Protecting Children
An Inquiry into Abuse of Children In Foster Care 2004

PROTECTING CHILDREN

AN INQUIRY INTO ABUSE OF CHILDREN IN FOSTER CARE

JANUARY 2004

CRIME AND MISCONDUCT COMMISSION
QUEENSLAND

CMC Vision:
To be a powerful agent for protecting Queenslanders from major crime and promoting a trustworthy public sector.

CMC Mission:
To combat crime and improve public sector integrity.

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Crime and Misconduct Commission
140 Creek Street, Brisbane, Australia 4000

GPO Box 3123
Brisbane Qld 4001

Tel.: (07) 3360 6060
Fax: (07) 3360 6333
E-mail: mailbox@cmc.qld.gov.au

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CRIME AND MISCONDUCT COMMISSION

GPO Box 3123
Brisbane Qld 4001

Level 3, Terrica Place
140 Creek St
(Cnr Creek and Adelaide)
Brisbane, Queensland

Tel: (07) 3360 6060
Fax: (07) 3360 6333

Toll Free:
1800 061 611

E-mail
mailbox@cmc.qld.gov.au

www.cmc.qld.gov.au

QUEENSLAND

The Honourable P D Beattie MP
Premier and Minister for Trade
15th Floor
Executive Building
100 George Street
BRISBANE QLD 4000

The Honourable R Hollis MP
Speaker of the Legislative Assembly
Parliament House
George Street
BRISBANE QLD 4000

Mr G Wilson MP
Chairman
Parliamentary Crime and Misconduct Committee
Parliament House
George Street
BRISBANE QLD 4000

Dear Sirs

In accordance with section 69 of the *Crime and Misconduct Act 2001*, the Crime and Misconduct Commission hereby furnishes to each of you its report, *Protecting children: an inquiry into abuse of children in foster care*.

The Commission has adopted the report.

Yours faithfully

BRENDAN BUTLER SC
Chairperson

Foreword

This report has its roots in a series of articles published by the *Courier-Mail* newspaper in June and July 2003 about the possible abuse of foster children. Since then the Crime and Misconduct Commission has embarked on two major investigations, considered more than 200 submissions, and conducted two weeks of public hearings. The information gathered has resulted in this report, which assesses the quality of care provided to children at risk of abuse in Queensland and provides a raft of recommendations for systemic change.

A period of less than five and a half months has elapsed between the referral of these issues to the CMC by the Premier on 28 July 2003 and the presentation of this report to the Speaker on 6 January 2004. It is just two and a half months since the end of public hearings on 23 October 2003. The production of a report of this magnitude in such a limited timeframe reflects the total commitment shown by the talented team of social scientists, lawyers, investigators and other staff of the CMC working on this project. The team focused on delivering an early report, as requested at the time of the public hearings by the Premier, the Leader of the Opposition, the Queensland Public Sector Union and others. This has been achieved.

Over the years the CMC and its predecessor, the CJC, have produced a series of major reports into social policy issues confronting government. This report is in the tradition of the 1995 CJC report into client abuse in the Basil Stafford Centre (a state-administered residential facility for people with intellectual disabilities) and the 2003 CMC *Seeking justice* report into the handling of sexual offences by the criminal justice system. Because of the depth of its in-house investigative and social science expertise, the CMC is able not only to identify systemic failures but also to make proposals for public sector reform.

The Inquiry sought to identify factors contributing to abuse of children in foster care as well as recommend measures to protect those children. From early in the process the Commission recognised that, in order to address abuse of foster children, it would also be necessary to consider aspects of the broader child protection system. A report of considerable scope has resulted.

The investigative process will continue beyond the delivery of this report. Allegations of abuse of children are being pursued by the Queensland Police Service. One CMC investigation of possible official misconduct by officers of the Department of Families is complete, another is continuing, and many other complaints against departmental officers are still being assessed by the CMC. However, it is not sufficient merely to identify failings by individuals.

Over a long period of time the Queensland child protection system itself has failed to deliver the support and services that are required for children at risk of abuse. Reform is necessary. This report concludes that transformational change is required, and provides a vision for how that might occur. It outlines a blueprint for a new system which is capable of providing children with the protection so lacking at present.

The blueprint for reform provided by this report is both practical and achievable; but in many areas it does no more than outline the direction of change. More work will be required to sketch in the finer detail of the reform process. The recommendations are made on the assumption that the next Queensland Government will be totally committed to remedying the failings in the child protection system. This will involve the provision of additional staff and resources, the development of a new culture of service to children within the responsible department, and better targeting of existing resources across all relevant agencies to support and protect children.

This report identifies significant failings within the child protection system. Yet it is apparent that the majority of foster carers and departmental officers are caring and committed people. The Inquiry has heard from departmental officers, either

individually or through their union, who are seeking reform of the system. Implementation of the recommendations in this report will provide the opportunity for a new start, where the focus is on the protection of children. Those caring officers still within the Department of Families, and those former officers who may have left in frustration, must be encouraged to participate in the process of building a new culture of service to children. The contribution of foster carers must be valued and their role supported. The new system will need the skill and expertise of all these people.

This report would not be possible without the contribution of the many people who made submissions and appeared at the public hearings. In reading the submissions and listening to many hours of testimony, I have been constantly impressed by the dedication and selflessness of those who truly have the interests of children at heart. Foster children, parents, grandparents, foster carers, community sector workers and family services officers expressed themselves passionately about the needs of children. We are indebted to all those who, with directness and conviction, have provided their personal perspective on what is required to protect children in care.

A society can rightly be judged on how it treats its children. After all, they are the citizens of the future. The recommendations in this report provide a timely opportunity to redress the inadequacies of the past and benefit all children who are at risk.

Brendan Butler SC
Chairperson

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Summary

Most Queensland families provide a safe, secure and caring environment for their children. However, each year a number of Queensland children come to the attention of authorities because of allegations and concerns about neglect, or physical, sexual or emotional abuse. These notifications of child abuse and neglect have increased in Queensland (and elsewhere) over the last decade.

In Queensland in 2002–03 there were over 31 000 notified cases of child abuse and neglect. Just over 4000 children were subject to some form of protective response, of whom the majority were under orders granting custody and/or guardianship to the Director-General of the Department of Families. Most of these children were placed in alternative or 'out-of-home' care, which is predominantly family-based care, either with foster carers or relatives.

Clearly, if a child has been abused or neglected to the point where they have to be removed from their home by the state, it is absolutely unacceptable for the state to then place them in an environment where they are further abused, at the very hands of those entrusted by the state with their welfare.

In addition, reports of abuse or neglect are made and substantiated, the focus of the child protection system must be on preventing any recurrence. In its 2003 *Report on government services*, the Productivity Commission published the following disturbing statistics (p. 15.16):

> In Queensland, the proportion of children who were the subject of a resubstantiation [that is, another incidence of substantiated abuse or neglect] within three months after an initial substantiation in 2000–01 was 10.4 per cent … the proportion who were the subject of a resubstantiation within 12 months was 24.8 per cent.

During 2003 information came to light, from a number of sources, indicating that the foster care and child protection systems in Queensland, as administered by the Department of Families, had failed many children. The evidence about such failures pointed, in some cases, to systemic failures over many years to prevent children placed in foster care being further abused or neglected. The CMC responded by undertaking two major misconduct investigations and an independent public inquiry: the Inquiry into Abuse of Children in Foster Care in Queensland.

During that inquiry's public hearings, Ms Gwenn Murray, an independent consultant appointed by the Department of Families in June 2003 to audit abuse notifications made against current Queensland foster carers, said:

> The Department of Families, I think, is dangerously becoming like one of the children for whom it has a statutory obligation … that is, it is like a neglected child. Major reforms need to be planned and implemented to ensure the safety and well-being of children and young people …

Other criticisms of the Department of Families advanced at the CMC Inquiry were often as severe. Although some critics may have failed to recognise the significant steps taken in recent times by the Queensland Government and the Department of Families to confront known shortcomings in the child protection and foster care systems, it is clear that the problems have existed for many years and that the department is perceived by many stakeholders to be in a state of crisis and incapable of responding adequately to child protection issues.

As a result of the evidence that it has gathered, the Commission can only conclude that the current child protection system has failed Queensland children in many important respects. These problems are not merely ones of perception; they are longstanding problems of great substance. The adverse outcomes for children highlighted by the evidence before the Commission do not derive from a few unfortunate and atypical cases, reflecting poor decisions by individual departmental officers. Collectively, the evidence indicates organisational failure to equip officers at

virtually all relevant levels of the Department of Families with the information or skills and resources to make the right decisions in the best interests of children in care in a satisfactory number of cases. The facts of the particular matters considered by the CMC underscore the ultimate effect of these systemic failings: they have human costs that should not be tolerated as part of any modern state-administered child protection service.

Everyone agrees that major change is required. In the Commission's view, this change should be effected through fundamental structural and organisational reform. A new and better approach is required. The Commission considers that this can most readily be achieved by creating a new department, the Department of Child Safety, exclusively focused upon protecting children. The Commission has come to this view as a result of the evidence arising from its investigations and the Inquiry.

Catalyst for the CMC Inquiry

In late May 2003, information was passed to a Department of Families area office outlining a disclosure by a woman who alleged that while in care with a foster family she was subjected to sustained and serious abuse by family members and others. The allegations included a complaint that she was sexually abused by one family member who had been an approved foster carer, as well as by visitors and friends of the family. The alleged sexual abuse included acts of sodomy and indecent dealing and of procuring the woman (then a child) to commit indecent acts with other children. The alleged abuse was said to have happened over a period of 13 years. The woman stated that other children in care with this family had also been subjected to sexual and physical abuse, and that some of these children still resided with the family ('family X').

Subsequently, documents relating to allegations of abuse involving other children placed with this family were made public. The material suggested apparent failures on the part of the Department of Families to deal with these allegations. Intense media interest was generated and questions were also raised as to the extent of the knowledge of and action taken by respective ministers responsible for the Families portfolio at the relevant times.

Inquiry methods

In early August 2003 the CMC commenced Operation Zellow, a misconduct investigation into the original allegations that:

- various employees of the Department of Families had failed in their statutory duties and obligations to protect children placed in the care of family X, and
- successive ministers and director-generals of the department had failed to act appropriately to protect children placed with family X.

As a result of the audit conducted by Ms Murray, further allegations relating to the handling of suspected abuse in another foster family ('family Y') came to light, and another CMC investigation, called Operation Ghost, was begun. That investigation is still continuing at this time.

The Commission also determined to examine systemic issues concerning the provision of foster care in Queensland and accordingly, on 14 August 2003, resolved to hold public hearings, supported by consultations and the receipt of submissions. The terms of reference of the Inquiry were as follows:

(a) To examine any systemic factors contributing to the incidence of any abuse of children in foster care.

(b) To examine the suitability of measures to protect children in foster care from abuse, and in particular:
   — the adequacy of systems and procedures to prevent and detect abuse
   — the adequacy of measures to respond to and deal with suspected abuse including abuse reported by foster carers.

(c) To make any recommendations as may be considered appropriate in relation to (a) and (b), including recommendations for any necessary changes to current policies, legislation and practices.

Submissions from interested parties and the public were called for on 16 August 2003. Public hearings were held over a two-week period commencing 13 October 2003.

Operation Zellow

The CMC investigated nine 'flashpoints' in the fostering history of family X.

'Flashpoints' are specific incidents where issues came to light that should have generated concern about the welfare of the foster children placed with the family. These flashpoints included several reports of alleged abuse upon foster children, notifications about incidents where three young children with the family were found to be suffering from gonorrhoea, and the circumstances surrounding some ministerial responses to letters raising complaints about the welfare of the children.

The Commission is of the view that in the majority of these matters the response of the Department of Families was completely inadequate. Over a period of many years, opportunities to act to protect the foster children were missed, time and time again. In relation to the gonorrhoea incident, the weight of the evidence is that the departmental officers, in determining to leave the children in care, were prepared to accept an explanation (advanced by one of the carers) to the effect that the three young children each contracted this disease from a contaminated face washer. In the circumstances, the Commission considers that placing reliance on an explanation such as this, in determining what action should be taken (or not taken) for the children, was disgraceful and indefensible.

In another flashpoint, a child had been removed from her home where she had resided with her mother and stepfather, because of concerns about the risk of abuse to her. The child was placed in foster care with family X. Some time later the child complained that she had been sexually abused by her stepfather. Inquiries established that this man was then residing with the child at the foster family's house. At the risk of stating the obvious, the point must be made that this man was one of the people from whose care the child had been formally removed because of concerns about the risk of abuse.

Factors such as the lack of adequate records, retirements of relevant staff and the passage of time have hampered the Commission in making recommendations for disciplinary action against departmental officers, except in one instance. However, the difficulties in attributing fault among individual officers should not detract from the Commission's primary conclusion — that in many of the incidents investigated there was undoubtedly grievous fault.

The Commission's investigations did not establish evidence of official misconduct by the current or former ministers or directors-general.

The Inquiry

The evidence arising from Zellow reflected systemic problems and organisational failures that were addressed at length before the Inquiry and in the many submissions received. The Commission acknowledges the assistance afforded to it by all those who appeared at the Inquiry, forwarded submissions or made themselves available for consultations.

The following key questions were considered by the Inquiry under its terms of reference:

- Is the current system of responding to and dealing with allegations of abuse effective and sufficient to protect children, including children in foster care?
- Is the Department of Families able to meet its obligations to protect children, including foster children, from abuse?

- Are foster carers adequately selected, trained, resourced, supported and monitored?
- Can accountability, complaint and review processes be improved?
- Are the needs of Indigenous children in foster care being adequately met?
- Are there alternatives to, or modifications of, family-based foster care that might better meet the future needs of children?

The Commission's primary recommendation: a whole-of-government response

The *Child Protection Act 1999* states the fundamental principle that every child has a right to protection from harm. Children in foster care are a particularly vulnerable group but their need for protection cannot be met unless inadequacies in the broader child protection system are remedied. In turn, child protection cannot be separated from the provision of wider support for families and carers.

Effective protection of children requires a system that supports the development of *all* children as well as one that identifies vulnerable families for targeted interventions on behalf of at-risk children. No one agency can be expected to achieve all of this. A multi-agency, cross-government response is required.

The evidence from the Commission's investigations and Inquiry demonstrates that the child protection system in Queensland has failed to adequately protect all the children for whom it bears responsibility. The problems identified are significant and systemic. Although in part this failure reflects the incapacity of the broader system to implement an effective preventive program that reduces the need for children to be placed in protective care, it also reflects a lack of clarity and focus about the roles of the Department of Families and other key stakeholders in protecting children at risk. Additional resourcing alone will not provide a solution to this problem.

The evidence about the current system presents a bleak picture — not only for the wellbeing of children who need the state's protection, but also for those agencies that regularly interact with the department about child protection issues and for those departmental officers who are attempting to perform their present duties with professionalism and compassion.

These problems have existed for many years across different governments and administrations. In evidence before the Inquiry, the current Minister for Families, the Honourable Judy Spence MP, and the current Director-General of Families, Mr Frank Peach, acknowledged the need for change. Mr Peach noted that the implementation of organisational change was a staged process, which has been ongoing for the two years that he and Ms Spence have held their positions, and which he saw would require a further five to seven years to fully implement. The Commission is of the view, given all of the evidence before it, that such a timeframe is unacceptable in terms of the harm that children would undoubtedly continue to suffer over any such period. Urgent reform is needed.

