Report of the Special Commission of Inquiry into Child Protection Services in New South Wales (the Wood Report)

A review and commentary

Patricia Hansen and Frank Ainsworth

The Wood Report is the product of a Special Commission of Inquiry into Child Protection Services in NSW that was set up in June 2006 and reported in November 2008. In March 2009, the NSW Government published a response to the report, 'Keep them safe: A shared approach to child wellbeing'. The NSW Parliament in April 2009 also passed the Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009 with little debate. This legislation has introduced many of Justice Wood's recommendations and has enacted other changes that were not included in the Commission of Inquiry report. While many of the amendments are welcome, there is cause for concern about the likely consequences of some of the new provisions.

Patricia Hansen, PhD
Head, School of Social Work
Australian Catholic University, Strathfield Campus, Sydney, NSW
Email: patricia.hansen@acu.edu.au
Dr Hansen is also a lawyer practising part-time in the NSW Children's Court.

Frank Ainsworth, PhD
Senior Principal Research Fellow (Adjunct)
School of Social Work and Community Welfare
James Cook University, Townsville, Qld
Email: frankainsworth@hotmail.com
Dr Ainsworth is a Guardian Ad Litem in the NSW Children's Court.

The Wood Report (www.lawlink.nsw.gov.au/cpsinquiry) is the product of the Special Commission of Inquiry into Child Protection Services in NSW (the Inquiry) that was set up in June 2006 and reported in November 2008. The result is a mammoth 1107 page report that contains 111 recommendations. In his Executive Summary at the beginning of the report, Justice Wood rightly emphasises that:

> The child protection system in NSW consists of much more than the Department of Community Services (DoCS). NSW Health through its Area Health Services and The Children's Hospital at Westmead fund and deliver many services for children, young people and their families, including prenatal care, home visiting and counselling, with the aim of preventing or minimising harm. Similarly, the Departments of Education and Training, Juvenile Justice and Ageing, Disability and Home Care, Housing NSW and the NSW Police Force offer programs, funding and services, ranging from breakfast programs, diversionary sentencing options for young people, respite for parents of children with disabilities, and housing and youth support activities (Wood 2008, i).

Nevertheless, the Inquiry came about because of considerable negative publicity principally aimed at the NSW Department of Community Services (DoCS) following a number of child deaths that attracted considerable media attention.

Since the release of the Wood Report (2008), the NSW Government has published a response titled 'Keep them safe: A shared approach to child wellbeing' (NSW Department of Premier and Cabinet 2009). On 3 April 2009, the NSW Parliament also passed the *Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009.* Once commenced, this legislation will pave the way for implementing 106 of the Wood Report recommendations, albeit across a five year time period.

The Wood Report is divided into three volumes and 27 chapters. Volume 1, which has 2 parts, is made up of 10 chapters that address broad themes relating to DoCS Structure and Workforce, as well as Early Intervention and Child Protection. Volume 2 is also in 2 parts with the first part, part 3, focusing on the Legal Basis for Child Protection and consisting of 8 chapters. Part 4 is about Out-of-Home

Care and consists of 1 chapter. Part 5, entitled Specific Issues, consists of 3 chapters that cover the important issues of Domestic and Family Violence, and the Representation of Aboriginal Children in Child Protection. Finally, volume 3 consists of parts 6 and 7 that contains 8 chapters. Part 6 covers Homelessness, Children, Young People and Parents with Disabilities; and Disaster Recovery. Part 7, consisting of one chapter, focuses on the implementation of the Wood Report recommendations

A comprehensive coverage of the total Wood Report is not feasible in this review because of the amount of information and analysis contained within the document. As a consequence, this review will focus on those things that the authors think Justice Wood has done well, those recommendations about which there should have been more debate, as well as some recommendations that the authors of this review regard as unhelpful, if not harmful, to children, families and the community.

RECOMMENDATIONS THAT DESERVE SUPPORT

The following recommendations from the Special Commission of Inquiry are very positive proposals.

