Crime and Misconduct Commission
Submissions in Response to Discussion Paper

Introduction

In 2004, the Crime and Misconduct Commission ('CMC') conducted an Inquiry arising out of specific allegations of abuse and neglect of children within the foster care system in Queensland.[1] These were children who were under the responsibility of the State by reason of long-term guardianship orders, administered by the then-Department of Families.[2] The Inquiry revealed systemic failings in the operation of the Department, and the Report concluded that fundamental change in the way the (particularly tertiary) child protection system in Queensland was administered was needed. Accordingly, a number of recommendations were made to that end.

It is submitted to be important to keep in mind that the CMC did not then, and does not now, have a standalone function regarding child protection, nor a specific statutory responsibility regarding child protection matters. Rather, the CMC's interest in the child protection process is derived from its broad statutory charter "to continuously improve the integrity of, and to reduce the incidence of misconduct in, the public sector".[3] It is in that context that the CMC's 2004 inquiry was undertaken.

Chief among the recommendations made in the 2004 Report was the establishment of a standalone Department, focused exclusively on child protection. This recommendation was adopted through the coming into being of the Department of Child Safety. Otherwise, the implementation of the 2004 Inquiry's recommendations was the subject of a 2007 CMC Report and has also been the subject of consideration by this Commission.[4]

Given the Terms of Reference for this Commission of Inquiry, the CMC's involvement has necessarily been limited. As such, the submissions which follow are primarily advanced in the hope that they might assist the Commission. They are confined to two principal areas:

1. Lessons which, it is submitted, should still be heeded from the CMC's 2004 Inquiry; and

2. Oversight of the operation of the child safety system (particularly in reference to those issues raised in Chapter 9 of the Discussion Paper).

The CMC does not wish to supplement these submissions orally.

Chapter 3

Questions 1 and 2

> *What is the best way to get agencies working together to plan for secondary child protection services?*
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> *What is the best way to get agencies working together to deliver secondary services in the most cost effective way?*

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1 *"Protecting Children: An Inquiry into Abuse of Children in Foster Care"*, Crime and Misconduct Commission, 2004
2 Footnote 1 at p xvii
3 *Crime and Misconduct Act 2001*, s4
4 Under Term of Reference 3(a)

The CMC adopts the submissions put forward by other agencies to the effect that an integrated approach to child protection is required. In this regard, although the CMC's 2004 Report recommended the establishment of a standalone department, it was expressly acknowledged that in creating such a department, the governmental commitment to prevention should not be diminished. In particular, it was made clear that "with increasing levels of reported child abuse, a commitment to primary and secondary abuse prevention is necessary."[5] Indeed, Recommendations 4.4 and 5.14 were in the following terms:

> "4.4 That the government maintain its commitment to developing primary and secondary child abuse prevention services (p. 141)
>
> 5.14 That the Department of Families (or some other agency separate from the DCS) retain responsibility for delivering prevention and early intervention services, including services for all children, and for programs targeting communities or families identified as vulnerable (p. 152)"

Unfortunately, and as has been observed by others, the creation of a standalone Child Safety department was not met with a commensurate increase in resources dedicated to primary and secondary intervention.[6]

Specific recommendations for a coordinated approach were made in the 2004 Report at 139. There it was acknowledged that the approach to child protection must be a whole-of-government one, requiring the co-ordination of all relevant agencies. Ultimately, though, it is submitted that a single entity with overarching responsibility must be responsible for co-ordination.

Non-government agencies presently play a significant role in providing primary and secondary care and intervention in child protection. The assistance of such agencies is not only laudable, they form an indispensable part of the overall system, and expansion of primary and secondary services will provide increased opportunities to reduce the burden on the tertiary protection system. It is acknowledged that there may be cost-savings derived from utilising private and non-government suppliers to fulfil some of these early intervention services. However, it must be borne in mind that "agencies that provide cheaper services because of the employment of inexperienced or unqualified staff do not necessarily represent an efficient allocation of resources. Funding needs to be directed to quality services that deliver desired outcomes for children and their families."[7]

For that reason, as discussed in the CMC's 2004 Report, it is essential that the peak statutory body (presently Child Safety Services within the Department of Communities, Child Safety and Disability Services) maintains the overarching obligation of co-ordination, as well as monitoring and evaluating service delivery.[8]