The immediate need is to better protect children by sharpening the focus on the safety and security of children at risk. The Commission is persuaded that the Department of Families is so overburdened, and its stakeholders so lacking in trust, that only through a new approach unambiguously directed towards meeting the needs of at-risk children will it be possible to make the necessary changes, and restore public confidence in the child protection system. This can most readily be achieved by way of creating a new department — the Department of Child Safety (DCS) — exclusively focused upon core child protection functions.

This primary recommendation is not an exercise in transplanting existing problems. Supported by the many other observations and recommendations contained in this report, it is designed to ensure that an adequate and better child protection system exists, through a specialist agency committed to:

- addressing the needs of children as its number one priority
- providing a broad range of options for case-managing children at risk of harm

- being the lead agency in a coordinated, whole-of-government response to child protection issues
- using effective and sophisticated intake, assessment and investigative procedures in responding to allegations of abuse and neglect
- adhering to best-practice standards in working with children in care, foster carers, biological parents, private care providers and other agencies involved in the provision of child protection services
- supporting staff through appropriate induction, training and professional development opportunities
- being open and accountable at all levels, both in its internal processes and through external and public scrutiny.

The call for a new department should not be seen as an attack upon the current workforce of the Department of Families. While the CMC's investigations have highlighted significant failings by various individuals, the Commission accepts that the majority of frontline child protection workers are caring and committed in their endeavours. Their work is often demanding and difficult. These staff deserve to be supported by an adequately resourced agency with a commitment to a new and revitalised culture of proper service to Queensland children. In this context, the evidence is clear that there needs to be a significant increase in the current size of the child-protection workforce. The Inquiry has been given every indication that the majority of frontline staff would welcome the opportunity to work for such a department.

Structure of the report

This report is divided into nine chapters.

Chapter 1 provides background information about the CMC's investigations and the Inquiry, and the current child protection system in Queensland.

Chapter 2 reports on the CMC's Operation Zellow investigation in detail and the Commission's conclusions in respect of each of the nine flashpoints investigated. The chapter also contains information about the other CMC investigation, Operation Ghost, and some further disturbing matters recently referred to the CMC. As well, it reports on two child-death investigations carried out recently by the Queensland Ombudsman, and on Ms Murray's audit findings of the Department of Families. Those processes all produced evidence of systemic failings reflecting those identified in the CMC's Zellow investigation. The chapter concludes by summarising those systemic failings.

Chapter 3 relates some of the key themes and issues arising from the evidence before the public Inquiry. These are: the needs of children, workplace issues in the Department of Families, some specific foster care issues, enhancing accountability, protecting Indigenous children, and effecting change.

Chapters 4 to 9 contain the Commission's 110 recommendations for reform. ***(A full listing is provided in Appendix E.)***

Chapter 4 outlines the Commission's recommended approach for responding to the needs of children in general, and those in the care of the state in particular. It explains the Commission's vision for a new strategic focus on children and the scope of the proposed Department of Child Safety. The chapter outlines how a whole-of-government response is required in this area, and recommends the formation of a Directors-General Coordinating Committee, and new positions of Director of Child Safety in relevant departments and other agencies.

Chapter 5 describes in more detail the key operational features of the proposed new department in terms of its focus and ethos, its funding base and recommended workforce numbers, the training and professional development of staff, the core child protection functions of the new department, its administration, and how proper levels of internal and external accountability can be achieved.

Chapter 6 describes how the new department would operate with other relevant agencies, including non-government agencies, concerned with the provision of child protection services. This chapter also contains information about the operation of the existing Suspected Child Abuse and Neglect teams (SCAN) teams and makes recommendations about enhancing the functioning of these important multidisciplinary teams. The chapter concludes with an examination of requirements for the mandatory reporting of suspected child abuse and neglect.

Chapter 7 sets out how the foster care system administered by the Department of Child Safety should work for children who are removed from their homes and placed in alternative care. The recommended framework includes detailed descriptions and recommendations about the department's interaction with non-government agencies providing care; placement options; foster care protocols (such as the recruitment and approval of carers); and casework for children in care. That final topic incorporates discussion and recommendations about the involvement by all relevant parties in casework (including children, foster carers and biological parents) and some discussion about long-term planning and placement options.

Chapter 8 examines some particular issues that affect Aboriginal and Torres Strait Islander children and communities who come into contact with the child protection system. The CMC consulted widely with Indigenous communities and representatives of relevant agencies during its Inquiry processes and identified some specific issues clearly relating to Indigenous children that are not present (or not to the same degree) for non-Indigenous children. However, the Commission envisages one overarching child protection system applying to all children, and therefore many of the recommendations made in this chapter need to be read in conjunction with those in the other chapters, which apply equally to Indigenous and non-Indigenous children.

Chapter 9 highlights some of the recommendations contained in the report for legislative reform and review.

The report concludes with a number of appendixes containing relevant data arising from the CMC's inquiry processes, a list of the recommendations made by Ms Murray as a result of her audit, and a full list of the recommendations contained in this report.

Concluding remarks

It cannot realistically be expected that any child protection system will be infallible. The problems revealed in this report are not unique; several other Australian states have recently undertaken wide-ranging reviews of their own child protection systems. Nevertheless, it must be accepted that the current system has failed. A new system must be embraced as quickly as possible.

It is the Commission's expectation that the adoption of the recommendations contained herein will be of clear and lasting benefit to, most importantly, the children of Queensland, particularly those in foster care, and to all people and organisations associated with the provision of child protection services.

To assess this, the Commission recommends that the Queensland Government review and report on the implementation of the report's recommendations in two years' time.

Catalyst for the CMC Inquiry

Despite the care and security that the vast majority of Queensland families provide for their children, there are unfortunately some children who suffer neglect, or physical, sexual or emotional abuse.

Notifications of child abuse and neglect have increased significantly in Queensland (and elsewhere) over the last decade. In Queensland in 2002–03 there were 31 068 notified cases of child abuse and neglect, and 3966 children were under child protection orders, of which 3642 were orders granting custody and/or guardianship to the Director-General of the Department of Families. The majority of these children were placed in alternative care, which is predominantly family-based care, with either foster carers or relatives (Queensland Government submission).

There is no doubt that the majority of foster carers and the majority of people working in the child protection system are caring and committed in their efforts to assist and protect vulnerable children. However, it is also clear that there are widespread and serious problems besetting the Queensland child protection system.

In 1979 an Indigenous child — a girl identified in this report by the pseudonym 'Jane' — came to the attention of the department and was placed with a family of approved foster carers, 'family X'. This child was among the first to be placed with this particular family, which over the ensuing years accepted more than 50 children from the department.

In or about late May 2003 information was passed to a Families area office outlining a disclosure by Jane alleging that, while in care with family X, she was subjected to sustained and serious abuse by family members and others. The allegations included a complaint that she was sexually abused by a member of the family, who had been an approved foster carer, and by people who were visitors and friends of the family and were also members of the Queensland Police Service (QPS). The alleged sexual abuse included acts of sodomy and indecent dealing, and procuring Jane to commit indecent acts with other children. The alleged abuse was said to have happened over a period of some 13 years. Furthermore, Jane stated that other children in care with family X had also been subjected to sexual and physical abuse, and that some of these children still resided with the family. As a consequence of these allegations, a notification of alleged harm or risk of harm to children was raised and investigations by the Department of Families and the QPS commenced.

In late May to early June 2003, the following two documents were taken (by an unknown person) from a Department of Families area office:

- an Assessment of Protective Needs (APN) report relating to a particular sibling group of children
- an affidavit relating to an application for care and protection of a baby born to one of those children, who was still in care.

These documents outlined the history of this group of siblings, who were in the care of the Department of Families and had been fostered since 1988 with family X. At this time three of the children were under care orders to the Director-General of Families and were still living with family X. The documents contained information outlining:

- the circumstances under which the children came into the care of the department
- allegations that certain children had been subject to further harm while in the care of their approved foster carers
- apparent failures on the part of relevant employees of the department to address this abuse.

Copies of the documents were provided anonymously to Ms Hetty Johnston of Bravehearts Inc., a support group for victims of child abuse. Ms Johnston supplied these documents to the QPS and to the Commission for Children and Young People. At some stage, these documents were also provided (by a source unknown to the CMC) to the *Courier-Mail* newspaper. Commencing on 18 June 2003, a series of articles appeared in the *Courier-Mail* concerning these issues. The articles increasingly called for some form of inquiry to be undertaken into how the family came to be approved foster carers, and how it was that children were permitted by the department to remain with family X.

In response to the concerns being raised about family X and foster care generally, the Department of Families undertook:

- an independent external review of the files relating to the family; this review was conducted by Mr David Rolls and Mr Darcy Turgeon, with assistance from a Families employee, Ms Pam Philips
- an independent external audit of notifications of harm in respect of current foster carers, conducted by Ms Gwenn Murray.[1]

During this period of intense media interest, questions were also raised as to the extent of the knowledge of and action taken by respective ministers responsible for the Department of Families portfolio at the relevant times.

The former Minister for Families and present Minister for Education, the Honourable Anna Bligh MP, stated publicly that she had no knowledge of family X and the children placed with them. She further stated that neither the family nor the children had been drawn to her attention while she was Minister for Families. Subsequently, other files relating to the children were located in the relevant area office of the department. These files contained a copy of a letter from Mr Darryl Briskey MP, written on behalf of a local resident, raising complaints about the welfare of the children fostered with family X. The files also contained a ministerial briefing note from the Families area office in response to this letter. The briefing note, which formed the basis of a subsequent response by Ms Bligh to Mr Briskey, stated: '… there are no current concerns about this family'. None of the details of the history of the family was outlined in this briefing note. Ms Bligh responded to Mr Briskey's letter in accordance with the information provided in the briefing note.

It was also revealed that another letter had been written to Ms Bligh, while she was Minister for Families, by Mr Ted Malone MP on behalf of a constituent who was the biological mother of some of the children then in care with the family. Mr Malone's letter expressed his constituent's dissatisfaction about her perceived lack of contact with her children. Following a further ministerial briefing note, a letter was sent from Ms Bligh to Mr Malone responding to the issues raised by him in respect of these children.

Further information then came to light, indicating that in 1992 and 1993 the father of another sibling group that had been placed with family X had also raised complaints with the then Minister, the Honourable Anne Warner MP, and also with the State Ombudsman, who referred his concerns to the then director-general, Ms Ruth Matchett.

On 28 July 2003 the Premier referred all of these issues to the CMC. On 29 July 2003 the CMC resolved to conduct an inquiry into the handling by the Department of Families and responsible ministers of allegations of abuse committed against foster children. It was further determined that the inquiry would focus on the more recent allegations of abuse, and on the recommendations that should be made about future responses to such allegations.

The CMC response

The CMC approached these matters through two simultaneous processes: misconduct investigations (codenamed Zellow and Ghost) and a public inquiry (Project Park).

Operation Zellow, which commenced in early August 2003, was an investigation into the original allegations that officers of the department and the responsible ministers mishandled allegations about abuse of foster children in the care of the family X. This investigation was undertaken by a dedicated multidisciplinary project team.

As a result of the audit conducted by Ms Gwenn Murray, which was being drawn upon by the CMC, further allegations relating to the handling of suspected abuse in another foster family (family Y) were identified, and a further investigation, called Operation Ghost, was established. That investigation is continuing at the time of this report. The two investigations are detailed in Chapter 2.

In addition to these investigative responses, Project Park was commenced to examine more general systemic issues concerning the provision of foster care in Queensland. As part of this exercise, on 14 August 2003 the Commission resolved to hold public hearings, supported by consultations and the receipt of submissions. The Inquiry's terms of reference were as follows:

(a) To examine any systemic factors contributing to the incidence of any abuse of children in foster care.

(b) To examine the suitability of measures to protect children in foster care from abuse, and in particular:

— the adequacy of systems and procedures to prevent and detect abuse

— the adequacy of measures to respond to and deal with suspected abuse including abuse reported by foster carers.

(c) To make any recommendations as may be considered appropriate in relation to (a) and (b), including recommendations for any necessary changes to current policies, legislation and practices.

The terms of reference were announced on 16 August 2003. Submissions from interested parties and the public were called for on the same day, with the official closing date specified as 29 September 2003, although submissions continued to be received and considered by the CMC up to the end of November 2003. Public hearings were held over a two-week period commencing on 13 October 2003. Further information about the hearings and the submissions appears in Chapter 3 and in Appendixes A–C.

Misconduct issues for the CMC

Operation Zellow investigated the circumstances surrounding the ongoing placement of children with family X and the alleged failure of the department to act upon notifications of abuse of those children. The CMC investigation sought to determine whether there was sufficient evidence to support criminal charges or disciplinary action, including for official misconduct or police misconduct, against any person. The focus of Operation Ghost is similar.

Operation Zellow specifically considered the following allegations:

- that diverse employees of the Department of Families failed in their statutory duties and obligations to protect children placed in the care of family X, and
- that successive ministers and directors-general failed to act appropriately to protect children placed with this family.

At the outset, it should be noted that the CMC does not have statutory functions that enable it to determine whether or not a person is guilty of any criminal or disciplinary offence where, as in the Zellow case, allegations of possible criminal offences are raised for investigation. It may sometimes be necessary for the Commission to reach

conclusions about factual matters for the purposes of reporting on an investigation, but the Commission is not a court and it has no adjudicative role.

The CMC determined, together with the QPS, that where allegations of criminal activity were made against members of the public (such as the allegations that foster carers committed sexual offences on children in care), these matters would be investigated in the first instance by the QPS. It was also agreed that the QPS would approach the CMC if its assistance was required in these investigations.[2] The QPS investigation also extends to the allegation that such abuse was at times perpetrated by two police officers. The CMC has adopted a monitoring role in respect of the QPS investigation into the alleged criminal conduct by these officers.

Further information about the legislative basis for the CMC's investigative and monitoring roles is set out below.

Legislative basis

One of the main purposes of the *Crime and Misconduct Act 2001*, as stated in section 4(1)(b), is 'to continuously improve the integrity of, and to reduce the incidence of misconduct in the public sector'. 'Misconduct' is defined in Schedule 2 of the Act as 'official misconduct or police misconduct'.

'Police misconduct' is also defined in Schedule 2 as conduct (other than 'official misconduct') that:

a) is disgraceful, improper or unbecoming an officer
b) shows unfitness to be an officer, or does not meet the standard of conduct reasonably expected by the community of an officer.

Official misconduct is defined in section 15 of the Act as:

Conduct that could, if proved, be —

a) a criminal offence; or
b) a disciplinary breach providing reasonable grounds for terminating the person's services, if the person is or was the holder of an appointment.

Conduct is defined in section 14 as follows:

a) for a person, regardless of whether the person holds an appointment — conduct, or a conspiracy or attempt to engage in conduct, of or by the person that adversely affects, or could adversely affect, directly or indirectly, the honest and impartial performance of functions or exercise of powers of:
   (i) a unit of public administration; or
   (ii) any person holding an appointment; or

b) for a person who holds or held an appointment — conduct, or a conspiracy or attempt to engage in conduct, of or by the person that is or involves —
   (i) the performance of the person's functions or the exercise of the person's powers, as the holder of the appointment, in a way that is not honest or is not impartial; or
   (ii) a breach of the trust placed in the person as the holder of the appointment; or
   (iii) a misuse of information or material acquired in or in connection with the performance of the person's functions as the holder of the appointment, whether the misuse is for the person's benefit or the benefit of someone else.

Section 14 also provides that to 'hold an appointment' means to hold an appointment in a unit of public administration, which in turn means to hold any office, place or position in the unit, whether the appointment is by way of election or selection (s. 21).

