is an emphasis on planning with children, families and carers to maintain identity and belonging. Identity work includes supporting the child's connection to their heritage, traditions and personal story. Children are helped to understand their life history in a safe and developmentally appropriate way, ensuring that they grow up with pride in who they are.

## 9. Legal & Financial

Ensures that prompt assessment is undertaken to determine the funding and resources required to support a child's needs. Case managers and key workers must be aware of potential legal claims and actions. Children are assisted in developing financial literacy to support their successful transition to independent living. Children who have impaired decision-making capacity are provided with support and assistance through the Public Trustee.

# INQUIRY AUTHORISING ENVIRONMENT

This Inquiry was undertaken in accordance with the following functions detailed in the *Commissioner for Children and Young People Act 2006 (WA)*.

## Section 19:

- (c) to promote and **monitor** the wellbeing of children and young people generally;
- (f) to **initiate and conduct inquiries into any matter**, including any written law or any practice, procedure or service, affecting the wellbeing of children and young people;
- (g) to **monitor and review** written laws, draft laws, policies, practices and services affecting the wellbeing of children and young people.

## Section 44:

The Commissioner may from time to time prepare a report on –

- (a) any inquiry, review or research conducted in the performance of the Commissioner's functions; or
- (b) any other matter arising in the performance of those functions.

## Section 46:

A report may include recommendations for changes to any written law, draft law, policy, practice or procedure, or for the taking of other action, that the Commissioner considers appropriate to safeguard and promote the wellbeing of children and young people.

## Section 47:

Before including in a report any matters adverse to a person or body, the Commissioner must give the person or body a reasonable opportunity to make representations to the Commissioner concerning those matters.

## Section 48:

- (1) The Commissioner must give the Minister a draft of each report.
- (2) The Minister may issue written comments to the Commissioner on a draft report.
- (3) The Minister may, in writing request the Commissioner to consult with any person in relation to a draft report.
- (4) The Commissioner is not required to –
  - (a) undertake consultation in response to a request under subsection (3); or
  - (b) make changes to a draft report as a result of any comments issued under subsection (2) or consultation undertaken in response to a request under subsection (3).
- (5) A report must include a copy of any comments issued under subsection (2).

## Section 49:

The Commissioner must cause a copy of a report to be laid before each House of Parliament, or dealt with under section 61, within 21 days after finalisation of the report.

## Methodology

This Inquiry adopts a systems level, mixed methods methodology designed to capture the complexity of young people's experiences across child protection, OOHC and transition pathways. The approach recognises that system performance cannot be understood through a single moment in time assessment; rather, it requires the integration of lived experience, administrative data and cross sector insights.

A mixed methods design was selected to integrate qualitative depth with quantitative evidence. This approach enables the identification of systemic patterns while preserving the nuance of individual experiences.

In preparing to undertake this Inquiry, the CCYP team reviewed a significant amount of literature and evidence from previous reviews, inquiries and research undertaken in relation to the context of Australian child protection and care systems.

## Data Sources

This Inquiry drew on multiple data sources, including:

- case files and internal departmental records
- policy, legislation and practice guidance documents
- Secure Care models
- OOHC therapeutic models
- an historical perspective of First Nations child protection
- mechanisms for embedding the child's voice in child protection systems.

## Qualitative Components

The qualitative component included:

- A case file audit of young people with three or more admissions to KFSCC between 1 January 2020 and 1 January 2025.
- Thematic analysis of narratives, case notes and child safety practitioner assessments.

A qualitative approach was used to identify primary themes, sub-themes and cross-cutting systemic drivers. This method supports the identification of systemic trends, challenges and opportunities.

## Quantitative Components

The quantitative analysis included:

- Descriptive analysis of administrative data from child protection.
- Analysis of early indicators of trajectory, such as placement instability, school disengagement and mental health presentations.

## Limitations

This inquiry acknowledges several methodological limitations:

- **Sample size:** The small sample (n = 19) limits generalisability and requires cautious interpretation.
- **Missing data:** Incomplete case files and inconsistent recording practices reduced the ability to track full trajectories.
- **Data fragmentation:** Data relating to carers, including complaints from or about carers, are contained within the carer file with no cross-matching to the child's file.
- **Restricted data sharing:** Lack of a shared cross-sector database constrained the ability to analyse cumulative risk and protective factors.
- **Variability in practice:** Differences across districts and agencies affected data consistency.

These limitations are commonly encountered when assessing government practices and agencies, highlighting some of the systemic challenges this Inquiry sought to investigate. Despite the challenges outlined above, the breadth of documents provided and the depth of qualitative insight provide strong evidence of the systemic patterns and opportunities for reform.

## Ethical Considerations

The methodology adhered to ethical principles, including:

- confidentiality and secure data handling
- vicarious trauma awareness.

## Selection Criteria

This Inquiry focused on those children and young people in OOHC who were determined as being 'high risk' and having 'high needs', which is defined as children and young people admitted to Secure Care three or more times over a five-year period.

The DoC identified 19 children and young people who met the selection criteria.

The provided sample was used to assess the ability of the DoC to meet its statutory obligations for a cohort acknowledged as the most vulnerable, which more broadly reflects the ability of the out of home care system to achieve core functions for those most in need of support.

## Process

The Inquiry was focused on alignment of practice with legislation, policy and procedures contained within the CCS Act and the relevant DoC legislation, policies and frameworks.

A request was made to the DoC to provide access to the data management software (ASSiST and Objective) to enable CCYP staff to review the case files for all 19 children. The DoC advised that direct access was not possible; instead, they provided case files for each of the 19 identified children to the Commissioner's office via a secure link.

A small team with experience in child protection systems, investigations, research and inquiries was established to undertake the Inquiry. Key 'questions' were then applied to each of the children's experiences as detailed in their case files.

The key questions related to decision making and whether this occurred in alignment with the Objects and Principles of the CCS Act, DoC policies and frameworks, and the children's voices as detailed in Viewpoint reports. The questions included:

- Age when entered care, including whether the child had been reunified and subsequently re-entered care.
- Number of placements and types of living arrangements.
- Education planning and engagement.
- Health planning, including mental health.
- Criteria alignment when child was admitted to Secure Care.
- Alignment and actions relating to the Nine Dimensions of Care.
- Discharge plans from Secure Care and how these were embedded in the child's overall care plan.
- Connections to family and culture.
- Leaving care planning.

On several occasions, we made further requests for information that appeared to be missing from the records provided. It should be noted that not all information related to a child is maintained in their case files. For example, if a carer raises concerns about a child in their care, this information is only recorded in the carer's file. This approach is concerning as it means there is currently no holistic client management system that provides all the information related to a child in one place.

Following numerous follow-up requests for further information, in February 2026, eleven months from the date of announcement of the Inquiry, it was agreed that no further information would be sought and the Inquiry would focus on the documentation already provided. It is therefore possible that some information identified in this report as 'missing' may have been available but was not provided within the Inquiry time frame.

As the Inquiry is based on an assessment of the 'system' applying to children in OOHC, the assessments considered each component for each child and then brought the information together to identify key findings, concerns or themes. Recommendations were developed to improve OOHC practices within the DoC, particularly relating to children with high needs and considered to be at 'high risk'.

# CASE REVIEW FINDINGS

## Demographics

Of the 19 children and young people whose case files were reviewed, the majority (73.68%) were female. Approximately one-quarter (26.31%) identified as Aboriginal\* and a minority (10.52%) were from Culturally and Linguistically Diverse (CaLD) backgrounds.

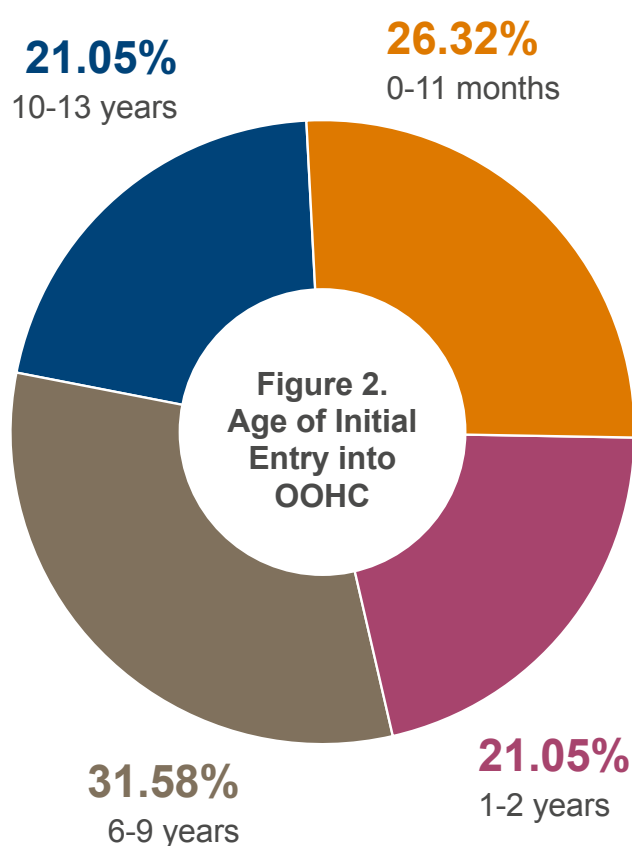
While in care, just over half of the children (57.90%) lived within the Perth metropolitan area, whereas the remainder lived either regionally or remotely. More than a third of the sampled children (36.84%) were born in regional areas and relocated to the metro area to be placed in care.

The age of initial entry into OOHC varied up to the age of 13 years (see Figure 2). Almost half of the children and young people (47.37%) were brought into care before the age of 2 years. The remainder initially entered care between the ages of 6 and 13 years, with none entering OOHC between the ages of 3 and 5 years.

Part 4, Division 1, section 28 of the CCS Act outlines the reasons where a child may be considered in need of protection, including suffering, or likely to suffer, harm as a result of one or more of the following: physical abuse; sexual abuse, emotional abuse, neglect, and the parents are unable or unwilling to provide adequate or effective care.

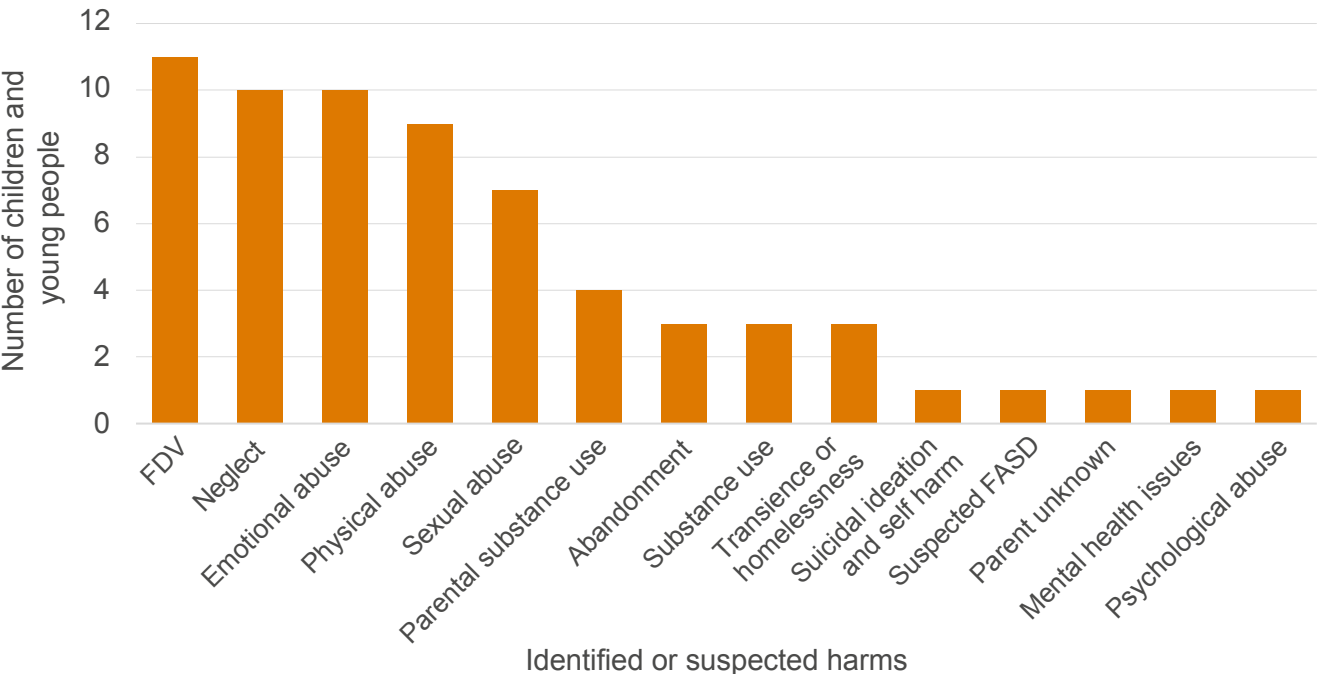
The factors leading to entry into OOHC reflected identified and suspected harms that posed significant risks to the safety and wellbeing of the sampled children and young people. Direct experiences of violence were the most common factors influencing removal from family and community, with

over half of all 19 children and young people experiencing Family and Domestic Violence (FDV; 57.89%), neglect (52.63%) or emotional abuse (52.63%). In assessing reasons for entry into OOHC we considered complicating factors reflective of significant risk or of parents being unable to provide care for their children, such as substance misuse, homelessness and mental health issues. Harm was also cumulative, with 84.21 per cent of the sampled children and young people experiencing three or more of the adverse childhood events presented in Figure 3.



\* Aboriginality represented here is in accordance with official DoC documentation and may not reflect self-identification.

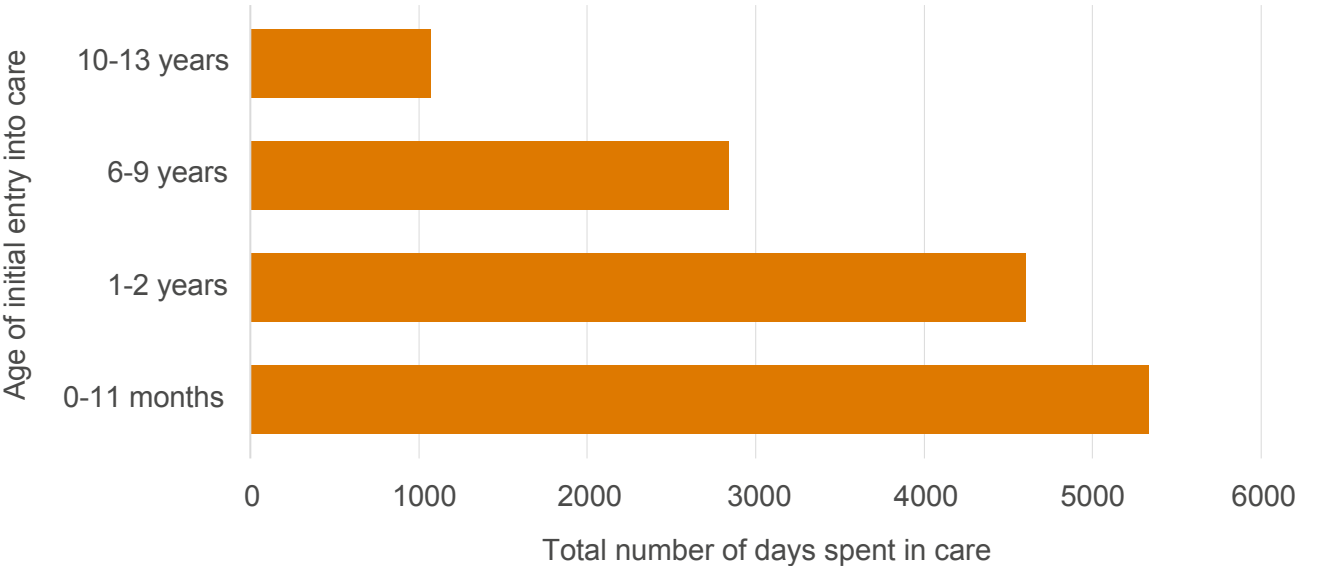
**Figure 3. Factors Influencing Entry into OOHC**



Note: The sampled children and young people often had multiple reasons provided for admission into care.

The total amount of time spent in care by each of the sampled children and young people individually ranged from 610 to 6,577 days. The average amount of time spent in care was 3,492 days. The average total time spent in care was higher for children entering care at younger ages, decreasing as the age of entry rose (Figure 4). This indicates that those children and young people who entered early in life spent a large proportion of their childhood in OOHC.

**Figure 4. Age of Initial Entry into Care and the Average Number of Total Days Spent in OOHC**



At 1 January 2025, over half of the children and young people (57.89%) were still in care, whereas over a quarter (36.84%) had aged out of the care system and a minority (5.27%) were reunified with their parents. Where the child entered care at less than 12 months of age, 40 per cent had aged out. Distinct admissions for this age group into OOHC ranged from one to two, with the majority experiencing two admissions. For those who entered care between the ages of one and two years, half remained in care until the age of 18. This age group had the widest range of separate admissions into OOHC, ranging from one to three. Of the children and young people who entered care between the ages of 6 and 13 years, 30 per cent remained in care until 18 years of age, and the majority (80.00%) had one distinct admission into OOHC. Less than half of the 19 children and young people (42.10%) were formally reunified with one or more parents, while a small number (10.52%) experienced unendorsed reunification or temporary placement at home. Children who entered care by the age of two years accounted for over half (62.50%) of all formal reunifications. However, the majority of reunifications (90.00%) resulted in the child or young person returning to OOHC.

The average total time in care, periods of care and reunification, and the number of children who aged out of care indicate that several of the children who entered care early in life were engaged with OOHC for the duration for their childhood.

A similar trend was identified in the age of initial entry into care and the total number of admissions into Secure Care between 2020 and 2025 (see Figure 5). For all age groups, the number of admissions into Secure Care ranged from three to six, except for those children who entered care between the ages

of one and two years, who experienced up to 13 distinct admissions within the timeframe. While all the sampled children had experienced multiple admissions into Secure Care by virtue of the selection criteria, those children with lower initial entry ages appear to have engaged the most with Secure Care. This appears to support a trend of both more time spent in OOHC and more time engaged with Secure Care during these periods for those children who enter care before the age of two years.

From the time they initially entered care up to the Inquiry census date of January 2025, the sampled children and young people most commonly had five foster placements (including Kinship Care, General and Community Foster Care, and Emergency Care), ranging from 2 to 17. This does not include the children and young people who moved from a placement and then returned to the same placement. The most common number of Therapeutic Residential Care admissions was three (including Group Foster Care and Complex Care), ranging from 2 to 14. The lowest number of admissions to Secure Care was three (see Figure 6). However, the most common number of admissions was 4, with the highest number of admissions to Secure Care being 14. Respite placements had the highest total for the sample; however, it was not consistent across the children and young people, ranging from zero to 39 distinct respite placements. Every one of the 19 children and young people had self-selected their placement at least once, with the number of self-selected placements ranging up to 12.