Chapter 3 DoCS workforce capacity

R. 3.1 *From 1 July 2009 all appointed Managers Casework should be required to possess a relevant tertiary qualification, in addition to experience in child protection work.*

Chapter 6 Risk of harm reports to DoCS

R. 6.1 *DoCS should revise its case practice procedures to develop guidelines to classify risk of harm reports made and information given to the Helpline. Information which does not meet the statutory test for a report should be classified as a contact and not as a report. Information which meets that test should be classified as a report. The circumstances in which reports are referred for further assessment or forwarded as information only should be clarified and consistently applied.*

R. 6.2 In relation to the *Children and Young Persons (Care and Protection) Act 1998*

a. *Sections 23, 24, and 25 should be amended to insert 'significant' before the word 'harm' where it first occurs, and s.27 amended to insert 'significant' before the word 'harm" wherever it occurs.*

b. *Section 23 should be amended to insert as paragraph (g) 'the child or young person habitually does not attend school'.*

c. *A provision should be inserted defining that (with the exception of s.23 (d)) harm may be constituted by a single act, omission, or circumstance or accumulate through a series of acts, omissions or circumstances.*

d. *The penalty provision in s.27 should be deleted.*

R. 6.3 *Reporters should be advised, preferably electronically in relation to mandatory reporters, of the receipt of their report, the outcome of the initial assessment, and, if referred or forwarded to a CSC, contact details for that CSC should be provided. Caseworkers and their managers should be required to respond promptly and fully to requests for information about the report from mandatory reporters, subject to ensuring the integrity of any ongoing investigation.*

Chapter 7 Early intervention

R. 7.1 *DoCS should revise its Brighter Futures Guidelines to clarify the account to be taken of child protection history in determining eligibility.*

The many supported recommendations will reshape the mandatory reporting system and progressively transfer to the non-government sector the responsibility for early intervention programs ...

Chapter 8 Assessment and response

R. 8.5 *The NSW Government should develop a strategy to build capacity in Aboriginal organisations to enable one or more to take on a role similar to that of the Lakidjeka Aboriginal Child Specialist Advice and Support Service, that is, to act as advisers to DoCS in all facets of child protection work including assessment, case planning, case meetings, home visits, attending court, placing Aboriginal children and young persons in OOHC and making restoration decisions.*

Chapter 9 Assessment and response: issues arising

R. 9.7 *DoCs should develop models of professional support for novice caseworkers, such as those offered in other disciplines like medicine, which involve safety and risk factors in decision making.*

R. 9.8 *The work of the DoCS Drug and Alcohol Expertise Unit should be expanded to include mental health and domestic violence.*

Chapter 10 Directions for the way forward

R. 10.1(part) *Mandatory reporters from each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of*

Ageing, Disability and Home Care who suspect that a child is otherwise at risk of significant harm should report their concerns to a newly created position or Unit within their own agency ('the Unit'). That Unit should be staffed by specialists with knowledge of the work of the agency and knowledge of child protection work.

That Unit should determine whether the report meets the statutory threshold, by use of a common assessment framework, and if so, make the report promptly to the Helpline.

If the report does not meet the statutory threshold, and the Unit considers that the child or young person is in need of assistance, one or more of the following should occur:

a. *The child or young person or family is referred by the Unit or the initial reporter to a newly created Regional Intake and Referral Service. That service should be located within an NGO and should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for services such as case management, home visiting, intensive family support brokerage, quality child care, housing and/or parenting education.*

b. *Families who are assessed by the Unit as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.*

c. *A referral to the Domestic Violence Line should be made by the Unit or the initial reporter if the concern arises primarily from the presence of domestic and family violence and the non-offending parent (usually the mother) requires assistance.*

d. *The agency works with the child or young person, alone or in combination with another appropriate agency or NGO.*

R. 10.2 (part) *The Regional Intake and Referral Service described above should be operated and staffed by an NGO, with one or more child protection caseworkes seconded from DoCS. Where the child protection caseworker forms the view that the child or young person may be at risk of significant harm, the caseworker should perform a history check on KiDS and, if in the caseworker's view, the statutory test is met, the caseworker should refer the matter to the Helpline. There should be at least one Regional Intake and Referral Service in each DoCS region.*

R. 10.3. *DoCS should remain as a single department with a centralised Helpline, it should be divided into regions which are aligned with other key agencies and each region should contain such number of CSCs as are appropriate for the level of demand within the region.*