Section 20 defines a unit of public administration as including, among other entities, the Executive Council, the Legislative Assembly, the police service and public sector departments (such as the Department of Families).

An elected holder of an appointment, such as a minister, only commits misconduct if the conduct in question could, if proved, amount to a criminal offence — the first limb of section 15. This is because there is no code of conduct or disciplinary regime

applying to people such as members of parliament, breach of which might properly be characterised as a 'disciplinary breach'. In the absence of such a disciplinary breach, the possibility of terminating an office holder's services on that basis cannot arise.

Subsection (a) of the definition of conduct applies to anyone, whether or not they hold an appointment. However, subsection (b) refers to conduct of a person 'who holds or held an appointment', so there must be a connection between the relevant conduct of the person and their appointment in a public office. Three limbs of proscribed conduct follow. Paragraph (i) is concerned with the honest and impartial discharge of an office holder's official functions and exercise of powers. Paragraph (ii) concerns breaches of the trust 'placed in the person as the holder' of an office and paragraph (iii) is broadly concerned with the misuse of information or material acquired in connection with the performance of official functions.

In returning to paragraph (ii), for present purposes, this means that what must be shown, for a potential case of official misconduct to be established against a member of parliament, would be a breach of the trust placed in that member as the holder of their appointment as a member of parliament (and which, for the reasons set out above, must also be capable of amounting to a criminal offence, if proved). It follows from the decision in *Re Mullen*[3] [1995] 2 Qd R 608 that for paragraph (ii) to apply to an office holder there must be misconduct by the officer in the course of or pertaining to the exercise of the powers, functions, duties or responsibilities attaching to his or her office.

In summary, the jurisdiction of the CMC to investigate allegations relating to a minister's alleged conduct in office is limited to circumstances where that conduct could, if proved, amount to a criminal offence. The CMC can investigate the conduct in office of both present and former officers of the Department of Families. In relation to officers of the QPS, the CMC can investigate their conduct in office and also their private conduct, where that conduct could constitute 'misconduct' under the Crime and Misconduct Act.

Section 33 of the Act provides that the CMC has the function of ensuring that a complaint about, or information or matter involving, misconduct is dealt with in an appropriate way. Section 46 of the Act provides the CMC with the authority to itself investigate complaints of misconduct.

When assessing how to perform its misconduct functions, the CMC must have regard to the principles outlined in section 34, which are:

(a) Cooperation
- To the greatest extent practicable, the CMC and units of public administration should work cooperatively to prevent misconduct.
- The CMC and units of public administration should work cooperatively to deal with misconduct.

(b) Capacity building
- The CMC has a lead role in building the capacity of units of public administration to prevent and deal with cases of misconduct effectively and appropriately.

(c) Devolution
- Subject to the cooperation and public interest principles and the capacity of the unit of public administration, action to prevent and deal with misconduct in a unit of public administration should generally happen within the unit.

(d) Public interest
- The CMC has an overriding responsibility to promote public confidence —
  - — in the integrity of units of public administration; and
  - — if misconduct does happen within a unit of public administration, in the way it is dealt with.
- The CMC should exercise its power to deal with particular cases of misconduct when it is appropriate having primary regard to the following:
  - — the capacity of, and the resources available to, a unit of public administration to effectively deal with the misconduct;

— the nature and seriousness of the misconduct, particularly if there is reason to believe that misconduct is prevalent or systemic within a unit of public administration; and
— any likely increase in public confidence in having the misconduct dealt with by the CMC directly.

The CMC can deal with complaints in the manner outlined in section 46 of the Crime and Misconduct Act and may take the following actions, among others:

a) deal with each complaint about official misconduct that it considers should not be referred to a public official to be dealt with
b) refer a complaint about official misconduct to a public official to be dealt with by the public official or in cooperation with the CMC, subject to the CMC's monitoring role
c) without limiting paragraph (b), refer a complaint about official misconduct of a person holding an appointment in a unit of public administration that may involve criminal activity to the Commissioner of police to be dealt with …

Section 59 of the Act also states, among other things, that the CMC and units of public administration are to work cooperatively to achieve optimal use of available resources and that, in performing its functions, the CMC must liaise with and coordinate its activities with the activities of units of public administration to avoid needless duplication of the work of the units for the purpose of performing the CMC's functions.

Under section 60(1) of the Act the CMC may give evidence of, or information about, a possible offence against a law to an entity or a law enforcement agency the CMC considers appropriate. Under section 60(2) the CMC may give information coming to its knowledge to a unit of public administration if the CMC considers that the unit has a proper interest in the information for the performance of its functions.

Section 64(1) of the Act provides that the CMC may report in performing its functions. The Act also provides various means by which the CMC can report on an investigation, including a public report (as is the case here), where the report relates to a public hearing or where under section 69 an appropriate direction has been obtained from the Parliamentary Crime and Misconduct Committee. Under section 64(2) a report may contain recommendations.

As noted, the CMC's functions do not include determining issues of criminal or disciplinary guilt. The CMC will assess whether there is sufficient evidence against an individual to justify making a report under section 49 of the Act to an appropriate body to consider instituting criminal or disciplinary proceedings.

The CMC also has a function of helping to prevent misconduct. Under section 24 of the Act, the CMC can perform this function in many ways, including by making recommendations to units of public administration and reporting on ways to prevent misconduct.

Some points about the investigation

Detailed information about the methodology employed in the Zellow and Ghost investigations is set out in Chapter 2 of this report. However, in view of what has been said above about the misconduct issues examined and the limits of the CMC's investigative jurisdiction, some points should be emphasised.

Given the current status of family X members as people of interest in a police investigation, and following consultation with the QPS, no member of the family who has been an approved carer has been interviewed by the CMC. As noted above, the QPS is investigating the various allegations of sexual and physical abuse that have been levelled against these family members and will determine whether any criminal charges should be pursued. If so, those charges will be brought and determined by the courts in the usual way.

Many of these allegations came to the attention of Department of Families officers over the years and decisions were made at the time by those officers, and by others such as the responsible ministers. In some cases it was determined by departmental officers that such notifications of suspected harm should be recorded as 'substantiated'. In

other cases, little or no action appears to have been taken. The CMC has not sought to completely reinvestigate the truth or otherwise of those allegations, which appear, as far as can now be established from the available records, to have been put to the relevant carers by the department whenever they were considered to be substantiated. However, there were some cases where consideration of the specific allegations by the CMC was felt to be necessary. These were situations where it was said that departmental officers failed to respond adequately to the allegations, and harm consequently flowed to children. In order to establish whether or not allegations of abuse were correctly acted upon by the department, the CMC needed to investigate what acting upon the allegations might have revealed. Only then could it be determined whether an apparent lack of action was justified (if, for example, there was in reality no criminal activity). It should, however, be clearly understood that the Commission expresses no conclusions about the alleged criminal acts of the carers and other members of the public against whom such allegations have been made.

The CMC's investigations have focused on the Department of Families' processes and the responses of its officers to the receipt of relevant information about the alleged actions of the carers and others. These investigations have centred upon the actions of the officers who fall within its jurisdiction. Formal interviews were conducted with many current and former departmental officers and the relevant directors-general and ministers. Current officers were advised, by way of a letter from the director of the department's Review and Evaluation Unit, of the subject matter of the CMC's investigation, its processes and the officers' right to seek legal advice and have a support person attend any interviews. In formulating the conclusions expressed in this report about the particular matters investigated, all of the responses put forward by those interviewed have been taken into account.

The systemic issues

Legislative basis

Section 23 of the Crime and Misconduct Act provides:

> The CMC has a function (its 'prevention function') of helping to prevent major crime and misconduct.

Section 52(1) of the Act provides:

> The CMC has the following functions —
>
> 1. to undertake research to support the proper performance of its functions;
> 2. to undertake research into the incidence and prevention of criminal activity;
> 3. to undertake research into any other matter relating to the administration of criminal justice or relating to misconduct referred to the commission by the Minister;
> 4. to undertake research into any other matter relevant to any of its functions.

Section 176 permits the CMC to authorise the holding of a hearing in relation to any matter relevant to the performance of its functions.

Methodology

To address the terms of reference, the CMC:

- called for and reviewed written and oral submissions from a range of individuals and organisations
- conducted public hearings
- consulted widely with many stakeholders
- engaged a consultant to undertake a literature review
- undertook broad-based research and data analysis
- incorporated conclusions from misconduct investigations.

Submissions

When releasing the terms of reference for the Inquiry on 16 August 2003, the CMC called for submissions through a media release, advertisements in most Queensland newspapers and specific letters of invitation to representatives of relevant government agencies, concerned interest groups and some individuals.

By the end of November 2003, 228 written submissions had been received from:

- 19 Queensland and interstate government agencies
- 38 non-government organisations and other groups
- 10 relatives of children in care, both past and present
- 29 biological parents
- 14 children formerly in care
- 49 foster carers, both former and current, and their representative groups
- 22 former and current Department of Families workers
- 11 academics
- 36 other members of the public.

Written submissions were also received from the Queensland Government and the Queensland State Opposition. Where submissions contained allegations of misconduct, these were also referred for consideration through the CMC's complaints processes. A list of written submissions received by the Commission is provided in Appendix A. (That list is not exhaustive, however, as some of the contributors did not wish their names to be published.)

Public hearings

Public hearings were held over eight sitting days, 13–16 October and 20–23 October 2003. The Chairperson of the CMC, Mr Brendan Butler SC, presided over the hearings. Mr Trevor Morgan of the private Bar appeared as Counsel Assisting. The hearings provided an opportunity to examine publicly the systemic issues involved in the provision of foster care services in Queensland.

A total of 40 witnesses appeared at the hearings, including the current Minister for Families, the Honourable Ms Judy Spence MP, and the Director-General of the Department of Families, Mr Frank Peach. Other witnesses included Ms Robyn Sullivan, Commissioner for Children and Young People; Ms Beverley Fitzgerald, President of the Children Services Tribunal; Mr Robert Atkinson, Queensland Police Commissioner; the Honourable Lawrence Springborg MP, Leader of the Opposition; academics; foster carers; foster children; representatives from Indigenous communities; and representatives from non-government organisations involved in the provision of alternative care arrangements for children and child protection programs. The hearing schedule is documented in Appendix B of this report. Transcripts of the hearings (CMC 2003) will remain available on the CMC website at <www.cmc.qld.gov.au> for a limited period.

Consultation

Members of the Inquiry project team consulted widely with stakeholders such as:

- Indigenous groups, in both metropolitan and regional areas
- several academics with expertise in the area of child protection
- child advocacy and support groups such as Bravehearts, Abused Child's Trust and CREATE
- foster children
- medical practitioners
- Queensland Police Service, particularly Juvenile Aid Bureaus
- foster care associations
- Commission for Children and Young People
- Children Services Tribunal

- Queensland Ombudsman's Office
- non-government sector organisations
- various officers of the Department of Families from across Queensland
- legal service groups
- Queensland Public Sector Union (QPSU)

Some of the medical practitioners and police officers consulted during the Inquiry were or had been members of Suspected Child Abuse and Neglect (SCAN) teams. SCAN teams have been established throughout Queensland in an endeavour to provide a multidisciplinary and coordinated response to child abuse and neglect notifications. The role of the SCAN teams is described in more detail in Chapter 6.

A full list of those groups and individuals consulted who have consented to having their names published is contained in Appendix A. In addition, a number of people who wished to make complaints regarding the provision of foster care services by the Department of Families were also interviewed and their concerns considered separately from the broader Inquiry, through the CMC's complaints processes.

Research

In order to gain further knowledge of the areas covered by the Inquiry's terms of reference, a team of CMC legal and social science researchers:

- reviewed recent domestic and international reports on child protection and foster care systems
- collated information about current policies, procedures and programs relating to the provision of child protection and foster care in Queensland
- commissioned, from a leading Queensland academic, a literature review covering both domestic and international literature relating to the training of foster parents
- analysed Department of Families data to determine relevant trends in foster care in Queensland.

This information has been incorporated throughout this report and contributes significantly to the CMC's recommendations.

Findings of departmental internal audit

In view of what follows in this report, it is noteworthy that in April 2003, before the events generating the CMC's Inquiry had come to public notice, the Review and Evaluation Branch of the Department of Families reported on the findings of an internal audit of departmental regulation of care services under the *Child Protection Act 1999*. That Act had been in operation for over three years by the time these audit findings were reported. Extracts from the findings are reproduced below (pp. 1–2, 10).

> 1.1.1 Key areas of risk are no longer in residential and institutional care, but rather, in foster care settings where the majority of children coming into care are now placed. The regulatory regime for alternative care is new and not sufficiently robust at this stage to provide adequate safeguards for children in foster care ...
>
> 1.1.4 The regulatory regime for foster care does not assess the quality of care provided to children in care, against the Standards of Care in the Act. Casework policies and processes do not appear to fill this gap. The FSO [family services officer] is assumed to be responsible for monitoring standards of care for each child on caseload, but there are no departmental policies, frameworks or systems in place for this to occur ...
>
> 1.1.6 The department has not developed a framework of minimum service standards and performance measures for alternative care, as the foundation for licensing ...
>
> 1.1.7 The current scope of the regulatory system has been defined by the department to exclude alternative care services that care for children placed in care under voluntary arrangements. This may present a level of risk that is not acceptable to the department.

1.1.8 There is no quality assurance system, which collates and allows monitoring of state-wide data relating to children's wellbeing and safety in care, which might be used to inform licensing decisions ...

1.1.9 There are policy gaps in relation to children's rights, safety and wellbeing, whilst in alternative care. There are no formal mechanisms to ensure child safety and wellbeing in care ...

1.1.10 Data on substantiated notifications on children in alternative care indicate that the substantiation rate continues to rise. The vast majority of substantiated harm occurs in foster care, rather than in residential care settings ...

1.1.11 Children under voluntary care arrangements appear to be in an ambiguous position whereby some of the safeguards in the Act do not apply to them ...

Whilst the legislation articulates the rights and needs of children in alternative care, there appears to be a lag in policy and framework development, to assist the Department in realising these rights.

The audit findings were considered by the department's Executive Management Committee. In June 2003 the department resolved to implement a number of strategies in response, including commitments to developing new quality assurance and accountability frameworks.

This report

The first chapter outlines the history of child protection in Queensland and the current scheme. Chapters 2 and 3 detail the evidence obtained during the Zellow and Ghost investigations; they also include key aspects of the evidence presented to the public hearings and significant evidence arising from other sources such as the two recent investigations into child deaths conducted by the Queensland Ombudsman and the results of the independent audit carried out by Ms Gwenn Murray.

It is accepted that substantial improvements to the system are being developed and in some cases implemented by the Department of Families. However, the information obtained and considered by the CMC does not provide a reasonable basis for believing that the current system as managed by the department is capable of meeting the needs of children who require the state's protection.

The second half of this report outlines a new vision for a whole-of-government response to the needs of children generally, and those in the care of the state specifically. Chapter 4 proposes a new Department of Child Safety, which would concentrate exclusively on providing more integrated and child-focused protective services. The subsequent chapters expand upon how the new system should function.

A note on use of the term 'Indigenous people'

The CMC recognises that Aboriginal and Torres Strait Islander peoples are distinct, ethnically and culturally. However, in seeking comments from all areas within Queensland during the Inquiry the CMC identified no issues in relation to Indigenous Australians that were particular to either the mainland or the Torres Strait Islands. Therefore, for the purposes of this report the term 'Indigenous people' incorporates both Aboriginal and Torres Strait Islander peoples.