Both missing events and hospital stays were typically one-time occurrences; however, these placement types also varied widely (up to 26 and 29 occurrences, respectively).\*

**Figure 5. Age of Initial Entry into Care and Total Number of Admissions into Secure Care between 2020 and 2025**

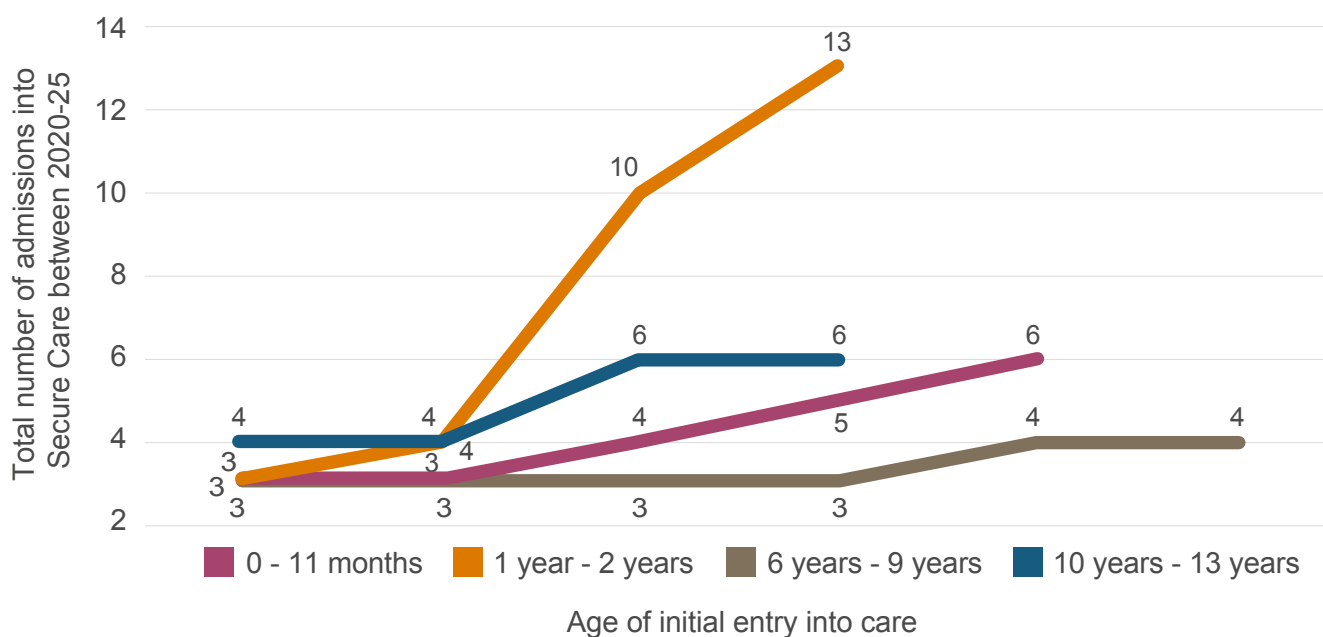
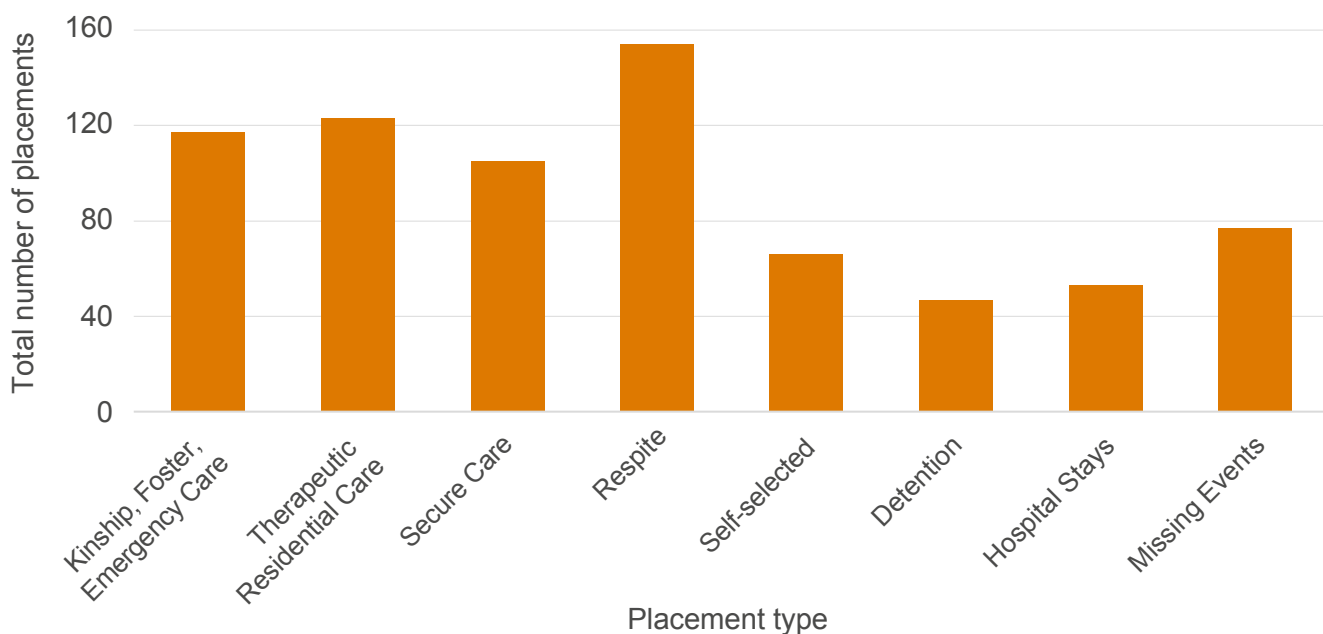


**Figure 6. Total Number of Placements for all 19 Children and Young People Throughout Time in Care as per Placement Type**

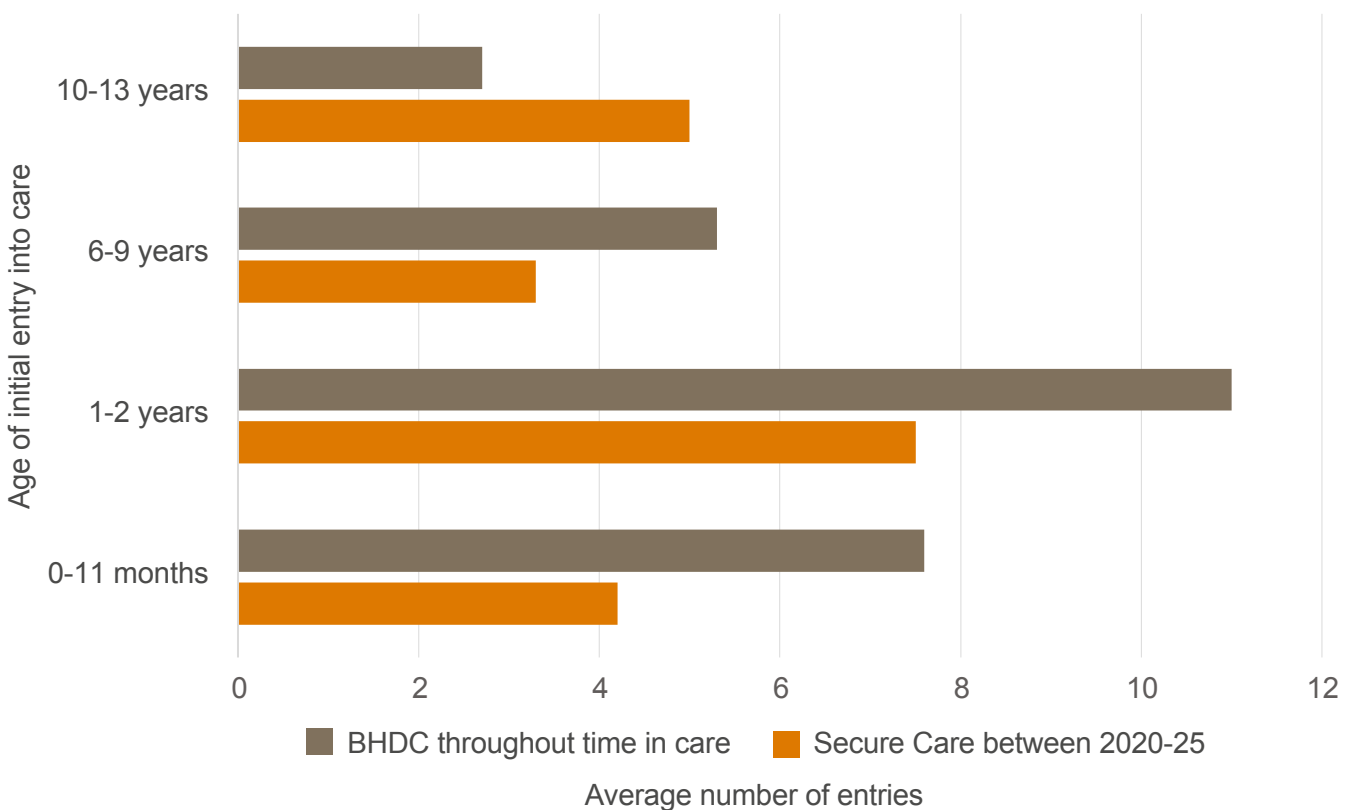


\* Due to the recency of Complex Care and Group Foster Care to DoC OOHC reform placement resources, there were few occasions when the sampled children and young people were matched with such placements and therefore for data analysis they were included in Therapeutic Residential Care.

Fifteen of the sampled children and young people (78.94%) were placed at Banksia Hill Detention Centre (BHDC), each at least twice during their time in OOHC, with the majority (86.66%) remaining at BHDC for more than one day. Of those who spent more than one day at BHDC, 61.54 per cent had been in Therapeutic Residential Care facilities prior to their detention. Almost all (88.88%) the children who entered care between birth and two years of age had experience of juvenile detention, and the majority (70.00%) of those who entered care between the ages of 6 and 13 years had been placed in detention. Of those detained, the number of admissions to BHDC ranged from 2 to 33, with 21.05 per cent of children spending time within the Intensive Support Unit during one or more of their periods of detention. None of the children were detained at Unit 18.

While the majority of the sampled children and young people experienced juvenile detention during their time in OOHC, it was those who entered care before the age of two who appeared to spend more time in BHDC than those who entered OOHC later in childhood. Across all 19 children and young people, those who were under government care for the majority of their childhood had spent more time in places of restriction or detention than those who entered the OOHC system at an older age (Figure 7).

**Figure 7. Age of Initial Entry into Care and Average Number of Admissions to Banksia Hill Detention Centre Throughout Time in OOHC and to Secure Care between 2020 and 2025**



## Fulfilment of Legislative Obligations

This Inquiry reviewed the individual case files of 19 children and young people to identify alignment with the Objects and Principles of the CCS Act.

We assessed, as a cohort, the evidence of alignment with Objective (e) of the CCS Act, ‘to provide for the protection and care of children in circumstances where their parents have not given, or are unlikely or unable to give, that protection and care’.

In reviewing the case files of the 19 children and young people, it was difficult to determine whether they would have achieved improved outcomes if they had remained with their families, given the level of supports and services required to assist them in keeping their children safe, happy and healthy. However, it was evident that quality outcomes for these children and young people were not consistently achieved while in the care of the DoC. This was evidenced by an analysis of the achievements against the key principles contained within the CCS Act, represented by the Nine Dimensions of Care.

Figure 8 provides a visual representation of the findings of this Inquiry, conceptualised as a typical experience of OOHC for the sampled 19 children and young people.

## Safety

We found numerous and persistent safety concerns throughout the case reviews of all 19 children and young people, including sexual vulnerability, abuse by carers and extensive absconding. Risks to physical and emotional safety were most often identified by the children and young people themselves and once reported, were not effectively mitigated, managed or resolved.

Physical and emotional safety is of primary concern for children and young people placed in OOHC. By the nature of admission into care, these individuals have been assessed as at risk of or experiencing harm of sufficient concern to justify their removal from family, friends and community. The significance of safety is reflected in the General Principles of Care within the CCS Act, namely sections 8 and 9, which require that safety and wellbeing be ensured throughout care by protecting children and young people from harm and providing an environment free from violence.

Safety is a feature of most all the Nine Dimensions of Care, but specifically of Care Arrangements, Health, Social & Family Relationships and Emotional & Behavioural Wellbeing. FDV, crisis management, mental ill health and adverse childhood experiences prior to being placed in care are discussed within these other dimensions and will therefore not feature in this discussion of physical and emotional safety while in OOHC. The discussion here focuses instead on how effectively the DoC protected the sampled children and young people from harm during their time in care through risk identification, mitigation and management.

**Figure 8. Common OOHC Experiences of the Sampled Children and Young People, as per the Nine Dimensions of Care**



## Sexual Safety

The most prevalent safety concern noted throughout our case review was sexual vulnerability and exploitation. Over half of the sampled 19 children and young people (52.63%) directly reported sexual assault while in OOHC, with a similar number (42.10%) reporting engaging in concerning sexual behaviours with adults. Concerningly, 40 per cent of the perpetrators identified in reported sexual assaults against the 19 children and young people were either carers or DoC staff. This raises significant questions regarding the veracity of vetting processes undertaken by the DoC when accepting carers and recruiting OOHC staff to protect vulnerable children and young people. Further, we found limited evidence of actioned follow-up in response to these allegations. For some children and young people (40.00%), we noted proposed or actioned reporting to the Western Australian Police (WAPOL), involvement of Royal Perth Hospital and Sexual Assault Resource Centre, and referral to the Child Assessment and Interview Team or family safety planning. However, the outcomes of these intended actions were unclear. The remaining children and young people (60.00%) had no evidence of reporting, assessment, psychoeducation or support following their reports of sexual assault. While we acknowledge that this absence of follow-up may be due to not receiving complete information for all 19 children and young people, the significant occurrence of sexual assault and the required post disclosure reporting and support should be clearly documented in care plans, review reports and case notes to allow for transparent, trauma informed, wraparound responses.

Sexual exploitation was also identified in reported consensual sexual activities and relationships. Some children and young people (21.05%) repeatedly engaged in sexual acts in exchange for substances or while intoxicated, whereas others (21.05%) reported involvement with or interest in older adults. Evidenced actions in response to reported or observed sexual exploitation included Safety and Wellbeing Assessments, consultations with WAPOL and Childfirst, counselling, sexual safety psychoeducation and safety planning. These steps are encouraging, although they were not consistently applied to all the sampled children and young people identified as being sexually exploited (only 62.50% of those identified). Concerningly, when a child or young person reported being in a relationship with an adult, there was evidence that the DoC passively condoned the situation through awareness and inaction. For example, one young person was sexually involved for several years with an adult more than 30 years older than themselves and with whom the DoC reported they lived for the majority of their time in OOHC. While the DoC actioned a Violence Restraining Order against this adult, there was no evidence of consistent or meaningful follow-up to mitigate or cease this ongoing exploitation. At one point the DoC noted: "Child disclosed 'she doesn't care' about the age difference with her new boyfriend, stating she's getting drugs from him and that he 'takes care' of her. When asked what he's doing to take care of her, child responded, 'he gives me fresh needles and a place to sleep, it's better than me sharing needles and sleeping on the street'." Given that the primary reason for removing children and young people from their families and communities is for protection from harm, it is of significant concern to us that an individual in OOHC would perceive better care from an adult

actively exploiting and harming them than from the DoC. Further, it is unclear why mandatory reporting processes were not followed, why WAPOL was not more actively involved in enforcing the Violence Restraining Order and returning the individual to their care placement, and why the DoC openly acknowledged this relationship for multiple years without employing ongoing mitigation or cessation strategies.

### **Physical and Emotional Safety**

Physical and emotional abuse experienced while in OOHC was also noted across the sampled children and young people. Over a quarter of the 19 children and young people we reviewed (26.31%) reported abuse perpetrated by carers, including experiences of physical assault, verbal degradation and inappropriate discipline. Despite some of these alleged behaviours being witnessed by DoC staff and WAPOL, we again found minimal evidence of follow-up actions to address the identified safety risks. When a child or young person had developed an intimate partner relationship involving violence, the DoC's responses were inconsistent. We identified two reports of repeated physical and psychological violence perpetrated by a partner. In one case, there was no evidence of mitigation strategies, emotional supports or legal action being enacted, whereas the other resulted in the perpetrator being imprisoned for assault. In situations involving reported physical or emotional risks to safety, a child or young person should receive consistent and meaningful responses to help them feel secure, believed and supported.

### **Environmental Safety**

Absconding from placements also presented a significant safety concern, often coinciding with risk-taking behaviours or attendance at unsafe places. Almost three-quarters of the children and young people sampled (73.68%) engaged in repeated absconding for varying lengths of time. While unsupervised in the community, reported behaviours included approaching and travelling with strangers, engaging in concerning sexual activities, using substances, self-harming and engaging in violent behaviours. We found more evidence of effective mitigation and management of absconding than we did for sexual exploitation and FDV. Where absconding was a concern, the common response was to admit a child or young person into Secure Care to allow for psychoeducation, safety planning, service referral, substance withdrawal and disconnection from antisocial peers or unsafe adults. In a minority of circumstances where cognitive capacity was low, risk to self was ongoing, risk to others was high, community-based services were exhausted or safety planning was ineffective in mitigating behaviours, we observed collaboration between WAPOL and Complex Care staff in attending unsafe residences and returning the children and young people to their placement. In one instance, a young person was known to abscond for extensive periods, with over 90 absconding reports lasting up to one month. While absconding, the young person regularly contacted the DoC regarding their whereabouts and urgent care needs, which led to the decision to provide them with a mobile phone so they could contact the DoC or emergency services if needed. While it is preferable for a child or young person to remain in their placement, it is pleasing to note that the DoC exhibited responsive risk management regarding this identified safety concern.

We acknowledge the innovative and collaborative approach taken by the DoC in managing the complex issues involved in a child or young person's absconding behaviours, particularly in circumstances where remaining in a particular care arrangement is against their wishes.

Overall, we identified an ongoing trend of poor risk management by the DoC, resulting in a gross failure to protect children and young people in care from harm and violence. Risk identification was largely led by the child or young person themselves and where reports were made, there was ineffective and inconsistent application of mitigation, management or resolution strategies. Protecting children and young people from harm is the primary purpose of OOHC, as outlined in the CCS Act. While harm experienced at home may result in a child or young person being placed in care, harm experienced while in care constitutes a failure on the part of the DoC to fulfil their core obligations. Beyond immediate and cumulative harm, the inability to provide safety for children and young people in care negatively influences their sense of trust and security in others, compromising the development of their wellbeing and leading to poorer outcomes throughout adulthood.

## Care Arrangement

We observed that plans and arrangements for care placements were unstable due to inconsistent case management, cumulative gaps in recordkeeping, limited pre-emptive planning and premature decision making.

Arranging safe, stable and culturally responsive care that supports children and young people to thrive physically and emotionally is a central aim of OOHC under the CCS Act. Following the decision to remove a child or young person from their home environment, several Principles must be observed when determining where they should be placed. In initially determining what is in the best interests of a child or young person in OOHC, sections 8 and 9 require prompt planning for continuous and stable care placements. Further, care arrangements should incorporate plans for reunification with parents as early as possible. Where a child or young person is Aboriginal, section 12 mandates that any decision regarding the placement arrangement must prioritise kinship or community over non-Indigenous individuals. Overall, OOHC care arrangements must support a child or young person's connection to family, community, culture, traditions and Country as much as possible (A.05 of the Child Protection Guide).

## Living Arrangements

All 19 children and young people experienced unstable care placements during their time in OOHC. We identified an average of 39 separate placements, ranging from 12 to 79 from the time they initially entered care up to the Inquiry census in 2025. Given the small size of this sample, the number of distinct placements is concerningly high and reveals a pattern of consistent instability in care arrangements. The highest number of total placements was Respite Care (154), followed by Therapeutic Residential Care (123), Kinship, Foster or Emergency Care (117) and Secure Care (105).

The main reason for the observed instability was commonly behaviour management issues, although we often found that the reasons for the cessation of a placement were not recorded within the plans, reports or notes provided to us. Where a child or young person was identified as having a high level of emotional, cognitive or physical needs, or as engaging in behaviours challenging to manage, we noted erratic placements encompassing Kinship/Family Care, Community Care, Therapeutic Residential Care, Secure Care and detention for short periods of time. For example, one young person moved residences over 40 times during a 13-year period due to their emotional and behavioural needs impacting their carers and other children placed with them. While the DoC acknowledged that these needs were significant and provided funding for a private psychologist after seven years of unstable arrangements, there was no evidence of consistent support over the 13 years for either the young person or their carers to address these needs and manage the resulting behaviours. Often, we observed that a child or young person experienced numerous short-term placements and admissions, being moved on once carers or staff advised that they were unable to safely manage externalised or dysregulated behaviours. This included placements within the Transitional High Needs facilities, which were evidenced to both move on children and young people with complex needs and to decline referrals made by DoC staff. While we acknowledge the right of all to feel safe and the need to protect other children and young people in OOHc, it is unclear why the externalised behaviours were not managed using the trauma informed conflict resolution strategies that are part of DoC staff and carer training or why specifically designed facilities were declining referrals.

