REVIEW

OF CHILD PROTECTION PRIVACY INCIDENTS

AND CARER AND CLIENT SAFETY

FOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FINAL REPORT

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CONTENTS

1 INTRODUCTION

1.1 Background

On 13th July 2016, the Minister for Families and Children announced that she had sought a full independent review of a sample of Child Protection ("CP") privacy incidents over a five year period ("the review"), to reduce the risk of further incidents.

The primary purpose of the review is to consider the circumstances of a subset of privacy incidents where, due to possible actions/omissions of departmental staff, information became available about placements to third parties that could have been expected to place children, or their caregivers, at risk of harm. The review is required to provide advice on any additional controls required to reduce incidents of this type.

The review was announced during significant media publicity between 12 and 15 July 2016. It was alleged in this publicity that a violent father had been given the undisclosed address of his children in out-of-home care.

1.2 Terms of reference and methodology

The following terms of reference are included in the project brief for the review. The full project brief is included as *Attachment "A".*

The reviewer will:

- Inquire into the circumstances of a sample of privacy incidents reported via Incident Reports over the past 5 years. The focus of the review will be on incidents where information became available to third parties that could have been expected to place children and or their caregivers at direct risk of harm.
- Determine the extent to which policy and practice advice, or, compliance with policy and practice advice, contributed to the reported incident.
- Examine the adequacy of the department's response method(s) to reported incidents and the application of risk assessments.
- Provide advice proportional to risk, on improvements to policy, practice or systems including client information systems, to improve controls and reduce the recurrence of future incidents of this type.

The following overview of proposed methodology is also included in the project brief:

The methodology.....will include:

- Examination of incident reports and other relevant documentation, related to reported privacy incidents over the past five years.
- In consultation with operational divisions and based on agreed criteria, an in depth examination of a sample of incident reports - where information became available which could have been expected to place children and /or their caregivers at direct risk of harm. Consideration should be given to perceived risk versus the actual risk. This examination should consider whether any systemic issues are evident.
- Examination of compliance in these instances with applicable legislation (in particular the Children, Youth and Families Act 2005), related policy and practice settings and any obligations related to information sharing or protection.
- Consideration of custom and practice in the provision of departmental reports to the Children's Court, including court report format, to determine the level of client placement details to be provided, and how exceptions related to safety are managed.
- Examine the client record information system in terms of functionality, presence or absence of controls, and potential enhancements.

1.3 Process of conducting the review

John Leatherland ('reviewer") was approached by the Deputy Secretary, Operations on 12 July 2016 to undertake this review.

On 14 July 2016, the Commissioner for Privacy and Data Protection announced that he would be conducting a wide ranging investigation that would focus on DHHS's foster care and domestic violence operations and an overall review of DHHS's information on

security governance and controls, not limited to the department's Child Protection program. The reviewer met with the Commissioner during the course of the review to brief him on the preliminary findings and recommendations of this review.

The incidents

Sixty category one incident reports of privacy issues over the last five years involving child protection were examined by the reviewer. These reports contained 61 incidents that were determined by DHHS staff to be within the scope of the review. These are referred to as the "in scope incidents".

Significant documentation was examined in relation to the incident that was reported in the media ("the publicised incident").

The review undertook an in depth examination of the circumstances of 18 of the incidents to examine the adequacy of the department's response method(s) to reported incidents and the application of risk assessments. This sub sample was selected on the basis that these incidents had some similarities with the publicised incident and also raised some matters of follow up that had important policy and practice implications.

Interviews

Key staff within the child protection program in the four operational divisions were interviewed. The discussions canvassed the incidents in the division and the response to them. They also canvassed such matters as divisional practice and training as well as plans and suggestions to minimise the recurrence of such incidents.

Specific attention was given to the publicised incident through conducting separate interviews with staff of the relevant divisions, as well as an extended telephone discussion with the carer.

The reviewer decided to interview several external stakeholders, some of whom made comment in the media on the publicised incident and privacy breaches in child protection. It was considered that external stakeholders would be able to provide an important perspective that would be different from that provided by staff within DHHS. Interviews were conducted with

The reviewer was keen to gain a perspective on privacy management from another department that also had a large number of client contact staff. Accordingly, a discussion was held with Department of Justice and Regulation. This discussion was arranged by within DHHS who also attended.

Given that the interviews conducted with divisional staff largely comprised the reviewer indicated that he wished to meet with a small number of together with one of A focus group that was arranged provided a useful "on the ground" perspective on how to minimise the risk of privacy breaches.

A complete list of the roles of those interviewed is contained in *Attachment "B".*

Governance of the Review

The department's engagement with this review and the review conducted by the Commissioner for Privacy and Data Protection was supported by a working group.

The reviewer discussed a draft report with the working group on 22 August 2016 and received comments from its members.

Day to day oversight was provided by Executive Services and Oversight and who arranged many of the interviews, the assembling of documentation and provided invaluable advice. The reviewer met with Child Protection Specialist Intervention who provided data as well as important advice and follow up information in relation to child protection matters.

Organisation of this report

This report is ordered as follows:

Firstly, the analysis of incidents and their impact derived from an examination of the incident reports, associated material and interviews.

- Significant attention is given to providing an account and analysis of the publicised privacy incident (section 2). Apart from its intrinsic importance, it exemplifies many aspects found in the broader sample of privacy incidents.
- An analysis of the "in scope incidents" (sections 3 and 4).
- The impact of the incidents on the children and the carers (section 5).

Secondly, the following areas are examined which are informed by the methodology requirements and the analysis of the incidents:

- The privacy framework and child protection (section 6).
- Information sharing requirements and practice (section 7).
- The Client Relationship Information System (CRIS) functionality and required enhancements (section 8).

Thirdly, conclusions, findings and recommendations are contained in sections 9 and 10.