Chapter 5

Question 15

> *Would a separation of investigative teams from casework teams facilitate improvement in casework? If so, how can this separation be implemented in a cost-effective way?*

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5 Footnote 1 at 139-140

6 See, for example, submission of Department of Communities, Child Safety and Disability Services' at p 12

7 Footnote 1 at p 179

8 Ibid

As submitted above, in 2004 the CMC recommended the creation of a specialised entity focused on child protection. The Report adverted to the need for a focus to remain across the whole of government on primary and secondary protective supports. The Report also recognised the benefits in having workers in specialised roles, and that a differentiation in responsibilities would prevent workers being required to undertake work outside their area of expertise[9] (a key problem identified with workers in the Department of Families[10]).

The child protection system covers a wide range of needs, from primary support and assistance to families, to tertiary protection involving investigation of harm and intervention by the courts. It is important to acknowledge that skills which may apply to one facet of this work may not translate into other areas.

In a practical sense, primary and secondary intervention requires the willing participation of those who need that help. The whole rationale for early intervention is to prevent matters reaching the tertiary stage, and to assist parties to avoid coming into contact with this level of the process. Overlap between these early intervention services and the tertiary level has the potential to stigmatise those early intervention services, and may serve to discourage people from seeking assistance which they need to avoid tertiary intervention.

Equally, the dual role of caseworkers in managing relationships with families, and at the same time investigating, initiating and maintaining statutory intervention, gives rise to a natural conflict. The Commission has heard evidence that parents involved in the protection process comply with directions of caseworkers, not as a way of seeking assistance, but as a way of 'jumping through hoops' to regain the care of their children. It could be readily inferred that this may undermine the effectiveness of treatment/assistance being sought.

For the sake of effectively utilising expertise and specialist skills available, and of avoiding the stigmatisation of therapeutic interventions, separation of investigative and casework functions should be considered.

Question 17

> *What alternative out-of-home care models could be considered for older children with complex and high needs?*

This question is understood to be directed to the proposal for a 'secure care' model to be considered in Queensland.

The CMC does not wish to make submissions about the merits of this proposal, other than in two minor respects.

First, the CMC adopts the submissions of the Department of Communities, Child Safety and Disability Services ('the Department of Communities')[11] to the effect that any model of secure care should be court-ordered. The idea of containment or detention of young people simply because they are subject to intervention by the child protection system and have complex care needs is controversial. In the CMC's view, it is singularly appropriate that such grave decisions be made by the courts, with clear statutory guidance on the principles to be considered in determining whether to make such an order.

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9 Footnote 1 at p 144

10 Footnote 1 at p 107, citing submission from Legal Aid Queensland

11 At p 44

Judicial responsibility for decisions regarding 'secure care' would allow for ultimate oversight of such decisions, through the existing framework of judicial review and appeal.[12]

Secondly, it is imperative that any 'secure care' model which is adopted be subject to appropriate scrutiny and oversight. For this reason, the CMC submits that any 'secure care' facility should be run by the State. 'Secure care' must be the 'last resort' in terms of the child protection continuum. The children likely to be subject to a 'secure care' regime are those with complex and extreme needs. Such therapeutic interventions cannot be provided on a commercial basis – the objective cannot be the lowest cost treatment, but rather the treatment that most effectively addresses those extreme and complex needs. Moreover, that any 'secure care' model be State-run is absolutely necessary for effective oversight.[13] State-based entities, by and large, fall within the jurisdiction of the various statutory oversight bodies, such as the CCYPCG, the Ombudsman and the CMC. Recourse to appropriate oversight bodies where the system does fail is critical to ensure, as far as possible, that historical lessons of children in secure care facilities[14] are not repeated.

Chapter 7

The issue of Indigenous overrepresentation in the child protection system remains a complex one, without ready solutions. The issue was explored extensively in Chapter 8 of the CMC's 2004 Report.

Question 21

> *What would be the most efficient and cost-effective way to develop Aboriginal and Torres Strait Islander child and family wellbeing services across Queensland?*

As noted at pp 173-174 of the Discussion Paper, the CMC took the view in 2004 that an expanded network of Aboriginal and Islander Child Care Agencies (or equivalent organisations) should play a significant role in a reformed child protection system. The government's Blueprint for implementing the CMC's recommendations proposed that approximately 23 agencies be funded to deliver five distinct programs, comprising:

- Family restoration and support, primary prevention, parenting support and early intervention;
- Intensive family support;
- Placement services;
- Carer support; and
- Child advocacy and statutory advice.