Where stability was observed, we noted a trend of long-term placements followed by unanticipated or undisclosed cessations and extended periods of placement instability. Stable placements were typically found with Kinship Carers, Community Carers and within Therapeutic Residential Care facilities. During these placements, children and young people reported feeling happy, stable and secure, and experiencing a connection with carers and staff. We found that while there was evidence of updated Annual Care Plans and Quarterly Care Reports regarding the ongoing arrangement, including carer needs and the views of the child or young person, there were also instances where no information was provided for extended periods of time up until the placement broke down. For example, one child had been in a successful kinship placement for over five years; however, there was an absence of both care planning and quarterly reporting in the year preceding the breakdown of this placement. We were therefore unable to determine what happened to this child and their carer over the year and what, if any, steps were taken by the DoC to support them. Where long-term placements broke down, children and young people reported feeling anxious about their future care arrangements as they were aware that no definitive placement had been planned. In instances where a carer became ill or died, children and young people often externalised their feelings of grief by engaging in dysregulated behaviours. It was encouraging to find that alternative care was often arranged; however, there was minimal evidence of emotional or behavioural support for either the individual in care or their carer, leading to a secondary placement breakdown. An absence of timely planning of placements supported by wellbeing services not only fails to uphold the best interests of children and young people in OOHc per the

obligations of the CCS Act but also impedes the development of trust and fostering of security among this cohort of vulnerable individuals.

We were pleased to find evidence of good practice in seeking advocacy and consultation when planning care arrangements and transitioning children and young people following placement cessation. In one instance, due to the grief a young person had experienced following a move from a stable care arrangement, their new carer requested that the young person be allowed time to heal and build resilience before continuing to reside with them. The issue was raised with the Children's Advocate and District Director, where it was agreed that the placement should be put on hold pending a comprehensive psychological assessment of the young person's attachments, best interests and views about their new carer. While we acknowledge that this approach to arranging care aligns with the obligations of the CCS Act, it was identified as an exemplar rather than standard practice.

### **Case Management**

In addition to instability in care arrangements, we noted inconsistencies in the management of the placements, services and supports for the 19 sampled children and young people. The average number of Case Workers throughout their time in OOHC was 21, ranging from 2 to 36. Further, the average time spent with no allocated Case Worker was 319 days, ranging from 11 to 1,018 days. Only one of the children and young people spent no time without an allocated Case Worker. The impact of interrupted case management was evident in the inconsistent, inaccurate and absent Annual Care Plans, Quarterly Care Reports, Case Plan Supervision notes, Living Arrangement Summaries, Secure Care files,

Cultural Support Plans, Education Plans, Duty of Care notifications, Critical Incident notifications and Viewpoint responses identified throughout this Inquiry. Across all 19 children and young people, there was a misalignment between Living Arrangement Summaries and plans, reports and notes. Hospital admissions were not recorded, emergency placements in hotels or with DoC staff were not transparently reported, and there was no clear distinction between self-selected placements and instances where the child or young person was missing. The average completion rate for mandatory Annual Care Plans was 74.79 per cent, ranging from 33.33 per cent to the expected 100 per cent. The average completion rate for Quarterly Care Reports was 30.82 per cent, ranging from 10.44 per cent to 59.70 percent. These absences, inconsistencies and inaccuracies resulted in incomplete and confused chronological documentation of each child and young person's journey throughout OOHC.

Annual Care Plans and Quarterly Care Reports were developed to provide continuous updates on the care, needs and wellbeing of the children and young people in care. However, where recorded as completed, we found that numerous plans and reports were either blank, partially completed, contained information copied from previous documents or contained inaccurate information. Often actions and outcomes pertaining to assessments and referrals were not clearly recorded. Errors and omissions were carried through the documentation and were not corrected, misrepresenting the background, experiences and needs of the sampled children and young people. Care arrangements planned using outdated information from previous Annual Care Plans and Quarterly Care Reports resulted in confusion regarding the current situation

of those in care as the reports failed to accurately track placements, record decision making, report action outcomes or identify misalignments. We found that risk assessments decreased over time, leading to placement instability, which spurred hastily planned failed reunifications.

We acknowledge that the DoC has recently updated both the Annual Care Plan template and Quarterly Care Report policy; however, it is not clear how these changes will address the concerns we have raised. For example, the updated Annual Care Plan template includes prompting questions related to each of the Nine Dimensions of Care; however, it still fails to address the actions taken and outcomes achieved. Rather, it is assumed that Case Workers will provide a register of previous needs, decisions, actions and outcomes within the questions. There is no safeguard against continued copying of information without updates or vetting. These concerns extend to the recent update to the DoC practice guidance policy, which allows for the non-submission of Quarterly Care Reports where a visit to a child has occurred within one month of the report due date (A.07.6 of the Child Protection Guide). We encourage the DoC to reconsider this policy in light of the poor recordkeeping of care arrangements, safety risks and individual needs identified within this Inquiry.

### Reunification

Timely, safe and long-term reunification with family is a primary goal of OOHC in maintaining best interests of the child in accordance with the CCS Act. However, we found minimal evidence of successful reunifications for the sampled 19 children and young people, with fewer than half (42.10%) experiencing a formal reunification and all except one returning to OOHC following this.

Where reunification did occur, it was often not safe for the individual in care or for their family.

Given that the most common reason for placement in OOHC for these children and young people was FDV, and that 57.89 per cent reported being exposed to FDV while in care, we expected to observe rigorous risk assessment and comprehensive safety planning as part of reunification attempts. However, attempts at reunification often lacked evidence of appropriate risk assessment and collaboration with parents, family or community, resulting in a premature return to the home environment and an increased risk to both the child or young person and their family. We found that 37.50 per cent of formal reunifications occurred with parents considered at risk of perpetrating either FDV or child abuse. Further, all those formally reunified with one or more parents had initially entered OOHC following substantiated or suspected FDV in their home environment. Often the decision to attempt reunification was due to a lack of suitable care arrangements, reflecting decision making resulting from desperation rather than appropriateness. Safety planning was often reported as being conducted; however, it was typically neither comprehensive in its consideration of strategies nor collaborative in its involvement of parents and outside agencies, resulting in parental anxiety, misalignment with WAPOL and an eventual return to OOHC. Further, we found no evidence of regular assessment and management of risk through completion of parenting capacity assessments, recording of evidence of perpetrator accountability or use of appropriate tools, such as the Common Risk Assessment and Risk Management Framework, to track and support the reduction of unsafe behaviours

as part of reunification planning or monitoring. For example, following difficulties in securing Foster Care, behavioural issues resulting in removal from Therapeutic Residential Care and delays in escalating the need for a high need complex placement, one child was reunified with a parent known to be in a relationship with active FDV. We identified one mitigation strategy put in place, in the form of parental counselling, although we could identify no evidence of collaborative safety planning or engagement with the child regarding their experiences of FDV. The DoC appeared satisfied with the appearance of safety, noting following one home visit that “the family violence appears to be resolved or at least, well managed”. It was not clear to us how this assessment of risk was conducted or what evidence supported this conclusion.

Despite legislative updates and the introduction of FDV training for DoC staff, reunification assessments were not FDV informed and therefore were not cognisant of ongoing risk. We would argue that legislative requirements and standalone training courses are not sufficient to ensure rigorous and reliable assessment of reunification risks, particularly when FDV concerns are present. Recently, the DoC stopped funding the delivery of reunification programs and Reunification Care Teams are not consistently available at all DoC hubs. We encourage the DoC to reconsider the need for dedicated reunification resources, in light of this Inquiry’s findings and the core functions of OOHC under the CCS Act.

### **Aboriginal and Torres Strait Islander Child Placement Principle**

Where a child or young person is Aboriginal, section 12 of the CCS Act requires that placements be arranged in accordance with a clear order of priority, conceptualised as the ATSICPP. As with all children and young people in OOHC, priority is given to placement with a family member. Further to this, an Aboriginal child or young person is to be placed with an Aboriginal person who is either a member of the individual’s community or who lives in close proximity to the community. If no such person can be identified, a non-Indigenous carer may be arranged, provided they live in close proximity to the child or young person’s community, are responsive to their cultural support needs, and are able to support connection with the traditions of family and community. Only after these arrangements have been attempted can an Aboriginal child or young person be placed with a non-Indigenous carer away from their community. This carer must be responsive to cultural support needs and be both willing and able to support connection with culture and traditions of family and community. The ATSICPP does not allow placement of an Aboriginal child or young person with a non-Indigenous carer who lives away from their community and lacks the ability or willingness to support their connection with traditions, culture, family and community. The importance of proximity and connection is reflected in the five core elements that inform the ATSICPP: prevention of removal from family, community and culture; partnership with Aboriginal peoples regarding decision making; placement with family as priority; participation of the Aboriginal child, parents and family in decision making; and connection of the child with family, community, culture, traditions, language and country.

We discuss the issues presented by self-identification of cultural heritage in our assessment of Culture & Identity, where we found that the DoC was not responsive to self-identification of Aboriginality. Therefore, in this discussion we will focus only on those children and young people the DoC formally recognised as Aboriginal.

Due to enduring inconsistencies, inaccuracies and absences in Living Arrangement Summaries, Annual Care Plans, Quarterly Care Reports and Cultural Support Plans, we were unable to ascertain a clear record of the decision-making processes supporting adherence to the prioritisation of the ATSICPP. All but one of the children and young people formally identified as Aboriginal had been placed with a family member at least once during their time in OOH; however, these placements were often short lived, unendorsed or unsafe. Once these placements had been identified as such, the child or young person was removed from Kinship Care and moved into either Therapeutic Residential Care or Secure Care.

For a minority of the sampled Aboriginal children and young people (40.00%), there was evidence that family members had requested intervention by the DoC. For example, following substantiated physical abuse during kinship placement, one child's biological parents requested placement with a non-Indigenous carer, which was honoured by the DoC. This was a straightforward situation in which the legislated prioritisation process was superseded by the wishes of the child's parents. At other times, family members appeared to acknowledge that they were unable to keep the child or young person safe and requested that they be brought into care. Whether prioritisation of kinship and cultural connection was followed in these situations was unclear, as we noted this quickly led to entry into Therapeutic

Residential Care or Secure Care. For one child, it was only after their third admission into Secure Care that exit planning incorporated a meeting with a local Aboriginal Community Controlled Organisation to explore options for a one-on-one placement on Country and therapeutic crisis intervention services for their carer and family. However, these plans did not appear to have been fully actioned; at the child's fourth entry into Secure Care, it was noted that the "District are working hard to create a therapeutic care arrangement in Country. Current arrangement is [residential care]".

Where placement with family was attempted, the DoC reported difficulties in securing kinship assistance. At times, the DoC reported that family members nominated by parents did not play a consistently active role in supporting the child or young person. However, at other times, services designed to support kinship placement and connection with community could not be sourced in a timely manner or were not designed to address the complex therapeutic needs of the child or young person. Where family or community were not adequately supported, placements broke down and the children or young people were moved to placements with non-Indigenous carers or entered either Therapeutic Residential Care or Secure Care. We observed that non-Aboriginal carers lacked an understanding of culture and tradition, as evidenced by their misunderstanding of the child's interest in hunting and desire to engage with Lore. This reflected an unsuitable choice of carer, in accordance with the ATSICPP. When placed in Therapeutic Residential Care or Secure Care, we identified a pattern of children and young people absconding to stay with family or their community. At times, the parents themselves would collect their child, which was documented by the DoC as "taken without authority", and resulted in the child being removed from the care of their

family. In one instance, we observed that a child was repeatedly removed from family and placed in hotels and chalets. While we acknowledge the dangers of pre-emptive and unsupervised reunification, placement in locations such as hotels, with no assigned carer, fails to satisfy any of the placement options deemed culturally suitable for an Aboriginal individual under section 12 of the CCS Act.

Concerningly, beyond inconsistently evidenced adherence to the ATSICPP, we noted one instance of significant decision making by the DoC that reflected a gross misunderstanding of Aboriginal familial structures and the core principle elements of prevention and participation. We found that the DoC admitted one child into OOHc at birth despite the presence of family members who were committed to caring for the child. These family members became Kinship Carers under the DoC, providing stable care for the child on Country for a period of 12 years and contributing to the best outcomes we observed of any of the Aboriginal children in this sample. After the kinship placements broke down due to ill health and movement to a different community, the child began absconding and engaging in harmful behaviours. While we acknowledge the effective use of Kinship Carers, it is unclear why the DoC initially intervened in a family system where it was not required, impeding the family's sense of empowerment and self-determination.

Overall, we were unable to confidently determine whether the DoC consistently and completely adhered to the prioritisation of care arrangements outlined in section 12 of the CCS Act. Further, the decision making we were able to evidence did not align with the five core elements that underpin the full realisation of the ATSICPP.

### Admissions to Secure Care

Due to the restrictive and involuntary nature of Secure Care placement, both the CCS Act and DoC policies enforce several eligibility criteria for admission. Section 88 of the CCS Act requires that the DoC be satisfied there is an immediate and unmanageable risk to self and others before authorising admission of children and young people. Further, children under the age of 12 are not admitted by the DoC unless there are extenuating circumstances and admission on the basis of mental health instability is permissible only when it cannot be addressed by mental health services (E.56 of the Child Protection Guide). Once admitted, periods of stay should not exceed 21 days unless by formal extension. We found that admissions to KFSCC were often not aligned with legislation and policies relating to age and mental health exclusions or the use of Secure Care only when immediate safety is of significant concern.

The number of admissions to KFSCC between 2020 and 2025 was high, ranging from 3 to 13. We acknowledge that the high number of admissions reflects the sample selection criteria; however, the range of admissions to a 'last resort' placement option over this five year period remains a concern. The average total number of days in Secure Care for all 19 children and young people was 105 days, ranging from 51 to 258 days, with 63.57 per cent having at least one admission formally extended beyond 21 days. While the majority of the 19 children and young people sampled were first admitted at age 12 or older, we observed that a minority (21.05%) were initially admitted between the ages of 7 and 11. The extenuating circumstances allowing for these admissions varied in the extent to which they were reported. Some admissions were accompanied by broad statements relating to limited cognitive capacity or the need for constant supervision, whereas other

circumstances were more clearly recorded and outlined cumulative concerns regarding violence, self-harm, criminal behaviour, substance use and truancy. For the majority of Secure Care admissions, we identified clear reasons for entry into KFSCC, which were linked to intended goals to be achieved prior to discharge. Again, however, we noted a paucity of information chronicling the events, needs, decisions, placements and supports leading up to admission to KFSCC. Absences and inconsistencies across plans, reports and notes impeded a clear understanding of what changes occurred, what impacts they had and what steps the DoC took to manage their escalating concerns before seeking admission to Secure Care.

The reasons for admission into Secure Care were typically recorded clearly on entry; however, we found that these reasons did not always meet the requirement of significant and unmanageable harm to self or others. In reviewing the reasons for admission into Secure Care, we found that all 19 children and young people had been placed in KFSCC at least once during the study period due to the absence of an alternative placement, the need for drug and alcohol rehabilitation or for mental health concerns. One young person described KFSCC as “being like prison, decided due to lack of placements”. Often when there was no clear immediate risk of harm, Secure Care was sought as a ‘circuit breaker’ to disconnect a child or young person from unsafe environments or antisocial peers, or to allow them to receive medical attention. While these are valid reasons for seeking additional supports and services, they do not satisfy the legislated requirement for admission to Secure Care. Disappointingly, one of the sampled children entered Secure Care as their first OOHC placement, indicating that

no attempt was made to provide alternative care arrangements.

As will be discussed in our assessments of Health and Emotional & Behavioural Wellbeing, the majority of sampled children and young people exhibited significant mental health concerns, often presenting as dysregulated behaviours. We noted collaboration between KFSCC and community service providers, such as the Child and Adolescent Mental Health Service (CAMHS) and the East Metropolitan Youth Unit, for the arrangement of mental health assessments, services and plans during Secure Care stays. We support multi-agency collaboration for the holistic addressing of children and young people’s needs; however, current policy excluding admission to KFSCC on mental health grounds also precludes necessary oversight. As KFSCC is intended only to be used for supporting children and young people with behavioural issues, there are currently no legislated requirements for impartial oversight or advocacy of mental health-related matters. This means KFSCC is not subject to regulations relating to use of restrictive practice and children cannot access independent mental health advocacy supports. We acknowledge that section 125A of the CCS Act provides a legislated oversight mechanism for the assessment of Therapeutic Residential Care and Secure Care facilities. However, we actively monitor section 125A Assessor reports and have previously raised concerns that as the only legislated oversight mechanism of OOHC in WA, the current model lacks the independence, investigative powers, methodology, transparency and resources to evaluate whether residential and secure care services are operating in a manner consistent with the rights and wellbeing of children and young people.

Further, as we identify throughout this Inquiry report, complex trauma experienced by children and young people within OOHC cannot be separated from behavioural or mental health issues. Where an agency or service manages individuals who demonstrate significant mental health behaviours resulting in severe concerns of harm to self and others, appropriate advocacy and oversight are required to ensure the safety, wellbeing and rehabilitation of children and young people.

Overall, the focus of arranging care for these 19 children and young people appeared to be on where to place the child rather than what is in the best interest of the child. We identified a pattern of inconsistent case management, which led to inaccurate reporting and incomplete information, resulting in unsafe decision making and unstable care arrangements. Tailored resources and independent oversight are required to support the DoC in meeting its core obligations of providing safety, stability, healing and reunification to the children and young people in OOHC.

## Health

We consistently identified missed opportunities to provide holistic and timely support for physical health needs of the sampled children and young people throughout their time in care. Where mental health concerns were identified, we found evidence of effective inter-agency interaction when children and young people were responsive to help seeking.

Section 8 of the CCS Act requires consideration of the need to protect a child or young person from harm and to meet any of their physical, emotional and developmental needs. Health needs are a significant aspect of determining the best interests of a child in care, as children and young people in OOHC are placed there specifically because they have been found to be either in danger or not adequately cared for. Often these children and young people have experienced abuse, neglect, family violence, substance misuse or homelessness, negatively impacting both their physical and mental health.

### Assessment of Health Needs

DoC policy requires a Health Assessment be completed within the first 20 days of a child or young person entering care to allow for the identification and prioritisation of their physical and mental health needs (A.07.3 of the Child Protection Guide). As each of the 19 children and young people sampled had experienced multiple admissions to care, we expected to find evidence of multiple Health Assessments reported within Annual Care Plans and Quarterly Care Reports. We found evidence supporting the completion of at least one timely initial Health Assessment for a minority of the sampled children and young people (31.57%); however, we also identified the completion of at least one Health Assessment outside the 20-day

time frame for 15.78 per cent of sampled children and young people. In the majority of cases (52.63%), there was no evidence to support the completion of an initial Health Assessment on placement into care. In one instance, we found that no Health Assessments had been completed on admission into care and the child's overall health condition was unknown, despite ongoing concerns regarding neglect and malnutrition. Across all 19 children and young people we found no evidence of timely completion of an initial Health Assessment for every admission into care. This highlights a significant recordkeeping issue, as this information must be documented within the Annual Care Plan and Quarterly Care Reports. This then informs the prioritisation of needs and decision making that serves the best interests of the child or young person in care (A.07.3 of the Child Protection Guide). Without completion and documentation of timely Health Assessments, the DoC is unable to accurately consider the physical, developmental and mental health needs of the children and young people in care.

Within this sample, almost half of the children and young people (47.37%) were either registered or had applied for registration with the National Disability Insurance Scheme (NDIS), whereas a minority (15.79%) had their NDIS application denied. We identified challenges with timely NDIS assessments and documentation by the DoC for children and young people identified as needing an assessment but with no evidence of referral. Where there was consistent documentation regarding possible disability assessments and NDIS registration, this often did not occur until a young person's final year in care, resulting in open ended referrals with unclear outcomes.

