30th September 2025

Mr Robert Benjamin, Implementation Monitor
Hobart
TAS 7001

Dear Mr Benjamin,

I am very pleased to be able to make this submission in respect of informing future activities, priorities and focus areas for the Child Safety Reform Implementation Monitor. This submission is made in a personal capacity.

I rely on submissions previously made to the Tasmanian Parliament Joint Committee into the Recommendations of Final Report of the Commission of Inquiry, which I believe have already been made available to you.

Rather than repeat my comments, I have outlined below any further comments to add since the submission earlier this year.

I have also provided separate comments on the recommendations of the Independent Inquiry into the Tasmanian Department of Educations' Responses to Child Sexual Abuse (the Independent Inquiry). While some relate to the Commission of Inquiry findings, I have endeavoured to keep those separate in the context of education relevance.

Commission of Inquiry's Final Report

Children in the Education System

Recommendation/s	Summary	Any new information/comments
6.2, 6.3, 6.5 Office of Safeguarding and safeguarding policies	• Inconsistency in provision of policy and procedural information • Lack of public access • Outdated procedures, policies and specialist practice advice • Unclear guidance	No new comments

	on crimestoppers	
6.4 (& 20.2) Professional Conduct Policy	• Inconsistencies in guidance for alcohol and drug use in the workplace • Online technology (including third party apps accessible to students, parents and staff)	I note that guidance for smoking and vaping directs no smoking/vaping inside facilities and on school grounds. However, despite regular and frequent access by members of the public, children, families and professionals to the grounds or areas of agencies outside of schools (e.g. CSS) there is no instruction that prohibits smoking/vaping in these environments (with the implication of exposure for visitors and passers-by, and the implications of the visual appearance). It is also worth noting that the instruction for smoking/vaping is much more directive than the subsequent one for alcohol and drugs. This includes the fact there is no explicit prevention of consuming alcohol *inside* government facilities, including school grounds.
6.5 (& 20.2) Mandatory reporting training	• Awareness of *prescribed person* meaning in practice • Lack of detailed training on mandatory reporting	I do note that the nature of wording in different pieces of legislation effectively increases the applicable mandatory responsibilities which are not necessarily the same as being a *prescribed person*. For example, the Children, Young People and Their Families Act 1997 applies the mandated reporting in the context if a child is being abused *in the home*. If there is any ambiguity or uncertainty about whether a crime is being committed (the exclusionary principles apply), and the concerns relate to abuse occurring outside of the home

		context, the remaining legislation is the State Service Act 2000, which contains the Code of Conduct (applying an ethical requirement for reporting mandated through legislation). From the point of view of a student making a disclosure, this can lead to potentially complex explanations of mandated responsibilities in certain circumstances.

Children in out of home care

Recommendations	Summary	Any new information/comments
9.6 Empowerment and participation	• Use of Viewpoint	No new comments
9.5, 9.7 and 9.15 (12.29 YJ) Aboriginal recognition	• Failure to determine cultural identity before applying for care orders	There does appear to have been some progress in 2023/2024, according to data from the Australian Institute of Health and Welfare - 15 children on care and protection orders with status unknown
9.5, 9.9 Outcomes and reporting framework	• Poor data collection	No new comments
9.6 Case management and caseload	• The process for children prior to coming into care • Delays in processing/actioning unborn referrals • Lack of longer term work with families without using an order	No new comments