As noted in the discussion paper, the funding and delivery of such programs has become increasingly fragmented. Contrary to the aspirations of the 'Blueprint', there remain only four agencies providing all core services.

It is noted that there is support for a return to this 'Blueprint'.[15] However, the CMC made specific recommendations regarding the funding of indigenous non-government organisations that, it is submitted, are as valid today as when they were made. See: Recommendations 8.1-8.3, p. 233.

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12 Dealt with further below in reference to Chapter 9

13 Dealt with below in reference to Chapter 9

14 As revealed in the 1999 'Forde Inquiry'

15 Discussion Paper, p 175

Chapter 8

Questions 26 & 27

Should child safety officers be required to hold tertiary qualifications in social work, psychology or human services?

Should there be an alternative Vocational Education and Training pathway for Aboriginal and Torres Strait Islander workers to progress towards a child safety officer role to increase the number of Aboriginal and Torres Strait Islander child safety officers in the workforce? Or should this pathway be available to all workers?

The CMC's 2004 Report dealt with the issue of training and development of child safety staff. By Recommendations 5.6 to 5.9 (P. 150), it was recommended that training processes should be undertaken with new child safety officers before commencing any casework, and that ongoing professional development should be required to consolidate induction training and experience gained 'in the field'.

It is difficult to say whether child safety officers should be required to hold tertiary qualifications in social work, psychology or human services. Certainly such qualifications would be desirable. At the same time, it is important to recognise that different areas of responsibility within the Department may require different sets of skills, such that it is not possible to be prescriptive about specific qualifications that may be suited to particular roles.

That said, it is imperative, for the sake of attracting and retaining a professional workforce, that meaningful and continuing training, along with opportunities for development and progression within the Department, be maintained.

Chapter 9

Issues – Oversight and Accountability

Questions 32 to 36

Are the department's oversight mechanisms – performance reporting, monitoring and complaints handling – sufficient and robust to provide accountability and public confidence? If not, why not?

Do the quality standards and legislated licensing requirements, with independent external assessment, provide the right level of external checks on the standard of care provided by non-government organisations?

Are the external oversight mechanisms – community visitors, the Commission for Children and Young People and Child Guardian, the child death review process and the Ombudsman – operating effectively? If not, what changes would be appropriate?

Does the collection of oversight mechanisms of the child protection system provide accountability and transparency to generate public confidence?

Do the current oversight mechanisms provide the right balance of scrutiny without unduly affecting the expertise and resources of those government and non-government service providers which offer child protection services?

As outlined above, the CMC's 2004 Inquiry into the foster care system in Queensland arose out of significant systemic failures that were revealed, initially, by two tragic cases.[16] The earlier 'Forde Inquiry' also served as a reminder that such failures in this context can have tragic consequences.

It has been suggested that, following the CMC's 2004 Inquiry, there developed a 'risk-averse' culture regarding how child protection was dealt with in Queensland. This is, in the CMC's submission, an understandable response to the circumstances which gave rise to the inquiry, and a recognition that such circumstances, so far as it is within the power of government to control, should never be repeated.

The events that gave rise to the 2004 Inquiry represented a systemic failure of the child protection system to notice signals that substantial neglect and abuse was occurring, and consequently, a failure to intervene to put a stop to it. Abuse and neglect of children in any form is a tragic occurrence. Such tragedies are compounded where the child neglected or abused is in the State's care for the sole reason of ensuring that the child is protected from such abuse and neglect. It is understandable, in light of the memory of those events (and the Forde Inquiry before it) that a degree of risk aversion will always attend child protection decisions.

There presently exist several levels of oversight relevant to child protection, both specific to child protection, and generally in relation to public sector entities which have involvement in the child protection system. The CMC's submission is that such structures serve to promote public confidence in the system, and to provide accountability by ensuring that action (or inaction) is subject to appropriate scrutiny.

Many of these oversight bodies, though, do not have jurisdiction over the private sector, or non-government agencies. If, as has been canvassed, such bodies are to have increased functions within the child protection system (and therefore, presumably, in receipt of an increased proportion of public funds), then it is imperative that they also be subject to appropriate oversight.