### Supported Management

All 19 children and young people had comorbid physical and mental health concerns, with 73.68 per cent formally diagnosed with between two and four health issues and 26.32 per cent reported as having more than five diagnoses during their time in OOHC. We identified 36 different physical and mental health diagnoses and 14 different suspected health concerns. This a concerningly high rate of identified health issues for a relatively small sample of young people, reflecting the known experienced disadvantage and resulting high needs of children in OOHC. The most diagnosed physical health concerns included sexually transmitted infections (26.31%), asthma (21.05%) and allergies (15.78%). Neurodivergence and mental health disorders were much more prevalent, with the most common diagnoses including Attention Deficit Hyperactivity Disorder (52.63%), PTSD (52.63%) and various attachment disorders (31.57%).

Complex comorbidity during childhood, as identified in this case review sample, is known to have significant impacts on adult development, functioning and wellbeing, requiring holistic support underpinned by the collaboration of multiple agencies. This is recognised in section 22 of the CCS Act, which requires the DoC to work in cooperation with public authorities, non-government agencies and service providers to fulfil the best interests of the children and young people in care. Despite the development of inter-agency Memorandums of Understanding and the section 22 amendments to the CCS Amendment Act, we found that the intersectionality of the DoC, the Department of Health (DoH) and WAPOL was inconsistent and reactive. Information sharing between the DoC and the DoH was often not evident in the documents provided to us, potentially resulting in delays in identification and

missed opportunities for early prevention. We identified evidence of medical testing being conducted with no recorded outcomes; vaguely described or absent follow-up actions after medical incidents or procedures requiring hospitalisation; and a lack of health-based support to address reported trauma or noted behavioural concerns. Symptoms observed by DoC staff or reported by children and young people were not always followed by timely assessment. We noted instances where Polycystic Ovarian Syndrome, Insomnia and seizures went unaddressed for extended periods of time despite suspected links with behavioural issues, emotional instability or substance use. There appeared to be a trend of siloing between the DoC and the DoH, often leading to poor outcomes for children and young people. For example, in one instance it was reported that “comments were made to [DoC] staff that the hospital did not appreciate [young person] being brought to the Emergency Department for behavioural issues and that [young person] would not be provided a hospital bed in the future”.

Where mental health concerns were evident, available documents supported more effective interactions with CAMHS and non-government service providers. We found evidence of consultation or service provision for the majority of the 19 children and young people (89.47%), including neurodevelopmental assessments, psychiatric assessments, medication reviews, drug and alcohol counselling, psychological therapeutic interventions and mental health safety planning. Referrals were often made to multiple mental health services, including CAMHS, Parkerville, Drug and Alcohol Youth Service, Headspace and private mental health practitioners. This is pleasing to note, given the known adverse childhood experiences of children placed in OOHC and the high rates of mental ill health within

this sample. However, we again found that for several of the sampled children and young people there was no evidence of the outcomes of the referrals made, impeding assessment of the efficacy of the sought consultations. We also found that almost half of the children and young people referred to CAMHS (46.66%) were resistant to engaging in counselling, and that there were few proactive, collaborative responses. Those children and young people resistant to receiving help often either refused to engage or failed to attend scheduled appointments, leading CAMHS to discharge them due to dissatisfaction with their engagement. Encouragingly, most of these children and young people were referred to alternative services and engaged with these supports. However, there remained a minority who were discharged without any evidenced mitigation strategies or alternative referrals being arranged. In one instance, a child reported finding it difficult to engage with CAMHS following the unexpected death of their previous CAMHS counsellor, which led to this child being discharged due to unsatisfactory engagement without any evidence of grief support or referrals to alternative agencies.

We observed additional references to inter-agency collaboration indicating that the intended holistic approach to healthcare is occurring to some degree. Care plans and reports noted general practitioner appointments, paediatric reviews, psychologist appointments, psychiatric assessments and functional capacity assessments taking place in the community, in addition to mental health and clinical neuropsychological assessments occurring at Perth Children’s Hospital and Fiona Stanley Hospital. In a minority of cases there was also evidence of the DoC advocating for psychiatric intervention in consultation with hospitals, community paediatricians and

CAMHS or arranging post-care continuity of service where further mental health support was required. These indications of holistic, wraparound healthcare were encouraging to see. However, there remained a gap between assessment and management, evidenced by the absence of clear descriptions of how outcomes from healthcare consultations were incorporated into care arrangements or supports. Encouragingly, during this Inquiry, we became aware of an ongoing initiative making positive progress in achieving holistic healthcare within the OOHC system – the Health Navigator Pilot Program. Currently based in Mirrabooka and the South West, this program employs Health Navigators to support children in care, specifically with health assessments and ongoing health coordination. This program incorporates the DoC and the DoH, and works in partnership with local Aboriginal and CaLD medical services. In light of these findings, we encourage the DoC to conduct a review of the current procedures facilitating inter-agency cooperation regarding timely and holistic healthcare as part of their obligations under section 22 of the CCS Act.

## Education

We found partial evidence of intentional, consistent and individualised learning opportunities fostering meaningful participation in education. Attendance of mainstream or alternative schooling was inconsistent and evidence of active facilitation of educational pursuits was minimal for the majority of the 19 children and young people.

In determining the best interests of the child, section 8 of the CCS Act requires consideration of educational needs. Formal education and vocational training are significant aspects of childhood development, providing life skills and supporting the attainment of employment the leads to fulfilling careers and sustained prosocial lifestyles in adulthood.

We found that most of the sampled children and young people (89.47%) had engaged in some form of education during their time in OOHC, whether through mainstream or alternative schooling, educational activities or vocational training. Almost three-quarters (73.68%) had an education plan developed during their placement; however, most (71.42%) had only one plan developed throughout their entire time in care. This is concerning, considering that none of the 19 children and young people had remained at one school throughout their time in OOHC. These children and young people were often not engaged in mainstream education at the time they entered care, and we were pleased to find that a majority (94.73%) sought alternative education options when mainstream schooling was not possible.

However, it was evident that mainstream education was often considered not possible due to placement instability, disinterest in attending school, lack of engagement in educational activities or complex behavioural issues (47.36% of sample). Further, for several children and young people (15.78%),

it was recorded that educational needs were classed as a low priority due to the presence of other complex needs or a lack of educational development. For one child, it was openly acknowledged that they had “not been in formal education since being brought into care due the Department of Education being unable to provide a service to meet [their] educational needs, as a result of the child’s behaviours due to the complex trauma [they] experienced in [their] childhood”. This statement recognises a clear inability to act in the best interests of the child and to provide better outcomes for children in the care of the government, as outlined in the General Principles of the CCS Act. We acknowledge that the safety of self and others is important; however, this identified trend reflects a limited understanding of the Nine Dimensions of Care model and the related underlying CCS Act requirements as a holistic approach to addressing of the needs and interests of children and young people in OOHc. PTSD, often a consequence of trauma, impairs recall and concentration and requires additional support or alternative learning options rather than a de-prioritisation of educational pursuits. In reviewing the cases within our sample, we could identify only one example where the DoC facilitated alternative arrangements in response to complex needs and behavioural issues, whereby a child was homeschooled by their carer for several years. With the availability of DoC internal tutoring, online educational programs and alternative schooling options, responsiveness to foreseeable challenges such as placement instability and complex needs should be standard practice rather than an exemplar.

We also observed minimal responsiveness to voiced concerns about school attendance. When a child or young person expressed an aptitude for learning – whether through a desire to return to mainstream schooling or a passion for reading – there did not appear to be any follow-up action taken, missing the

opportunity for intrinsically led engagement in education. Where children and young people reported being bullied, treated differently at school or exhibiting signs of ‘school can’t’, there was no evidence of supports being put in place to facilitate continued attendance or alternative educational pathways being sought in a timely manner. Alternatives were sought only after periods of non-attendance across several school placements or suspension from mainstream schools, leading to significant periods of inconsistent engagement in education. When considered in conjunction with the enduring placement instability highlighted in the discussion of care arrangements, this pattern of reactive response to attendance fails to account for the complexities faced when placement changes occur. Changes in placement bring new schools and displace established social networks, impacting the development of the child’s social and emotional wellbeing.

In a minority of cases (15.78%), we noted that individual schools were developing trauma-informed and child-centred Individual Education Plans. This is positive; however, in each instance, plans were developed by the school with no evidence of involvement from the DoC, which led to siloed, ad-hoc completions lacking inter-agency collaboration and, therefore, continuity. We also observed inconsistencies in funding for educational items, fees and supports, which highlighted a lack of clarity in DoC processes resulting in inequitable access to opportunities. A minority of children and young people (10.52%) reported receiving funding for books or educational aides; however, there was no clear record of the mechanisms used to advocate for, establish or monitor this funding. In two cases we noted that private schooling was identified as a positive option for the young person; however, in one instance the carer was asked to pay the school fees, whereas in the other, the DoC applied for special purpose

funding to cover the fees. It was unclear why the process and outcome differed in these two cases.

Almost half of the 19 children and young people (47.36%) attended alternative schooling institutions. Several children and young people (26.31%) were referred to or enrolled in alternative educational institutions; however, they either advised that they did not want to attend or did not have a clearly recorded outcome of referral or enrolment. As employment and post care became a focus, several young people enrolled in TAFE (21.05%) or began a Certificate II in General Education for Adults (15.78%); however, it was not clear whether they completed their courses. The content of the educational and vocational pursuits varied across the 19 children and young people for whom there was a record of interests, which is encouraging. Classes undertaken at alternative schooling institutions included art and cooking, whereas some TAFE courses focused on attaining future employment in childcare or labouring. For a few of the sampled children and young people (15.78%), their most substantial or meaningful period of education was while in Secure Care or BHDC, indicating that, for at least some, a more intensive and integrated style of education is required. Similarly, it was noted one young person achieved their best educational outcomes when attending a community school on Country, which was linked to the ability to receive consistent support in a smaller classroom responsive to individual learning capacities.

Overall, we found consistent missed opportunities for meaningful engagement in education and vocation due to the de-prioritisation of learning, reflecting an ignorance of its role as a significant aspect of childhood development.

## Emotional & Behavioural Wellbeing

Social, physical or emotional difficulties, combined with experiences of trauma, often present as behavioural issues such as dysregulation and risk taking. In responding to these behaviours trauma-informed, timely emotional support and therapeutic planning are required to assist children and young people in developing the mental wellbeing that will facilitate positive behavioural change.

In providing care to children and young people in OOH, section 8 of CCS Act requires the DoC to consider the need to protect them from harm and address identified physical, emotional, intellectual, spiritual and developmental needs. Further, section 22 of the CCS Act requires acts of protection and care to be carried out in collaboration with public authorities, non-government agencies and service providers.

Due to confidentiality stipulations, we were not provided with psychological or medical reports; therefore, information was drawn from Annual Care Plans, Quarterly Care Reports, Case Plan Supervision notes, Living Arrangement Summaries, Secure Care files, Cultural Support Plans, Education Plans, Duty of Care notifications, Critical Incident notifications and Viewpoint responses. In acknowledgement of the absence of specific medical or psychological reports and referrals, due to the need to protect the privacy of the 19 children and young people sampled, and the above discussion of timely, holistic healthcare, we comment below on the trends identified when analysing responses to emotional distress and dangerous behaviours.

We found that 94.73 per cent of the sampled children and young people had expressed suicidal ideation or engaged in self-harm behaviours during their time in care. Further, all the identified cases

involved repeated reports of either voiced intentions or evidenced acts of harm, indicating that responses were consistently ineffective in supporting the child or young person to address the underlying causes of these behaviours. A majority of children and young people (73.68%) were also engaged in volatile substance use during their time in care – the intentional inhalation of household or industrial chemicals to achieve intoxication. Of these children and young people, 31.57 per cent had evidence of a referral to or attendance at a volatile substance use support service, although we found no evidence of mitigation strategies implemented by carers or DoC staff, such as an established process for safe storage. Considering this in combination with the identified comorbidity of physical and mental diagnoses, it was evident that this sample represented a state of chronic mental health crisis.

Early intervention opportunities, such as carer support plans or engagement with preventative healthcare supports, appeared to have been either missed or not detailed in the documents provided to us. We noted an absence of early attempts to support emotional regulation and self-care. In instances where carers directly raised concerns about escalating behaviours (21.05%), there was limited evidence of actioned referrals for the individual in care or of supports for the carers themselves, such as enrolment in trauma training or the Parent Support Program. Linking this with findings related to treatment resistance identified in the discussion of the Health dimension, earlier intervention may have reduced resistance to receiving help once the behaviours had become harmful or mitigated risk-taking behaviours altogether.

Overall, we noted a pattern of reactive and punitive responses to significant dysregulation and risk taking without

evidence of appropriate steps being taken to support the navigation of traumatic life crises. Typically, a critical incident would occur involving self-harm, threats to self or others or offending. This would trigger the involvement of WAPOL, leading to admission to either Secure Care or involuntary hospitalisation followed by psychological assessments resulting in referral to support services. Eventually the child or young person was returned to their placement with minimal evidence of ongoing services or safety plans. This was followed by a lapse into ideation, self-harm, threats to others or offending. In one instance, a young person was admitted to Perth Children's Hospital 11 times in one year for ideation and harmful behaviours. While we appreciate the evidenced inter-agency collaborative response, it was clear from the information provided to us that the current process does not result in sustained mental wellbeing or positive behavioural change. Critical incident response and management was poorly documented in terms of both the severity and category of behaviours, as well as the resulting responses to individual needs and situations. Arguably, this cycle is exacerbated by the identified links between externalised behaviours, placement instability and pre-emptive Secure Care admissions discussed in the Care Arrangement dimension.

It is noted that the DoC has now implemented a new care arrangement process, Stepping Stones, an intensive step-down approach for children and young people exiting Secure Care. Care is now provided at a ratio of three staff members to two children and is aimed at providing ongoing support while implementing the requirements of the discharge summaries. This process will ensure continuity of support and care by KFSCC staff during the transition to an alternative care arrangement.

## Social & Family Relationships

Across all the 19 children and young people, we observed both barriers to, and missed opportunities for, social and family connection. Development, maintenance and support of safe and healthy relationships that foster connection and belonging beyond OOHC remains a significant gap in ensuring the best interests and wellbeing of children in care.

Support for the development and maintenance of relationships meaningful to a child or young person placed in care is a core aspect of ensuring the safety and best interests of the individual while under the protection of the DoC. This is evident in the outline of the Objects and Principles of the CCS Act, where the importance of family and social relationships is repeatedly emphasised. A central objective of the CCS Act is to acknowledge the primary role that parents, families and communities play in safeguarding and promoting the wellbeing of children. Section 8 of the CCS Act outlines this objective as a requirement to consider when determining the best interests of a child or young person, as well as the need for a child or young person to develop and maintain contact with parents, siblings, other family members and people who are significant in their life. Section 9 further stipulates that supporting parents, family and community is the preferred way for the DoC to protect and promote a child or young person's wellbeing. It is therefore clear that the DoC has a primary obligation to identify and foster safe relationships when taking on the temporary protection and care of an individual through OOHC. Such relationships may lead to a child or young person exiting formal care, supporting healing and providing structure for healthy adulthood development.

## Family Relationships

Over a quarter of all sampled children and young people (36.84%) reported being negatively impacted by their separation from parents, siblings, grandparents and extended family. Some felt significantly disconnected, perceived themselves as abandoned or saw themselves as unloved. Others requested connection and interaction with those they missed. We found no evidence to support actions undertaken by the DoC to fulfil these requests; instead, we found that family members or the children and young people themselves had taken steps to develop these relationships. Relatives were reported to have taken a child or young person to visit other family members, with no clarity as to if or how the DoC supported this, while some children and young people either arranged their own visits with family or repeatedly and extensively absconded from care in order to reside with family. These actions taken by relatives and the children and young people themselves demonstrate the failure of the DoC to both prioritise consistent family connection and consider the views of those in OOHC.

Barriers to consistent and meaningful contact with safe family members were largely related to ongoing safety concerns regarding active FDV affecting the individual in care, or to geographical distance, where relatives resided in another state or country (42.10% of the total sample). Where contact with family was recorded, limited information was provided beyond stating who the child or young person had lived with or had regular contact with prior to coming into care, or that unspecified regular contact was occurring. Beyond safety and geography, we identified that the DoC itself was a barrier to fostering stable and healthy relationships. We noted that several children and young people (42.10%) had possible or previous significant relationships with immediate or extended

family, although there was no evidence of the DoC confirming these relationships, initiating contact or facilitating interaction. In one instance, extended family was identified through a DoC process, Finding Families; however, we could find no evidence of any action taken following this. We appreciate the development of policies, processes and systems designed to fulfil legislative obligations; however, without follow through these structures contribute little to outcomes for those in OOHC.

Encouragingly, we identified examples where the embodiment of CCS Act obligations was evident. DoC staff recorded attempts to model and scaffold positive relationships while directly interacting with the children and young people or overseeing visits with their families. In one instance, there was evidence of ongoing collaboration with community organisations to support family members in responding therapeutically to the dysregulated behaviours of their child. Further, there was evidence that some of the children and young people were connected with mentors, who acted as role models for safe, stable and healthy adult functioning.

### **Social Relationships**

There was minimal information available on social relationships, whether established or developing. For over a quarter of the sampled children and young people (31.57%) it was noted that they had experienced trouble making friends or demonstrated poor social skills. Some were admitted into Secure Care, in part, to stop them from associating with antisocial peers. Concerningly, there were reports of sexually exploitative relationships with adults for over a quarter of the sampled children and young people (26.31%). Beyond admission to Secure Care as a 'circuit breaker' or involvement of WAPOL where conduct was criminal in nature, we identified minimal evidence of strategies, supports or

services implemented to assist with limited social functioning or the cessation of harmful relationships while in the community.

In fostering meaningful social and family connections, we also identified missed opportunities to support children and young people in developing resilience and healthy coping mechanisms when significant relationships ceased due to death. Several children and young people (26.31%) were reported to have experienced the death of one or more friends or family members with whom they had a close connection, although we were unable to find evidence of support in understanding, processing or accepting these losses.

Stable, unconditional emotional connections between a child and their parents, siblings, family and other people important to them, not only increase stability in the child's life and support reunification but also foster resilience and healing from trauma, which promotes long-term better mental and physical health (A.06.01 of the Child Protection Guide). Despite social and family relationships being a core aspect of the obligations under the CCS Act, there are significant gaps in the persistent identification and consistent fostering of safe connections.

## Identity & Culture

We found that exploration of sexual, cultural and religious identities was not actively supported. Further, opportunities for each of the 19 children and young people to express their views and inform decisions regarding their placement were limited and inconsistent.

Section 8 of the CCS Act includes in the best interests of the child the requirement to consider age, maturity, sex, sexuality, background and language, including cultural, ethnic and religious identity. In fostering cultural, ethnic or religious identity, there is a requirement to develop and maintain connections with the traditions of the child or young person's family or community. Where the culture is Aboriginal, section 14 of the CCS Act requires consultation with appropriate community representatives. Throughout childhood, identity is developed through the formation of traits, values and perceptions, which are largely shaped by a child's interactions with their caregivers and connections with community. Integral to developing adult independence, stability and healthy functioning is self-awareness and agency to make safe and suitable decisions aligned with internal beliefs and values.

### Exploration of Identities

Across the sample of 19 children and young people, there was minimal diversity in recorded sexuality, culture, ethnicity and religion. In one instance, all details of identity and culture had been redacted by the DoC, so we were unable to assess the exploration of this individual's sense of self. It was not made clear to us why this information had been redacted.

All the sampled children and young people identified as cisgender, with one reporting as bisexual. It was not clear whether any additional or sexuality specific supports

were provided to this individual to assist with further understanding and embracing their identified bisexuality.