2 THE PUBLICISED PRIVACY INCIDENT

2.1 Outline of the case situation

2.2 The privacy breach

2.3 Mitigation and risk assessment

Containment and safety planning

Risk assessment

2.4 Media coverage

On 12, 13 and 15 July 2016, *The Age* ran a series of articles.

On 12 July, in an article on page 1 and 2 headed *Violent father security breach/ Violent father given address of his children in foster care:*

- The Director of Kinship Carers Victoria is quoted as saying that the privacy breach put the carers at 'extreme risk' and that a solution had still not been agreed to despite weeks of talks with DHHS. "We can understand human error and forgive it, especially since the pressures on DHHS staff seem to be building day by day. However, this family is fearful and they should be our first concern".
- A Children's Court solicitor is quoted as saying "It happens all the time". "I have gone to the department and told them about breaches in their reports."
- The CEO of FCAV is quoted as saying that breaches occurred when caseworkers did not forensically check what was being included in DHHS reports". "Carers hope that the system has taken steps to avoid this, but I think that's a big hope".
- A DHHS spokeswoman was quoted as saying that:
    - Strict policies about the handling and sharing of sensitive information were in place and that client confidentiality was taken very seriously with client safety the utmost priority.
    - "In the rare cases where breaches of privacy occur due to human error, the staff involved are counselled and processes reviewed to identify opportunities for improvement."

The article on page 1 and 2 of the Age dated 15 July 2016, entitled *Watchdog acts: Human Services under the microscope. Foster care breach probe,* provides details of the investigation announced by the Commissioner of Privacy and Data Collection.

In this article the Principal Commissioner, Commission for Children and Young People is quoted as saying "we all know it's an overloaded system that that people are operating under real pressure, but we have to have the procedures in place to stop this happening when the safety of children is potentially at risk...we have to tighten up the system so this can't happen".

2.5 Conclusions

Causes of Privacy Breach

Containment of the breach and development of safety plan

Risk assessment

Addressing the safety issues with carers

3 CHARACTERISTICS OF THE SAMPLE OF INCIDENTS

The sample of 60 incident reports over the previous five years contained a total of 61 reported breaches (with one incident report containing two different incidents).

It is likely that the sample of incidents is an under-representation of all the incidents over the last five years where information became available to third parties that could have been expected to place children or their carers at direct risk of harm.

who were in similar roles five years ago, advised that in 2011 and 2012 some privacy breaches may well have not been recorded on the critical incident reporting system.

3.1 General characteristics

Substantiated breaches

58 out of the 61 incidents were substantiated as privacy breaches.

The circumstances of the other three were:

The reviewer examined the evidence for not substantiating these as contained in the case material and concurs with the department's decisions.

Geographic representation

The following data is provided on the representation by divisions and areas:

- North Division- 14; South Division- 14; East Division- 8; West Division- 22.
- Privacy breaches in 7 regional areas and 7 metropolitan areas.
- 33 incidents in metropolitan areas; 25 in regional areas.

Thus there was a reasonably even distribution of privacy incidents in terms of geographical coverage. It is noted that in proportion to the distribution of child protection cases there was a greater proportion of privacy incidents in regional areas as compared with metropolitan areas.

Timeframe

The privacy incidents were selected for the last five years, from 1 July 2011 to 30 June 2016.

The following provides a breakdown per year of the substantiated incidents:

- 2011 (part year) 2
- 2012 11

- 2013 11
- 2014 10
- 2015 12
- 2016 (part year) 12

Thus there was a reasonably even distribution of privacy incidents over the five year period, with a somewhat greater number of reported breaches in the first six months of this year.

Risk assessment

The review examined the risk assessment level on the Privacy Breach Checklist for the 18 incidents that were examined in greater depth. It was not possible to identify the risk assessment level for the other incidents as the Privacy Breach Checklist is completed after the incident report and not attached to it.

In the 18 cases

- 7 were assessed as high risk
- 5 were assessed as medium risk
- 6 were assessed as low risk

Given the small size of the sub sample together with the fact that risk assessments in some cases have altered upwards and downwards in response to subsequent information becoming available, the data cannot be taken as conclusive.

However, the data is indicative that the assessed risk is high in a significant number of privacy breaches.

Incidents where information became available about placements to third parties

Forty out of the 58 substantiated incidents involved situations where information became available to third parties (in most instances, a parent) about placements that could have been expected to place children or their caregivers (in most instances, kinship carers) at direct risk of harm. Other incidents include ones where information was lost or provided in error to another person where the information were less likely to place children or their caregivers at direct risk of harm.

This group of 40 has been the focus of the review in terms of analysis, findings and recommendations.

3.2 Circumstances and contributing factors

The circumstances of the 58 substantiated breaches of privacy contained in 58 substantiated incident reports are summarised in the following categories:

- Provision of undisclosed addresses and other details in notices, applications related to Children's Court proceedings to third parties. **28**
- Provision of undisclosed addresses in non court related material **6**
- Loss of confidential material (USBs/laptop/court papers) in public places. **5**
- Failure to redact confidential court related information. **4**
- Provision of undisclosed information verbally **4**

- Letters/reports containing client information sent to the wrong person. **3**
- Publication of undisclosed information on a website, newspaper and Facebook **3**
- Correspondence sent to the wrong residential or email address. **2**
- Material sent by non secure means which was lost in transition **2**
- Disclosure of confidential information about one client to another client **1**

Total

58

While the contributing factors are many and varied, the common denominator in all but one of the incidents was human error which caused the inadvertent release of information or loss of information. In many instances, it appears that busy people under pressure to meet deadlines appear to have been working too quickly and not undertaking appropriate checks.

Reports to the Children's Court are signed both by the child protection practitioner and the team manager who approves the contents of the report. In several instances there appears to have been a lack of adequate scrutiny of the report by the team manager.