The CMC's misconduct jurisdiction relates to units of public administration. A unit of public administration is defined at s. 20 of the *Crime and Misconduct Act* 2001. Such units are generally governmental entities or departments[17], or other entities established under enactments for public purposes or funded with public monies[18]. Otherwise an entity may be prescribed as a Unit of Public Administration by a Regulation.

Otherwise, the Ombudsman is established to investigate the administrative actions of agencies.[19] An 'agency' is defined as a department, a local government or a public authority.[20] A 'public authority' is defined by s. 9 in broadly similar terms as a 'unit of public administration' under the *Crime and Misconduct Act* 2001. The *Ombudsman Act* 2001 also provides that a 'public authority' may be prescribed by a regulation. While the CCYPCG may investigate matters in relation to such private entities, it has no statutory power to take action and it is limited to making recommendations.[21]

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16 Footnote 1, Chapter 2

17 *Crime and Misconduct Act 2001* s20(1)(a), (b), (c), (d), (da), (g)

18 *Crime and Misconduct Act 2001* s20(1)(e), (f), (g)

19 *Ombudsman Act 2001* s6(b)(i)

20 *Ombudsman Act 2001* s8

21 *Commission for Children and Young People and Child Guardian Act 2001*, s80(1)(c)

At present the current regime of quality standards, legislated licensing requirements and independent external assessments do not, in the CMC's submission, provide a sufficient right level of external checks on the standard of care provided by non-government organisations.

Private, or non-government entities do not generally (and with good reason), fall within the jurisdiction of statutory oversight bodies. In the child protection sphere, there is a degree of oversight of private service providers by reason of service and licensing agreements between those providers and the Department of Communities. However, save for the prospect of commercial sanctions (termination of agreements, revocation of license, etc.) if contractual objectives are not met, there is little prospect of formal action being taken with respect to these entities. Thus these other entities are virtually exempt from supervision or oversight, save for a commercial imperative in maintaining agreements with the Department to provide services. (In this regard, the CMC acknowledges that many of these entities are not-for-profit. 'Commercial imperative' here refers to the need to maintain a relationship with the Department so as to be able to deliver its services.)

While this arrangement may be satisfactory in the provision of less controversial services, or where there is minimal expenditure of public funds, there are areas where such oversight may be beneficial for ensuring an appropriate measure of transparency and accountability. Residential care, for example, is an area of child protection where there exist a significant number of private service providers. The Commission has heard evidence that the level of service and quality of services provided can vary widely across this area. This is also an area which deals with older children, often with more complex needs and challenging behaviours than children who have other placement arrangements. Residential care facilities, for this reason, also attract significant amounts of public funds. In such areas there may well be a case for stronger scrutiny of these entities which are, in effect, public service providers.[22]

It does not necessarily follow that, by nominating these entities as a 'public authority' under the *Ombudsman Act* or a 'unit of public administration' under the *Crime and Misconduct Act*, there would be a commensurate increase in the work of the CMC or the Ombusdsman. The jurisdiction of the various external statutory oversight bodies is limited to specific circumstances of malfeasance, misfeasance, misconduct or maladministration. In such circumstances, one would hope that such oversight would yield very few examples of such conduct, and would require few investigations. It is the existence of the 'stick' that is important. At the same time, the availability of an investigative jurisdiction where such transgressions did occur, would substantially improve public confidence in the way such entities are administered.

It is noted that in the case of both the CMC and the Ombudsman, non-government organisations could be brought within jurisdiction by regulation declaring them to be 'units of public administration' or 'public authorities' as the case may be.

The CMC adopts the submissions of the Department of Communities to the effect that the cost of compliance with oversight requirements should not detract from provision of frontline services. It is trite to observe that, if more children are kept out of the statutory protection system, there is a reduced need for oversight. At the same time, the external monitoring and oversight has, in the past, revealed serious deficiencies within the system, which needed to be addressed.[23] It cannot be said that there is no risk of such problems arising again. Indeed, this

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22 The proposition that agencies which receive significant amounts of public funds should be subject to a greater degree of accountability for the expenditure of those funds was canvassed in hearings with various witnesses. See, for example, transcript of 16 January 2013, witness Natalie Lewis at p37-62 to 37-64; 17 January 2013, witness Shane Duffy, 38-17 to 38-18, speaking about Indigenous agencies.