Endnotes

1 Mr Rolls, Mr Turgeon and Ms Murray are all people with considerable expertise and experience in child-related social work within the community (non–public service) sector.

2 Chapter 2 of the *Crime and Misconduct Act 2001*, Part 2, contains provisions relating to the CMC's function of investigating 'major crime'. That term is defined, under that Act, as including (among other things), paedophilia.

3 A decision of Lee J of the Queensland Supreme Court, dealing with the corresponding provision under the previous legislation, the *Criminal Justice Act 1989*.

1

CHILD PROTECTION IN QUEENSLAND

This chapter provides a detailed profile of the child protection system in Queensland and the statutory framework within which that system operates. It looks at the information obtained regarding the profile of children in care in Queensland, and the services that the Department of Families actually provides.

THE CAUSES, CONSEQUENCES AND PREVENTION OF CHILD ABUSE

Why does child abuse occur?

Most child abuse takes place in the home and is perpetrated by people known and trusted by the victim. Although widely publicised, abuse in foster-care settings accounts for only a minority of notifications of child abuse — approximately 1–2 per cent of all notifications (see the data provided in Appendix C of this report and by the Australian Institute of Health and Welfare [2003a]).

The causes of child abuse and neglect have yet to be exhaustively identified, but research points to a number of risk factors for its occurrence. These include:

- biological and individual factors — such as parental substance abuse, poor coping skills and mental illness
- family factors — such as living in single-parent families which, for some children, may mean living in poverty and having limited family support
- community and societal factors — such as high unemployment and crime rates, few social services, de-institutionalisation, homelessness and community violence)
- social conflicts — such as war.

Similarly, a number of protective factors have been identified, such as good health in the child and the parent, a supportive family environment, and access to adequate health care, housing and education. See, for example, Bethea (1999), the World Health Organisation (2003) and Scott (2002).

What are the consequences of child abuse?

Ill health caused by child abuse forms a significant portion of the global burden of disease. Apart from physical injuries such as bruises, welts, lacerations and fractures, child maltreatment is associated with a number of long-term consequences such as failure to thrive, cognitive impairment, delays in reaching developmental milestones, refusal to attend school, poor school performance, highly sexualised or highly aggressive behaviours, poor relationships, suicidal behaviour and self-harm, an increased likelihood of substance abuse, high-risk health behaviours, criminal activity, mental health disorders such as post-traumatic stress disorder and panic attacks, and an increased likelihood of the cycle of violence with abuse towards their own children or spouse (Becker et al. 1995; Bethea 1999; Owens 1995; Scott 2002; Shore 1997; WHO 2003). The prevention of abuse, therefore, has the potential for considerable savings for individuals, communities and society alike.

Children in care have often been subjected to abuse of some kind, and may therefore be at an increased risk of experiencing some of the physical and mental health consequences noted above. Those who care for abused children need to be aware of

these consequences, and the potential benefits of ongoing support and targeted interventions to reduce the likelihood of further complications.

Findings of an internal review by the Department of Families

In 2001 the Department of Families conducted a review of Queensland children in care, as part of the Child Protection Service System Improvement Project (CPSSIP 2001). The review investigated the needs of 353 children who had been, or were still, in the care of the Department of Families. Aspects covered were behavioural problems, substance abuse, family relationships, social skills, sexual adjustment, health, living skills, intellectual functioning, education, and culture.

In broad terms, the review found that 3 per cent of the population sample had extreme needs and a further 12.4 per cent had very high needs. Another quarter of the sample (about 23%) were classified as having high needs, while the remainder (approximately 62%) were classified as having standard needs. The review also found that children ceasing care after less than 2.5 years were more likely to have lower-level needs across a number of indicators (such as sexual adjustment, substance abuse, problematic family relationships and social skills) than children who remained under child protection orders for more than 2.5 years.

In brief, some of the findings were as follows:

- Seven per cent of the sample had major behavioural or emotional problems that severely affected the child's ability to function. An additional 21 per cent were identified as having significant problems. Males in the sample were more likely to have higher levels of behavioural and emotional problems than females.
- About 11 per cent of the sample were identified as having major sexual adjustment or behavioural problems that severely affected their ability to function, including a small proportion (less than 2%) who were identified as sexual offenders.
- One per cent of the sample was identified as substance dependent causing serious dysfunction and 5 per cent had a substance abuse problem that caused problems within the child's school or community.
- In nearly 4 per cent of cases the children's family relationships were described as violent, threatening or out of control. A further 28 per cent of children had conflict or major problems in their family relationships.
- In just under half of the sample (57%) the child was identified as having good or adequate social skills or a positive peer group; males were less likely to form appropriate relationships than females.
- While 60 per cent of children in the sample were identified as having no health problems or being in good health, 3 per cent were thought to have severe or chronic health problems or disabilities and a further 6 per cent were identified with serious health problems that affected their functioning.
- Twenty per cent of the sample were identified as below normal in intellectual functioning; almost 21 per cent had significant educational needs.
- About one-quarter (26%) of the Indigenous children in the sample were identified as having limited or non-existent contact with or understanding about their culture or heritage.

Limitations of the review

While the department's research represents an important attempt to identify the needs of children in care, there are some serious limitations that need to be considered. The review was based solely on departmental files, without independent verification of any of the information they contained. In addition, it is clear that a large proportion of data were missing, and this severely hampered the analysis of the data extracted. The way in which the missing data were treated (it was assumed that if there was no information available there was 'no apparent need') may also have resulted in a significant understatement of the problems identified, particularly in relation to Indigenous children. This is recognised by the authors, who emphasise that:

> … the needs of Indigenous children were consistently understated … a reflection on the lack of information recorded on the case file. It indicates that systematic assessment of a child's needs should be undertaken and documented to ensure government has a comprehensive portrait of need. The process should involve Indigenous workers … where appropriate to ensure the needs of Indigenous children are assessed accurately. (CPSSIP 2001, p. 8)

Other limitations of the review are as follows:

- Behavioural and emotional problems such as depression, head banging and frequent defiant or disobedient behaviour were regarded by the reviewers as problems that had no impact on children's functioning — a coding decision that may be considered by some to be inaccurate, or at the very least to have resulted in an underestimation of the severity of the problems under review.
- Although over 70 per cent of the sample were identified as having no substance abuse problems, or only minor problems, there is no indication of the age range of the children reviewed. Relatively low rates would be expected if the sample consisted mostly of young children rather than adolescents.
- The educational needs of the children are likely to have been underestimated, as it appears that children who were not of school age were combined with schoolchildren for these analyses.
- Overall, there is no evidence that the coding decisions were based on the results of objective instruments or assessments (such as intelligence or psychiatric tests), or that the reviewing officers were clinically trained and thus had the capacity to form such views.

The information provided and the conclusions drawn, therefore, need to be interpreted with caution.

Supporting evidence

Despite the limitations of the department's research summarised above, the Inquiry was provided with much evidence that supported or augmented these findings. For example, the Inquiry was told that in 2002 there were 500 children in the care of one region alone who had been identified as having significant physical, medical or psychiatric disabilities, serious intellectual, psychological impairment or significant challenging behaviours (CMC 2003).

Similarly, Dr Jennifer Smith (SCAN team, Royal Brisbane Hospital) told the Inquiry:

> Children who enter foster care had three to seven times as many acute and chronic health conditions, developmental delay and emotional adjustment problems as other children. So, we're flagging that this is a group that significantly needs services because there are a whole range of problems that are more common in this population. (CMC 2003, p. 447)

Hilary Lennon (Regional Resource Officer, Child Protection, Department of Families), contributed the following:

> Other young children as young as four or five try to kill themselves by standing in the road, hanging themselves, overdosing, drinking detergent or jumping off balconies and bridges. Child abuse is ugly and the behaviours of children who cannot be placed with foster carers, those children who are victims of child abuse, their behaviours can be ugly too. (CMC 2003, p. 498)
>
> We have children who can't be placed with foster carers who have pets because these children have been subject to sexual abuse including bestiality. Consequently, these children act out sexually with the carer's pet dog or other animals or with other children, and foster carers have to be vigilant 24 hours a day. (CMC 2003, p. 498)

Implications

Research such as that undertaken by the department highlights several important factors:

- the importance of understanding the experiences of children who have been abused, the consequences, and the need for targeted interventions

- the subsequent effects of being in care on children who have been abused
- the importance of collecting, interpreting and monitoring information about children in care to ensure that appropriate interventions are applied.

The impact of being in care

In addition to the findings reported above, whereby the longer children are in care the greater is the likelihood that they will suffer from more serious behavioural, emotional and health concerns, the Commission heard during the Inquiry that some children in care often resort to crime to support themselves, subsequently coming into contact with the juvenile justice system (CMC 2003).

It is perhaps appropriate to note here recent CMC research (undertaken in collaboration with the Department of Families) indicating that of *all* children who had been subject to at least one Families care and protection order as well as a supervised juvenile justice order in 1994–95, 91 per cent had progressed to the adult correction system (custodial and community corrections) by September 2002. This compares with a 77 per cent progression rate for children subject only to a juvenile justice order. A care and protection order is an indicator of substantiated maltreatment, but it is not a measure of frequency or severity; it is therefore likely to be a conservative indicator of child abuse (Lynch, Buckman & Krenske 2003).

This research project makes an important contribution to whole-of-government research and policy development. Four main points that can be drawn from its preliminary analyses relate to:

- the adequacy and appropriateness of current responses
- the paucity of evaluations of current intervention strategies
- the need for multidisciplinary, inter-agency collaborations for intervention
- the importance of developmental and early intervention responses that address the precursors of juvenile offending (Lynch, Buckman & Krenske 2003).

What is child abuse prevention?

According to the United States Department of Health and Human Services (Administration for Children and Families 2003), the aims of child abuse prevention are to:

- stop child abuse and neglect from happening in the first place
- spare children and families emotional and physical trauma
- decrease the need for costly intervention and treatment services.

There is no single risk factor that can be used to predict who will be abused or who will become an abuser, so prevention strategies are most likely to be effective if multiple levels of risk are targeted simultaneously (World Health Organisation 2003). Professionals working to prevent child abuse and neglect often work within a three-level framework: primary, secondary and tertiary prevention. This framework has been 'borrowed' from a number of disciplines, including public health, education and mental health.

Primary prevention

Primary prevention can be defined as both the prevention of an adverse outcome before it occurs and the reduction of its incidence. Primary prevention programs are usually directed at the general population and can include activities such as increasing the economic self-sufficiency of families, making health care more accessible and affordable, expanding and improving coordination of social services, providing more affordable child care services and preventing the birth of unwanted children.

Secondary prevention

Secondary prevention activities focus on those who are at high risk. They are provided

to populations with one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, young parental age, parental mental health concerns, or parental or child disabilities. These activities may include home visitation programs, parent education programs and respite care.

Tertiary prevention

Tertiary prevention activities focus on families where adverse outcomes of some form have already occurred. They seek to reduce the detrimental consequences of such adverse outcomes and to prevent their recurrence. These programs can include mental health services for children and families affected by maltreatment to improve family communication and functioning; alternative out-of-home care for children identified as being at high risk; and respite care and crisis care services for children whose families are in crisis.

Clearly, to be effective, prevention should be recognised as a continuum from primary to tertiary levels rather than as mutually exclusive activities.

HISTORICAL BACKGROUND

The history of child protection in Queensland can be divided into four main periods:

- 1860s and 1870s (*Industrial and Reformatory Schools Act 1865* and *Orphanages Act 1879*)
- 1870s to 1911 (*State Children Act 1911*)
- 1911 to 1965 (*Children's Services Act 1965* and *Aborigines' and Torres Strait Islanders' Affairs Act 1965*)
- 1965 to 2000 (repeal of Children's Services Act and its replacement by the *Child Protection Act 1999* in 2000).

1860s and 1870s

Two seminal Acts were passed in the mid-nineteenth century by the Queensland Parliament — the *Industrial and Reformatory Schools Act 1865* and the *Orphanages Act 1879*.

The 1865 Act established industrial and reformatory schools for the care and custody of neglected children and young offenders under the age of 15. A child deemed to be neglected could be sent to such a school for a period of one to seven years. While the courts could not place children with other people in the community, the Governor-in-Council could release a child from an industrial or reformatory school to a person 'willing to receive and qualified to provide for and take care of such an inmate' (s. 15).

The Orphanages Act was the first attempt to consolidate Queensland's legislation on the protection of children. This Act permitted destitute or deserted children under the age of 12 to be sent to an orphanage, and to remain there until they were 12 years old unless boarded out with a trustworthy and respectable person, hired out or apprenticed. A child could be hired out or become an apprentice at 10 years of age. Parents or relatives of children living in these institutions were expected to contribute to their support.

1870s to 1911

The Industrial and Reformatory Schools Act and the Orphanages Act were repealed and replaced by the *State Children Act 1911*. This Act created the State Children Department, the first department with single responsibility for dealing with children in state care and the forerunner of the Department of Families.

Under the State Children Act the department's director had the care, management and control of all state children until they turned 18 years of age, whether the children were inmates of institutions, placed out or apprenticed, or placed in the custody of a suitable person willing to take care of the child. A state child was defined as a

neglected child, a convicted child, or any other child received into or committed to an institution or to the care of the department, or placed out or apprenticed under the Act (s. 4). The term 'neglected child' was defined very widely: it included 'destitute children and all children whose surroundings were such as to degrade or brutalise them or to make them tend to fall into the criminal class' (Commission of Inquiry into Abuse of Children in Queensland Institutions 1999, p. 291). The Act permitted the director to place a child back with their natural parents, and permitted placement with licensed foster mothers. Unlike placements with a 'foster parent', a placement with a foster mother did not entail the child's employment or apprenticeship.

The State Children Act required a foster mother to 'provide every child while in her care or charge with proper clothing, food, nursing and attention, and with all other necessaries of life, and keep every part of the home at all times in a fit and proper state for the reception of children' (s. 63). The minister was allowed to pay a foster mother for the care and maintenance of a state child.

1911 to 1965

Children's Services Act

The State Children Act was later repealed and replaced by the *Children's Services Act 1965*. The stated purpose of the Children's Services Act was to 'promote, safeguard and protect the wellbeing of the children and youth of the State through a comprehensive and coordinated program of child and family welfare'.

Under the Children's Services Act, the Children's Court could make two different types of child protection orders: a care and protection order, and a care and control order. The orders were generally based on information that children were neglected, in physical or moral danger, falling into a life of crime or addiction to drugs, uncontrollable, or associating with persons of ill repute (ss. 46 and 60). The effect of both orders was to transfer guardianship of the child from the child's parents or guardian to the director of the (renamed) Department of Children's Services until the child turned 18 years of age, unless they were discharged earlier by a court, the minister or the director (ss. 53 and 61).

Unlike the current child protection legislation (which says nothing about voluntary placements), the 1965 Act provided a mechanism for a parent, guardian or relative of a child or a person of good repute to apply to the director for a child to be voluntarily admitted into the director's care and protection until the child turned 18 years of age (s. 47). Under the State Children Act, the director had the power to refuse to discharge a child from the care of the department where the child had been voluntarily admitted into state care. This anomaly was rectified in the 1965 Act (s. 48).

A child who was the subject of a care and protection order, or a care and control order, or who had been voluntarily admitted into the director's care, could be placed by the director with approved foster parents, relatives or friends of the child, in a licensed institution, in a boarding school, hostel or any other place considered by the director to be in the child's best interests (ss. 58 and 65).