	• Poor management and organisational issues contributing to caseload pressures	
9.18, 9.20, 9.22, 9.25 and 9.26 Care planning	• Lack of consistent care planning involvement • Poor information availability • Use of terminology such as 'self-selecting'	I draw attention to the lack of a statutory/legislated requirement for a care plan to be updated at least once a year (compared to other states, such as QLD and WA)
9.29, 9.31 and 16.1 Child sexual exploitation	• Over-reliance on referrers to collect sufficient evidence for police to investigate further	No new comments
9.30 S.95 and s.96 of CYPF Act enforcement by police	• Lack of clarity on barriers to investigating specific crimes	No new comments
9.31, 16.3, 16.4 and 16.2 Police policy on refusing to take criminal reports	• Prior refusal of the police to record reports of crimes	I have received anecdotal evidence that this situation has improved, but my concerns remain at the lack of data available for how many potential crimes have not been recorded after being reported. I would also note that the process for police investigation remains opaque. In one instance, despite a very clear set of disclosures by a student, police said that they would not investigate unless the alleged perpetrator refused to engage with CSS. However, delays in allocation with CSS meant that no substantive work was initiated for nearly two months, and the student continued to reside in the home with the alleged abuser

		without any progress in safety.It was not clear if CSS had liaised with police (since this type of information is not routinely provided to education, despite being the primary agency involved in the student's day-to-day life).

Children in youth detention

Recommendations	Summary	Any new information/comments
12.1 Closing Ashley Youth Detention Centre	• The centre has not closed	It is still open
12.31 Searches and use of force	• Lack of clarity about searches	No new comments

Criminal justice responses

Recommendations	Summary	Any new information/comments
16.1 Specialist units to investigate child sexual abuse	• Lack of effective coordination in CSS involvement and police	No new information
16.6, 16.1, 9.11, 9.13 and 9.17 Non-fatal strangulation	• Lack of knowledge or awareness of NFS in child abuse cases	Anecdotally, I have seen a number of cases since my Joint Committee submission where NFS is a feature, either in the present or in the past. Reporting to the police or other services is not evident (in terms of specifically reporting NFS at the very least).

Redress, civil litigation and support

Recommendations	Summary	Any new information/comments
17.8 Right to information	• Lack of consistency in right to information processes	No new comments

Overseeing child safe organisations

Recommendations	Summary	Any new information/comments
18.4, 18.6, 18.7, 18.9, 9.14, 9.33, 9.34, 9.35, 9.37, 9.38, 12.38, 12.39 Commission for Children and Young People	• Comments on proposed legislation to create the new Commission • Lack of good faith in prior appointment process for the Commissioner for Children and Young People	The legislation was recently introduced with some improvements, but some other gaps still notable.

Independent Inquiry into the Tasmanian Department of Educations' Responses to Child Sexual Abuse

Recommendation 1: Safeguarding Records

There are considerable problems with the case management systems for the Department for Education, Children and Young People. It is clear from the Independent Inquiry that the expectation was held for a consolidation of various databases into a single case management system. This has not occurred.

The records management for education systems is profoundly inefficient, inconsistent and poorly designed.

At present, in order to access relevant information about a student, I need to use four separate databases:

- Student Support System (SSS)
    - Primary database system, recording school interactions with student and relevant family and external agencies, any significant events, professional support involvement, and other critical information such as health or alert issues;
    - SSS is the principal recording database for School Social Workers and other professional support.
- Edi
    - This database contains attendance information and history of each student in detail, as well as other statistical information about each school.
    - Professional support roles require permission to access for each relevant school.
- EduPoint
    - This database primarily contains contact details for each student, and timetable information. It is a quicker means of checking attendance on a day-by-day basis than Edi.
- Case Management Platform
    - This was meant to be the new consolidated database, but there appears to have been no functional progress made to consolidation.
    - I access this database primarily to review Learning Plans, and also to cross-check data with the other databases (the latter check is rare, not least because the information is not consistently recorded on the CMP).

If we take an example of a new referral to social work, for a single student (of any year), the following combined actions will need to happen in the first instance:

- Recording of referral and consent on SSS Social Work tab (SW tab).
- Review of case history in SW tab, Contact Log, Activities and various other tabs.
- Review of school attendance history on Edi.
- Review of current, most recent attendance on EduPoint.
- Review of CMP, especially if the Learning Plan is in place.