Twenty eight of the substantiated breaches involved disclosing of inappropriate information though reports to the Children's Court; notices of court applications and other documents related to Children's Court proceedings. In ten of the 28 incidents it was documented that the CRIS functionality (both in terms of a lack of profile of the non disclosure option, and the auto populating facility by which professionals' addresses are placed in the report) exacerbated the error and lack of checking by

The failure to redact confidential information in relation to documents for the Children's Court or to redact it in a way that the original text was completely invisible, was a contributing factor in four of the breaches.

It is apparent that the significant majority of the in scope breaches occurred in the context of the child protection specific environment.

3.3 Responsibility for the breaches of privacy

The primary responsibility for the 58 substantiated breaches is categorised as follows:

- Child Protection 48
- Community Service Organisations 6
- Other 4

In relation to child protection, the primary responsibility generally lay with with a small number involving More often than not appeared to have had limited experience. Responsibility for 14 of the 58 matters involved reports to the Children's Court which were presumably approved by thus the responsibility must be seen as a shared one in these instances. In a small number of incidents were responsible for the breach of privacy.

Several of the six breaches that were the responsibility of community service organisations ("cso") involved a failure to use secure transmission methods

4 ADEQUACY OF THE DEPARTMENT'S RESPONSE

Comments on the adequacy of the department's response is based on an analysis of the 61 incidents and follow up material sourced in relation to 18 of these. This follow up material included the Privacy Breach Checklist, ministerial briefings; action plans and case notes.

The conclusions of this analysis mirror to some extent those in respect of the publicised incident.

Steps taken to assess and contain the breach and undertake initial planning and remedial action were in almost all instances comprehensive and undertaken expeditiously.

In many situations, for example, several where the breach is contained and there is minimal or no risk, there was not a need for strategies to prevent future breaches arising out of the circumstances of the incident.

In others, especially those that had become 'high profile' following communication with external agencies, a detailed action plan was put in place and monitored.

In several situations, there is no written evidence that has been made available to the review that steps planned to prevent future breaches were actioned. In others, it is considered that steps that would have been appropriate were not identified in the initial assessment process. One such example was

The following examples of incidents provide exemplify some of the above comments.

Example 1: A complex incident involving a community service organisation

Key details

Comment

Example 2: An incident involving a complaint of an undisclosed address being included in a report to the Children's Court.

Key details

Comment

Example 3: An incident involving court paperwork that identified the foster carers' address.

Key details

Comment

5 IMPACT OF INCIDENTS ON CHILDREN AND CARERS

Potential impact

As indicated in section 3.1, 40 of the incidents in the sample involved information becoming available to third parties that could have been expected to place children and or their caregivers at direct risk of harm.

In several instances the possibility of any direct harm was nil or negligible. These included where the material disclosing the confidential details of the carer was intercepted (eg by a lawyer, prison management) prior to the parent receiving it, and the view of the carer that despite the non disclosure provision they have a good relationship and understanding with the parents and thought that the release would not create any difficulties.

In a small number of instances there was a risk of severe and potentially catastrophic impact (eg serious injury of a carer or child).

Actual impact

Fortunately, there were no instances of catastrophic impact. This outcome appears at least in part to have been due to thorough containment measures and safety planning being put in place in an expeditious manner.

In six instances there was a recorded significant impact of either some direct harm or detriment:

- assaulting the carer, taking car keys and car. Police acted immediately to locate A full exclusion order was taken out by police. There is no record that the injury sustained from the assault required medical treatment.
- A carer having petrol poured over car, cat stolen, plants poisoned and receiving threatening letters, immediately after the privacy breach.
- One instance of serious threats of harm made by to a carer.
- One instance of repeated abusive telephone calls made by to a carer.

From an examination of related case material, it is concluded that the impact in these instances was a direct result of the breach of privacy, rather than part of a pattern of conflict between a carer and a parent.

In a further two instances substantial measures had to be put in place to avoid possible harm:

- In both instances carers with the children were relocated as a priority to properties in different areas. One of these involved a move from to Given both carers were caring for primary school age children it is assumed that such an impact would have had a disruptive effect on the children as well as the carers.

In instances the carer was a kinship carer. This is not considered to be surprising given that the majority of carers in the sample incidents were kinship carers, and the fact that difficult and conflictual relationships can exist between members of the extended family following child protection intervention.

There were undoubtedly other impacts.

It is apparent, carers were very anxious and apprehensive of being contacted or abused by the person who had been given their confidential information, particularly immediately after the discovery of the breach. There is reference in some of the records to carers preventing the children going outside, staying up all night and being hyper vigilant. Thus, there were impacts that while they did not result in direct harm did have a distressing and disruptive impact on the children and the carers.

6 THE PRIVACY FRAMEWORK AND CHILD PROTECTION

The review's focus was on child protection rather than the broader policy settings and procedures within DHHS as a whole. However, the comments on the experience within child protection may have wider implications.

6.1 Significant developments

Significant developments have occurred in recent years that have strengthened the policy settings in relation to privacy within DHHS as they impact on child protection.

Positive developments over recent years have included:

- The categorisation of all alleged privacy breaches as category one incident reports. The escalation to the Director of Child Protection and other senior staff has doubtless strengthened the quality of the containment strategies and immediate assessment of risk.
- The establishment of privacy officer roles within the Client Outcomes and Service Improvement ("COSI") branches of each operational division. In most divisions, this function is combined with the complaints coordination function. The presence of such a role outside the management of the operational areas to provide expert advice and monitoring of the progress of the handling of the privacy breach is clearly of significant benefit.
- The introduction and use of the Breach of Privacy Checklist which was considered both by the reviewer and operational staff as a very useful tool.
- The commissioning of an Internal Audit for DHHS on the Application of Information Privacy Principles. The report of this audit was submitted in July 2015. Several of the findings of this departmental wide audit are consistent with and have informed this review.

6.2 Areas requiring strengthening

The analysis of this sample of incidents leads to the conclusion that, in relation to child protection:

- A greater profile and focus needs to be given to the area of privacy and handling of confidential information at many levels within child protection. Greater monitoring of compliance is warranted.