The Children's Services Act required foster parents to be approved by the director. The Act did not spell out any assessment criteria but simply said that the director, upon being satisfied that an applicant was a fit and proper person to be a foster parent, could approve an application (s. 104[3]). The Act required an applicant to provide a medical certificate, but did not require any other suitability checks to be carried out. Males were allowed to be foster parents, but only if they lived with and supported their wife who was also an approved foster parent (s. 105).

Unlike the current child protection legislation, the Children's Services Act did not provide for foster parent approvals to be renewed on a regular basis. The Act did, however, enable the director to 'revoke an approval at any time' (s. 104[4]). The Act provided for a foster parent to be paid an allowance for the care of a child.

Under section 120 of the Children's Services Act, the parents of a child in care were liable to pay or contribute to the maintenance of their child according to their respective abilities.

Like the State Children Act and its predecessors, the Children's Services Act originally regulated the placement in care of both neglected children and children who had been convicted of criminal offences. It was not until the *Juvenile Justice Act 1992* repealed the provisions about juvenile offenders that the Children's Services Act became an Act that dealt exclusively with the protection of neglected children.

Aborigines' and Torres Strait Islanders' Affairs Act 1965

In the same year that the Children's Services Act was passed, the Queensland Government also passed the *Aborigines' and Torres Strait Islanders' Affairs Act 1965*. This Act repealed the *Aboriginals Preservation and Protection Act 1939* and the *Torres Strait Islanders Act 1939*.

Under the 1939 Acts and their predecessors, the Director of Native Affairs (and previously the Chief Protector) had the power to remove Indigenous people to and between reserves, and to separate Indigenous children from their families. The Director of Native Affairs became the legal guardian of every Indigenous child under the age of 21 and was able to exercise the powers of guardianship when, in his opinion, the parents or relatives of the child were not exercising their powers in the interests of the child (Department of Families 2003b). The director had virtually total control of the lives of Indigenous children (HREOC 1997).

1965 to 2000

There was a period of 35 years between the passing of the *Children's Services Act 1965* and its replacement by the *Child Protection Act 1999*, but the child protection system did not stagnate during that time.

In the 1960s there were major developments in child welfare theory, aimed at enhanced understanding of the psychological and social development of children, and of the harmful effects of abuse and neglect. Practices within the Department of Children's Services evolved to reflect these developments, with increasing numbers of departmental officers holding university degrees in social work or equivalent qualifications. Whereas there had previously been an emphasis on the conviction of abusive parents, the new aim of the child protection system was to help support parents and, wherever practicable, to work to either restore families or keep them together (Forde Inquiry 1999).

In the 1970s there was a significant increase in child protection notifications and, for the first time, notifications began to raise allegations of child sexual abuse. In 1980 amendments were made to the *Health Act 1937* which resulted in some important changes, including:

- mandatory reporting of child abuse by medical practitioners to the Director-General of the Department of Health
- a 96-hour hold order to retain a child in hospital for medical assessment.

At the same time, Suspected Child Abuse and Neglect (SCAN) teams were established throughout Queensland, with core members from the Department of Health, the Department of Children's Services and the Queensland Police Department.

The Department of Children's Services responded to these developments with a number of important initiatives, which included:

- a central register to record data on child protection cases
- a crisis care service in Brisbane, operating seven days a week, 24 hours a day, to deal with calls about child protection and juvenile justice concerns
- a specialist sexual abuse treatment program
- a child protection unit to function as a specialist unit within the department, to provide support and consultation to departmental officers and represent the department on metropolitan SCAN teams
- a special needs unit to facilitate the adoption or placement of older children and children with disabilities

- a Centre for the Prevention of Child Abuse (Commission of Inquiry into Abuse of Children in Queensland Institutions 1999).

Consultation on what became the Child Protection Act was very extensive, spanning seven years and three governments. The consultation process began in 1993 with the distribution of an issues paper. According to this document, reform of the child protection system in Queensland was necessary because:

> the Children's Services Act reflects the social values and community standards of that time. The primary focus is protection from neglectful acts and behaviour by parents, and protection from unacceptable living conditions.
>
> Since the enactment of the Children's Services Act knowledge and expertise about physical, sexual and emotional abuse has changed and the strategies and services used to deal with these problems have expanded. The focus of child protection has moved from an essentially medical approach towards a holistic family approach that takes account of the needs of children within the family. The emphasis now is on a multidisciplinary response in the investigation, assessment and intervention process. The inter-agency process for coordinating responses to protect children which are now accepted as 'best practice' are not reflected in the current legislation. (Department of Family Services and Aboriginal and Torres Strait Islander Affairs 1993a, p. 4)

The Child Protection Bill was introduced into Parliament on 10 November 1998 and was passed, after extended debate, on 25 March 1999. However, it was not until a year later, on 23 March 2000, that the Act became fully operational.

During the minister's second-reading speech (when the Bill was first introduced into Parliament), the Honourable Anna Bligh emphasised the following features of the Bill:

- The Bill entirely replaced the outdated and limited Children's Services Act, which was drafted at a time when society's understanding of child abuse was limited.
- The Children's Services Act had an inappropriate emphasis on a reactive approach to child protection and contained orders that were inflexible, unresponsive and inadequate.
- The Bill was innovative and would place Queensland at the forefront of child protection in Australia.
- The paramount consideration was the child's right to protection.
- There was an emphasis on accountability, and a recognition that both parents and children have a right to information and to participate in planning and decision making.
- There was a preference for working cooperatively with families to protect children.
- If intervention was necessary, it must be taken at the least intrusive level that was compatible with ensuring the child's protection.
- The Bill gave statutory recognition to the Indigenous child placement principle.
- Foster carers were to be provided with support and training. (Queensland Parliamentary Debates, 10 November 1998, pp. 2850–52)

Considering what the CMC Inquiry has revealed about recent abuse of foster children, it is particularly interesting to note what the minister had to say about the importance of protecting children in state care from further abuse:

> vulnerable children — those who are in care because of abuse or neglect — must not be further disadvantaged by treatment they receive while in our care. This Bill places special emphasis on ensuring that this does not occur. Under the Bill, children's living arrangements under child protection orders are to be reviewed at least every six months to ensure that standards of care are being met and the needs of children properly assessed [emphasis added]. (Queensland Parliamentary Debates, 10 November 1998, p. 2851)

The following comment by the Opposition (Ms Judith Gamin, member of the National Party) is also thought-provoking:

> The Bill before the House has very high aims and ambitions for the assistance and protection of children who suffer abuse and neglect. I can only hope that these high aims and ambitions do not become obscured in the day-to-day internal workings of the huge and monolithic Department of Families, Youth and Community Care, [emphasis added]and that departmental officers are constantly reminded of the stated objectives of this legislation and the stated means of achieving these laudable objectives. (Queensland Parliamentary Debates, 10 March 1999, p. 450)

Like the *Children's Services Act 1965* after it was amended by the *Juvenile Justice Act 1992*, the *Child Protection Act 1999* deals exclusively with children in need of protection; it does not deal with the placement of young offenders.

CURRENT LEGISLATIVE FRAMEWORK: *CHILD PROTECTION ACT 1999*

The Child Protection Act has quite a narrow focus. Apart from section 7, which sets out 19 functions of the Director-General of the Department of Families, there is no real mention of the department taking a preventive approach to child abuse. The focus of the Act is on how the department should respond to a notification about harm to a child, the placement of children in need of protection in out-of-home care, and the licensing and regulation of individuals and services providing out-of-home care.

The Act can be divided into five main parts:

- underlying principles, and the functions of the director-general
- notifications and assessments
- child protection orders
- licensing and regulation of individuals and services involved in providing out-of-home care
- placing and monitoring of children in out-of-home care.

Underlying principles and the functions of the director-general

Section 5 of the Act sets out some principles that are intended to guide how the Act is administered. Some of the key principles are:

- Every child has a right to protection from harm (s. 5[a]).
- The welfare and best interests of a child are paramount (s. 5[b]).
- Families have the primary responsibility for the upbringing, protection and development of their children (s. 5[c]).
- The preferred way of ensuring a child's wellbeing is through the support of the child's family (s. 5[d]).
- Children and their parents should have the opportunity to take part in making decisions affecting their lives (s. 5[e] and [h]).
- Action taken to protect a child must not be unwarranted in the circumstances (s. 5[f]).
- If a child is removed from their family, the aim [of Department of Families workers] is to safely return the child to their family if possible (s. 5[g]).
- If a child does not have a parent able and willing to give the child ongoing protection, the child has a right to long-term alternative care (s. 5[i]).

This emphasis on family preservation and reunification, and on minimal intervention, is found in most child protection legislation throughout Australia. In 1990 the Australian Government ratified the United Nations Convention on the Rights of the Child. Among other things, this convention places an obligation on signatory states to hold the best interests of the child as the paramount consideration in government decisions and actions relating to children.

Section 7 of the Act sets out 19 functions of the director-general, most of which are not mentioned anywhere else in the Act.

Examples are:

- providing information for parents about the development of children and their safety needs (s. 7[a])
- providing preventive and support services to strengthen and support families and reduce the incidence of harm to children; and helping Indigenous communities to establish their own preventive and support services (s. 7[b] and [f])
- negotiating a statement of commitment between the state government and Foster Care Queensland that addresses the provision of support and resources by the Department of Families to foster carers (s. 7[h])
- cooperating with government entities that have a function relating to the protection of children (s. 7[l])
- educating the public about child abuse and neglect, and encouraging people who work with children and members of the public to report suspected child abuse and neglect to the director-general (s. 7[p])
- collecting and publishing information and statistics about harm to children; and promoting research into the causes and effects of harm to children (s. 7[q] and [r])
- encouraging tertiary institutions to provide instruction about harm to children and its prevention and treatment (s. 7[s]).

Notifications and assessments

Section 14(1) of the Act states that, if the director-general becomes aware (whether because of a notification or otherwise) of alleged harm or alleged risk of harm to a child and reasonably suspects the child is in need of protection, he or she must immediately:

(a) have an authorised officer investigate the allegation and assess the child's need of protection, or

(b) take other action the director-general considers appropriate.

If the director-general reasonably believes alleged harm may have involved the commission of a criminal offence, he/she must immediately give details of the alleged harm to the Commissioner of the Queensland Police Service (s. 14[2]).

The Department of Families does not record as a child protection notification every concern about a child that is conveyed to it. For a concern to be recorded as a notification, it must 'suggest that a child has been harmed or is at risk of harm and does not have a parent willing and able to protect them from the harm' (Department of Families policy no. 272-1, Recording a Child Protection Notification).

The department will only consider investigating a concern if it has first been recorded as a notification, and it does not investigate every child protection notification. If the harm that a child has suffered or is at risk of suffering is not 'significant', the department will respond by issuing a 'protective advice' to the person who made the notification. This means that the department advises the notifier that it will not be taking the matter any further. The term 'significant harm' is not defined in the Act but is defined by the department to mean harm that:

- constitutes serious impairment or is likely to constitute serious impairment, and
- is demonstrable or is likely to be demonstrable in the child's body, bodily functioning or behaviour (Department of Families policy no. 272-1, Recording a Child Protection Notification).

However, a protective advice cannot be issued where a notification concerns a child who has been placed in out-of-home care. Departmental policies stipulate that these notifications must be investigated (Department of Families policy no. 271-1, Child Protection Notification Response — Protective Advice).

The Act recognises that not every child protection notification will be investigated, because it says that the director-general can respond to a notification by either

investigating the allegation or by taking 'other action the director-general considers appropriate' (s. 14[1]).

Some of the words and phrases used in section 14 are specifically defined. For example, section 14 refers to a notification about a 'child', defined in section 8 as 'an individual under 18 years'. One consequence of this definition could be that the director-general does not have an obligation under section 14 to respond to concerns raised about an unborn child.

Section 14 also refers to 'alleged harm or alleged risk of harm': the word 'harm' is defined in section 9 as meaning 'any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing'.

Section 9 also states that it is immaterial how the harm is caused — and that harm can be caused by:

- physical, psychological or emotional abuse or neglect, or
- sexual abuse or exploitation.

Finally, section 14 refers to the director-general having a reasonable suspicion that a child is 'in need of protection'. Section 10 states that a 'child in need of protection' is a child who:

- has suffered harm, is suffering harm, or is at unacceptable risk of suffering harm, and
- does not have a parent able and willing to protect the child from the harm.

All Australian states and territories, apart from Queensland and Western Australia, have provisions in their child protection legislation that make it mandatory for an extensive list of professionals and other workers who deliver services to children to report a suspicion that a child is at risk of harm to an appropriate child protection agency.

Although the Queensland Act does not contain an equivalent provision, there are still some statutory provisions in Queensland that impose a reporting obligation:

- Section 76K of the *Health Act 1937* requires a medical practitioner who 'suspects on reasonable grounds the maltreatment or neglect of a child in such a manner as to subject or be likely to subject the child to unnecessary injury, suffering or danger', to notify the Department of Families, the police service or a senior medical practitioner within 24 hours.
- Section 148 of the Child Protection Act requires Department of Families officers, as well as employees of juvenile detention centres and residential facilities, who become aware or reasonably suspect that harm has been caused to a child residing in a juvenile detention centre or residential facility to make a report to the director-general immediately.
- Section 20 of the *Commission for Children and Young People Act 2000* states that if the Children's Commissioner considers that a child may be in need of protection, he or she must refer the matter to the director-general or the police.

If the Department of Families decides to investigate a child protection notification, its investigation must entail an assessment of the child's need of protection (s. 14[1]([a]). A full assessment will typically involve a medical examination. If a child's parents refuse to consent to such an examination (or it is not practicable to try to obtain parental consent), an authorised officer of the department can apply to a magistrate for a temporary assessment order (s. 25) or to the Children's Court for a court assessment order (s. 39).

A **temporary assessment order** can:

- authorise an officer of the department to have contact with the child
- authorise an officer of the department to take the child into the director-general's custody for the duration of the order — which is a maximum of four days, including an extension (ss. 29 and 34)

- authorise medical examinations and/or treatment of the child
- direct a parent not to have contact with the child, or not to have contact except when a stated person or a person of a stated category is present
- authorise an officer of the department, or a police officer, to enter and search a place for the purpose of finding the child (s. 28).

The magistrate must be satisfied that reasonable steps have been taken to obtain the consent of at least one of the child's parents to proceed with an order, or be satisfied that it is not practical to take steps to obtain the consent (s. 27[2]). At least one parent and the child must be given details of the order once it is made and the parent(s) advised of their appeal rights (s. 32).

A **court assessment order** is very similar to a temporary assessment order. There are two major differences:

- The maximum duration of a court assessment order is much longer — a maximum of eight weeks, including an extension (ss. 47 and 49).
- The child's parents are respondents to an application for a court assessment order and are entitled to contest the application (s. 42).

A child's parents can appeal against the making of an assessment order (ss. 48 and 117). An appeal against a temporary assessment order is heard by the Children's Court constituted by a judge. An appeal against a court assessment order is heard by the Court of Appeal, if the original decision was made by the Children's Court constituted by a judge; or by the Children's Court constituted by a judge if the original decision was not made by a judge (Schedule 3, definition of 'appellate court').

Child protection orders

If the department investigates a child protection notification and decides that the child is in need of protection, an application can be made to the Children's Court for a child protection order (s. 54). The child's parents are respondents to the application and are entitled to contest it (s. 57).