From this information, and possibly further conversations with teaching staff and parents, a priority is applied to the student, from 1 (highest priority) to 4 (lowest priority). High priority is not necessarily indicative of direct involvement, more risk management. This might occur because direct services may be provided by an

external source, and principle role of the School Social Worker (SSW) is to manage risk issues at school.

SSS access prioritises a single school, based on the assigned responsibilities of the SSW. This is problematic given most SSW are assigned to multiple different locations, so the preferred school has to be selected to access Search options and assigned records.

Recorded assignment of records is inconsistent across SSW, because of the lack of effective and intuitive interface. In many cases, students are allocated to SSW no longer based at that school, or no longer employed by DECYP. It is just as easy to individually search for a student than to monitor allocations for a certain school. Reports for caseloads can be created in different formats, but do not allow for limiting at a particular school and list all students by name, not separated by school.

Recording casenotes is problematic if any change needs to be made, or a note or document recorded out of sequence. SSS will automatically prioritise the most recent note created rising to the top of the case note list, even if it is not the most contemporaneous. This requires careful recording practices to ensure the right notes are recorded in the right order.

Professional support roles have separate tabs to complete notes, which are not ordinarily accessible to other professionals or school staff. For example, the Social Work tab cannot be accessed by anyone else at the school except a School Social Worker.

Recording of relevant interactions by school staff (usually teachers and teaching assistants) is inconsistent from school to school. It is not unusual to find records with no recent (i.e. last six months) involvement recorded, but with significant expectations of high priority by school staff.

There is no ease of cross referencing where multiple students are involved in a single incident. It is quite possible it will be recorded on one student file but not another. This is hugely problematic in situations such as bullying, or harmful sexual behaviours (for example).

Guidance for database recording is inconsistent; SSW are advised to anonymise other students in recording casenotes (i.e. if the allocated student references another one). However, the Activities tab has a specific function clearly allowing a teacher to reference multiple students by name. It is not clear what is being protected by anonymity in a limited-access tab that is not protected in an open-access tab.

SSW are advised to tell students that information recorded can only be accessed by other social workers. In the context of the school itself, this is generally correct.

However, other SSW in the state can access any social work tab for any student at any time. Legal officers can and do access, primarily to manage information requests from courts, child safety etc. It is asinine to explain to a student all the various people that can access their student records, but it is misleading (by omission) to not fully account for how the system can be accessed.

It is my understanding that external access by an unrelated party, such as a SSW from another part of the state, is not recorded on SSS. This means potential irregular or inappropriate access can occur without any referencing or chain of data collection.[1]

Recording systems are highly problematic for staff at Child and Family Learning Centres (CFLC's), with no consistent access for staff to use. Many staff record notes on a work folder, but there is no collated means of accessing these documents. Some record on Microsoft Teams, but this does not allow for safe access that compartmentalises or limits access.

Not all pre-school children are listed on SSS either, so there is no functional way to record many of the interactions social workers have (or any professional support for that matter). This lack of listing includes children under Care and Protection Orders.

I have seen no evidence of any effort to consolidate databases. A recent process was undertaken by DECYP earlier this year (post-state election) requesting feedback on potential savings that could be made by making certain systems and processes more efficient. The presence of multiple databases was noted in the feedback, but it is not clear what action is to be undertaken to resolve this.

In terms of analysing patterns and trends, the lack of integration, coupled with lack of consistency, makes this practically impossible for DECYP to undertake.

Recommendation 2: Best Interests of Students

I see no evidence that the principle of 'acting in the best interests of students' has been properly or meaningfully embedded in all considerations, decisions and actions concerning student safeguarding.

I see many examples of derogatory and dismissive language used by various DECYP staff in referencing students and their conduct, even when there are clear safety issues either in the present, past or both. Evidence of trauma is not well recognised or accepted.

[1] A users' web history would record the access, but this would be problematic to access and can be deleted with ease.