- The role relationship between the divisional privacy officers and the central Complaints and Privacy unit needs to be clarified and strengthened.

often have heavy workloads and very tight time constraints. However, the significant number of occasions where carers' addresses which were to be withheld yet were disclosed on notices of applications and reports to the Children's Court indicates a lack of focus, attention and checking of details on the documents. The review found a lack of awareness among staff about the legislation, delegated responsibilities and the associated policy with regard the non disclosure provisions.

This situation requires a cultural change and a change in some systems to enable child protection staff to be supported to ensure privacy.

The role relationship between divisional privacy officers and the Complaints and Privacy Unit can be strengthened by such measures as:

- Ensuring stronger input by the Complaints and Privacy Unit to define key capabilities and core responsibilities of privacy officers in the operational divisions in order to achieve a reasonably consistency approach. At present there are some differences in how the privacy function is undertaken by the privacy officers in different operational divisions and the boundaries of their responsibilities.
- Ensuring that the role relationship is one where the Complaints and Privacy Unit leads by influence and promulgation of practice requirements. It is considered appropriate that the privacy officers are part of the COSI teams and line managed within their Divisions. It is assumed that the form of the relationship is not dissimilar to the relationship between Statutory and Forensic Services (within the Community Programs and Service Design Division) or the Centre for Learning & Organisational Development and staff in the operational divisions.
- Ensuring that systemic emerging issues that need central attention are raised in the central forum and addressed. has informed the review that they had raised concerns about CRIS functionality increasing the likelihood of privacy breaches over a year ago but that their concerns were not acted on by the previous central management.
- Ensuring sufficient and regular meeting time is provided on a monthly basis for privacy officers and to discuss key central and divisional developments and performance with privacy matters. It is understood that regular meetings to cover substantive issues are relatively new.

The review was provided with information from the Executive Services and Oversight Branch regarding the development of a new information technology tool to support the management of privacy incidents as well as complaints and compliments. It is understood that the project scope includes end-to-end recording and resolution of complaints (including privacy complaints) and privacy incident investigations.

It is considered critical that such a tool is developed that contains key details and action steps and investigations in relation to all privacy complaints. There is very limited capacity in the current arrangements to track operational compliance as well as track aggregate trends and performance.

It is proposed that the Breach of Privacy Checklist be extended to include a sign off when medium term steps (i.e within three months) have been taken to prevent future breaches (e.g. staff training, policy review an audit of information handling). At present it is unclear whether proposed actions in the medium term have occurred.

Additional matters warranting attention

There are two additional areas that were discussed during the interviews that warrant further attention.

Firstly, it is recognised that several departmental wide policy documents are in draft form or are working papers, including the Breach of Privacy Checklist. It is understood that the delay in finalising them is at least in part to the machinery of government changes that led to the creation of DHHS and consequential organisational and staff changes.

The documents that were provided to the review are considered to be valuable in terms of content. Updating them to include any changes made as a result of this review and

promulgating them as final documents with a review date will assist providing clarity and structure to the privacy policy framework.

Secondly, there is significant inconsistency between operational divisions on a range of matters including how and what divisional privacy training is provided to child protection staff through the division; when the Breach of Privacy checklist is finalised and the role of the privacy officer vis-a-vis the role of managers within child protection. It is not proposed that complete uniformity is a possible or a desirable goal or that a whole raft of new procedures is instituted. However, some greater consistency would enhance the overall approach and have the added benefit of facilitating involvement of cso s that span more than one division.

6.3 Training, support and compliance

While there is a differential approach across divisions regarding the coverage of privacy considerations in orientation training for child protection staff, the review was advised by that the matters of privacy and handling of confidential information are given emphasis in the Beginning Practice ("BP") program that is undertaken by all new child protection staff of whatever classification. Privacy matters are also given a profile in the leadership training that is provided to team managers and other management positions.

However, the BP program does not capture new child protection practitioners in the first week of the employment or students and new administrative staff working in child protection. Feedback from is that the BP training is fairly 'crowded' and it is difficult to give due attention to all important issues within that framework.

It is proposed that an E Learning module be developed by CLDU in conjunction with the Complaints and Privacy Unit, which is specific to child protection. This module should be no more than 30 minutes. The focus of the module will be on the do's and don'ts of privacy/ information handling in the child protection program. Given that the majority of the privacy breaches in the sample are program specific (e.g. including addresses in reports to the Children's Court) as distinct from more general issues (e.g. the need to send documents by secure mail or email), it is proposed that the majority of the time be devoted to program specific matters.

It is understood that CLDU has the capacity to monitor compliance with such training and report back on take up rates to operational managers.

It will be important that supervisors hold discussions with new staff on the learnings from such training and ensure that operational practice matches the expectations. The value of the E Learning is significantly diminished unless reinforcement is embedded in the supervisory process,

It is also proposed that an E Learning module be developed for team managers and other child protection staff in leadership positions. The focus of this module would not just be on the staff's delegated responsibilities in relation to this area but on the broad strategic developments that are relevant to child protection.

7 INFORMATION SHARING REQUIREMENTS AND PRACTICE

7.1 Legislation and related policy and practice settings

In the instances of privacy breaches, the reviewer is required to examine the compliance with applicable legislation, related policy and practice settings, and any obligations related to information sharing or protection. There is also a requirement to consider custom and practice in the provision of departmental reports to the Children's Court to determine the level of client placement details to be provided.

Section 178(1) of the Children, Youth and Families Act 2005 ("CYFA") provides that the Secretary is required to provide information, including personal information, to the parents about the child who is in out of home care because of a protection order or a therapeutic treatment (placement) order. This requirement is subject to several qualifications contained in s 178(2) including that the Secretary considers that it is not in the best interests of the child to provide the information. Neither information nor personal information is defined in terms of the CYFA.