The court must be satisfied of the following matters before it can make an order:

- The child is in need of protection and the order is appropriate and desirable for the child's protection.
- A meeting between representatives of the department and the child's parents[1] has been held in accordance with section 96 of the Act, or reasonable attempts to hold such a meeting have been made.
- If the making of the order has been contested, a conference between the department and the child's parents has been held or reasonable attempts to hold a conference have been made.
- The child's wishes or views, if able to be ascertained, have been made known to the court.
- The protection sought to be achieved by the order is unlikely to be achieved by a different order on less intrusive terms (s. 59[1]).

A range of child protection orders can be made, the most important ones being:

- a protective supervision order
- a custody order
- a short-term guardianship order
- a long-term guardianship order.

Protective supervision orders. Under a protective supervision order made under section 61(c) of the Act), the child's parents retain both custody and guardianship of the child. The significance of the order is that the director-general is required to supervise the child's protection. A protective supervision order entitles the director-general to direct a parent to take, or refrain from taking, certain action (s. 78). The child's parents are obliged to allow officers of the department to have reasonable

contact with the child (s. 77). The maximum duration of a protective supervision order is one year (s. 62[2][a]), but the order can be extended (s. 64). The Act does not place any limitations on the number of times a protective supervision order can be extended.

Under section 61(d) of the Act, the Children's Court can grant custody of the child to a member of the child's family (who is not a parent) or to the director-general. Because the word 'family' is not defined in the Act or in the *Acts Interpretation Act 1954*, the precise ambit of this provision is not clear. For example, it is not clear whether the word 'family' should be given a wider meaning where the child is an Indigenous child. In practice, custody orders are almost always made in favour of the director-general and not in favour of a member of the child's family.[2]

Custody orders. The effect of a custody order is that the child's parents lose the right to have the child's daily care, and the right and responsibility to make decisions about the child's daily care, for as long as the order remains in force (s. 12). These rights are vested in the person who gains custody of the child. Under a custody order, however, the child's parents still retain guardianship of the child. The maximum duration of a custody order is two years (s. 62(2)(b)) but the order can be extended (s. 64). The Act does not place any limitations on the number of times that a custody order can be extended.

Short-term guardianship orders. Under section 61(e) of the Act, the Children's Court can grant short-term guardianship of the child to the director-general. The effect of a short-term guardianship order is that the child's parents lose, and the director-general gains, the right to have both custody and guardianship of the child for as long as the order remains in force. What this means is that the director-general can make both day-to-day and long-term decisions about the child. The maximum duration of a short-term guardianship order is two years (s. 62[2][b]) but the order can be extended (s. 64). The Act does not place any limitations on the number of times that a short-term guardianship order can be extended.

Long-term guardianship orders. Under section 61(f) of the Act, the Children's Court can grant long-term guardianship of the child to a member of the child's family (who is not a parent), or to another person who is nominated by the director-general, or to the director-general. To do this the court must be satisfied that:

- there is no parent able and willing to protect the child within the foreseeable future, or
- the child's need for emotional security will be best met in the long-term by making the order (s. 59[3]).

Because the word 'family' is not defined, the precise ambit of this provision is not clear. A long-term guardianship order cannot be made in favour of a person who is not a member of the child's family unless the child is already in custody or guardianship under a child protection order (s. 59[4][a]). In practice, long-term guardianship orders are almost always made in favour of the director-general, and not in favour of a member of the child's family or some other person nominated by the director-general. This practice is clearly inconsistent with section 59(4)(b) of the Act which says:

> ... the court must not grant long-term guardianship of a child to ... the chief executive if the court can properly grant guardianship to another suitable person.

The effect of a long-term guardianship order is that the child's parents lose, and the director-general (or other person) gains, the right to have both custody and guardianship of the child until the child turns 18 years of age. This means that the director-general (or other person) can make both day-to-day and long-term decisions about the child until the child becomes an adult. A long-term guardianship order ends on the day before the child turns 18 years of age (s. 62[2][c]).

A child's parents can appeal against the making of a child protection order (s. 63). The appeal is heard by the Court of Appeal, if the original decision was made by the Children's Court constituted by a judge; or by the Children's Court constituted by a

judge, if the original decision was not made by a judge (schedule 3, definition of 'appellate court').

Under section 65 of the Act, an authorised officer of the department, a parent of a child, a person (other than the director-general) having custody or guardianship of the child, or the child may apply to the Children's Court for an order to vary or revoke a child protection order; or to revoke a child protection order and make another child protection order in its place.

Licensing and regulation of those involved in providing out-of-home care

Where the director-general has custody or guardianship of a child under the Act, section 82 of the Act states that 'the chief executive may place the child in the care of a licensed care service, approved foster carer or other person that the chief executive considers appropriate'.

The licensing of care services and the approval of foster carers is regulated by Chapter 4, Part 2 of the Act. The main purpose of these licensing and approval provisions is to ensure that children in the director-general's custody or guardianship are cared for in a way that complies with the statement of standards set out in section 122 (s. 123) of the Act and page 16 of this report.

Licensing and regulation of care services

An application for a licence to provide care services, including a renewal, is made to the director-general (s. 125). The application must be made by a corporation and must nominate an adult to be the nominee for the licence. The licence and any renewal is effective for three years (s. 128).

Because the Act does not define a 'care service', the scope of section 125 and the other licensing provisions is not entirely clear. The Act does define a 'licensed care service' as a service, operated under a licence, to provide care for children in the director-general's custody or guardianship (schedule 3, dictionary), but this definition is not particularly helpful. The licensing provisions appear to apply to all agencies that provide some type of care to children who have been placed in the director-general's custody or guardianship because of an assessment or child protection order (or through some other section of the Act or some other court order). An agency that provides care only to children who are placed in out-of-home care on a voluntary basis (and who are therefore not in the director-general's custody or guardianship) is not required to be licensed.[3] It does not seem to matter whether the agency is personally responsible for providing the care (as is the case with a residential facility) or merely organises for someone else to provide the care (as is the case with a shared family care agency that organises foster care placements).

Since the Department of Families also gets involved in directly organising foster care placements, it is arguable that the department is itself a care service that could be licensed under the Act. The department disagrees with this interpretation, pointing out that 'it is problematic for an entity to license itself'.[4] It has been suggested that agencies providing intervention services do not need to be licensed if they are not involved in providing daily care to children. The CMC does not have a firm view about this. It is clear, however, that the licensing provisions need to be amended so that there is no ambiguity about which agencies are required to be licensed.

Although the Act became fully operational nearly four years ago, the department has not attempted to license all care services. Instead, it has focused on licensing 'those services whose primary purpose is the provision of placement services, and therefore the provision of daily care, to children subject to statutory child protection intervention'.[5] There are currently 20 licensed residential care services (providing non-family-based care), three of which are Indigenous services; and 26 shared family care services licensed to recruit, train, assess and support foster and relative carers, six of which are Indigenous services.[6] All other agencies that provide care for children in the director-general's custody or guardianship are currently unlicensed. These include one

Aboriginal and Islander Child Care Agency (AICCA) that currently organises foster care placements, and some of the agencies that are listed on the department's register of preferred providers of placement and support for children with complex needs. The department is, however, currently 'reassessing which agencies need to be licensed'.[7]

Before granting an application for a licence or renewal of a licence, the director-general must be satisfied that:

- the applicant is a suitable entity to provide care services
- the directors of the applicant, the nominee for the licence, the people who will be responsible for directly managing the service, and all people (including volunteers) who work for the service are suitable people[8]
- the standard of care provided complies with the statement of standards
- the methods for selecting, training and managing people engaged in providing the services are suitable (s. 126).

Under section 2 of the Child Protection Regulation 2000, the director-general must also obtain a written evaluation, from a person who is independent of both the applicant and department, of the care services provided or proposed to be provided. The purpose of this requirement is to help the director-general decide if the standard of care provided, or proposed to be provided, complies with the statement of standards of care for children, as set out in section 122 of the Act.

Suitability of nominees for a licence

A person is a 'suitable person' to be a nominee for a licence if that person:

- does not pose a risk to the safety of children who, under the Act, are in the care of the service, and
- is willing and able to fulfil the responsibilities of a nominee under section 130 of the Act (s. 9[5] of the Child Protection Regulation).[9]

A person is a 'suitable person' for managing a licensed care service if the person:

- does not pose a risk to the safety of children who, under the Act, are in the care of the service
- is willing and able to manage the service in a way that ensures the provision of care complies with the statement of standards
- implements the selection, training and management methods mentioned in section 126,[10] and
- understands, and is committed to, the principles for administering the Act (s. 9[3]) of the Child Protection Regulation).[11]

A person who is not directly engaged in caring for children is suitable to work for a licensed care service (including on a voluntary basis) if the person does not pose a risk to the safety of children who, under the Act, are in the care of the service (s. 9[6] and [7] of the Child Protection Regulation).

A person who is directly engaged in caring for children is suitable to work for a licensed care service (including on a voluntary basis) if the person satisfies the following definition:

> A person is a suitable person for having the daily care of a child if the person:
>
> (a) does not pose a risk to the child's safety; and
>
> (b) for a person other than an approved foster carer, is willing and able to provide the care in a way that meets the standards of care in the statement of standards; and
>
> (c) understands, and is committed to, the principles for administering the Act; and
>
> (d) has completed any training reasonably required by the chief executive to ensure the person is able to properly provide the care; and
>
> (e) understands the policies and procedures implemented by the chief executive to ensure the care meets the standards of care in the statement of standards (Child Protection Regulation, s. 9[2]).[12]

The 'statement of standards' set out in section 122 and referred to in sections 126 and 130 of the Act is as follows:

(a) the child's dignity and rights will be respected at all times;

(b) the child's needs for physical care will be met, including adequate food, clothing and shelter;

(c) the child will receive emotional care that allows him or her to experience being cared about and valued and that contributes to the child's positive self-regard;

(d) the child's needs relating to his or her culture and ethnic grouping will be met;

(e) the child's material needs relating to his or her schooling, physical and mental stimulation, recreation and general living will be met;

(f) the child will receive education, training or employment opportunities relevant to the child's age and ability;

(g) the child will receive positive guidance when necessary to help him or her to change inappropriate behaviour;

(h) the child will receive dental, medical and therapeutic services necessary to meet his or her needs;

(i) the child will be given the opportunity to participate in positive social and recreational activities appropriate to his or her developmental level and age;

(j) the child will be encouraged to maintain family and other significant personal relationships;

(k) if the child has a disability — the child will receive care and help appropriate to the child's special needs.

When an application for, or renewal of, a licence is made, the director-general can — but is not required to — ask the Police Commissioner and the Director-General of Queensland Transport to provide written reports about the criminal, domestic violence and traffic history of:

- the person who will be, or is, responsible for directly managing the service
- the directors of the applicant for the licence or the licensee
- the nominee for the licence
- all persons who work for the service (s. 142).[13]

If an application for a licence to provide care services, or an application for a renewal of a licence, is refused, the applicant can apply to the Children Services Tribunal to have the decision reviewed (s. 129).

The director-general may suspend or cancel a licence to provide care services if:

- the holder of the licence is not meeting the standards required under the licence
- there has been a contravention of the Act
- the licence was issued because of a misrepresentation; or
- if a director of the licensee; the nominee for the licence; or a person managing, or working for, the service is not a suitable person (s. 139).[14]

If a licence is suspended or cancelled, the holder of the licence can apply to the Children Services Tribunal to have the decision reviewed (s. 140).

Section 4 of the Child Protection Regulation imposes an obligation on a licensed care service to keep certain records, including:

- identifying details about each child who is placed in care
- the relevant dates when each child was placed in care
- the location of each child who is placed in care
- details about any complaint, received by the licensed care service, about the care received by a child and any action taken
- if a child is residing in a licensed residential facility, details of any significant event relating to the child.

Approval and regulation of foster carers

An application for a certificate of approval as an approved foster carer, including a renewal, is made to the director-general (s. 132). An initial certificate has effect for one year and a renewal certificate has effect for two years (s. 135). An approved foster carer must be an individual, and a person living with his or her spouse may only hold a certificate jointly with the spouse (s. 131).

Before approving a person to be a foster carer, the director-general must be satisfied that:

- the applicant is a suitable person to be an approved foster carer[15]
- all members of the applicant's household are suitable persons to associate on a daily basis with children
- the applicant is able to meet the standards of care in the statement of standards
- the applicant is able to help in appropriate ways towards achieving plans for a child's protection (s. 133).

When an application for a certificate of approval, or for renewal of one, is made the director-general can — but is not required to — ask the Police Commissioner and the Director-General of Queensland Transport to provide written reports about the criminal, domestic violence and traffic history of the applicant or an adult member of the applicant's household (s. 142).

If an application for a certificate of approval, or an application for a renewal of an approval, is refused the applicant can apply to the Children Services Tribunal to have the decision reviewed (s. 136).

The director-general may suspend or cancel a foster carer's approval if:

- the foster carer is not meeting the standards required under the approval
- there has been a contravention of the Act
- the approval was issued because of a misrepresentation, or
- if the foster carer is no longer a suitable person to be an approved foster carer or if a member of the carer's household is not a suitable person to associate on a daily basis with children (s. 139).[16]

If a foster carer's approval is suspended or cancelled, the foster carer can apply to the Children Services Tribunal to have the decision reviewed (s. 140).

If an approved foster carer agrees to care for a child who has been placed in the director-general's custody or guardianship, the director-general and foster carer must enter into a written agreement for the child's care (s. 84). The agreement must contain the following terms (s. 7 of the Child Protection Regulation):

- the duration of the agreement
- the period of time that the foster carer will care for the child
- information, from any case plan prepared by the director-general, about matters involving or affecting the foster carer
- details of the information given to the child's parents about the foster care placement
- arrangements for contact with the child's family
- the responsibilities of the director-general and foster carer to provide medical, therapeutic, schooling and other services to the child
- information about any special needs of the child, including any health or behavioural needs
- the allowance to be paid to the foster carer.

Regulation of other carers

The director-general is entitled to place a child who is in their custody or guardianship with 'another person that the director-general considers appropriate' (s. 82). The Act

does not require this 'other person' to be formally approved or to satisfy any particular criteria.

The Department of Families has developed a number of policies that regulate the appointment and use of other carers. Two of these policies are:

- The Assessment and Approval of Relative Carers (policy no. 293-1, January 2003)
- The Assessment and Approval of Limited Approval Carers (policy no 292-1, January 2003).

A full description of these policies and the role of relative and limited approval carers is given under 'Foster care in Queensland', later in this chapter.

The use by the department of relative and limited approval carers is essentially unregulated by the Act. However, there are two provisions that are relevant.

Section 95 of the Act states that the director-general can — but is not required to — ask the Police Commissioner and the Director-General of Queensland Transport to provide written reports about the criminal, domestic violence and traffic history of a person other than an approved foster carer who has agreed to be the child's carer. The director-general can — but is not required to — ask the Police Commissioner to provide written reports about the criminal and domestic violence history of all adult members of the proposed carer's household.

Section 9(2) of the Child Protection Regulation contains a definition of a person who is suitable 'for having the daily care of a child'. This definition is included in this chapter under the heading 'Suitability of nominees for a licence' (see page 15). The scope of section 9(2) of the regulation is not clear: it may or may not be interpreted by a court as applying to relative and limited approval carers. During the Inquiry a legal officer of the department expressed the view that, at the time the regulation was drafted, it was intended that section 9(2) would apply to relative and limited approval carers as well as foster carers. Certainly, the department's policies on the assessment and approval of relative and limited approval carers are consistent with what section 9(2) of the regulation says.

Placing and monitoring children in out-of-home care

The director-general can place a child with an approved foster carer, a licensed care service, a relative carer or a limited approval carer ('in out-of-home care'):

- if the director-general has custody or guardianship of the child under an assessment or child protection order
- if the director-general has custody or guardianship of the child under sections 18 or 21 of the Act, or
- with the consent of the child's parents.