Diagnosis of particular conditions, especially neurodivergent ones such as autism and Attention Deficit Hyperactivity Disorder (ADHD), does not lead to effective interventions or work undertaken with students in the classroom.

Time and again, problematic student behaviours are regarded in terms of aberration by the student, without reference to any traumatic experience they have had or been exposed to.

For example, in working with one student who had disclosed significant levels of physical abuse, both in the present and documented historically, I was told by a senior teaching staff member that the student was a 'pathological liar'. This is despite the well documented issues of students with traumatic experiences amending narrative descriptions as a measure of mitigating risk, and discounted the reality that the student was still exposed to the risk of physical abuse (living with the alleged perpetrator at the time).

It is not uncommon for DECYP staff to acknowledge a diagnosis of a condition like autism, but continue to criticise the student for failing to alter their behaviour in the classroom and with peers. Students are faced with significant delays in being diagnosed in the first place, only to be faced with no effective support systems in place after diagnosis.

The 'best interests' consideration is also problematic in that the legislative basis is not readily accessible, or accessed, by education facilities. The 'best interests' of the child are not explicitly outlined in the Education Act 2016. The Children, Young Persons and Their Families Act 1997, which outlines an explicit interpretation of the 'best interests' of the child, is not actively used by education staff, except in the context of mandatory reporting processes (and this is generally accessed through specific policy and procedure).

Recommendation 3: Embedding Prevention

Processes for student safeguarding systems are woefully inadequate. Part of this problem is not entirely the fault or responsibility of schools and CFLC's; the dependency on prompt and effective intervention by Strong Families Safe Kids/Advice and Referral Line (SFSK) and/or Child Safety Service (CSS) leaves educational institutions often powerless to exercise any effective intervention. However, internalised DECYP systems are hugely problematic.

A notable example is the issue of the Tell Someone process, which leaves a great deal to chance in terms of relying on the professional, and usually untrained, acumen of education staff. Even SSW may have limitations if not experienced or trained specifically in these processes. Given that few SSW are allocated to a school every day, the availability of trained staff is limited. At time of writing, some internal work is

being undertaken to review this process, but the regular measure of undertaking this work is not clear.

The Tell Someone process leaves students exposed to inconsistent delivery and unclear recording practices, depending on which staff are involved.

For example, the 'Step by Step Guidance for Concerns, Information and Incidents of Child Abuse' clearly states at Step 2 that a DECYP worker 'must not interview the child or investigate further (unless authorised by the department)'. However, the source of this authorisation is not clear. Step 3 outlines the option of using a 'Tell Someone' form, but without clarity as to the distinction between that process compared to an investigatory one.

Furthermore, the Tell Someone process is an example of victims of abuse being compelled to make repeat disclosures for the same experience. A Tell Someone form is only used *after* an initial disclosure.

The form itself references other agencies that might be informed or involved, including Tasmania Police, Teachers Registration Board (for internal concerns) and Registration to Work with Vulnerable People. Curiously, SFSK/Child Safety Services are not referenced.

The process from undertaking investigations contains a serious, egregious ethical failure in that for any concern relating to the conduct of a worker, students and parents are denied the opportunity to give informed consent for the completion of this process. Principals are expected to undertake coordination roles in communicating with student and families in the context of gathering further information. I have seen instances of students being offered the support of principals in attending interviews with investigators, including the principal sitting in on the interview.

However, the ED5 guidance for principals/managers clearly outlines the role of the principal in supporting the accused/alleged staff member, including keeping in regular contact.

This means that a person in regular communication with a staff member alleged to have harmed/abused a student may be privy to the statement/disclosure made by that student to investigators.

There is no publicly available documentation about the process to be followed (although the Step by Step guidance is available on DECYP's Document Library, but this is presumably by virtue of a requested disclosure, not standard publication on the main website.