Section 265 (1) of the CYFA provides that a "parent is entitled to be given details of the child's whereabouts under an interim accommodation order unless the Court or bail justice making the order directs that those details be withheld from the parent". Section 265(2) provides that the direction to withhold the whereabouts of the child from the parents can only be given by the Court or bail justice "if it is of the opinion that the direction is in the best interests of the child".

The delegation of the Secretary to withhold information rests with the child protection team manager and more senior staff. It is a case planning decision.

In most instances where there was a privacy breach, information that was deemed to be withheld from parents was contained in notices of applications or reports to the Children's Court, copies of which are provided to parents. In several instances this was through providing the address and telephone number of the carer.

Detailed policy advice is provided in the Child Protection Manual[1] in relation to the use of personal information in court reports and preparing the court report.

This advice specifies factors that should be given particular consideration in determining whether private information should be withheld from court reports. It specifies that "in all cases child protection practitioners must consider whether the inclusion of identifying addresses/contact details for children, parents or third parties in the notice of protection application, other applications or subsequent reports has potential to compromise their privacy, safety or wellbeing".

This advice also indicates that the child protection practitioner is not required under the CYFA to disclose the child's address in court reports unless this is relevant to the application.

It is understood that a significant but a not universal practice has been to provide addresses and other contact details of professionals in reports to the Children's Court. It is concluded that provision of these details is not required by the Court in these reports. As with the report provided in the publicised incident, inappropriate inclusions of contact details of other professionals can contribute to privacy concerns.

It is proposed that no addresses of professionals are provided in such reports. If a judge or magistrate requires contact details, a specific request can be made at the hearing. This change would remove a significant risk of contact details being inadvertently included which may breach privacy.

7.2 Other documents relating to Children's Court proceedings

[1] Advice numbers 2224 and 2225.

The review was alerted to the fact that in a Summary Information Form completed for all Emergency Care Applications by child protection to be provided to all legal parties, does not contain any specific reference as to whether or not an undisclosed placement is sought by the department.

Including such information in the form is likely to highlight the issue for both legal and child protection practitioners.

who were interviewed suggested that there were other forms in which a prompt or question may highlight the issue of whether a placement is undisclosed or sought to be undisclosed. It appears appropriate for a review of such forms to be taken to identify other opportunities where this matter is able to be appropriately highlighted.

7.3 Use and knowledge of non disclosure provisions

Anecdotal information provided by interviewees suggests that it is a very small number when compared with the total number of placements, and that it has not changed very much in recent years.

indicated that most parents, even if they are confronting challenging circumstances such as drug abuse or custodial sentences, want to do the right thing in terms of not traversing the boundaries or breaching conditions of court orders in respect of where their children are residing.

A view was put that there probably should be a small increase in undisclosed placements, and pointed to "near misses" where a parent's violent past had not been taken into account or the animosity between the parent and a kinship carer was not known and the growth in placements with kinship carers.

It is apparent that there are a small number of placements that need to be undisclosed and a comprehensive safety plan put in place, in such circumstances as where a parent has committed violence against a child or a relative. To fail to arrange for such a placement to be withheld, or to release the details in error has the potential for harm to be suffered by the carer or the child. It is considered that all possible due care and supports need to be put in place to minimise the avoid breaches of privacy occurring.

In some instances, withholding information from a parent may need to be a long term necessity. In other instances, consideration should be given to reviewing the decision to withhold information, within the context of the case plan direction and situation of the parent. Given the relevant legislative provisions and associated policy, it is considered to be just as important to cease to use this option when it is not needed as it is to use the option when it is necessary to do so.

The review concluded, from discussions with that in relation to several instances there was a lack of knowledge by some of the legislative provisions, policies and delegated responsibilities in relation to withholding information from parents. From anecdotal information provided in several interviews there is also a lack of adequate safeguards taken by them in terms of handling sensitive and confidential information securely.

7.4 Addressing safety issues with carers

It is concluded that, contrary to the requirements in the Child Protection Manual, in a significant number of cases child protection practitioners are not giving specific consideration to whether the inclusion of address/contact details in documents relating to court proceedings has the potential for a compromise of privacy and safety.

From discussions with and it is apparent that in many instances no conversation had been initiated with carers regarding their safety needs.

The responsibility for having a discussion about this with foster carers lies with the cso responsible for the selection and training of foster carers and for arranging and supporting particular foster care placements. informed the reviewer that no discussion had taken place during any of foster placements by the cso about assessing safety needs and risks.

A view was put to the review that there is a prevailing assumption held by many foster carers that their addresses and contact details would be withheld from the parents as a matter of course. This view is supported by explicit references in two of the incident reports to the effect that the foster placement could not be disclosed to the parents by virtue of it being a foster placement.

The responsibility for having a discussion about this with kinship carers generally lies with child protection.

The reviewer was advised that on occasions the issues relating to the policy around provision of information to parents and the grounds for non disclosure are not always discussed with kinship carers during the *Preliminary assessment of the Child Protection Kinship Carer Assessment* (referred to as "Part A").

It is concluded that a significant change of what appears to be prevailing practice needs to occur.

Changes in the procedures and advice is required in both the Child Protection and Out-of-Home Care manuals regarding the legislative requirement to provide information to parents of the whereabouts of the child unless it is decided by the delegate or the Court that it is in the best interests of the child for such information to be withheld from the parents following discussions with the carer about their views and safety concerns.

It is proposed that the Part A Assessment form be reviewed with a view to providing a more specific prompt in terms of providing such information to carers.

It is also proposed that correspondence be sent to chief executive officers of all organisations providing out-of-home care requesting that they take necessary steps to ensure that their staff and carers receive appropriate training in relation to privacy and information sharing. In particular it will be important to ensure that they are aware of the legislative and policy requirements relating to the provision of information to parents regarding a child, and the circumstances in which a person with delegated authority can determine that information is to be withheld.

It is considered that this proposal would be a timely reminder for chief executive officers to take stock of these requirements and gain a level of understanding about staff and carers' knowledge of this sensitive area.