R. 10.4 (part) *NGOs and state agencies should be funded to deliver services to the children, young persons and families who fall within the groups listed in recommendations 10.1 a and b and 10.2 a and c above. These services should cover the continuum of universal, secondary and tertiary services and should target transition points for children and young persons. Such services should include:*

a. *home visiting, preferably by nurses, high quality child care, preferably centre based, primary health care, school readiness programs, routine screening for domestic violence, preschool services, school counsellors, breakfast programs and early learning programs.*

b. *sustained home visiting, parenting education, supported playgroups, counselling services, the Home School Liaison Program and accommodation and rental assistance.*

c. *drug and alcohol counselling and rehabilitation services, sexual assault counselling, forensic services for sexual assault victims, PANOC services, services for adolescents 10-17 years who display sexually abusive behaviours, allied health services such as speech pathology and mental health services.*

d. *secondary and tertiary services that include intensive, short term, in house and crisis interventions and that provide links to other services following intensive support, where needed.*

e. *the availability of counselling or other similar services from other agencies should not be dependent upon a risk of significant harm report being made by DoCS, or DoCS having allocated the report/case.*

R. 10.5 (part)

a. *Brighter Futures should be extended to provide services to more children aged 0-8 years and integrated into the service system.*

c. *The number and range of family preservation services provided by NGOs should be extended. This should include extending Intensive Family Based Services to Aboriginal and non-Aboriginal families.*

Chapter 13 Court Processes in statutory child protection

R. 13.6 *DoCS caseworkers should be given more specific training and guidance in relation to the nature of care proceedings and in relation to the evidence to be placed before the Court, to ensure its relevance, accuracy and fair balance.*

R. 13.9 *A District Court Judge should be appointed as the senior judicial officer in the Children's Court.*

Chapter 16 Out-of-home care

R. 16.2 *Over the next three to five years, there should be a gradual transition in the provision of OOHC for children and young people as follows:*

a. *Most children and young people in OOHC should be supported by one of the two following models:*

i. DoCS retains parental responsibility and a non-government organisation is responsible for case management, placement and casework services. The agency has responsibility for assessment, case planning, implementation, review, transition and case closure as well as the placement of the child or young person with an authorised carer, and for any decision to remove a child or young person from a carer. DoCS retains the key decision making role in restoration decisions, developing and approving the initial care plan and has a role in implementation. DoCS and the agency have joint responsibility for decisions to apply to change Court orders and for providing after care assistance.

ii. DoCS delegates parental responsibility and transfers case management, placement and casework services to a non-government organisation (while retaining residual powers) subject to consultation with the Children's Guardian.

iii. Children and young persons with significantly complex needs or who are assessed as at high risk of immediate or serious harm or whose case management requires high level collaboration with other government agencies will remain case managed by DoCS.

b. *At an early stage, DoCS should progressively commence the transfer of long term kinship/relative carers to NGOs so as to allow the NGOs to carry out any necessary training and to provide ongoing support for these carers.*

c. *At an early stage DoCS should progressively reduce its role in the recruitment of foster carers and transfer current long term foster carers to NGOs.*

R. 16.4 *NSW Health should appoint an OOHC coordinator in each Area Health Service and at The Children's Hospital at Westmead*

R. 16.5 *The Department of Education and Training should appoint an OOHC coordinator in each Region.*

R. 16.8 *Within 30 days of entering OOHC, all preschool and school aged children and young persons should have an individual education plan prepared for them which is reviewed annually by the Department of Education and Training and by the responsible caseworker. A mechanism for monitoring, evaluating and reviewing access and achievement of outcomes should be developed by the Department of Education and Training and DoCS.*

R. 16.12 *Due to the large number of Aboriginal children and young persons in OOHC, priority should be given to strengthening the capacity for Aboriginal families to undertake foster and kinship caring roles.*

RECOMMENDATIONS THAT REQUIRED FURTHER DEBATE

Chapter 3 DoCS workforce capacity

R. 3.2 *A review should be undertaken to identify tasks that could be appropriately delegated by caseworkers.*

Chapter 6 Risk of harm reports to DoCS

R. 6.2 (part)

b. Section 23 should be amended to insert as paragraph (g) 'the child or young person habitually does not attend school'.

Chapter 10 Directions for the way forward

R. 10.5 (part)

b. Brighter Futures should be extended progressively to provide services to children aged 9-14 years with priority of access to services for Aboriginal children and their families.