From the case file information provided, we found that over a quarter of children and young people (26.31%) were identified by the DoC as Aboriginal, with an additional 10.52 per cent identified as CaLD. All 19 children and young people had a Genogram completed; however, there was no evidence that any of these were updated to reflect any later identified connections. Further, we found that Cultural Support Plans were completed sparingly, with an average of 41.65 per cent of the required plans completed across the sample. Where completed, the plans often consisted of generic statements lacking meaningful depth and were linked to intentions with no corresponding actions or outcomes. At times, the Cultural Support Plans were blank and we often identified statements such as "Department to continue to discuss with child's family about [their] identity and culture". We found no evidence that completed plans were updated after placement changes. The absence of detail, including updates to changes in family or environment, rendered these activities as 'tick box' exercises with no evidenced, practical utility afforded to them by DoC policies or practices. This is particularly disappointing given that Cultural Support Plans were introduced following the 2021 amendment of the CCS Act in order to enhance the cultural responsiveness of OOHHC.

Where a CaLD background was identified, meaningful exploration of practices, needs, values or connections was not evidenced. We identified the use of generic CaLD team leaders rather than designated, specialist CaLD representatives for cultural consultation, which led to generic plans and recommendations that failed to address the voiced feelings of disconnection from family, community and culture.

All the sampled children and young people who were identified as Aboriginal by DoC, completed Aboriginal Practice Leader (APL) Consults during their time in OOHC. This mandated process is undertaken to meet the obligations of sections 12 and 14 of the CCS Act, ATSI CPP and the Principle of Community Participation (A.05.01 of the Child Protection Guide). Under these sections, either family, community or a representative organisation of Aboriginal peoples are to be given the opportunity to participate in the decision-making processes. Consideration must also be given to the wishes and views of the child or young person.

We found variance in the consistency and meaningfulness of these consults, with evidence of both ongoing engagement in consultation embedded within Annual Care Plans and infrequent or absent APL Consults. Infrequent or absent consults were in the minority; however, in all identified cases, the child or young person was reported to have directly requested to know more about their Aboriginality, highlighting a failure to respond to the wishes and views of the individual in care. In one instance, after directly raising the question of culture over a five-year period through Viewpoint responses, requesting the completion of a family tree and asking to learn more about their connection to culture, a child arranged their own contact with family. In response to this it was reported that “there are currently no known cultural obligations that the Department needs to be aware of”. This constitutes a gross failure to be culturally responsive, to respond to the wishes of a child in care and to uphold their best interests.

Similarly, we found that the DoC was not responsive to self-identification of Aboriginality. Our review of the case notes revealed that several children and young people (36.84%) self-identified as Aboriginal but were not recognised as such by the

DoC. Outcomes for those who self-identified were varied and inconsistent. Where family supported self-identification, outcomes ranged from inaction to completion of a Cultural Support Plan without an APL Consult and unsubstantiated plans for an APL Consult. None of these outcomes resulted in the formal identification of the child or young person as Aboriginal. Where there was conflicting information regarding self-identification, the DoC was inconsistent in its investigation of the matter and, when investigated, the outcome was not always clear. Overall, we found that the DoC was not proactive in investigating self-identification or supporting children and young people to understand and explore potential cultural connections.

We were unable to confidently determine the number of children and young people with a religious affiliation or an interest in learning more about a specific religion. Almost three-quarters of the sampled children and young people (73.68%) had no reported information on religious interest or practices and there was no evidence that religious identity was directly explored. Where religious identity was reported, details were superficial and only referenced that the child or young person celebrated birthdays, Christmas and Easter. In one instance, it was reported that a child had begun exploring spirituality themselves, through tarot readings and the use of crystals. Whether this was supported as an exploration of identity was not clear.

The available evidence did not support any meaningful exploration of sexual, cultural or religious identity, as required under section 8 of the CCS Act. Sexuality and religion were superficially reported and did not appear to be actively investigated as potentially significant aspects of self-understanding. Where culture was confirmed by the DoC and was Aboriginal, mandated APL Consults took place for the majority of sampled children

and young people. However, significant gaps remain in the meaningful completion of Cultural Support Plans and consistent consultation with Aboriginal peoples. Where culture was self-identified, we found that the DoC was passive in its attempts to confirm or support cultural connection. Overall, we found minimal evidence of authentic fulfilment of section 14 of the CCS Act.

### **Genuine Consultation and Informed Decision Making**

We observed insufficient opportunities for children and young people to express their opinions during decision making. This included decisions impacting several different dimensions of care, such as healthcare, education, recreation, contact with family and admission to Secure Care. Evidenced, consistent consideration of a child or young person's needs, interests and desires is not only a legislative requirement for the DoC in decision making but also an integral part of the development of a young person's agency and sense of self.

Regarding matters directly related to gathering and embedding a child's voice, section 10 of the CCS Act requires that if a decision is likely to have a significant impact on a child's life, the child must be given clear, age-appropriate information about the decision being made, why the DoC is involved, how they can participate and how to request a review or make a complaint. They should have a genuine opportunity to express their views, with any support they need to do so. Their views must be recorded and considered in the decision-making process, and they should be told what decision was made and why. Finally, they must be given a chance to respond to the outcome.

The DoC has implemented the following tools and mechanisms to assist in meeting these obligations:

- **Viewpoint.** An optional, interactive online platform that collects feedback from children and young people regarding their care plans and experiences. Questions reflect the Nine Dimensions of Care and range from asking the young person's opinion on their day-to-day life, perceived safety in their environment and how they feel about their own and others' behaviours. DoC policy states that Viewpoint should be undertaken as part of the Annual Care Planning cycle, with corresponding actions to be completed within two business days.
- **Strengths and Difficulties Questionnaire.** A behavioural screening tool designed for children and young people to assess their emotional and behavioural difficulties. This questionnaire can be completed by the young person themselves, their main caretaker or their teachers.
- **Needs Assessment Tool.** A mandatory assessment completed on entry to OOHC to inform care planning, case management and care arrangements. This tool is designed to help support workers on the child's care team consistently identify and assess the complexity of the child's needs and circumstances as the child ages.
- **Care Team Approach.** A practice framework that provides strategies for encouraging the participation of children and young people in the development and review of their care plans. Strategies are tailored to age, cognitive and cultural differences, and aim to support all children and young people with providing input.

In our review of the provided documentation, we found evidence of the use of Viewpoint and the Care Team Approach only.

Viewpoints were inconsistently completed across the 19 children and young people, and where it was not completed, there was either insufficient or no reasoning provided for the non-completion. For over a quarter of the sampled children and young people (36.84%), there was no evidence of any Viewpoints being completed during their time in care, or Viewpoints were referenced in case notes but couldn't be located by the DoC when requested. Where Viewpoints were completed and there was indication of action needing to be undertaken, such as disclosure of risky behaviours, concerns about physical health or expression of unhappiness with case workers, we found no evidence of follow-up. It appeared that there were no mechanisms for DoC staff to follow up and evidence direct action taken in response to Viewpoint information in conjunction with the completion of care plans or case reviews. A small number of children and young people had documented evidence of caseworkers using strategies such as 'Words and Pictures' and/or 'Three Houses' to facilitate input in an age-appropriate manner.

We acknowledge that the absence of evidence of other tools or strategies may be due to our not having been provided access to all the documentation for all 19 children and young people. Therefore, we comment below on broader evidence of responsive, informed and documented consultation.

In the period from July to December 2024, the DoC analysed 2,959 Viewpoint responses from children and young people collected between 2022 and 2024. A copy of this report was provided to us. The DoC found that less than half of the children and young people had enough help and information to make decisions about their future, had a caseworker explain decisions to them or consistently had a say in what happened to them regarding where they lived, their schooling and learning, or

their future. The findings from our case reviews align with this low rate of genuine consultation and informed decision making. Evidence of consultation was partial across all Nine Dimensions of Care for the duration of time in care, with our review able to identify only a minority of specific requests made by the child or young person in relation to health, educational, recreational or cultural matters. Actioning of these requests was inconsistent, with follow-up often not documented. On one occasion, a young person threatened self-harm if returned to a particular care placement, yet they were returned to this placement regardless, resulting in continued threats and abscondment. Evidence gleaned from Standards & Monitoring Reports completed by residential care facilities often noted that children were "briefly spoken with", but not in a confidential or private setting. In many reports, it was noted that the children were not available for consultation. Some Annual Care Plans and Quarterly Care Reports included quotes from the child or young person regarding their social and familial relationships; however, other Care Plans described incorporating expressed views of the child where possible, without providing further detail that identified these views or explained how they were incorporated. Several Care Plans consisted of information copied and pasted from previous plans, providing no updates or details regarding how input from the child or young person was supported. While there was sometimes mention of a child or young person being present during Care Plan meetings, this was often accompanied by comments relating to an inability to engage in consultation due to generalised disengagement, "limited capacity", difficulties with attention span or disability. Where barriers were identified, there was no evidence of supports or strategies implemented to facilitate input, as required by the CCS Act.

In addition to the right to informed consultation and supported input, section 10 of the CCS Act outlines the right of children and young people to request a review of a decision or to respond to a placement outcome. We found that the majority of the 19 sampled children and young people (84.21%) were given the choice to appeal the decision to admit them to Secure Care on each separate occasion of admission. However, we also identified an absence of any recorded opportunity to appeal Secure Care admission for a minority of children and young people (5.26%), effectively denying them a fundamental right afforded by the CCS Act. This is even more concerning when considering that half of those children and young people who were provided the opportunity to appeal their Secure Care admission completed an application for reconsideration for at least one of their periods of admission, and 15.78 per cent also applied for State Administrative Tribunal intervention while placed in Secure Care.

Good practice was identified only in a minority of cases. We observed consideration of children and young peoples voiced wants and needs in relation to social and family relationships. One example of good practice was evidenced during a case review, in which the child was clearly advised of the role and function of the review process and panel,

the avenues for appealing decisions and the option for the child to speak alone with panel representatives. On a minority of occasions, it was noted that the Charter of Rights was provided and explained during care planning meetings involving the child or young person. These practices are encouraging; however, they should be standard procedures rather than exemplars. On one occasion, a Care Plan was modified to intentionally highlight the child's and carer's views, which aligns with legislative requirements. However, this was in response to a carer's complaint that their own views were not being adequately considered and therefore this action remains reactive rather than procedural.

Inconsistent integration of the tools designed to facilitate participation, and partial evidence of responsive consultation, reflects an overall failure to meet the obligations of section 10 of the CCS Act. We found that the majority of decisions did not evidence input from or consultation with the children or young people they impacted.

Training staff in the responsive use of each of the tools is essential to engage children and young people in conversations across all Nine Dimensions of Care, especially when the children or young people demonstrate cognitive, language or cultural differences.

## Recreation & Leisure

Across all 19 children and young people there was minimal evidence of individualised social activities or support for community participation to foster wellbeing through belonging.

In determining what is in the best interests of a child or young person in care, section 8 of the CCS Act requires that age, maturity, sex, sexuality, background, language, physical, emotional, intellectual, spiritual and developmental needs be taken into account. Recreation and leisure allow for the exploration and development of these aspects of wellbeing, while also fostering social connection, adaptive skills and relational trust.

We found consistent missed opportunities to foster or strengthen the interests voiced by the children and young people. While interests were often noted – for example, listening to music, swimming, dancing, playing sport, creating art, cooking, camping, hunting on country, playing an instrument and volunteering – there were minimal records of organised or funded social activities linking these interests with the community. Instead, hobbies and pastimes were facilitated on an ad hoc basis by individual carers. In one instance, a young person's carers reported displeasure with the recreational and leisure activities being undertaken, although no further requests for information or actions were taken following this disclosure. We also observed that when a child or young person had previously engaged in an arranged activity, such as equine therapy or football, this was noted but not continued.

Often, the child or young person was reported as being uninterested in, or unable to engage in, recreation or leisure, although these contexts were neither elaborated on nor actively addressed. Case notes cited placement instability, substance use,

poor social skills, behavioural concerns or the need for NDIS functional capacity assessments as reasons why community-based activities could not or should not be arranged. However, we found no evidence of supportive emotional or behavioural strategies being implemented, nor of required assessments being completed within the time period of the case review. Further, there was no evidence that voicing the interests of these children and young people was explored as a means of addressing the identified issues. These were significant missed opportunities to build resilience and foster wellbeing through the development of adaptive strategies and community connection. Disappointingly, we observed evidence of young people developing health conscious hobbies and habits while in BHDC, such as physical exercise or art therapy, that were not fostered with the same consistency in the community.

For over a quarter of the sampled children and young people (31.57%), there was no clear record of any recreational interests or activities. Often, we found that when there was no evidence of a discussion with a child or young person about their needs, interests or hobbies, these individuals had significant emotional, behavioural and health issues. While we appreciate that there was likely a prioritisation of immediate risks to self and others, the absence of attempts to engage the children and young people in discussions about positive, social, adaptive or health conscious activities is a missed opportunity to build a foundation of resilience and connection in line with consideration of the best interests of the child. When we considered the lack of proactive engagement of children and young people in recreational activities alongside the noted concerns regarding difficulties initiating prosocial friendships, the need for consistent action in fostering community involvement becomes highly significant.

For a minority of children and young people there was evidence of care workers encouraging interests or involving family in recreational activities, which is encouraging. In these cases, the children and young people were supported in learning new recipes or in performing songs and poems for their family. We also observed one occurrence where care providers arranged transport for a young person to go fishing with a family member.

Overall, we found limited evidence of meaningful attempts to ascertain the needs of the children or young people or to engage them in community activities. This does not align with considering the best interests of the child while they are placed in OOHC, as required by section 8 of the CCS Act.

## Legal & Financial

Leaving care planning, including legal compensation, financial literacy and transition to independent living, is required to begin at age 15 (A.08.1 of the Child Protection Guide). Over one-quarter of the 19 children and young people reviewed (26.30%) had not yet turned 15 by the end of the Inquiry period.

When assessing the dimension of care related to legal and financial support, we found an overwhelming focus on involvement with the criminal justice system and a lack of direct skill building for future financial stability or long-term independence. The assessment below does not incorporate certain documents supplemental to care plans and case reviews, such as case support cost data and legal advocacy documentation, which were not part of the case files requested or provided by the DoC. We acknowledge this absence of evidence and therefore comment on the broader evidence of appropriate skill building and timely legal advocacy.

### Financial Literacy

Over one-quarter of the 19 children and young people reviewed (26.31%) had not yet turned 15 and therefore we observed no records of independent advocacy being used for financial matters in this group. However, 15.78 per cent of the sampled children and young people were over 15 but had no recorded evidence of advocacy or financial support. It was not clearly documented why this minority of eligible young people did not appear to receive this support.

We identified a minority of cases (21.05%) in which direct support with financial literacy skills was evident. This included completion of a budget plan, referral to the Salvation Army for support with budgeting, and setting up the payment of pocket money by carers in exchange for community-based jobs such as lawn mowing. The provision of pocket

money, identified from case notes and Viewpoint responses, was well received, whereas more help with managing money was wanted after completing the Salvation Army budgeting course. At times, carers and relatives were involved in supporting financial literacy and making safe financial decisions, with evidence of carers receiving information on building financial skills and relatives managing bank accounts with the consent of the young person. These are helpful supports for the development of financial literacy and stable independent living; however, they are indirect supports that require additional direct work with the young person.

Almost half of all 19 children and young people (42.10%) were assisted with applying for various financial and legal documents such as proof of age card, passport, driver's licence, voter's registration, bank accounts and Tax File Number. Some young people (21.05%) were also assisted with applying for JobSeeker or Youth Allowance payments through Centrelink; however, there was no evidence that this support was supplemented with planning or upskilling for future financial literacy or stability. This resulted in young people receiving income they were unable to manage efficiently or safely. For example, one young person reported that people were taking their money. In response, the DoC enacted involuntary income management without providing any supplementary financial counselling or budgeting education to develop the child's financial literacy for future successful independent living. This trend of removing agency in regard to finances was also seen with a young person who was considered unable to make safe decisions, including money management, due to either disability or mental health issues. For over a quarter of the young people (26.31%), referral to the State Administrative Tribunal for guardianship or administration was considered necessary, although there was evidence that only a minority of these

referrals were both actioned and approved. Reasons for seeking guardianship or administration varied, ranging from the perception that the young person could not make safe decisions to suspected cognitive impairment or diagnosed disability. For the majority of the young people referred for guardianship however, there was no clearly recorded reasoning. Further, only one young person reported via Viewpoint that they were aware of and fully informed about their legal rights, indicating that most of those referred to guardianship may not have fully understood the process being undertaken by the DoC. We noted that for several young people, referrals for guardianship or administration were not planned to begin until the young person reached 18 years of age. These findings are concerning, noting that DoC policy acknowledges a comprehensive plan involving the young person and their support network in decision making is only possible if guardianship is considered early in the leaving care planning process, with opportunities to be considered from 15 years of age. Further, it was unclear what rationale supported these referrals and whether any steps were taken to assist the young people in making safe and informed financial decisions in the event their referral was denied, as was the outcome in one instance.

Financial support during the period of transition out of care was identified in a minority of cases, with 15.78 per cent of young people assisted by either a leaving care team or a post-care support team in joining the waiting list for Salvation Army housing, linking with CREATE for leaving care support or applying for a Transition to Independent Living Allowance to help cover the costs associated with moving towards independent living. However, it was not always clear whether the applications had been lodged or approved. In preparing to leave care and live independently, some young people

voiced concerns about paying outstanding Transperth fines. In response, the DoC stated that they do not pay fines and suggested that the young person set up a payment arrangement, without providing support to facilitate this. This highlights an inconsistency in the DoC's approach to the financial literacy needs of the children and young people, with responses largely constituting either a removal of agency through involuntary management or placing responsibility wholly on the person in care. This approach lacks the professional judgement and discretion necessary for responding to the unique circumstances of young people in OOH. Instead, we encourage a meeting of these two approaches, with a consistent and direct plan for developing financial literacy skills commencing before the age of 15 and the receipt of income.

Overall, where there was evidence of financial support, it appeared that setting up financial services and arranging financial documents were mistaken for the development of financial literacy skills, which includes understanding and effectively managing financial decisions, such as earning, spending, saving, investing and borrowing. While access to services and possession of documentation are important aspects of independent living, the young people themselves voiced that this was not enough to ensure they could responsibly manage money and make safe financial decisions.

### Legal Advocacy

In preparation for leaving care, when a young person turns 15 years of age, the DoC must determine whether the young person has any potential legal claims, such as Criminal Injuries or Native Title compensation (A.08.1 of the Child Protection Guide). In addition to advocating for legal claims, the DoC is required to provide timely legal assistance for any criminal justice matters.

We identified plans to investigate Native Title, Criminal Injuries and National Redress Scheme compensation through the General Law Unit for over half of the sampled children and young people (52.63%); however, in most of these cases (70.00%) there was no evidence that these plans were actioned. The assessment of potential legal claims appeared to be a 'tick box' exercise, superficially noted as part of the leaving care planning process. For a minority of the cases (15.78%), legal information had been redacted or there was no record of the assessment of legal claims, even when there was evidence indicating that the person in question was a victim-survivor. It was unclear why the DoC had redacted sections of the received case file documents, which impeded our analyses in several areas.

In analysing the 2,959 Viewpoint responses collected between 2022 and 2024, the DoC reported that 39 per cent of the children and young people said they had been provided with a copy of the Charter of Rights for Children and Young People in Care, and it had been explained to them. However, 29 per cent reported that they did not know what the Charter of Rights was. We assessed evidence of age-appropriate information being provided to children and young people regarding their legal rights and status. Almost half of the sample (42.10%) indicated within Viewpoint that they had received their own copy of the Charter of Rights for Children and Young People in Care, although only half of

these children and young people reported that the document had been explained to them. Encouragingly, 15.78 per cent had received QR codes or physical copies of the Charter of Rights for Children and Young People in Care, the Advocate for Children in Care, the Charter of Rights for Parents and Families, and the Care Plan Review Panel. The use of QR codes reflects a concerted effort towards making information accessible and age appropriate. However, almost half (42.10%) either indicated in Viewpoint that they did not know what the charter was or had no evidence within their case files that they had been provided with any documents outlining their legal rights and status. Our findings appear to align with those of the DoC, with a majority of the children and young people either not being advised of or not understanding their legal status and rights. This is concerning, given that over three-quarters of this sample (78.94%) had criminal justice matters ongoing throughout their time in OOHC.