It will be important that program and training manuals for carers address privacy issues in practical terms related to their specific role. The reviewer was shown an extract from a manual where the reference to privacy issues was written in a way that did not inform carers about what they actually needed to know.

7.5 Addressing the interface with the Children's Court

A key pressure point is the interface with the Children's Court, and in particular in the situation where Emergency Care applications are being heard.

both referred to the fact that, contrary to what occurs in some other jurisdictions, child protection practitioners are having to do what was described by as "legal work" in terms of serving affidavits and redacting material for a court hearing in situations of very tight timelines.

These comments should not be interpreted as an implied criticism of does not have the resources to assume an additional function.

From discussions held with it appears that this situation has contributed to errors where privacy breaches have occurred in redacting information from documents to be distributed to parties, and in the provision of notices of applications and other court related material.

It is proposed that a working group be established to consider strategies in the short and longer term to address the pressure points faced by child protection practitioners in their interface with the Children's Court and to develop an action plan.

8 CLIENT RELATIONSHIP INFORMATION SYSTEM (CRIS)

As is apparent from the analysis of privacy incidents relating to departmental reports to the Children's Court, that the privacy breach is caused by human error.

However, in several instances the current functionality of CRIS does not provide checks and balances for the child protection staff.

In discussions with senior members of and a significant number of two broad areas were identified.

Firstly, the issue of whether a client's details should be restricted is not a prominent feature of the 360 degree page. If the relevant box is not actioned the practitioner can progress through the screens.

The review was advised that a scheduled enhancement was currently being prepared for release in November 2016.

It is understood that this scheduled enhancement will require a yes/no answer to whether an address is to be withheld prior to allowing the user to progress through the screens. This will substantially improve the visibility of and compliance with the "withheld" address option and should reduce, very substantially, the risk of human error.

Secondly, the court report templates on CRIS automatically populate address and contact details unless otherwise withheld in CRIS. Practitioners have not always considered whether identification of address or other contact details in the documents may place children or carers at risk.

As referred to in section 7.1, it is recommended that as part of a further enhancement, no address and other contact details of any of the professionals are included in the Professional's table in reports to the Children's Court.

It is understood that a change to effect this in CRIS has been endorsed by for an enhancement to receive high priority for release early in

2017. It is further understood that this change to the CRIS application will retain the names of involved professionals (but not their contact details or their addresses).

It is recognised that it will be several months before the enhancements are implemented. This raised for the reviewer the matter of what steps have been or should be taken interim. The reviewer was advised that there have been two recent alerts to CRIS users related to this specific issue of privacy and structured advice about how to manage the system so that the content of the report reflects the new expectations. Discussions have also been held about the privacy issues at scheduled senior child protection managers' meetings.

9 CONCLUSIONS AND FINDINGS

The number of reported breaches of privacy over the last five years is of significant concern.

Child Protection is the "high voltage" program within DHHS. The combination of constant interactions with traumatised and damaged families and vulnerable children, large workloads, tight timelines and the intensity of the interface with the Children's Court differentiates it from other programs.

Coupled with these factors is a workforce that has a high turnover in comparison with most other programs, as well as a significant number of child protection practitioners who do not have prior experience in working with organisations handling very sensitive client information.

Against this backdrop it is not surprising that privacy breaches in child protection form a significant proportion of the total within the community service programs of DHHS[2]. Many such breaches not only have the potential to place children and their carers at direct risk of harm, but cause considerable anxiety. They can also undermine in the eyes of the public the very effective work of child protection staff on a day to day basis.

Almost all the privacy breaches in the sample involve privacy incidents involve human error by busy and often relatively new staff who are working under pressure.

Many of these findings contain opportunities to strengthen systems, processes and supports and the general profile of the increasingly complex area of privacy and information sharing in order to minimise the occurrence of future breaches.

FINDINGS

The publicised incident

[2] In 2015/16, Child Protection privacy beaches comprised the largest number of any program component of CYF, Disability Services and Housing programs and represented 30% of the total. In one operational division it comprised 75% of the total.

The sample of incidents

5. A sample of 60 incident reports (containing 61 incidents) was provided to the review. Fifty eight of these incidents were substantiated as privacy breaches. Of the 58 incidents:
    - 57 were the result of human error.
    - 48 were caused by the actions of child protection staff.
    - 40 involved information becoming available to third parties that could have been expected to place children and or their caregivers at direct risk of harm.

6. In relation to the 18 incidents that were examined in depth:
    - 7 were assessed as high risk.
    - 5 were assessed as medium risk.
    - 6 were assessed as low risk.

7. Child protection staff put adequate measures in place to undertake a preliminary assessment, contain the impact and mitigate the risks through safety planning.

    Future actions specified on the incident report to be undertaken in the medium term to prevent future such breaches were, in a significant number of instances, not undertaken or not recorded as having been undertaken.

8. There was some direct harm or detriment to the carer(s) in four of the 58 incidents. These included an assault; taking car keys and a car; stealing a cat and poisoning plants; sending threatening letters and making abusive telephone calls.

    In two other instances, carers with their children were relocated to properties in different locations to mitigate a substantial risk of a parent making unauthorised contact with the carer and children.

    All six instances involved kinship carers.

Adequacy of privacy policy and practice settings

9. Significant positive developments have occurred in recent years to strengthen the policy and practice settings. These include:

- all alleged privacy breaches being category one incident reports (thus being immediately escalated to the Director Child Protection and to other senior staff).
- establishing privacy officer roles in each division and the introduction of a Breach of Privacy checklist.
- the commissioning of an Internal Audit for DHHS on the Application of Information Privacy Principles.

10. The role relationship between the central Complaints and Privacy Unit and the privacy officers in the operational divisions needs to be strengthened to ensure adequate monitoring and oversight by the central unit and that systemic issues that lead to privacy breaches can be addressed in a strategic manner.