The first of these options has already been discussed above. Where a child is placed in out-of-home care under a child protection order, the child and the child's parents are entitled to apply to the Children Services Tribunal to have the director-general's placement decision reviewed (s. 86).

An authorised Department of Families officer who is investigating a child protection notification has the power to take a child into the director-general's custody immediately if the officer reasonably believes the child is otherwise likely to suffer harm (s. 18). The officer must, as soon as practicable after taking the child into custody, apply for a temporary assessment order (s. 18[5]) — see pages 11–12 for an explanation of temporary assessment orders. The director-general's custody ends when the application for the temporary assessment order is decided, or eight hours after the child is taken into custody (whichever is first) (s. 18[7]).

An authorised officer of the department who reasonably believes that a child under 12 years of age is at risk of harm may move the child to a safe place if a parent or other member of the child's family is not present at the same place as the child and cannot,

after reasonable inquiries, be contacted (s. 21). A parent's custody and guardianship rights are not affected by a 'section 21 move'. A child who is moved to a safe place may be cared for at the place until the child's parents or family members resume or assume the child's care (s. 21[4] and [5]).

The director-general can also place a child in out-of-home care, with the consent of the child's parents. Unlike the equivalent Acts of all other states and territories in Australia, the Queensland Act does not regulate these types of 'voluntary' placements. These placements are regulated only by Department of Families policies.[17]

If the director-general intends to place a child in out-of-home care and the child is an Aboriginal or Torres Strait Islander, the chief executive must:

> give proper consideration to placing the child, in order of priority, with:
> - a member of the child's family; or
> - a member of the child's community or language group; or
> - another Aboriginal person or Torres Strait Islander who is compatible with the child's community or language group, or
> - another Aboriginal person or Torres Strait Islander (s. 83).

The director-general can remove from the carer a child who has been placed in out-of-home care under an assessment or child protection order, if satisfied that removal is in the child's best interests (s. 89). In certain cases, the carer and the child are entitled to apply to the Children Services Tribunal to have the director-general's decision to remove the child reviewed (ss. 90 and 91).

When a child protection order is made for a child, the director-general is subject to a number of obligations under the Act as described below.

Director-general's obligations. Where the order is a protective supervision order, a custody order or a short-term guardianship order, section 73 imposes an obligation on the director-general 'to take steps that are reasonable and practicable to help the child's family meet the child's protective needs'. Section 73 also requires the director-general to have regular contact with the child and the child's family.

Where the director-general is granted custody or guardianship of a child under a child protection order:

- section 88 requires that the director-general 'review the arrangements in place for the child's protection to ensure the arrangements are in the child's best interests'; the reviews must be conducted at least every six months
- section 75 imposes an obligation on the director-general 'to ensure the child is provided with help [including financial assistance] in the transition from being a child in care to independence'
- section 74 imposes an obligation on the director-general 'to ensure the charter of rights for a child in care in schedule 1 [of the Act] is complied with'. Section 74 also requires the director-general to ensure that the child is told about the charter of rights and its effect; and is given written information about the charter (unless the child would not be able to understand the information).

The charter of rights establishes the following rights:

(a) the right to be provided with a safe and stable living environment

(b) the right to be placed in care that best meets the child's needs and is most culturally appropriate

(c) the right to maintain relationships with the child's family and community

(d) the right to be consulted about, and to take part in making, decisions affecting the child's life (having regard to the child's age or ability to understand), particularly decisions about where the child is living, contact with the child's family and the child's health and schooling

(e) the right to be given information about decisions and plans concerning the child's future and personal history, having regard to the child's age or ability to understand

(f) the right to privacy, including, for example, in relation to the child's personal information

(g) if the child is under the long-term guardianship of the director-general, the right to regular review of the child's care arrangements

(h) the right to have access to dental, medical and therapeutic services, necessary to meet the child's needs

(i) the right to have access to education appropriate to the child's age and development

(j) the right to have access to job training opportunities and help in finding appropriate employment; and

(k) the right to receive appropriate help with the transition from being a child in care to independence, including, for example, help about housing, access to income support and training and education.

Section 12 of the Child Protection Regulation imposes an obligation on the director-general to keep the following records:

- any report given to the director-general about harm caused, or suspected to have been caused, to a child who, under the Act, is in the care of an approved foster carer or licensed care service
- any report given to the director-general about a breach, or claimed breach, of the statement of standards
- the results of an investigation into either of these types of reports.

The records must be kept in a way that enables the director-general to access or collect information about a particular carer or licensed care service or analyse trends across all the recorded information. The director-general is also required to give the Children's Commissioner regular written reports about the records that have been kept under section 12 (s. 13 of the Child Protection Regulation). The commissioner can ask the director-general for additional details of a particular matter mentioned in the records.

This section of the report has focused on what the Child Protection Act says about the protection of children who come to the attention of the Department of Families. The Act, however, is not a code and clearly does not regulate the entire spectrum of child protection work (policy no. 345-1). The following section of this report contains a more comprehensive description of the child protection role as implemented by the department.

THE CURRENT CHILD PROTECTION SYSTEM

The Department of Families is the primary agency for providing services to children who have suffered, or are at risk of suffering, abuse and neglect. The department categorises the services it provides to children and families into prevention services, early intervention services, immediate response services and continuing support services.[18]

The legislative basis for the provision of child protection services consists of the *Child Protection Act 1999* and the Child Protection Regulation 2000. However, the prevention, early intervention, immediate response and continuing support services provided by the department are intended to meet the requirements of a variety of legislation that it administers, such as the *Child Care Act 1991*, the *Domestic Violence (Family Protection) Act 1989,* the *Family Services Act 1987* and the *Juvenile Justice Act 1992*.

Powers and responsibilities of the director-general

The *Child Protection Act 1999* gives the Director-General of the Department of Families a number of powers and responsibilities to provide for the protection of children, and allows the director-general to delegate powers to other employees of the department (s. 156).

As detailed under 'Notifications and assessments' in the previous section of this chapter, the Act specifies that the department must investigate any allegations that indicate that a child has suffered, or is at risk of suffering, significant harm. Departmental policy (no. 273-1, Child Protection Notification Response — Initial Assessment) states that an investigation into allegations of harm, or risk of harm, will either substantiate or not substantiate the allegation(s) made. These are the only two outcomes provided for. It seems, however, that there are many allegations made that are deemed worthy of investigation but are either not investigated or are investigated to an insufficient degree to allow their accuracy to be determined.

The Queensland Government's submission to the Inquiry provided statistics on allegations made to the department about harm to a child. In 2002–03 there were 27 218 instances of allegations made to the department of harm, or risk of harm, that were considered worthy of investigation. Of these, 12 203 (44.83%) were substantiated, 5339 (19.61%) were unsubstantiated and 9679 (35.56%) had no recorded outcome. Information provided by the department at the public hearings indicated that, of the 9679 cases with no recorded outcome, approximately 2300 (23.76%) did not have an outcome recorded because the department was unable to obtain sufficient information to allow a finding of either substantiated or unsubstantiated. Approximately 3700 (38.22%) were still under investigation and approximately 3500 (36.16%) were not investigated for 'workload reasons' (CMC 2003). This last figure is disturbing. Presumably, taking no action in relation to some of these 3500 allegations of harm or risk of harm against children can only be statutorily justified in terms of 'other action the chief executive considers appropriate' under section 14 of the *Child Protection Act 1999*.

Where an allegation of harm, or risk of harm, has been substantiated and further action is decided upon by the Department of Families, the department may choose to enlist a non-government agency to intervene directly or provide support services to the child and the child's family.

The case management framework

Where the Department of Families intervenes directly, departmental policy no. 263-1, Case Management Framework, is intended to be used by staff to address the protective and care needs of children subject to statutory child protection intervention 'through ongoing processes of assessment, planning, implementation and review, in accordance with the requirements of the departmental Case Management Framework'. This case management framework is said to apply to all matters where a decision is made that intervention by the department is necessary to ensure a child's protection. It includes both cases where a child's family voluntarily allows the department to involve itself in and monitor a child's wellbeing and cases where the department obtains a court order to meet a child's protective needs.

The department's case management framework indicates that a child's case can be managed through:

- **family meetings** between departmental staff and the child's parents that may also, where appropriate, be attended by the child and other significant people in the child's life; the purpose of these meetings is to review the child's circumstances and family situation and decide on a case plan
- **case discussion meetings** among departmental staff to reach decisions about action to be taken by the department, after which the relevant officer completes an Assessment of Protective Needs report, which sets out the evidence and reasons for intervening to protect the child.

Family meetings

The department's case management framework policy states:

> It is a legislative requirement that departmental officers take all reasonable steps to convene a family meeting if:
>
> - such a meeting has been ordered by the Children's Court; or

- the chief executive is satisfied that the child or young person is in need of protection and a child protection order is to be sought from the court [emphasis added].

For cases not involving Children's Court action, hold the initial family meeting as soon as possible after the decision to continue departmental intervention.

Section 96 of the *Child Protection Act 1999* specifies the obligation of an authorised officer in circumstances where a family meeting is to be convened:

96 Family meetings

(1) This section applies if —

(a) the chief executive is satisfied a child is a child in need of protection and action should be taken to ensure the child's protection [emphasis added]; or

(b) the Children's Court orders a family meeting be convened.

(2) An authorised officer must —

(a) take reasonable steps to convene a meeting with the child's parents and, if the officer considers it is in the child's best interests, the child and other family members, to provide an opportunity for decisions to be made to ensure, or contribute towards ensuring, the child's protection; and

(b) give the child's parents a written statement of the reasons the chief executive considers the child is a child in need of protection; and

(c) tell the child why the officer considers the child is a child in need of protection.

(3) If the child is an Aboriginal or Torres Strait Islander child, a member of the recognised Aboriginal or Torres Strait Islander agency for the child may also attend the meeting.

(4) The officer must record in writing the decisions made at the meeting about the child's protection and, as soon as practicable after the meeting, give a copy of the record to the child's parents, the child and anyone else the officer considers appropriate.

(5) If the meeting is convened under a court order, the officer must file the record in the court.

There seems to be some inconsistency between the department's current policy about family meetings and the Act. The policy states that a family meeting should take place if one has been ordered by the court (as per s. 96[1][b]), or if the director-general is satisfied that the child or young person is in need of protection (as per s. 96 [1][a]), but adds the further requirement that a court 'order is to be sought'. The Act requires that the department attempt to convene a family meeting when any action — not just court action — needs to be taken to ensure a child's protection. This interpretation is supported by the Explanatory Notes that accompanied the Child Protection Bill 1998. The notes read (in relation to what was clause 93, now s. 96):

> Clause 93 obliges a delegated officer to convene a family meeting when the officer has decided to intervene to protect a child and is able to take this action without a court order (i.e. it is possible and appropriate to work with the family while the child remains in their custody). In these circumstances, when an officer has, in their role as a statutory child protection officer, assessed a child as requiring protection by the state, a family meeting is required to provide a formal opportunity for the family to be advised of the reasons for the officer's decision, to have their say about the matters, and to receive relevant written information. A delegated officer is also required to convene a family meeting if one is ordered by the court.

Section 96 further requires that the relevant employee of the department:

- give the child's parents a written statement of the reasons the chief executive considers the child is a child in need of protection; and
- tell the child why the officer considers the child is a child in need of protection; and
- record in writing the decisions made at the meeting about the child's protection and, as soon as practicable after the meeting, give a copy of the record to the child's parents, the child and anyone else the officer considers appropriate; and

- if the meeting is convened under a court order, the officer must file the record in the court.

The department's case management framework policy requires these documents be prepared and provided only when an order is to be sought from the Children's Court. At a minimum, the case management framework specifies that the relevant officer must document what was discussed at a family meeting and the decisions agreed upon, and provide, or attempt to provide, this report to the relevant family members. It is apparent that the department's policy does not convey the full weight and intention of the Act about officers' responsibilities in relation to family meetings.

The Children's Court may make a child protection order only if it is satisfied that a family meeting has been held in accordance with section 96, or reasonable attempts to do so have been made (s. 59[1][b]). If the Children's Court considers it appropriate, it may adjourn a proceeding for a child protection order and order the department to convene a family meeting in accordance with section 96 (s. 68[1][d]). A family meeting must also be held or attempted in accordance with section 96 before the Children's Court transfers a child protection order interstate (s. 214[c]).

Placement meetings

A placement meeting should occur between department staff, a child's foster carers and a foster care or residential care service where such a service is involved. The purpose of these meetings is to:

- set goals for the placement
- agree on the responsibilities of the foster carer and the departmental employee with carriage of the case as they relate to the needs of the child
- provide information and support to the foster carer
- share information about the child's development and needs.

These meetings are intended to generate a placement agreement setting out goals of the placement and the ways in which those goals will be met, any arrangements specific to the placement, and the resources to be provided by the department.

Court orders

As mentioned above, the Department of Families may intervene to ensure the protection of a child, either with the consent of the child's parents or through a court order. The Child Protection Act provides staff of the department with certain powers to enter places and take a child into custody if the child is at immediate risk of harm. However, most of the director-general's powers in relation to assuming the custody and guardianship of a child are exercised by court order. There are three standard orders: temporary assessment orders, court assessment orders and child protection orders. These have been explained earlier in this chapter.

Out-of-home care

A child may be placed in out-of-home care during an investigation of a notification about the child or after an investigation when officers have concluded that a child's need for protection can only be met by placing the child in out-of-home care. When a child needs to be removed from their home and placed in out-of-home care, the department will usually attempt to obtain the consent of the child's parents (Department of Families policy no. 345-1, Placement of Children and Young People with Parental Consent). This approach is consistent with section 5(d) of the Act, which says that 'the preferred way of ensuring a child's wellbeing is through the support of the child's family'.[19] Where consent cannot be obtained, an authorised officer of the department will need to apply for either an assessment or a child protection order.

Voluntary placements

The Queensland Act, unlike those of all other states and territories in Australia, does not regulate placements that take place with the consent of a child's parents ('voluntary placements'). One consequence of this lack of regulation is that children

who are placed on a voluntary basis miss out on certain protections contained in the Act. For example:

- section 74, which requires the director-general to ensure that the charter of rights for a child in care is being complied with, does not apply
- section 88, which requires the director-general to review placements every six months, does not apply.

Another consequence is that these children fall outside the jurisdiction of both the Commission for Children and Young People and the Children Services Tribunal.

Voluntary placements are regulated by Department of Families policies. The two main policies are:

- Placement of Children and Young People with Parental Consent (policy no. 345-1)
- Intensive Family Support with the Consent of Family (policy no. 343-1).

Both of these policies were implemented only at the beginning of August 2003.

According to the first of these policies, the 'consent policy', a voluntary placement should only be arranged by the department if the following criteria are satisfied:

- the placement is necessary to meet the child's protective needs
- the parents are identified as responsible for the harm to the child and acknowledge their role in this harm
- the parents are assessed as able and willing to cooperate in meeting the child's protective needs by consenting to the placement and agreeing to intervention by the department
- there are no high-risk factors associated with the parents' ability to cooperate or adhere to the planned intervention
- the termination of the placement by a parent would not immediately endanger the child.

The consent policy says that voluntary placements are ideally made with extended family members or other people known to the child. However, according to a spokesperson in the department (Acting Manager of the Alternative Care Unit 2003, personal communication, 28 November) most children who are placed in out-of-home care on a voluntary basis are in fact placed with an approved foster carer because of time delays in the approval process for relative and limited approval carers. According to the consent policy, a voluntary placement with an approved foster carer or a licensed care service cannot exceed 28 days, but it is possible for extensions to be granted.