The recorded provision of legal advice and representation varied across those children and young people involved with the criminal justice system. We were pleased to note that legal support was provided both when a child or young person was an offender or a victim-survivor. Over half of those in need of legal advocacy (53.33%) received legal advice, support in attending court appearances and police interviews, or legal representation. A minority (13.33%) were referred to diversionary justice practices such as the Juvenile Justice Team or restorative justice, which was encouraging. However, this remained a small minority and was not always successful, which raised concerns regarding the adequacy of the support provided to the young person to engage with these alternative opportunities. Where cognitive capacity was identified as a concern, we found the actions of the DoC

to be divergent and again focused on risk over care. For example, two young people were considered unable to understand criminal justice proceedings due to cognitive impairments. One underwent a fitness to plea assessment, which resulted in the young person being found unfit to plead and the charges being abandoned. Another was found to be mentally impaired and was subject to *Parens Patriae*, resulting in denial of bail and an extended stay in BHDC, where ongoing offending occurred.

Despite the evidenced deployment of legal assistance, for over a quarter of those in need of legal assistance (26.66%), we could find no evidence in care plans or reports that legal advocacy or representation was provided for any criminal proceedings. In one instance, a young person was so anxious about their pending court case that they went missing for a month, which resulted in lapsed court appearances and a lengthy admission to BHDC. Timely legal advocacy, as required by DoC policy and encompassing protection of the best interests of the child under the CCS Act, could have resulted in a more positive outcome for this young person. While legal advocacy appears to be a priority for the DoC when caring for children in OOHC, there is still a gap in the provision of support. Given the known links between OOHC, criminal justice involvement and poor adult outcomes, this gap warrants immediate attention if the DoC is to uphold the legislative requirement to act in the best interests of the child.

# CONCLUSIONS

I acknowledge that the Inquiry was limited to information provided for only 19 children – a very small proportion of the total number of children in OOHC in WA – and extrapolating the data to the entire child protection system is therefore not a statistically viable approach. Nonetheless, these children are arguably some of the most vulnerable within the system and if we are unable to provide them with safety and support, then there is something drastically wrong.

In reviewing the available information for the 19 children identified by the DoC, it would be a falsehood to say that any of those children have had predominantly positive experiences during their time in OOHC. In fact, it is highly possible that if the family had been provided with the social services and supports they required and the children remained at home, they would have experienced better outcomes than those that occurred.

The information contained in this Report is stark – the system is not working. If the system is unable to protect the most vulnerable children in its care, or to demonstrate that the removal of a child resulted in improved outcomes, it is clear that the overarching principle of ‘the best interests of the child’ has been replaced with ‘the best interests of some adults’. If we remove children from their families, there is a moral imperative to remove them to a better place, not just a different place.

This Inquiry has identified multiple system failures impacting the 19 children and young people, from poor placement, health, education, recreation and cultural planning through to lack of action on sexual abuse. There were examples of good practice; however, these were ‘exemplars’ rather than standard practice.

Heartbreakingly, if you were brought into care under the age of 2 years, you are likely to have experienced significantly more disadvantage than those who entered care at a later age. I struggle to understand how a system cannot provide a safe, supportive environment for babies and toddlers that enables them to grow up to become strong, safe, healthy and educated young people.

Unfortunately, interventions are more often reactive than proactive and often come far too late. The CCS Act, the DoC practice frameworks and guidance all recognise the importance of ‘placement stability’, yet a feature of all the children and young people reviewed in this Inquiry was the instability in their living arrangements. In most cases, the children were not provided with a home – they were provided with a house.

Maslow's hierarchy of needs outlines five sets of basic needs: physiological, safety, love, esteem and self-actualisation. Physiological needs include shelter and sleep and are defined as the critical components required to meet the very basic essentials of life. Safety needs focus on health, personal security and emotional security. There has been widespread acceptance of this hierarchy, and the Nine Dimensions of Care used within the DoC align with those needs.

Critically, in reviewing the files of the 19 children and young people, it was extremely difficult to determine whether their basic needs for physiological wellbeing, safety and love were being met in these children's lives.

While the Signs of Safety practice framework is highlighted as a strengths-based approach, the focus appears to be on what is wrong and what needs to be done, with very little consideration of what is working well and how the family can be supported to make the required changes.

If we cannot guarantee to a child that removing them from their family will provide them with a better life rather than removal to change and instability, then there are fundamental flaws in how we are implementing legislation, policy and practice.

This is a system requiring a major overhaul – a comprehensive review of our approach to supporting children and their families to ensure that children and young people are safe and protected, loved and cared for and provided with the opportunity to live happy, successful lives.

## Appendix 1



**Hon Dr Tony Buti MLA  
Attorney General; Minister for Corrective Services;  
Commerce; Tertiary and International Education**

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Our Ref: 80-29700

Dr Jacqueline McGowan-Jones  
Commissioner for Children and Young People

Via email: [REDACTED]@ccyp.wa.gov.au

Dear Commissioner

**INQUIRY REPORT – DISCONNECTED, UNPROTECTED: WHAT HAPPENED TO THE  
BEST INTEREST OF THE CHILD?**

Thank you for your letter dated 25 August 2026 where you attached a copy of your draft report “Disconnected, Unprotected: What happened to the best interest of the child?” (the Report) and requested my review and comment.

While I write to you pursuant to Section 48 of the *Commissioner for Children and Young People Act 2006* (the CCYP Act), the matters raised within the Report largely fall under the portfolio responsibility of the Hon Jessica Stojkovski MLA, Minister for Child Protection. Accordingly, the below comments in relation to the Report have been prepared after considering the relevant agencies’ response.

In providing this response, I understand that the Department of Communities provided a letter dated 14 September 2026, outlining their response to your draft report. I also understand that you will have received a letter from the Department of Justice responding to the Report. I confirm that the recommendations within the Report will be considered at agency level in due course.

With respect to the letter from the Department of Communities, I understand the agency has raised concerns regarding errors and misunderstandings which they have requested be rectified. In the circumstances and noting that the Report concerns matters almost exclusively within the Child Protection portfolio, I would invite you to consider whether it is appropriate for the Department of Communities letter to be included in your final report.

Importantly, the scope of the Report relates to 19 children with three or more admissions to Kath French Secure Care Centre between 1 January 2020 to 1 January 2025. These children represent some of the most vulnerable young people within WA. I understand the Department of Communities has raised that while the scope of the inquiry was narrow, the Report includes broad findings and recommendations regarding the child protection system. In the circumstances, it may be appropriate for these findings and recommendations to be reviewed in light of the comments from the Department of Communities.

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With respect to the children who came within scope of the Report, I would like to acknowledge that these children often present with a range of complex behaviours and support needs and are likely to require a coordinated response across government agencies and non-government organisation. The Report brings important awareness to the circumstances of this cohort, and the challenge of supporting them effectively, holistically, and on a long-term basis, and I thank you for your efforts in this regard.

This letter constitutes my comment on the Report. Thank you for the opportunity to provide comment; I continue to welcome opportunities to work with your office to enhance the safety and wellbeing of young people involved with the youth justice system.

Yours sincerely



Dr Tony Buti MLA  
**ATTORNEY GENERAL**  
23 September 2026

## Appendix 2

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Government of **Western Australia**  
Department of **Communities**

Your ref: 26/05700  
Our ref: 2026/36916

Dr. Jacqueline McGowan-Jones  
Commissioner for Children and Young People  
Level 1, Albert Facey House, 469 Wellington Street  
PERTH WA 6000

Email: [REDACTED]@ccyp.wa.gov.au

Dear Commissioner

### **INQUIRY REPORT – DISCONNECTED, UNPROTECTED: WHAT HAPPENED TO THE BEST INTEREST OF THE CHILD?**

Thank you for your letter dated 25 August 2026 which provided a copy of the report, *'Disconnected, Unprotected: What happened to the best interest of the child?'* (Inquiry Report) and the opportunity to provide comments for inclusion in the final report which will be tabled in Parliament.

I would like to take this opportunity to acknowledge the work undertaken by yourself and your office to complete this Inquiry Report. As the Director General of Department of Communities (Communities), I value the contribution of oversight agencies and remain committed to continuous improvement and to learning from inquiries where opportunities to strengthen practice are identified.

To enable you to finalise the Inquiry Report, and to provide information about work already underway, Communities provide the following response:

#### The scope of the Inquiry

On 25 March 2025, Communities was formally advised that the Commissioner for Children and Young People (the Commissioner) intended to undertake an Inquiry into the processes, policies and practices related to children placed at the Kath French Secure Care Centre (Secure Care) (the Inquiry). The Inquiry would focus on children and young people with three or more admissions to Secure Care during the period 1 January 2020 to 1 January 2025. On 23 June 2025, your office wrote to me to provide the Terms of Reference for the Inquiry and stated 'The Inquiry will not focus on the broader child protection system. However, it will consider the context in which the most complex and traumatised children and young people move through the system and intersect with others'. For the purpose of assisting with the Inquiry, Communities identified 19 children and young people who met the criteria for consideration as part of the Inquiry and provided records as requested.

We note that while the scope of the Inquiry was initially narrow, the findings and associated recommendations outlined in the resultant Inquiry Report are much broader and that your office has reviewed the policies, practices and procedures of the entire child protection system (as outlined on page 5). Whilst Communities

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acknowledge this may be within your powers; Communities would have appreciated the opportunity to be advised of the broadening of the initial scope at an earlier stage and could have provided information for your consideration. We further note that according to your most recent correspondence Communities are not able to provide any new information for your consideration, a position that does not appear to be accurate or procedurally fair. Communities understands that a copy of your Inquiry Report was provided to a number of other agencies, ahead of Communities' first having the opportunity to consider and this too, is also not procedurally fair.

Communities are deeply concerned that findings in the Inquiry Report are based on 19 children and does not include accurate information about Communities existing policy and practice guidance or initiatives; with Communities not being afforded the opportunity to make submissions. Instead, the report uses 19 cases of vulnerable children to investigate systemic issues and make findings of perceived failures across the whole child protection system. There was a missed opportunity to engage with Communities earlier and to communicate in relation to changes to the scope away from earlier advice that your office would not be focussing on the broader child protection system. The Inquiry Report infers on page 21 that Communities did not provide information that was sought which differs to Communities understanding and records which reflect the information requested and provided. If Communities had been given the opportunity to provide broader information, then a range of inaccuracies, misunderstandings or information gaps that are contained in the Inquiry Report, may have been corrected or resolved. It would have been ideal if this opportunity was provided before the Inquiry Report was circulated to other agencies.

Feedback on the Inquiry Report's methodology

The Inquiry makes numerous broad statements based on a very small case sample (19). For example, '...the Inquiry was unable to provide information demonstrating these principles are being consistently upheld' (page 8). The findings and recommendations were based on a small number of children, when compared with 5,189 children in care (as at 30 June 2026). 19 children represent 0.36% of a population of 5,189 children. While there is no agreed minimum sample size at which the use of percentages becomes valid, there are well established statistical guidelines about when percentages can be interpreted reliably and when they should not be used to draw broader conclusions. These conventions suggest sample sizes of less than 20 should generally avoid reporting percentages or be interpreted with extreme caution as the margin for error in the accurate interpretation of these results is significant. As a result, it is statistical best practice to avoid reporting percentages and report counts only for this sample size.

Communities are of the view that findings from 19 cases cannot be statistically generalised to all children in out-of-home care. In addition, the 19 cases were selected based on specific criteria (that is, the most vulnerable children, with the most complex needs, with repeat admissions to Secure Care), therefore Communities question how conclusions can be drawn with accuracy about the broader population of children in care. This is a specific subset of children with the most complex and challenging needs in the out-of-home care system and is not representative of the entire out-of-home care population. Whilst we note the Inquiry Report refers to the small sample size as a limitation, this is not until page 36 of the

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Inquiry Report; there is an opportunity to be clear about this at the outset. It is also concerning that the findings use percentage figures to make broad claims about the safety and wellbeing of 19 children in care. For example, 'Concerningly, almost half of the perpetrators identified in reported sexual assaults were either carers or DoC staff (40 per cent)'. This alarming representation of findings is not representative of all children in care and highly likely to be misinterpreted. Finally, while the report acknowledges that '...the small sample size limits generalisability and requires cautious interpretation', and that the '...extrapolation of the data to the whole of the child protection system is therefore not a statistically viable approach', the Inquiry has '...identified multiple system failures'. Communities question the value of such a sweeping assessment based on a sample size of 0.36%.

Communities note reference to the use of 'multiple data sources' and 'research literature on out-of-home care' (page 41), however these sources, which have been relied upon to inform the Inquiry's findings, are not referenced for Communities' visibility or more generally for transparency. In the absence of references being supplied, Communities are not able to review the literature to inform Communities' response to the Inquiry Report. Communities has identified data referred to on page 37 that significantly misrepresents the reasons children enter care, referring to complicating factors that are not abuse types in accordance with the *Children and Community Services Act 2004* (CCS Act) and also referencing s.35 of the Act as a reason for entering care, however s.35 is a method a child may enter care through the use of a warrant, rather than a reason. This misrepresentation demonstrates a misunderstanding of the child protection system, which is just one example contained in the Inquiry Report.

Requested amendments, factual errors and misunderstandings

## (i) Requested amendments:

Communities have identified numerous factual errors and misunderstandings within the Inquiry Report and seeks amendments. We note commentary on pages 5 – 6 which refer to government policies, particularly the policies of the Western Australian Labor Party. Communities' interpretation of relevant legislation is that the Commissioner's powers and review of policies, should be limited to departmental policies, not a political party's platform. Communities are of the view this type of information is an irrelevant consideration and inappropriate for inclusion in an Inquiry into Communities' processes, policies and practices related to children placed at Secure Care.

Communities note references to 'removal' of children and children who have been 'taken' into care; which is not contemporary language. We respectfully request that these references throughout the report be removed in acknowledgement of the impact of past policies on Aboriginal people. Other non-contemporary language includes reference to care arrangements provided in more 'institutionalised' environments (page 26). Referring to institutionalised care is not helpful or accurate and may be interpreted as meaning historical institutional care which was characterised by regimented routines and limited individualised care. Therapeutic Care has moved far away from institutionalisation, by creating smaller, home-like environments with trauma informed supports. Institutionalised care in no way

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reflects WA's residential care system and this language may be harmful to children, young people, families and Communities' workforce.

## (ii) Factual errors:

Broadly there are factual errors in the Inquiry Report as it relates to the role of objects and principles in legislation, it misrepresents a number of provisions in the CCS Act and appears to misunderstand the nature and use of definitions in legislation. For example, the CCS Act does not refer to requirements for Communities to provide a 'better place' or 'remove to better' (pages 8, 9, 14 and 80). There are references in the Inquiry Report that oversimplify the complexities of the child protection system and the legislative basis underpinning child protection work. For example, the statement that 'The majority of the cases reviewed were unclear about the specific reasons for coming into care...' (page 7), overlooks the fact that the ultimate decisions about a child entering care are made by a Magistrate in the Children's Court, following an application and affidavit being submitted to the Children's Court. Similarly, on page 7 there is reference to the principles of the CCS Act and decision making in the 'best interests' of the child. The description of the principles and how they operate is not accurate. In performing the function, the paramount consideration must be the best interests of the child (s.7). In legislation there is guidance on how to determine this (s.8). There are numerous other principles to be observed. The Inquiry Report has selectively chosen some principles, and yet the weight given to each principle will depend on the circumstances of each child and family.

Communities have also identified numerous issues which would make it either impossible or challenging for Communities to be able to implement some of the recommendations. For example, Safety Recommendations 5 and 6 (on page 16) calls for a mental health oversight body and embedding a mental health advocacy service within Secure Care; as Secure Care is not a mental health facility this is not legally or ethically able to be achieved. Some recommendations are outside the scope and nature of the Inquiry including Recommendation 7 (page 13) to introduce a Child Rights Act in Western Australia (WA). This recommendation is far broader than the scope of the Inquiry which only considered a small number of children in a Secure Care setting, not all children in care, children in the justice system or children generally.

Finally, the Inquiry Report provides a simplistic analysis when comparing the provision of education and medical care by a birth parent, to that of Communities as the corporate parent, which does not appear to consider the impact of trauma (as a result of abuse and neglect) on children. This simplistic analysis also does not appear to consider the existing mechanisms whereby Communities work together with our partners in Department of Education (Education) and Department of Health to meet the educational and health needs of children in care. For example, Communities monitor NAPLAN results of children in care, with assistance from Education, to consider the academic achievement of children in care and to inform educational supports that a child in care may need. This is but one example.

## (iii) Misunderstandings:

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The Inquiry Report contains misunderstandings about Communities' processes, including the understanding about case planning and care planning that together guide decision making and planning for children in out-of-home care. The Inquiry Report fails to refer to many of the existing mechanisms, services and initiatives that are already in place and working well to support children in care. It also does not consider the significant expenditure of government on the out-of-home care system, which in the past five years has increased from \$120 million, to \$360 million. Despite this and other significant investments the Inquiry Report, refers to the system as 'under resourced' (page 4 and 7), without offering evidence of this.

Communities are concerned that the Inquiry Report does not acknowledge the challenges associated with supporting children in care in consideration of their vulnerability and complex trauma. Instead, the Inquiry attributes blame, without evidence, to Communities for the outcomes of children and young people in care. This has occurred without proper consideration to the complexities associated with the provision of care in the context of complex trauma related to abuse and neglect prior to a child entering care (and the enduring impact of this trauma throughout a child's life). Furthermore, the Inquiry Report oversimplifies certain circumstances, like children 'absconding' (page 44). The Inquiry Report does not identify or acknowledge the very complex issues regarding 'absconding' and how to ensure that a child remains in a care arrangement especially if this is against their wishes, where they are older and Gillick competent.

The Inquiry Report makes several references to Rapid Response and recommendation 15 (Emotional and Behavioural Wellbeing) calls for monitoring and evaluating of the Rapid Response Initiative (pages 17, 46 and 61). Rapid Response was a previously (2009) Cabinet endorsed, across government framework which was further strengthened via the *Children and Community Services Amendment Act 2021* (Amendment Act); s.22 amendments provides the legislative imperative which recognises the needs of children in care and the requirement for relevant agencies to prioritise services for meeting these needs. s.22 of the Act was amended to require that public authorities prescribed in the regulations as a public authority must prioritise a request for assistance to a child in the CEO's care, including under a Protection Order (Special Guardianship). Communities have undertaken considerable cross agency work to implement and monitor s.22 amendments to the Act and can provide further, more detailed information if the Commissioner is interested to understand the breadth and impact of this work that is delivering the intended outcomes for children in care.

It is important to note that the identified issues outlined above are not exhaustive given the short timeframe to consider and provide feedback on the Inquiry Report.

Summary of policy and practice reforms that have been implemented by Communities

Communities note your office will not make changes based on the provision of any new information; however, we would like to provide a summary of policy and reforms that have been implemented by Communities and in the absence of an earlier opportunity would like to provide this to you now. The below list is not exhaustive but is provided in the context of the Inquiry Report's 52 findings and 55 recommendations.

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Communities submits the below for your information and consideration of inclusion within the Inquiry Report.

*Therapeutic Residential and Secure Care (Therapeutic Care)*

Therapeutic Care implemented the Sanctuary Model (Sanctuary) and achieved accreditation from the ANDRUS Sanctuary Institute as a Sanctuary organisation in 2014 and again in 2017. Sanctuary is an internationally recognised framework for care and organisational change that integrates trauma theory with the development of therapeutic communities. It promotes a safe, supportive, and non-violent environment where healing from traumatic experiences can be addressed. The model aims to strengthen understanding of stress and trauma, reduce violence, and increase the level of safety for young people, workers, and interfacing systems.