Chapter 18 Aboriginal over representation in child protection

R. 18.1 (part)

b. *Working with the Commonwealth to income manage Commonwealth and State payments to all families, not only Aboriginal families, in circumstances where serious and persistent child protection concerns are held and there is reliable information available that income is not being spent in the interests of the safety, welfare and well-being of the relevant child or young person.*

RECOMMENDATIONS THAT SHOULD NOT HAVE BEEN SUPPORTED

There are a limited number of recommendations in the Wood Report that in our view should not have been supported. They are listed below.

Chapter 9 Assessment and response: issues arising

R. 9.1 *DoCS should test the use of Structural Decision Making tools at the Helpline and at CSCs in relation to assessment and intervention including restoration.*

Chapter 11 Statutory basis of child protection

R. 11.1 (part)

x. *The Act should be amended to limit the power of the Children's Court to make contact orders to those matters where the Court has accepted the assessment of the Director-General that there is a realistic possibility of restoration.*

Chapter 13 Court Processes in statutory child protection

R. 13.3 *Care applications by DoCS under s. 45 and 61 should be made by way of an application filed in the Court supported by a written report which succinctly and fairly*

summarises the information available to DoCS and contains sufficient information to support a determination that a child is in need of care and protection and any interim orders sought, without any requirement for the filing of any affidavit, unless ordered by the Court in circumstances where establishment is contested. The DoCS file or relevant portion of it should be made available to the parties.

We applaud the many recommendations that are about building capacity and funding services for the Aboriginal community given the over representation of Aboriginal children in OOHC services. This will not be an easy process but it is long overdue.

DISCUSSION OF THE WOOD RECOMMENDATIONS

As can be seen from this selective listing of recommendations, most of which have been enacted in the recent legislation, the Wood Report will result in massive change to the NSW child protection system. The many supported recommendations will reshape the mandatory reporting system and progressively transfer to the non-government sector the responsibility for early intervention programs such as 'Brighter Futures' and out-of-home care (OOHC) services, including foster care.

The proposed creation of Regional Intake and Referral Services located in the non-government sector that will determine the nature of services required by a family in need of support and assistance with child rearing issues responds to a long standing issue about access to services. Once established, these services will provide a new gateway that will allow families to seek assistance outside the framework of the statutory child protection system.

DoCS will rightly remain responsible for investigating suspected cases of child abuse and neglect although the threshold test for case substantiation will be raised and become 'significant harm' rather than the lower standard of 'at risk of harm'. The recommendation that each Area Health Service, the Children's Hospital at Westmead, the Department of Education and Training, NSW Police Force, the Department of Ageing, Disability and Home Care, and the Department of Juvenile Justice have at least one position responsible for co-ordinating reports to DoCS of suspected cases of 'significant harm' should also go some way toward stopping the practice of 'defensive reporting' by staff out of fear that they may face a personal fine for failure to report. The removal of the financial penalty for failure to report adds to this process of stopping the practice of unnecessary multiple reports in relation to a single incident.

We also applaud the many recommendations that are about building capacity and funding services for the Aboriginal community given the over representation of Aboriginal children in OOHC services. This will not be an easy process but it is long overdue.

Less satisfactory are the recommendations that refer to a) delegation of tasks by DoCs caseworkers, b) the insertion in s. 23 of a paragraph about school attendance, c) the 'Brighter Futures' program being extended to the 9-14 year olds, and particularly to Aboriginal families, and d) income management.

It is acknowledged that families in need and children and young people in OOHC find changes in casework personnel very unhelpful (Frederick & Goddard 2006). Working with vulnerable families requires sensitivity and high level skill. It is not just about parcelling out tasks to lesser trained personnel. Doing simple tasks for individual families in need may help to consolidate the family-caseworker relationship through which behaviour change and improved child rearing practice may be achieved. We need to be cautious.

The Section 23 proposal about inserting paragraph (g) 'the child or young person habitually does not attend school' is also a cause for concern given potential enforcement measures cited in paragraph 7.274 on page 274 of the report. This includes increased fines, imprisonment and alternative sentencing options to imprisonment for parents whose children fail to attend school. In our view there needs to be substantial debate about this issue before such draconian measures are put in place in NSW.