11. The lack of a privacy incident register that includes key details, action steps and investigations of all privacy complaints is an impediment to adequate monitoring and oversight.

    The reviewer was advised that a new information technology tool is being developed to support the management of privacy incidents as well as complaints and compliments.

12. In several instances did not give adequate consideration to the material to be included in reports to the Children's Court. did not monitor the contents of the reports before endorsing them. There has not always been a sufficient profile given to privacy and information sharing matters in day to day practice.

13. The *Beginning Practice* training for child protection staff gives some consideration to privacy and information sharing issues throughout the program. There needs, however, to be a specific E learning module provided that highlight the basic essentials of privacy for child protection practitioners, students and administrative staff within the Child Protection Program.

14. There is insufficient training and support on privacy given to staff in leadership positions including team managers given their different and increased responsibilities in this area.

Information sharing requirements and practice

15. Detailed policy advice is provided in the Child Protection Manual in relation to the use of personal information in court reports and in preparing a court report. In several of the incidents, this advice was not complied with. In these instances, did not appear to have sufficient awareness of the relevant legislation and policy.

16. It has been the practice to provide addresses and other contact details of professionals in reports to the Children's Court. This has created significant risk in terms of contributing to privacy breaches. In several documents that have been reviewed the potential for additional privacy complaints was apparent.

17. There appears to be an assumption held by a significant number foster carers (as well as by several that their addresses and contact details would be withheld from the parents as a matter of course. This is contrary to the relevant legislative provisions and associated policy.

18. It was reported that conversations are not always held in relation to information sharing provisions and safety needs when preparing the assessment for placing a child with a kinship carer. Some kinship carers consider that their safety needs are not addressed.

19. The Summary Information Form completed for all Emergency Care Applications by child protection practitioners does not contain a specific reference as to whether an undisclosed placement is being sought.

20. Anecdotal evidence suggests that the number of undisclosed placements is very small as a proportion of the total number of placements. It has been suggested while the number has not changed significantly over recent years, it may be increasing given the current context of an increased proportion of kinship placements.

21. Insufficient specific consideration was given in several instances by as to whether the inclusion of addresses and other contact details of carers in documents related to court proceedings has the potential to compromise the best interests and safety of the children.

Client relationship information system (CRIS)

22. The current functionality of CRIS does not provide sufficient prominence to the decision of whether the address is to be disclosed or not.

    The reviewer was advised that an enhancement is being undertaken that is scheduled for release in November 2016 that requires a yes/no answer to whether an address is to be withheld, prior to the user being able to progress through the screens. This should substantially improve the visibility of and compliance with the withheld address option.

23. The inclusion of addresses and contact details of professionals, which are automatically populated into a report for the court unless the non disclosure function is activated, is a significant risk issue in terms of inadvertent breaches of privacy.

    Toward the end of the review, the reviewer was advised that approval has been given for a further enhancement to CRIS that will result in address and contact details of professionals and carers not being in the court report format. It is understood that this enhancement will be scheduled for release for early 2017.

10 RECOMMENDATIONS

The reviewer has adopted a strategic approach in formulating recommendations that should have a key impact on substantially reducing the number of privacy breaches within the Child Protection program. Effort is needed across the domains of leadership in cultural change; training and development opportunities and the strengthening of various role relationships.

The review is conscious of the tight budget environment in which DHHS operates, and the concern to ensure that child protection practitioners are able to maximise their time on their core work. Proposing a raft of additional procedures and processes would be

counterproductive. It is recognised that there has been a shift in the Child Protection Program in Victoria from an emphasis on practice that can become overly proceduralised to a focus that developing professional expertise and practice consultation. The nature of the recommendations reflects this shift.

Addressing the development and support needs of child protection practitioners and senior child protection staff

1. **Additional learning and development tools are developed and implemented which are specific to the Child Protection program. These are to include:**

    - **An E learning module for child protection practitioners, students and administrative staff within the Child Protection program. This module should be no more than 30 minutes. The focus of this module should be on the basic do's and don'ts of privacy/information sharing, with most content being program specific.**

      This module should be included as mandatory training with associated monitoring of completion. It should also be followed by discussions with a supervisor to maximise the opportunity for learning to be embedded in practice.

    - **An E learning module for leadership staff, especially senior practitioners and team managers within the Child Protection program. The focus of this module the additional privacy and information sharing responsibilities associated with their roles and the broader policy context of information sharing.**

Addressing the needs of carers

2. **Changes are made to both the Child Protection and Out-of-Home Care Manuals to document procedures and appropriate advice regarding**

    - **The need to have discussions with carers immediately prior to or at the commencement of a placement about the legislative requirement of DHHS to provide information to the parents about the child, including the provision of personal information; and that this requirement is subject to several qualifications including consideration that it is not in the child's best interests to provide the information. These discussions need to be held in the context of the assessment processes that precede a placement.**

    - **The decision making and endorsement processes for withholding information from parents.**

    - **The communication and recording of such a decision.**

    - **Consideration being given to reviewing a decision to withhold information.**

3. **Correspondence is sent to chief executive officers of all community service organisations providing out-of-home care requesting that they take necessary steps to ensure that their staff and carers receive appropriate training in relation to privacy and information sharing. In particular it will be important to ensure that they are aware of the legislative and policy requirements relating to the provision of information to parents regarding a child, and the circumstances in which a person with delegated authority can determine that information is to be withheld.**

Court related documents

4. **That the following changes are made to court related documents:**

    - **By means of a CRIS enhancement, no address or other contact details of any professionals are included in the Professional's table in reports to the Children's Court.**

      It is noted that a number of enhancements are scheduled for release in November 2016 that will require a yes/no answer to whether an address is to be withheld prior to allowing the user to progress through the screens. This should substantially reduce the risk of human error.