It is considered best practice for therapeutic care services to be guided by two complementary trauma-informed models or systems. An overarching practice model, for which Therapeutic Care uses Sanctuary, and a practical crisis prevention, de-escalation and resolution system, for which Therapeutic Care uses the Therapeutic Crisis Intervention (TCI) System from Cornell University. The two models, Sanctuary and TCI, contribute to safeguarding young people in care and ensures Therapeutic Care takes a research-based approach to its compliance obligations under the National Principles for Child Safe Organisations and Better Care, Better Services' Standards for children and young people in care.

Independent certification in the use of Sanctuary is recommended every three to four years to ensure ongoing model fidelity and to identify areas of service improvement. Communities' Therapeutic Care was independently recertified by the ANDRUS Sanctuary Institute in August 2026. This is a significant achievement and demonstrates Communities' ongoing commitment to high-quality care for children in care.

*Early Intervention Family Support*

Early Intervention Family Support (EIFS) services provide services and support for families (both Aboriginal and non-Aboriginal) with differing levels of complexity and need. EIFS services aim to meet the needs of families facing complex challenges and those most at risk of involvement with the child protection system. EIFS programs are designed to complement each other and deliver a range of services for families to meet their family support needs, within a particular geographic location. EIFS Services include the Family Support Network, Aboriginal In-Home Support Service, Intensive Family Support Service (IFSS) and Regional Family Support Hubs. The government has invested over \$28 million in EIFS services for the 2026/2027 financial year, which is a significant investment to support families early and prevent children from entering care.

*Support to carers*

A number of new and existing initiatives focus on carer support including financial and other practical support. The government has invested significantly in supporting WA's Foster and Family Carers through a \$23.7 million subsidy uplift in this Budget to help ease cost-of-living pressure for households supporting children in care. The increase is for all approved foster and family carers, Community carers, and Special

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Guardian carers, providing care to children and young people in care arrangements, either through Communities, a Community Sector Organisation (CSO) or an Aboriginal Community Controlled Organisation (ACCO). \$14.5 million has been allocated to the Foster and Grand Carer Gold Card (the Gold Card) which will provide eligible carers access to discounts and benefits, including energy bill relief. \$6.9 million has been allocated to ensure all family carer households across WA are supported through the funded Family Carer Support Service. In April 2026, two digital resources were launched: 'Who can Say OK in WA?' which provides guidance to carers on who can make everyday decisions about children and young people in care; and 'Who Pays in WA?' to provide guidance on the financial supports' carers can access for the children in care placed with them.

Additionally, there has been the introduction of a new care category 'Community Carers' where carers are assessed and available to care for children from the same community or cultural group. This enables children from Aboriginal and Culturally and Linguistically Diverse (CaLD) communities to be cared for within community and within culture, until family are identified and assessed. This supports children to strengthen connections with community. Other supports include the provision of support services, including Family Care Support Services; free specialist therapeutic counselling services through OurSpace; and support to sustain the independent advocacy and support for foster carers, currently delivered by the Foster Care Association of Western Australia. Other supports include extending KidSport funding for the biological children of foster and family carers, in addition to the KidSport vouchers available to children and young people in care. Communities provide regular free events and activities for foster and family carers, such as during Foster and Family Carer week in 2026, when they received access to an 'Adventure Pass' which included free events, memberships and discounts for their whole household to enjoy during the April 2026 school holidays and beyond.

In December 2024, the WA Government launched the Fostering Connections unit, which provides a single point of contact for all foster and family carers on information such as carer entitlements, policy and procedures, and available supports. All Foster and Family carers are supported by the child's care team, including case management to support the child, family, and carers. All Communities' carers participate in an Annual Carer Review and Ongoing Learning Plan with a Senior Child Safety Practitioner to ensure supports and learning opportunities are implemented to maintain the care arrangement. Communities provides pre-approval training to all foster carers and a suite of training and development options for foster and family carers to continue to build their skills.

*Intersectionality of child protection and disability*

In 2023, Communities formed the Disability Division which has elevated the disability focus and consideration of the intersectionality with child protection.

The Child Protection Disability Project (the Project) delivers on WA's commitments under Safe and Supported: The National Framework for Protecting Australia's Children 2021 – 2031 (Safe and Supported). Children and young people with disability and/or parents/carers with disability, experiencing disadvantage or who are vulnerable, are a priority group within Safe and Supported due to their

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overrepresentation within child protection systems. Disability related Safe and Supported deliverables include:

- Action 7: Disability: Ensure effective and timely responses for parents and carers living with disability and children and young people with disability and/or developmental concerns: at risk of entering the child protection system, in out-of-home care, or transitioning to adulthood from out-of-home care.
- Action 8: Social Determinants of Child Safety and Wellbeing: Work across portfolios impacting Aboriginal and Torres Strait Islander children and families.

The Project is informed by, and responsive to disability reform priority agendas impacting on children and families with disability, including: WA's response to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability released 31 July 2024; changes following the Independent Review of the National Disability Insurance Scheme (NDIS) and subsequent National Cabinet decisions of December 2023, including NDIS legislative amendments, and the planning for and design of additional Foundational Supports. The Project adopts a cross-divisional approach to deliver work packages aimed at improving outcomes for children, young people and parents with disability who interface with the WA child protection system. The Project has three integrated workstreams including Child Protection Workforce Capability Supports; Navigating the Disability Ecosystem and Aligned Effort.

As part of the Navigating the Disability Ecosystem workstream, from 1 May 2026 the National Disability Insurance Agency (NDIA) Child Protection Liaison (CPL) Pilot expanded to include additional cohorts across all child protection districts. The CPL Pilot broadened its scope to include all children and young people with suspected or confirmed disability who are entering care or leaving care. The uptake of service expansion has been very positive across all districts as reflected in consultations with Regional Intensive Support (RIS) Coordination. Between 1 – 18 May 2026, NDIA CPL received over 60 referrals. The NDIA has confirmed an extension of the 12-month pilot continuing until 30 November 2026.

*Aboriginal strategic advice, oversight and Aboriginal ways of working*

The Aboriginal Strategic Advisory Group provides advice to the Director General of Communities, relating to the development and implementation of policies and strategies on matters that impact on Aboriginal communities in WA.

The Aboriginal Capability Framework 2024- 2034 was developed through extensive engagement with more than 800 Aboriginal stakeholders across WA and is aligned with the National Agreement on Closing the Gap (Priority Reform 3 – transforming government organisations) and complements the Aboriginal Empowerment Strategy 2021-2029. Communities works in partnership with Council of Aboriginal Services WA (CASWA) and the Noongar Family Safety and Wellbeing Council (NFSWC) to support implementation of Safe and Supported. This includes the development of the implementation plan for the National Child and Family Investment Strategy, jurisdictional plans for delegated authority and active efforts in the implementation of all five elements of the Aboriginal and Torres Strait Islander Child Placement Principle.

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In November 2024, Communities launched the Aboriginal Cultural Framework 2024-2034 to provide a whole of agency approach to promoting cultural safety, a culturally competent workforce, delivering culturally safe services to Aboriginal people, and embedding a 'culture at the heart' approach. The Framework is supported by a series of implementation plans, including Implementation Plan One 2024-2026.

*Aboriginal Representative Organisations*

The Amendment Act, includes provision for Aboriginal Representative Organisations (ARO) which have not yet been proclaimed, pending statewide rollout. Once proclaimed Communities must; consult with an ARO before a primary placement arrangement is made for an Aboriginal and/or Torres Strait Islander child and must; provide an ARO the opportunity to participate in the preparation and/or review of a Cultural Support Plan (CSP) for an Aboriginal and/or Torres Strait Islander child. Since November 2022, ARO services have been delivered to the Armadale district by Yorganop and in the Kimberley region by Aarnja. During the period of November 2022 to 9 July 2026, there have been 743 children referred to an ARO service. Of these 394 children were referred in the Kimberley, across East and West, and 349 were referred in Armadale. Approved funding of \$37.7 million over four years will facilitate the expansion of ARO from two pilot sites to 10 AROs statewide.

*Aboriginal Family Led Decision Making (AFLDM)*

AFLDM is a 'way of working' that empowers Aboriginal families to make decisions that address the safety needs of their children in a culturally safe way, promoting self-determination in child protection proceedings. AFLDM allows meetings between the family and Communities to be independently facilitated by an Aboriginal Convenor, employed by an ACCO. The model includes creating culturally safe spaces for Aboriginal families to develop family-owned plans to keep their children safe and connected to their family, culture, Country and community. On 10 April 2026, Minister Stojkovski announced the 2026 State Budget will commit an additional \$7.2 million to extend funding for the Mirrabooka and Midwest-Gascoyne AFLDM program through to 30 June 2030. Continued service delivery of AFLDM in both Mirrabooka and Midwest- Gascoyne will be supported with 12-month initial Grant Extensions, while consideration is given to further procurement and commissioning processes. Communities are committed to continuing to explore options for further expansion of AFLDM, as well as future evaluation and monitoring approaches, and all opportunities to strengthen the voice of families in child protection practice.

*Client Management System*

Communities currently uses ASSIST as its primary child protection case management system. The system supports the recording and management of child protection information, assessment of risk and safety, recording of decision-making, and case management activities. ASSIST operates on an ageing technology platform, and an audit by the Office of the Auditor General tabled in Parliament in March 2025 identified recommendations to strengthen information quality, confidentiality controls, and business continuity arrangements. The ASSIST Reform Program (the Program) was established in January 2023, to lead the replacement of the current system and deliver broader business transformation. The Program aims to deliver a contemporary child protection case management system that better

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supports frontline practice and places the needs of children, young people, families, and carers at the centre of service delivery. The Program is funded through the Digital Capability Fund, a State Government initiative aimed at enhancing digital transformation across public sector entities. The Program is focused on improving outcomes for children and families by reducing administrative burden on practitioners, enabling timely access to information, supporting informed decision-making, strengthening information sharing, and providing staff with modern digital tools that support safe and effective practice. On 31 August 2026, Communities released a public tender for a new Child Protection Casework Management System (CPCMS). The procurement process includes the development of a prototype to demonstrate key capabilities and detailed discovery and design activities to ensure the future solution meets the needs of child protection practice.

*Leaving Care Support*

Home Stretch WA is a flagship government initiative that helps young people leaving out-of-home care at 18 in WA, transition to independent living and adulthood by providing extended support and resources until 21. It is a voluntary (opt-in) program, which includes transitional coaching, the development of informal support networks, and financial supports including a Staying on Subsidy, Housing Allowance, and an Invest in Me Fund. Home Stretch WA was co-designed with sector stakeholders, including Aboriginal young people and carers during the 2019 Home Stretch WA trial. Young people are at the centre of the Home Stretch WA model and choose the type and level of support they want to receive. Home Stretch WA is being delivered in every region across the State through grant agreements with three CSO and 11 agreements with 10ACCO. As at 30 June 2026, there are over 720 young people being supported by Home Stretch WA service providers across the State. A total of \$6.6 million in subsidies have been funded since the program commenced to young people to support stable accommodation arrangements for over 520 young people. Home Stretch WA is aligned with broader policy priorities, including Communities' Aboriginal Family Safety Strategy 2022-32 and the National Agreement on Closing the Gap. The 2026-27 State Government budget has committed an additional \$29.5 million into Home Stretch WA over the next four financial years (2026-27 to 2029-30) to meet increased demand from care leavers in WA. Implementation of service agreements is anticipated from October 2027.

Communities are also implementing two new services to support children leaving care:

1. BRIGHT
2. Young Parents in Care

Communities are developing a new youth accommodation and support service, BRIGHT, which is expected to commence in the Perth metropolitan area from April 2027. This care arrangement service will replace the At-Risk Youth Accommodation (known as 'ARYA'), which provides emergency overnight accommodation for at-risk young people between the ages of 14 and 17 when no alternative suitable accommodation is available.

Following a review of ARYA, Communities is developing BRIGHT to better respond to the needs of vulnerable young people with complex support needs and limited stable accommodation options. BRIGHT will continue to provide emergency

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overnight accommodation, however, will introduce an intensive case management component for 6 to 12 young people concurrently, in supporting them to access longer-term accommodation pathways and other services. The case management component will focus particularly on young people with complex needs who are disengaged from existing supports and at risk of ongoing housing instability. The Request for Tender to deliver BRIGHT closed on 7 August 2026 with commencement of the new service anticipated in April 2027.

Through the Young Parents in Care Project, Communities is currently scoping a foster-care model of support whereby pregnant young people in out-of-home care are supported to have and provide care to their child, pre and post-pregnancy in a home-based supportive environment. External stakeholder consultation informing the development of this approach with ACCOs and non-ACCO out-of-home care providers, mother and baby support services and peaks is currently underway.

*Health Navigator Pilot Program*

In 2022, the Health Navigator Pilot Program (HNPP) was launched in two pilot sites in Mirrabooka and the Southwest. The program provides better access to health services and ensures timely coordinated health care for children in care. Each site employs health navigators to provide culturally safe support. The pilot is a collaboration between Health, Communities and ACCO, advocacy groups and non-government providers. Funding of \$3.5 million over two years was initially secured to implement the pilot, and the University of Western Australia Social Impact Centre has conducted an evaluation.

*Voice of the Child*

Viewpoint is a series of questionnaires designed for children and young people to provide feedback about their care, across all care domains. As your office will be aware, Communities have initiated a Viewpoint Redevelopment Project to strengthen the Viewpoint questionnaire including inclusion of more culturally appropriate questions. In addition, work is underway to incorporate improved graphics using the Story Animals and associated animations. To support use of the Viewpoint questionnaires for children with a disability an easy read version is also in development and will be tested during a short pilot with select child protection districts. The overall aim of the Project is to increase the use of Viewpoint, improve the cultural sensitivity, accessibility and inclusivity of the questionnaire. The new version of Viewpoint is anticipated for use in the coming months.

*Workforce capability and capacity*

As an agency, we are continually taking steps to strengthen frontline services, staffing, and training.

In recent years we have implemented several policies and practices to boost the capacity of child protection staff, promote safe and responsive practice when engaging with Aboriginal children and families and boost workforce recruitment and retention rates, particularly in regional areas.

Communities have also strengthened family-led safety planning through a revised Signs of Safety Child Protection Practice Framework, established an Aboriginal

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Cultural Capability Reform Program, and adopted the Safe and Together Model to improve responses where family and domestic violence is present.

Communities is continuing to strengthen its FDV responses across the State, expanding the operation of the Family and Domestic Violence Response Teams (FDVRT) to a seven-day operating model and boosting funding for frontline staff. FDVRTs provide a place-based response and have been further strengthened through the addition of Family Safety Service Officers, whose role is to coordinate and deliver culturally responsive and trauma informed responses including prioritising the coordination and facilitation of multi-agency case management meetings for high risk, high harm cases of family and domestic violence.

For the past 18 years the WA Signs of Safety Child Protection Practice Framework (the Framework) has been the core child protection framework in WA and continues to evolve through collaboration with child safety practitioners, people with lived experience and the sector. In September 2025, WA introduced an additional principle and discipline to the Framework to strengthen culturally responsive child protection practice. The new Principle: 'Culture at the Heart', refers to the respect and value for culture in child protection practice and promotes positive working relationships with families. The new discipline of 'Culture guides practice at every step' supports Child Safety Practitioners to adapt practice to the unique needs of each child and family with whom they work. The new principle and discipline were informed by Aboriginal people and built on decades of child protection practice which recognises the voices of children and the expertise of families to create safety in their own lives.

In July 2026, the third edition to the Framework was launched which supports Child Safety Practitioners to strengthen culturally responsive, family and domestic violence and trauma informed, accessible and inclusive child protection practice tailored to the individual needs of families and children. The Framework was revised to reflect what we have learnt over time through practice, evidence, and deep listening – particularly to Aboriginal children, families, Elders and communities. This includes promoting transparent, strengths-based child protection practice informed by place based cultural customs and protocols. In addition, the revised Framework also incorporates the new principle and discipline.

***Harmful Sexual Behaviours (HSB) Framework and tools***

In 2022, the Framework for understanding and guiding responses to harmful sexual behaviours was developed which focuses on understanding HSB, the continuum of behaviours and principles of practice. Communities also commissioned the Australian Centre for Child Protection (ACCP) to undertake extensive consultation across Communities and the community services sector to develop the Response Mapping Tools and associated Guidance launched in July 2025. The Framework and subsequent Response Mapping Tools set out the broad principles for understanding and responding to HSB, including in residential care settings.

***The Child Protection Guide and Therapeutic Care Guide***

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In February 2025 the Child Protection Guide replaced the former Casework Practice Manual. The Child Protection Guide is the overarching Guide informing our child protection system which is uploaded onto Livepro.

On 17 August 2026, the Therapeutic Care Guide was launched creating 48 entries. The new Therapeutic Care Guide has been carefully designed to provide practice guidance and promote professional judgement to support Therapeutic care workers in undertaking their roles in Therapeutic Residential and Secure Care. The revised content elevates the child and young person's voice, is culturally responsive, trauma informed, delivered in accessible language, grounded in relevant frameworks, and promotes a safe living environment for the child and a safe working environment for staff. The Therapeutic Care Guide has been uploaded onto Livepro alongside the Child Protection Guide. The Therapeutic Care Guide is additional content that will provide enhanced guidance and support to staff supporting children in Therapeutic Care arrangements. There will be an intensive consultation period from 17 August to 13 November 2026, which will provide staff with opportunities to provide feedback. Practice clinics have been scheduled to support Therapeutic Care staff with implementation of the new practice guidance.

*Independent oversight and Accreditation of Out-of-home care providers.*

In October 2025, the Ombudsman WA (Ombudsman) was appointed as the independent oversight body for organisations engaging in child-related work, in line with recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse. The oversight function will include out-of-home care providers, early childhood education providers and a range of organisations Communities contract to deliver child-related services. The Ombudsman will improve transparency and accountability of organisations complaints handling, reporting and responding to allegations of child abuse. The Department of the Premier and Cabinet (DPC) are supporting the Ombudsman to implement an oversight scheme in WA, to build organisational capability, monitor, and enforce compliance with the National Principles for Child Safe Organisations. The Ombudsman has expertise, functions and powers related to child safeguarding, including administration of the Reportable Conduct Scheme, a complementary scheme which commenced in 2023.

Concluding Comments

I appreciate your consideration of the above and note your comments that requests for changes to the Inquiry Report will only be actioned where there are factual errors and it can be shown that your office had received the evidence to support this. Given the scope of changes which Communities were not aware of, it is unlikely we will be able to show that your office received evidence, when the information Communities provided was limited to the initial scope of the inquiry related to 19 children. Furthermore, I note that your office will not make changes based upon the provision of new information. Reports in the public domain that refer to the 'harmful effects arising from contact with the system', 'multiple system failures' and describe the situation as 'alarming' and identify 'grave concerns', impact negatively on children and families in contact with our agency and our workforce and so I respectfully ask for you to carefully consider Communities' response and information before finalisation of the Inquiry Report. There is an opportunity to consider less emotive language and provide a more balanced view of your findings in the context

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of the small sample size and acknowledging that information provided by Communities was limited to the initial scope of the Inquiry.

Thank you again for the opportunity to provide Communities' response to the findings and recommendations contained within the Inquiry Report. Given the detailed information provided in this response and the complexities of the content, I would appreciate the opportunity to meet with you to discuss prior to you finalising the Inquiry Report.

If you have any further queries, please contact [REDACTED] Deputy Director General, at the Department of Communities on [REDACTED] or at [REDACTED]

Yours sincerely

Mike Rowe

**Director General**

14 September 2026

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## Appendix 3



Commissioner for Children and Young People  
Western Australia

CM: 26/06230

Mr Mike Rowe  
Director General  
Department of Communities

Attention: Deputy Director General, [REDACTED]  
Email: [REDACTED]

Dear Deputy Director General [REDACTED]

### **Inquiry report Disconnected, Unprotected: What happened to the best interest of the child?**

I was pleased to receive your response to the 'Disconnected, Unprotected: What happened to the best interest of the child?' report.