The 'Brighter Futures' 0-8 years program is currently being evaluated for DoCS by the Social Policy Research Centre (SPRC) at the University of New South Wales. The results of this evaluation are not yet available. Yet here we have a recommendation that the program be extended to another age group. Firstly, where is the evidence that 'Brighter Futures' 0-8 years program is effective? Secondly, even if the result of the SPRC evaluation is that this program is effective, where is the evidence that it will also be effective with the 9-14 year olds and with Aboriginal families? Why would anyone accept this recommendation before the evaluation has been completed and there is data to guide further development of these services?

The recommendation about income management is also highly contentious. There is as yet limited evidence from the Northern Territory and the trial in Western Australia that shows that this practice actually reduces the incidence of child abuse and neglect. There are also ethical issues that have to be addressed if this practice is to become commonplace. The Wood report does not address these

issues and, until they are addressed, this recommendation needs to be considered as a risky strategy in terms of ethical practice.

We now move to consideration of those recommendations that we think should have been opposed. There are only three but they are all important. These recommendations are for a) the testing of Structural Decision Making (SDM) tools, b) the removal from the Children's Court the capacity to make contact orders following a final hearing that places a child into the care of the Minster, and c) the replacement of affidavit evidence by caseworkers in favour of a report which succinctly and fairly summarises the information available to DoCS and contains sufficient information to support a determination that a child is in need of care and protection.

The evidence about SDM tools, which are essentially about assessing risk, is available (White & Walsh 2006). The finding is that such tools are flawed. As Shlonsky and Gambrill (2005) say:

> Methodological challenges to assessing risk include lack of reliability and validity of measures, definitional dilemmas, temporal issues (including changes in risk over time), the absence of baseline data, difficulty in predicting for individuals, and the lack of sensitivity and specificity of measures (Shlonsky & Gambrill 2005, p. 316).

All that risk assessment instruments do is offer false reassurance about the correctness of the decision that is being made in care and protection cases. They also constrain caseworkers from exercising discretion and that in turn negatively affects staff morale. As Shlonsky indicates, 'even the best risk assessment instruments do not predict maltreatment well enough to be used as the sole basis of decision making' (Shlonsky 2007, p.64). This recommendation shows a lack of knowledge about risk assessment instruments and should have been ignored.

The next recommendation that should have been ignored is R. 11.1 x. This recommendation proposes that the power of the Children's Court be restricted so that the Court can only make a contact order where there is a realistic possibility of a child being restored to her/his birth parents. This is rather illogical since, where there is a possibility of restoration, no contact order is needed as frequent contact as part of the restoration plan will almost certainly be included in such a plan.

At this point in time the Children's Court has the power to make a Contact Order allowing children who have been removed from their family to maintain contact with birth parents and other family members while they are in OOHC. When a Children's Court contact order is made, with limited variation, it gives parents 2 hours' contact once per month or, in some cases, four times per year with their child. The proposal by Justice Wood makes contact an administrative decision to be made by the Department of Community Services. Contact will cease to be shaped by the judiciary and it will be difficult for children or parents to challenge this administrative decision. Furthermore, decisions about contact will be hidden behind a veil of secrecy that surrounds the administrative child protection decision making in NSW.

Prior to the final Parliamentary debate in the Upper House, the Law Society of NSW and the Bar Association (2009) had issued a briefing note which argued that the changes to Section 86 of the *Children and Young Persons (Care and Protection) Act 1998* that relate to the power of the Children's Court to make contact orders be rejected. This recommendation was ignored by both government and the opposition parties.

The vast research about contact between children in care and their birth parents points to its importance in terms of helping children know where they came from and who they are. In essence, it gives them an identity (Macaskill 1988). The 'Stolen Generation' report confirms the harm that is done to children when parental contact does not occur and identity is lost.

Contact is too important to be left to administrative bureaucracies such as DoCS. To safeguard children's human rights and to guarantee parental contact, these issues should have remained as judicial decisions.

In addition, research about young people leaving care clearly shows that all but a small minority re-establish contact with their birth families (Biehal, Clayden, Stein & Wade 1995; Cashmore & Paxman 1996). In some instances they even return to live with their family. This surely is evidence as to why the Children's Court should have retained the power to make a contact order even when a child is in the care of the Minster.

Contact is too important to be left to administrative bureaucracies such as DoCS. To safeguard children's human rights and to guarantee parental contact, these issues should have remained as judicial decisions.