23 Again, see the Forde Inquiry and the CMC's 2004 Inquiry.

Commission of Inquiry has revealed aspects of the system which are, once again, in serious need of attention.

In the Department of Communities' submission,[24] reference is made to the layers of reporting mechanisms contributing to the workload by reason of reporting requirements and recommendations that follow investigations. While it may be the case that development of new policies and procedures leads to increased compliance requirements for staff, policy or procedure recommendations are generally targeted at addressing particular issues that have been identified, and establishing how those issues could be better resolved in future. While such policy or procedure recommendations may have short-term impact in adjusting to new processes, in the long-term, new policies and procedures would generally be introduced to prevent problems recurring, and in that respect, would serve to reduce ongoing issues of compliance and oversight.

That there is potential for duplication by reason of the overlapping monitoring roles of each of the statutory oversight agencies cannot be disputed. However, as observed by the CCYPCG in their submissions, these entities coordinate their functions through Memoranda of Understanding so as to avoid that duplication. In other areas, the duplication may be seen as a desirable thing and, otherwise, as a reflection of the gravity of the matters being dealt with.

In particular, the overlap between the functions of the Coroner and the Child Death Case Review Committee ('CDCRC') can be seen to reflect the fact that the death of a child in the care of the State, or who has had contact with the Department prior to their death, is a most grave matter, and one which requires the utmost scrutiny to determine whether any steps can be taken to avoid such outcomes in the future.[25] Further, while there is overlap between the Coroner and the CDCRC, their functions are not identical, such that their roles are not necessarily duplicates. While deaths of all children in care are referred to the Coroner, the Coroner may elect not to hold an inquest.[26] Even in circumstances where the Coroner does not investigate a death, lessons may still be learned by a comprehensive review. Further, the CMC notes the submissions of the Department of Justice and Attorney-General regarding the significant assistance the CDCRC provides to coronial investigations, and the cost-saving that derives from the overlap between those agencies.[27]

Finally, the CMC submits that specific attention should be paid to the oversight of 'secure care'. To the point, and for the reasons expressed above, if such a model is to be adopted in Queensland, the strongest oversight mechanisms should be put in place.

In the first instance, it is submitted that any decision to place a child in secure care should be by order of the court.[28] Judicial oversight of such decisions would serve to ensure that young people are not placed into 'secure care' merely because they are difficult to manage, but rather because they genuinely have complex needs and there is no other way of accommodating them in the community. A right to legal representation for children in such a position would also assist in ensuring that the process operates fairly. As suggested in the submissions on behalf of the Aboriginal and Torres Strait Islander Legal Services ('ATSILS'), regular review of such orders would provide further oversight. The CMC supports such an approach.

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24 At p 71

25 The Child Death Case Review Committee was established as a result of the CMC's 2004 Inquiry recommendations 5.25-5.28 (footnote 1 at p 163-166).

26 *Coroner's Act 2003* s28

27 Department of Justice and Attorney-General submission at p33-34

28 See also Department of Communities' submission at p 44, Aboriginal and Torres Strait Islander Legal Services' submission at p12 on this point.

If such a 'secure care' model is to be adopted, it is submitted that it will be crucial that such an entity be either State-run, or at least subject to the same statutory oversight as would be the case if it were a government entity. As highlighted above, public entities are subject to oversight from a number of statutory bodies responsible for ensuring that various aspects of public administration are carried out properly. Past events have revealed that young people in such institutions are extremely vulnerable, and susceptible of abuse.[29] It would of course be folly to think that discovery and public disapprobation of such events in the past means that they would not happen again in the future.

'Secure care' facilities should, it is submitted, be reserved for young people with the most complex and extreme social, behavioural, and psychological needs. The fact that the care is 'secure' suggests that some form of physical restraint can and will be used to control behaviours. Minds may differ on whether this is, of itself, something that should be accepted. That these young people may themselves be violently uncontrollable, or prone to acts of physical aggression, does not mean that they are not vulnerable, and equally susceptible to abuse. There can be no doubt that the availability of such strong powers in respect of such vulnerable people warrants the strongest oversight and accountability mechanisms, so as to ensure that these powers are not abused. In addition, strict protocols governing the use of physical restraint strategies and mechanisms will be essential and the protocols presently in use in secure mental health units may provide a good guide or, at least, a starting point for the proper consideration of this issue.

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29 See the Forde Inquiry