I advise we have now made some changes to the Report, based upon your feedback, including clarification in some areas. Further details are below.

I note your concerns regarding procedural fairness. Given the extremely tight timeframes, predominantly due to obtaining information and staffing issues within my office, the report was provided to all departments mentioned in the findings to give them appropriate time to review and respond to any recommendations impacting, or findings related to, their agency. The report was not, and will not, be made public until all comments have been reviewed. I advise that none of those agencies have requested any changes to the Report.

In terms of procedural fairness, you raised concerns about providing further information to me for consideration. Given that the Inquiry commenced in March 2025, and we sought considerable information (which was provided), and we advised we would not seek further information in March 2026, I am confident the Department was provided with sufficient time to provide necessary information. I also advised, when providing the draft report, that no further information would be considered unless the report contained factually incorrect information. Should you still have concerns, your correspondence to our office (both initial and any further response), can be included in our Report as per Section 48 of the CCYP Act. It is noted this section pertains to the Attorney-General; however, I would be pleased to extend that opportunity to you on this occasion. I am also able to attach to the information you have provided in relation to updated practices, policies, programs and supports.

#### Scope of the Inquiry

I appreciate your comments pertaining to confusion surrounding the scope and consultation process.

In undertaking this Inquiry I advised I would assess processes, policies and practices related to children placed at Kath French Secure Care Centre (KFSCC), more than twice in a specific period. I appreciate there may have been some confusion in believing the Inquiry would be limited to the admissions to KFSCC given the request to review case files pertaining to decision making process pre- and post-admission to KFSCC.

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Nonetheless, it was always the intent to review the entirety of the individual interactions of those children during their entire time in the child protection and care system and I completed the Inquiry in line with this scope, reviewing the out of home care system as it applied to the children and young people in question. I apologise for any confusion that may have arisen.

#### Report Methodology

I thank you for your detailed consideration of the methodology and analyses used throughout the report.

Concerning queries raised in regard to statistical generalisability, it would appear a misunderstanding of the use of the sample to illustrate the ability of the Department to meet its statutory obligations for a cohort acknowledged as the most vulnerable, which more broadly reflects the ability of the out of home care system to achieve core functions for those most in need of support. I appreciate this may not have been stated clearly in the initial report and so have clarified this within the Commissioners' Foreword, Executive Summary, Methodology and Conclusion.

A key factor in determining to use percentages, particularly in relation to areas such as demographics, was to ensure confidentiality of the children and young people in the sample.

I appreciate that the list of data sources provided within the Methodology refer broadly to case files, departmental records, practice guiding documents and research literature. Specific departmental documentation used to support individual findings are instead embedded throughout the report to provide clear and transparent foundations for the conclusions drawn. Research literature on out of home care was utilised within the initial stages of investigation as opposed during analyses or the formation of findings.

#### Requested Amendments

I welcome requests for clarification or elaboration, where meaning is unclear.

Taking into consideration your concerns relating to references to government policies, I have removed this commentary.

References to 'removal' of children and young people and the act of being 'taken' into care have been replaced with phrasing that aligns with formal shifts in child protection and care language. I appreciate the Department's comments in relation to the term 'institutionalised' however, this term remains objectively accurate and so I have clarified the term by way of providing a definition within the report.

#### Factual Errors and Misunderstandings

I have carefully reviewed your comments querying possible misrepresentation of facts.

Concerns regarding the selective discussion of out of home care principles do not appear to account for the outline of legislation used to guide assessment, which is provided within the Methodology, or the diverse range of principles, legislation, and policies referred to in support of individual report findings. Upon review of references to the phrase 'remove to better' within the report, I have clarified my stance that to fulfil the principle of best interests is to achieve better outcomes for children and young people in out of home care, in alignment with legislated obligations.

I appreciate that some recommendations will require system wide changes involving agencies and organisations outside of the Department, which may be challenging or require significant changes to current structures and processes. This however does not negate the need nor importance of these recommendations in light of the findings of this Inquiry.

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For example, the Inquiry recognises that KFSCC is not considered a mental health facility by the Department and was not established to support children and young people with mental health problems, yet it was found they are frequently being admitted for mental health concerns. The finding warrants a responsive change in practice in recognition of the needs of the children and young people in residence. In particular, if this was recognised mental health facility, the Department would be subject to matters such as the use of restrictive practices and the children and young people would be eligible for independent advocacy and support from the Mental Health Advocacy Service.

I thank you for providing a comprehensive summary of collaborative partnerships and contemporary initiatives employed by the Department in providing out of home care. As the Inquiry was a case review it was informed by case documentation and incorporated programs, services and strategies where they were evidenced as having translated to frontline changes for the sampled children and young people. Wherever possible the report acknowledges initiatives that featured in case documentation and/or of which we were advised. I note the majority of the increased funding is allocated towards the crisis end of the system rather than upstream approaches, which may account for the paucity of acknowledged mechanisms the Department has cited.

It is stated that the report provides no evidence of under resourcing however, I submit that this report itself is a body of evidence that demonstrates a lack of necessary resourcing. Further, where concerns have been raised in regard to attributing blame, I refer to the fact that the Department is the responsible party for children and young people in care, as outlined in legislation. This report stresses the poor outcomes where the Department has been the responsible guardian and concerns about the lack of intensive trauma supports and counselling for infants and young children.

Where the Department has regarded the discussion of absconding as oversimplified, I have expanded upon this discussion to acknowledge the additional complexities of managing children and young people's wishes, strengthening the existing appreciation for the responsiveness and collaborative efforts of the Department in this specific area.

I have also made the necessary changes to reflect the amendments made to s22 of the CCS Act and removed references to Rapid Response.

It is encouraging to hear of the Department of Communities implemented processes, policies and initiatives in relation to the improvement of out of home care, since the cessation of the Inquiry examination period.

I have attached a copy of the updated draft, which has also been provided to the printer. Please advise, no later than 1 October, if you wish to include your letter dated 14 September 2026 as an Attachment to the Inquiry Report. Please note I will also include my response and that of the Attorney-General.

Yours sincerely,

Dr Jacqueline McGowan-Jones  
**Commissioner**

30 September 2026

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## Appendix 4



Government of Western Australia  
Department of Health

Classification: Official: Sensitive  
Your Ref: 26/05701  
Our Ref: 26/1854  
Contact: oddg.sgd@health.wa.gov.au

Dr Jacqueline McGowan-Jones  
Commissioner  
Commissioner for Children and Young People Western Australia  
Level 1, Albert Facey House,  
469 Wellington Street  
PERTH WA 6000

Via email: [REDACTED]@ccyp.wa.gov.au

Dear Commissioner

### **REPORT: DISCONNECTED, UNPROTECTED: WHAT HAPPENED TO THE BEST INTEREST OF THE CHILD?**

Thank you for your correspondence dated 25 August 2026 and for providing a copy of the report, *Disconnected, Unprotected: What Happened to the Best Interest of the child?* (Report). Western Australia (WA) Health acknowledges the important role of the Commissioner for Children and Young People in promoting the wellbeing of all Western Australian children, particularly those in our community who are most vulnerable. The Report's focus on system improvements for children and young people in out-of-home care (OOHC) is valuable.

The Report examined the Department of Communities' (DoC) case files for 19 children in OOHC, and identified 52 findings and 55 recommendations designed to assist the DoC and Western Australian Government to take action to improve outcomes for children and young people in OOHC.

WA Health is deeply committed to ensuring that children and young people in OOHC receive timely access to health assessments and treatment, and coordinated health care planning, to promote their health and wellbeing.

While information from WA Health was not reviewed within the scope of this inquiry, I note that the Report identified positive collaboration between the Kath French Secure Care Centre, the Child and Adolescent Health Service and the East Metropolitan Youth Unit, to provide mental health assessments and coordinate health care. The Report also acknowledged the positive progress of the Health Navigator Pilot Program (HNPP), a partnership between WA Health, DoC, and Aboriginal Community Controlled Health Services in achieving holistic, wraparound health care for children and young people in OOHC.

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Of the Report's 55 recommendations, two recommendations are directed to the Department of Health in shared responsibility alongside other Government agencies.

| Findings                                                                                                                                                                                                                                                                                                                                    | Recommendation                                                                                                                                                                                                                                                                             | Responsibility                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| Health planning is ad-hoc, often in reaction to a crisis, and follow up planning is infrequent.                                                                                                                                                                                                                                             | 6. Endorse the Health Navigator Pilot Program, funding expansion to include mental health and cover all Department of Communities Districts                                                                                                                                                | Department of Health<br>Department of Treasury<br>DoC                                     |
| Cross-agency action for children in OOHC care is often reactive and does not enable a focus on the holistic needs of the child. As the State is the 'legal guardian' of the child, the State has a responsibility to ensure they bring the resources of all agencies together to effectively support the health and wellbeing of the child. | Design and implement shared systems across Department of Communities, Department of Health, Department of Justice, WAPOL and Department of Education which include universal referral forms, mechanisms for data collation, and a process for monitoring of outcomes for children in OOHC. | Department of Education,<br>DoC<br>Department of Health<br>Department of Justice<br>WAPOL |

Since the period examined by the inquiry, the Department of Health has been working in partnership with the Department of Communities, Health Service Providers, and Aboriginal Community Controlled Health Services to improve pathways and processes for providing health care to children in OOHC. Formal arrangements have been established under a Memorandum of Understanding program between WA Health and the DoC, with improvement to shared referral processes and escalation pathways strengthening collaboration and coordinated support for children and young people in OOHC. Significant improvements have been implemented, particularly in relation to access to mental health care, and the provision of annual health assessments and health care planning. Expansion planning for the HNPP is also being progressed.

Thank you for the opportunity to provide comment on the Report. I look forward to further opportunities to work with your office to improve the health and wellbeing of Western Australian children and young people.

Yours sincerely



Dr Shirley Bowen  
**DIRECTOR GENERAL**

// September 2026

cc:



## Appendix 5

OFFICIAL



Your Ref:  
Our Ref: fA3015501  
Inquiries: commissioner@police.wa.gov.au

WESTERN AUSTRALIA POLICE FORCE

### OFFICE OF COMMISSIONER OF POLICE

POLICE HEADQUARTERS  
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2 ADELAIDE TERRACE, EAST PERTH  
WESTERN AUSTRALIA 6004  
TELEPHONE: (08) 9222 1256

Dr Jacqueline McGowan-Jones  
Commissioner for Children and Young People  
Level 1, Albert Facey House  
469 Wellington Street  
PERTH WA 6000

Email: [REDACTED]@ccyp.wa.gov.au

Dear Dr McGowan-Jones

#### **REPORT - DISCONNECTED, UNPROTECTED: WHAT HAPPENED TO THE BEST INTEREST OF THE CHILD?**

Thank you for your correspondence of 25 August 2026 and for providing a copy of the report, *Disconnected, Unprotected: What happened to the best interest of the child?*, arising from your Inquiry into the processes, policies and practices relating to children placed in the Kath French Secure Care Centre between 1 January 2020 and 1 January 2025.

I acknowledge the significant work undertaken by you and your team in conducting this Inquiry. The report provides a sobering assessment of the experiences of some of Western Australia's most vulnerable children and young people and highlights the importance of ensuring that all agencies involved in their care and protection remain focused on their safety, wellbeing and best interests.

The Western Australia Police Force supports the Inquiry's broader focus on improving information sharing, strengthening accountability mechanisms and enhancing coordinated responses to children at risk. I also recognise and support the need for a coordinated, child-centred and trauma-informed approach to responding to children and young people experiencing vulnerability, trauma and complex behavioural needs.

Several recommendations have direct relevance to WA Police Force and highlight opportunities for strengthened collaboration between agencies. In particular I note Recommendation 7 under the "Improving Systems, Services, Support and Cross Government Action" section, which calls for the design and implementation of shared systems across the Department of Communities, Department of Health, Department of Justice, Department of Education and WA Police Force to facilitate information sharing, referrals, data collation and monitoring of outcomes for children in OOHC.

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This recommendation highlights the importance of integrated approaches to complex social issues and the need for agencies to share information and operate within a common framework to better support vulnerable children.

The findings relating to sexual exploitation, family and domestic violence, absconding behaviour, mental health concerns and repeated engagement with both secure care and the criminal justice system also reinforce the importance of continued collaboration between WA Police Force, the Department of Communities and other government agencies.

We acknowledge that many of the challenges identified by the Inquiry are systemic in nature and will require a whole-of-government approach to achieve meaningful and sustained reform.

WA Police Force will carefully consider those recommendations that have implications for policing and interagency practice. We remain committed to working collaboratively with partner agencies to improve outcomes for children and young people, particularly those experiencing significant risk, trauma and disadvantage.

Thank you again for providing a copy of the report and for your continued advocacy on behalf of children and young people in Western Australia.

Yours sincerely



COL BLANCH APM  
COMMISSIONER OF POLICE

15 September 2026

## Appendix 6



**Mental Health  
Commission**



Your ref: 26/05710  
Our ref: MHC26/90297  
Enquiries: [REDACTED]  
Telephone: (08) 6553 0468

Dr Jacqueline McGowan-Jones  
Commissioner for Children and Young People  
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469 Wellington Street  
PERTH WA 6000

By Email: [REDACTED] [@ccyp.wa.gov.au](mailto:[REDACTED]@ccyp.wa.gov.au)

Dear Dr McGowan-Jones

**‘DISCONNECTED, UNPROTECTED: WHAT HAPPENED TO THE BEST INTEREST OF THE CHILD?’ REPORT**

Thank you for providing me with a copy of the ‘Disconnected, Unprotected: What happened to the best interest of the child’ report (Report). I appreciate the opportunity to review the findings and the important perspectives it brings forward.

The role of the Commissioner for Children and Young People is vital in ensuring that the voices, experiences and needs of children, young people and their families and carers are heard and appropriately considered. Your Office plays an important role in bringing these additional perspectives to the attention of Government, agencies and the broader community, and in advocating for better outcomes for all Western Australian children and young people.

The Mental Health Commission (Commission) recognises the significant vulnerabilities often experienced by children and young people involved in the child protection system, particularly those in out-of-home care. We acknowledge the strong relationship between experiences of trauma, adversity and disruption, and subsequent mental health and wellbeing outcomes. The Report highlights the importance of coordinated, child-centred and trauma-informed responses that support safety, health, connection and wellbeing.

The Commission recognises the importance of listening to and responding to the experiences of young people and their families and carers. The Commission remains committed to improving mental health and wellbeing outcomes for children and young people, including through the implementation of the Infant, Child and Adolescent (ICA) System Transformation Program. The ICA Ministerial Taskforce recognised children in out-of-home care as one of Western Australia's most vulnerable cohorts and highlighted the importance of coordinated responses between child protection and mental health systems to meet their complex needs.

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The Commission also acknowledges the importance of ensuring that reforms and services are culturally safe, responsive and developed in partnership with Aboriginal children, young people, families and their communities, recognising their unique strengths, cultures and connectedness.

Meaningful and sustained improvement requires ongoing collaboration with children, young people and their families, carers, service providers and other stakeholders. Their lived experience and insights are critical to ensuring that reforms and services are responsive to the needs of those they are intended to support.

Thank you again for sharing the report and for the important work of your Office in championing the rights, wellbeing and voices of children and young people across Western Australia. I look forward to continuing to work constructively towards our shared goal of improving outcomes for children, young people and their families and carers.

Yours sincerely



Maureen Lewis  
COMMISSIONER

15 September 2026

cc. 

## Appendix 7

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Department of  
Education

### Learning changes lives

Your ref: 26/05703  
Our ref: D26/0678973

Dr Jacqueline McGowan-Jones  
Commissioner for Children and Young People

Email: [REDACTED]@ccyp.wa.gov.au

Dear Dr McGowan-Jones

Thank you for your letter dated 25 August 2026, providing a copy of the 'Disconnected, Unprotected: What happened to the best interest of the child?' report.

I acknowledge your commitment to improving the wellbeing of children and young people in out-of-home care in Western Australia and the considerable work undertaken by you and your team at the Office of the Commissioner for Children and Young People to produce this report.

The Department of Education has reviewed the draft report and will consider any recommendations relevant to its responsibilities, noting that some matters will require interagency collaboration. The report was an important reminder of the children and young people who may not experience safety and protection in their lives through the support and care of family requiring intervention by the Department of Communities. It was encouraging to hear of the dedication of staff, families and kin who work together to provide kinship and foster care for children and young people such as those mentioned in the report. I acknowledge the opportunities outlined in the report, to improve outcomes for children and young people in out-of-home care.

While I cannot comment on the majority of the report due to it being outside of the Department's remit, I can confirm the Department's new strategic plan, *Our plan for public education in Western Australia*, responds to many of the education-related challenges identified in your report. The plan provides system-level guidance on how the Department will address these issues, such as:

- improving attendance, achievement and wellbeing across different cohorts
- ensuring schools are inclusive places of learning, and that students feel a sense of belonging and connection to their school community
- creating the conditions for Aboriginal students to succeed, and that our system is a culturally responsive place to learn and work.

Regular attendance at school strengthens students' connection, belonging and wellbeing, and supports positive learning outcomes and that's why improving student attendance remains a key focus of the Department of Education. The reasons for non-attendance and school refusal are complex and contextual:

- Disability, neurodivergence and mental health challenges are significant risk factors, and student wellbeing is a critical factor influencing a student's capacity to attend school regularly.



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- For some students, anxiety, behavioural challenges, disengagement from learning and previous negative school experiences contribute to patterns of non-attendance/school refusal.
- Improving student attendance requires strong cooperation between schools, families, communities and government agencies.
- The Department of Education's Student Attendance in Public Schools policy reinforces the importance of early identification, early intervention and shared responsibility for attendance across schools, students, families and the broader community.

In the short term, the Department is progressing an Attendance handbook for school leaders to support and strengthen school-level attendance efforts. The State Government has invested in 64 FTE Complex Behaviour Support Coordinators across 192 schools to work with school staff to develop tailored and inclusive approaches to meet the needs of students, including those identified as school refusers or at risk of becoming school refusers. We prioritise building and maintaining collaborative relationships between students, their families, schools and key service providers to strengthen student attendance and meet the needs of students.

Our Specialised Learning Programs provide individualised, neurodiversity-affirming support for autistic students without an intellectual disability, helping them to build skills, stay engaged, and transition successfully into mainstream classrooms. In 2022, the State Government invested \$18.2 million to expand these in-demand programs from 16 to 24. As of 2025, all 24 programs are fully operational.

The School of Special Educational Needs: Behaviour and Engagement (SSEN: BE) provides assistance to schools through intensive support for students with complex behaviour. Developing the capability of staff in public schools through direct service for referred student cases, in combination with professional learning in behaviour support and trauma-sensitive practices, is a continued focus.

Thank you for sharing the draft summary report and for the opportunity provide comment on this work. The Department remains committed to continuing to work collaboratively with the Department of Communities, other government agencies and sector partners to support improved educational outcomes and wellbeing for children and young people in out-of-home care.

Yours sincerely



Jay Peckitt  
**Director General**

15 September 2026



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For immediate or urgent help, please call 000 for emergency services.

## **24-hour services**

### **13YARN**

If you, or someone you know, are feeling worried or no good, we encourage you to contact 13YARN on 13 92 76 (24/7) and talk with an Aboriginal or Torres Strait Islander Crisis Supporter.

### **Kids Helpline**

Provides 24/7 free online and phone counselling for children and young people aged 5 to 25.

Telephone: 1800 551 800  
[www.kidshelpline.com.au](http://www.kidshelpline.com.au)

### **Lifeline**

Offers suicide prevention support by phone or online chat.

Telephone: 13 11 14  
[www.lifeline.org.au](http://www.lifeline.org.au)

### **Mental Health Emergency Response Line**

Provides a rapid response to mental health emergencies.

Telephone: 1300 555 788 (Metro)  
Telephone: 1800 676 822 (Country)

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On request, large print or alternative formats can be obtained from:



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