To my knowledge, students and parents are not made aware that the principal may be in regular contact with the accused staff member. For this reason, if a student and/or parents request the principal to attend as support, it is almost certainly without knowledge that the principal is in regular contact with that staff member in question.

Furthermore, there is poor language used in the ED5 guidance for principals/managers. For example, the fact sheet for taking statements from students includes the following line:

If more than one student has witnessed an incident it is important to speak with them separately from one another to avoid collusion around an event and to obtain independent accounts.

Collusion means deliberate cooperation with the intention to deceive others. However, where a number of children experience the same incident, the primary purpose of separate interviews is to get clarity on subjective perception and recollection.

Separate interviews also provide the opportunity for them to freely disclose any other information that may be pertinent, but do not necessarily want their peers to hear.

This is not done with a cynical view that children will undertake deliberate misrepresentation, but to collate subjective perspective in as objective a way as possible. The assumption that a collection of students witnessing the same event might decide to actively misrepresent the event is a cynical one, and implies lack of trust in victim accounts.

Recommendation 17: Partnership with Tasmania Police
Recommendation 18: Partnership with Department of Communities Tasmania

One can assume that Recommendation 18 is no longer required in the context of merging education with communities to form DECYP. However, it is worth highlighting the very real divergence of activities between education and children and youth services, rendering DECYP as a *de facto* split department.

In particular, information sharing and cooperation between schools and SFSK/CSS is inconsistent, generally poor, and subject to hostility from SFSK/CSS when pressed to intervene or respond to a report.

There are significant delays in allocating children when they are referred to regional CSS offices (my main experience of this is in the North region, but I understand it to be a statewide problem). Delays of months can take place for investigations to start, with staff shortages being the reason most often cited. However, in my view, and

based on my experience, there is faulty decision-making being made at a triage level in terms of assessing which matters to refer to. Rather than focusing on immediate allocation as the preference, CSS should focus on immediate *response* to gather key initial data from relative agencies/sources, contact family (where safe to do so) and sight/speak with the child. Not only does this assist in triaging issues, it also saves significant time later in the process. While not directly relevant to the consideration of education, this would assist in promoting prompt action to build safety for students.

There is no active memorandum of understanding (MOU) between DECYP and Tasmania Police in the context of education. The only accessible MOU remains the outdated Tasmanian Police and Communities document from 2021, which appears to only apply to SFSK/CSS not education.

Bizarrely, the MOU between the former Department of Health and Human Services and the Department of Education (2015) remains on the DECYP intranet, even though in practice it cannot possibly be functional.

A bizarre circumstance has arisen in relation to family violence reports. These are sent to schools including SSW. A new instruction was issued to SSW earlier in 2025 which directed that SSW were not to access family violence reports unless a student was directly allocated to them. To my knowledge, principals and centre managers were not informed of this expectation.

However, SSW continue to receive the notifications by email, and have access to them on the SSS SW tab (being one of the few confidential recording places available). The reason that SSW continue to receive the reports by email is because there is no way to tell if a SSW is currently allocated to a student or not.

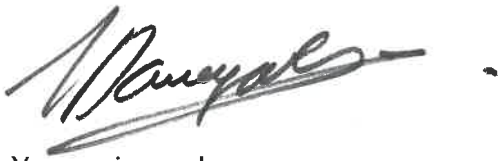
The instruction is that the emails should be deleted on receipt if they are not allocated, and the SSW should send the principal a message offering support for that student if required.

There is no practical way to avoid the awareness of the report or its content. An analogy would be asking a worker to take custody of a box, clearly labelling the contents and who it relates to, and to keep it on their desk, but not to examine the inside of the box. The specific detail might not be immediately apparent, but the implications and broad issues would be.

My understanding is that this came about due to family violence information being erroneously relayed from DECYP to a court probably the Family Court) that should not have happened.

Conclusion

I hope that this submission will be useful for your consideration, and I look forward to your first report to Parliament.



Yours sincerely,

Jack Davenport