    - **A Summary Information Form which is completed for all Emergency Care Applications be amended to contain a specific reference as to whether or not an undisclosed placement is sought by the department.**

Strengthening the privacy framework as it relates to child protection

5. **Measures are implemented that clarify the role relationship between the central Complaints and Privacy Unit and that strengthen the delivery of privacy function. These are to include:**

    - **The planned development of new information technology tool to include supporting the management of privacy incidents to provide end to end recording, investigation and resolution of all such incidents. Such a tool needs to enhance the monitoring and oversight of performance and facilitate the identification of systemic issues that arise. With the introduction of the new arrangements it is considered critical to retain the immediate reporting of the privacy incident to the relevant director.**

    - **The Complaints and Privacy unit defining the capabilities and core components of the privacy function within operations divisions to achieve greater consistency of approach and stronger oversight.**

    - **Extending the Breach of Privacy checklist to include a sign off when medium terms steps have been taken to prevent privacy breaches that were identified following a specific incident.**

Addressing specific pressure points of the interface of child practitioners with the Children's Court

6 A working group is established to consider strategies in the short and longer term to address the pressure points faced by child protection practitioners in their interface with the Children's Court and to develop an action plan.

Ensuring that the privacy issues are appropriately reflected in program documentation

7 The Child Protection and Out-of-Home Care manuals are reviewed to determine whether any changes are needed arising from the content of this review.

When reviewing manuals and policies or developing new ones relating to child protection and out-of-home care, adequate attention needs to be given to the findings and recommendations of this review.

Appropriate steps are taken to ensure that manuals and training materials for carers address the relevant privacy issues in practical terms that relate specifically to their role.

The reviewer is confident that the implementation of these recommendations, together with a sustained focus on privacy and information sharing requirements should lead to a substantial reduction of incidents of this type.

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Project Brief

Project name:	Child Protection privacy incidents and carer and client safety	
Reviewer:	John Leatherland, Human Services Consulting	
Contact details:	Ph	@gmail.com
DHHS project oversight:	Ph.	Executive Services and Oversight @dhhs.vic.gov.au .
DHHS project contact:	Ph	Child Protection Specialist Intervention Unit @dhhs.vic.gov.au

Background

The Minister for Families and Children Jenny Mikakos has sought a full independent review of a sample of child protection privacy incidents over a five-year period, to reduce the risk of further incidents.

The review will commence immediately and be completed by the end of August 2016.

Review Purpose

The primary purpose of the review is to consider the circumstances of a subset of privacy incidents where, due to possible actions/omissions of departmental staff, information became available about placements to third parties that could have been expected to place children, and or their caregivers, at direct risk of harm.

The review will provide advice on any additional controls required to reduce incidents of this type.

Terms of Reference

The reviewer will:

- Inquire into the circumstances of a sample of privacy incidents reported via Incident Reports over the past 5 years. The focus of the review will be on incidents where information became available to third parties that could have been expected to place children and or their caregivers at direct risk of harm.
- Determine the extent to which policy and practice advice, or, compliance with policy and practice advice, contributed to the reported incidents.
- Examine the adequacy of the department's response method(s) to reported incidents and the application of risk assessments.
- Provide advice proportional to risk, on improvements to policy, practice or systems including client information systems, to improve controls and reduce the recurrence of future incidents of this type.

Overview of proposed methodology

The methodology will include examination of documentation, analysis of incident data, consultations with relevant staff and preparation of a progress update and final report. This will include:

- Examination of incident reports and other relevant documentation, related to reported privacy incidents over the past five years.
- In consultation with operational divisions and based on agreed criteria, an in depth examination of a sample of incident reports - where information became available which could have been expected to place children and /or their caregivers at direct risk of harm.

Consideration should be given to perceived risk versus the actual risk. This examination should consider whether any systemic issues are evident.

- Examination of compliance in these instances with applicable legislation (in particular the *Children, Youth and Families Act 2005*), related policy and practice settings and any obligations related to information sharing or protection.
- Consideration of custom and practice in the provision of departmental reports to the Children's Court, including court report format, to determine the level of client placement details to be provided, and how exceptions related to safety are managed.
- Examine the client record information system in terms of functionality, presence or absence of controls, and potential enhancements.

It is noted a concurrent inquiry by the Commissioner of Privacy and Data Protection into the department's compliance with information privacy principle number 4 (which obligates the department to take reasonable steps to secure the personal information it collects and handles) will be undertaken, and this review may inform the Commissioner's review.

The department will be responsible for providing to the reviewer data and documentation as outlined and arranging meetings and site visits with operational, policy and program staff as required.

The reviewer may directly engage with stakeholders including

Any matter that may emerge outside of scope, will be discussed with People, Capability and Oversight Division for action as required.

Project Management and Governance

The independent review will be undertaken by Mr John Leatherland, Human Services Consulting with Department of Health and Human Services oversight provided by People, Capability and Oversight Division. Briefing, documentation and data to inform the project will be provided through the DHHS contact

A progress update will be provided early August. A final report will be provided to the Secretary, DHHS late August 2016.

Review components/milestones/timelines

Activity	Dates
Preliminary briefing, familiarisation with CRIS and other processes, examination of documentation and interviews in relation to the most recent incidents in the sample	Weeks commencing 18 and 25 July 2016
Examination of documentation in relation to privacy incidents over five years; interviews in relation to an agreed sample (up to 10 incidents) Progress update.	Weeks commencing 1 and 8 August 2016
Meetings with relevant department policy and program staff; interviews with key stakeholders	Week beginning 15 August 2016
Preparation of draft report	19 August 2016

Final review report submitted	29 August 2016

Deliverables	Dates
• Submission of final report of the review	29 August 2016

ATTACHMENT 'B'

INTERVIEWS AND CONSULTATIONS

External Stakeholders

Department of Health and Human Services

People, Capability and Oversight

Operations

Service Implementation and Support

West Division

North Division

East Division

South Division

Community Services Programs and Design

Focus Group

North Division
East Division
West Division
West Division
South Division
North Division