Finally, the proposition that care applications should be made by way of filing a written report to the Children's Court rather than by the filing of an affidavit by a DoCS caseworker cannot be seen as positive. Prior to the *Children and Young Persons (Care and Protection) 1998 Act*, this was the process that was followed for care applications; and

clearly it was regarded as unsatisfactory otherwise the process would not have been changed. So why reinstate this obviously unsatisfactory process?

In addition, having to file material by affidavit means that the DoCS caseworker has to state that the material presented in the affidavit is a true and accurate record of events and the affidavit has to be signed in the presence of a Justice of the Peace or a lawyer. This has the intended consequence of holding a DoCS caseworker legally accountable for the material they place before the Children's Court. Writing affidavits may be a time consuming and demanding process but there is no good reason as to why this accountability should be removed. Earlier, in recommendation 13.6, the Wood report had drawn attention to the need for caseworkers to be given more specific training 'in relation to the evidence to be placed before the Court to ensure its relevance, accuracy and fair balance'. Giving evidence by sworn affidavit, rather than by report, enhances the need for relevance, accuracy and fair balance.

CONCLUSION

Regardless of the above, the Government introduced the *Children Legislation Amendment (Wood Inquiry Recommendations) Bill 2009* on 23 March 2009. At the first reading and at the second reading on 1 April 2009, there was little opposition to the Bill. The most talked about issue related to the Wood recommendation about changes to the role of the Ombudsman contained in recommendation 23.1 of the report. The recommendation is as follows:

R. 23.1 *The relevant legislation including Part 7A of the Commission for Children and Young People Act 1998 should be amended to make the NSW Ombudsman the convenor of the Child Death Review Team and the Commissioner for Children and Young People, a member of that team rather than its convenor. The secretariat and research functions associated with the Team should also be transferred from the Commission for Children and Young People to the NSW Ombudsman.*

On 3 April, at the third reading of the Bill in the Legislative Council, an amendment to this recommendation was put by the Greens Party, but it was lost. ■

REFERENCES

Biehal, N., Clayden, J., Stein, M. & Wade, J. (1995) *Moving on. Young people and leaving care schemes*, London: Her Majesty's Stationery Office.

Cashmore, J. & Paxman, M. (1996) *Wards leaving care. A longitudinal study*, Sydney: NSW Department of Community Services.

Frederick, J. & Goddard, C. (2006) 'Pathways to and from state care: The experience of eight young people', *Children Australia*, 31, 3, 34-41.

Human Rights and Equal Opportunity Commission (1997) *Bringing them home: National inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*, Sydney.

Law Society of NSW/Bar Association of NSW (2009) *Briefing note: Contact orders*,23 March.

Macaskill, C. (1988) *Safe contact: Children in permanent care placement and contact with their birth relatives*, Lyme Regis: Russell House Publishing.

NSW Department of Premier and Cabinet (2009) Keeping them safe: A shared approach to child wellbeing, Sydney. March. Available at www.dpc.nsw.gov.au Accessed 30 March 2009.

Shlonsky, A. & Gambrill, E.B. (2005) 'Risk assessment in child welfare', in G.R. Mallon & P. McCartt Hess (Eds.), *Child welfare for the 21st century: A handbook of programs, policies and practices*, New York: Columbia University Press, pp. 312-318.

Shlonsky, A. (2007) 'Initial construction of an actuarial risk assessment measure using the National survey of child and adolescent well-being', in R. Haskins, F. Wulczyn & M. Bruce Webb, *Child protection: Using research to improve policy and practice*, Washington: The Brooking Institution, pp.62-80.

Special Commission of Inquiry into Child Protection Services in NSW (2008) *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, (The Hon James Wood AO QC, Commissioner), NSW Office of the Premier and Cabinet, Sydney. Available at <www.lawlink.nsw.gov.au/cpsinquiry> Accessed 30 December 2008.

White, A. & Walsh, P. (2006) *Risk assessment in child welfare*, Department of Community Services, Centre for Parenting Research, Funding and Business Analysis Division, Sydney.

Wood report—*see* Special Commission of Inquiry into Child Protection Services in NSW (2008).

STATUTES

Children and Young Persons (Care and Protection) Act 1998.

Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009.