If a child is placed with a relative or friend, the child's parents are expected to continue to pay for their upkeep. The department will not pay an allowance to a relative or friend unless there are special circumstances. Even then, the allowance is paid only for 28 days; however, it is possible for extensions to be granted. According to the consent policy, the department does not formally assess and approve relatives and friends unless it is paying them an allowance.

Figures provided by the department indicate that the number of applications for approval to extend the placement of a child with an approved foster carer, or to pay an allowance to a relative or limited approval carer, is small.[20]

According to the consent policy, a child who is placed on a voluntary basis with an unpaid (and thus unapproved) relative or friend may continue 'for as long as negotiated between the parents and the person providing care'. Departmental officers explained that the consent policy is intended to be interpreted subject to the second policy, the Policy on Intensive Family Support with the Consent of Family (the 'intensive family support policy'), which places a three-month time limit on the use of informal interventions. This second policy applies where a child protection notification has been substantiated, but the department has decided to address the child's

protective needs by providing intensive support to the child's family rather than by obtaining a child protection order. A child who is the subject of an intensive family support response may or may not be placed in out-of-home care on a voluntary basis. According to the policy, an intensive family support case can only remain an open case for a maximum of three months. If, after this period, a child's family cannot meet the child's protective needs without ongoing intervention by the department, an authorised officer of the department must apply for a child protection order.

Placements under a court order or other provision of the Act

As described earlier in this chapter, a child can be placed in out-of-home care if the director-general has custody or guardianship of the child:

- under an assessment or child protection order, or
- under other sections of the Act, such as sections 18 and 21.

Responsibility for placing a child in out-of-home care

Out-of-home placements are organised by the Department of Families directly, or through a shared family care agency on behalf of the department. Placements for children with complex psychological and behavioural problems may also be organised through one of the agencies listed on the department's register of preferred providers of placement and support for children with complex needs.

Children may be placed in a wide range of out-of-home care settings, including:

- with an approved foster carer
- with a relative carer
- with a limited approval carer
- in a residential facility
- in a supervised small group home
- in a setting that includes therapeutic treatment (for children with complex psychological and behavioural problems)
- on an independent basis with support.

In some cases, they are placed on a temporary basis in youth shelters, motels or caravan parks until a more appropriate placement can be found.

DEPARTMENT OF FAMILIES: ORGANISATIONAL STRUCTURE AND RESOURCES

Organisational structure

Central office

The Department of Families has a central office comprising the following major work groups:

- Office of the Director-General
- Review and Evaluation Branch
- Internal Audit Services Branch
- Non-Government Services Directorate
- Operations Directorate
- Policy Directorate
- Corporate and Executive Services Directorate.

These work groups focus on policy and departmental administration; they coordinate and apply the legislation for which the department is responsible.

According to information provided by the department, central office has a total of 465.4 full-time equivalent (FTE) staff. Of these an estimated 202 staff provide support for child protection services. The central office component is 21.9 per cent of the

department's total staff, and includes approximately 96 people allocated to Statewide Services, which provides services directly to regional clients (such as the after-hours emergency telephone line). Additionally, the Child Protection Branch, contained within the Policy Directorate, is responsible for the development of policy and direction in relation to the application of the *Child Protection Act 1999* and the regulations.

The Child Protection Branch, Policy Directorate has 36.1 FTE staff, compared with 43.2 located in the Child Care and Seniors Interests Branch, and 24.4 in the Youth and Individual Support Branch.

The organisational structure of the department is outlined in Figure 1.1.

Regional offices

Eleven regional directors report to the deputy director-general, and coordinate the activities of area offices in their region. They provide advice and professional support, disseminate information to and from head office, coordinate regional services, and allocate and oversee area budgets and resources. Regional offices are located throughout Queensland and vary considerably in size, usually being co-located with an area office. There is considerable variation in the size and responsibilities of regional offices, as a result of which Regional Director positions are graded from SO2 (e.g. Mackay) to SES2 (e.g. Brisbane). The structure of a sample regional office is outlined in Figure 1.2.

Area offices

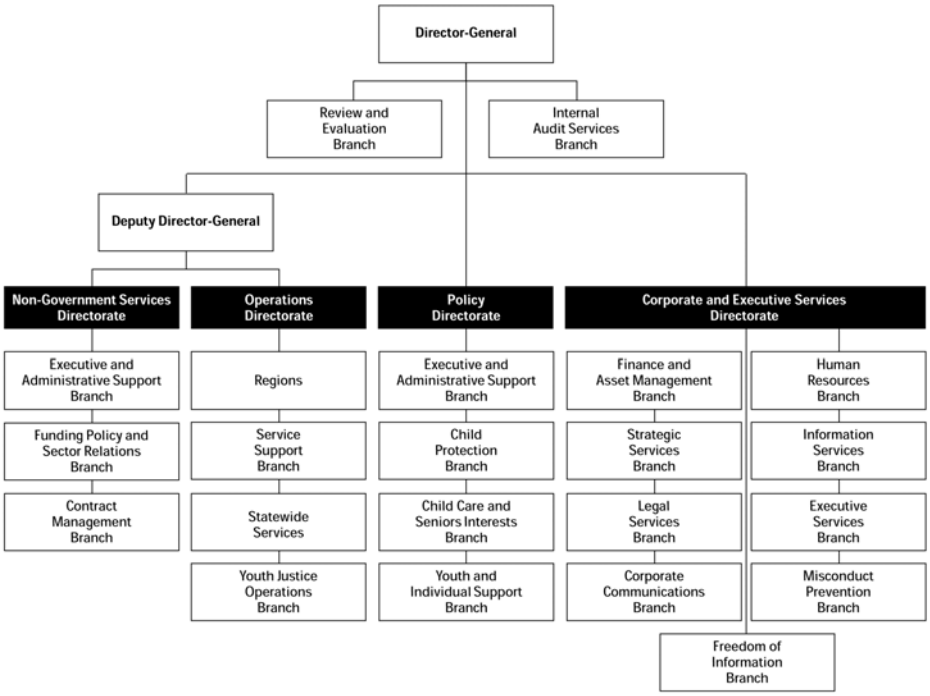
The Department of Families has 39 area offices located across the state. These offices deliver frontline departmental services in youth justice, child care, homelessness and individual support, family youth and community support, seniors' interests, child protection, and domestic violence prevention. In some areas — depending on the characteristics of the community being served — there may be a separate area office for youth justice or other programs. Further differences between area offices arise when internal work teams are customised to meet the service needs of the local population; for example the regional office may centralise or otherwise adjust practices for certain activities, or the area manager may institute specific or unique practices within the office. This variation between area offices makes it difficult to describe a typical area office structure; however, Figure 1.3 shows an example. Area Manager positions are graded AO6 or AO7.

Staff resources

As at 7 September 2003 the department had a total of 2129.3 FTE staff, 1663.9 (78.1%) of whom were allocated to regional and area offices. These figures do not include the staffing increases announced by the minister on 19 August 2003 and 7 September 2003, regarding the appointment of an additional 25 SCAN coordinators, five quality assurance officers, nine senior practitioners and 40 frontline child protection workers. The majority of these additional staff will be appointed to the regions and area offices, although all five quality assurance officers and three senior practitioners will be located in Brisbane, with quality assurance officers undertaking extensive travel across the state. A number of these additional staff will not take up their positions until early 2004.

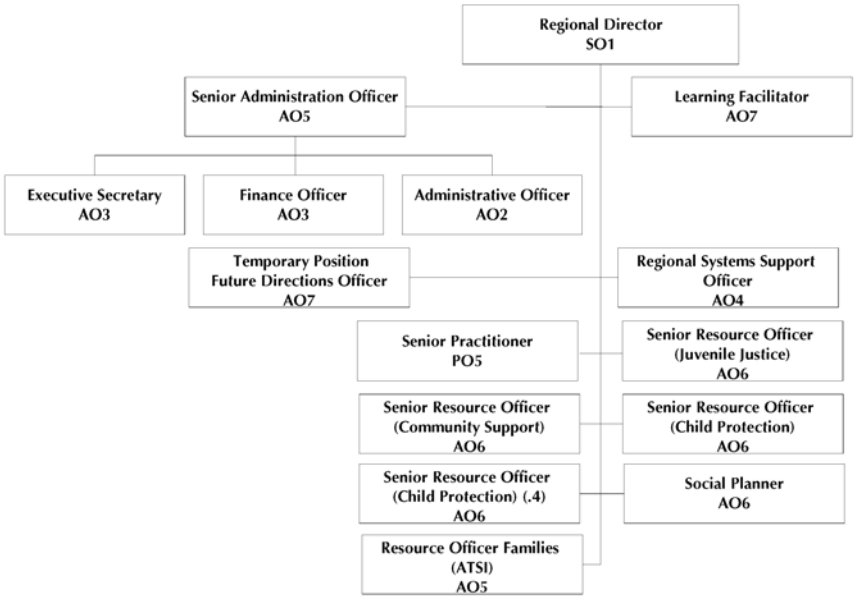
The exact number of regional and area staff dedicated to child protection work proved difficult to ascertain, as many family services officers (FSOs) perform this task while undertaking concurrent duties that could include, for example, working with the homeless or non-government agencies. The calculation of the number of FTEs performing child protection tasks was conducted using the department's draft *Resource allocation methodology project final report* (Department of Families 2003d). This report refers to the department's FTE Survey (May 2003) which indicated there were 383.84 FSOs in the regions/areas providing child protection services. The accuracy of the survey number is uncertain; but if it is correct, and should all 40 of the recently announced positions be filled, this number should rise to 423.84 FSOs in early 2004.

Figure 1.1. Organisational structure



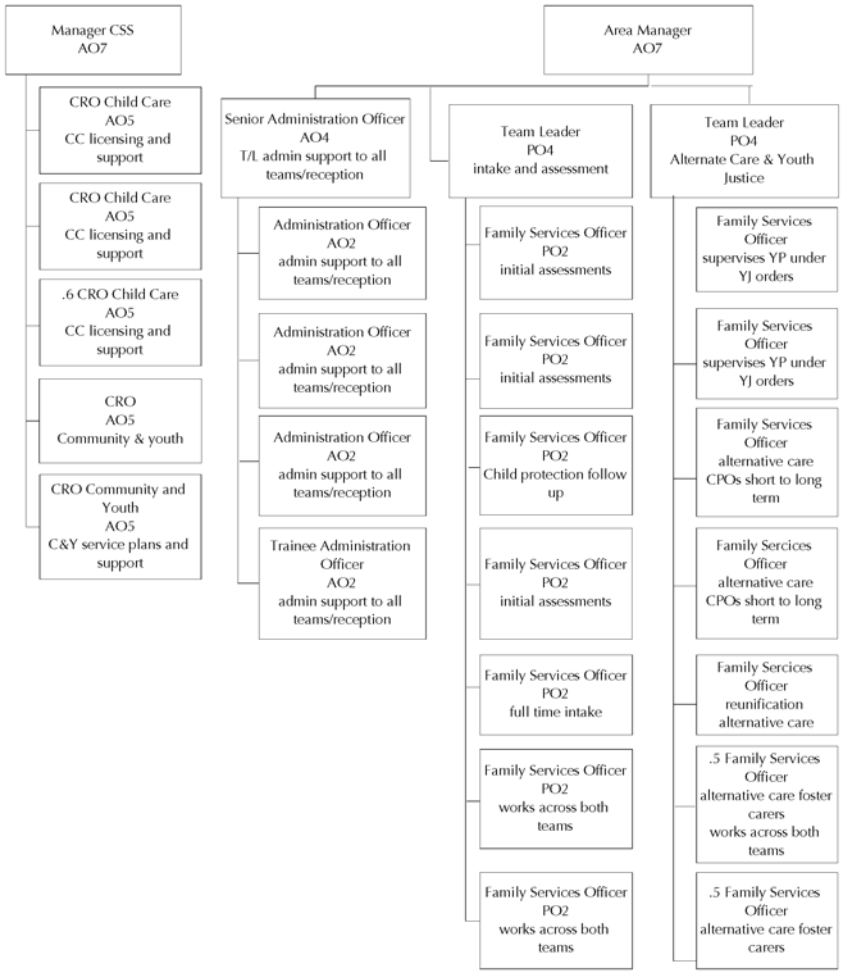
Source: Department of Families (2003c, p. 12).

Figure 1.2. Example of a regional office structure (Central Queensland)



Source: Department of Families, 9 September 2003

Figure 1.3. Example of an area office structure: Caboolture



Source: Department of Families, 9 September 2003

The exact number of regional and area staff dedicated to child protection work proved difficult to ascertain, as many family services officers (FSOs) perform this task while undertaking concurrent duties that could include, for example, working with the homeless or non-government agencies. The calculation of the number of FTEs performing child protection tasks was conducted using the department's draft *Resource allocation methodology project final report* (Department of Families 2003d). This report refers to the department's FTE Survey (May 2003) which indicated there were 383.84 FSOs in the regions/areas providing child protection services. The accuracy of the survey number is uncertain; but if it is correct, and should all 40 of the recently announced positions be filled, this number should rise to 423.84 FSOs in early 2004.

An alternative breakdown of the make-up of the child protection component of the department can be obtained by considering a 'head count' (rather than an FTE count) of child protection staff. As can be seen in Table 1.1, in March 2003 there were about 1121 child protection staff. It is instructive to note that, of these 1121 staff, little more than half are direct service delivery staff, and about 540 are engaged in management and administration functions (including a small number of staff involved in unspecified 'specialist' functions of some sort). This issue of organisational structure is returned to in more detail in Chapter 5.

Profile of family services officers (FSOs)

Data from the department presented to the Inquiry revealed that nearly 70 per cent of staff have less than three years' experience, and 82.6 per cent of women

Table 1.1 Department of Families child protection staff at March 2003

Current workforce area	Current Department of Families child protection staff
Area offices	
[a]Area office child protection staff	
Team leader	71
Family services officers	384
Subtotal of team leaders and FSOs	**455**
Support workers	65
Youth workers	7
Subtotal of area office staff	**527[1]**
[a] Area office management and administration	119[2]
Regional offices	
[b]Regional staff (management and specialist)	220[3]
[c]*Statewide services*	
Subtotal of statewide services staff	53[4]
Central office	
[c]Policy Directorate	54[5]
[c]Corporate and Executive Services	113[6]
[c]Non-Government Service Delivery	7[7]
[c]Operations	7[8]
[c]Review and Evaluation Branch	12[9]
[c]Quality Assurance Branch	9[10]
Subtotal of central office staff	202
GRAND TOTAL	**1121**

Source: Department of Families, 3 December 2003.

Notes:

[a] Based on Staff Allocation Methodology Project, final report of projected placements for 2003–04.
[b] Derived from a and c.
[c] Based on staff count at 31 March 2003 (rounded).
[1] Of a total of 800 service delivery staff, 527 provide child protection services and 273 provide juvenile justice services.
[2] Of a total of 181 area office management and administration staff, 66 per cent (119 staff) provide support for child protection services.
[3] Of a total of 334 regional management and specialist staff, 66 per cent (220 staff) provide support for child protection services.
[4] Of a total of 96 statewide services staff, 53 staff provide support for child protection services. The remaining 43 staff other services.
[5] Of a total of 133 staff in the Policy Directorate, 54 staff provide support for child protection services.
[6] According to the department, there are 171 staff in Corporate and Executive Services, of whom 66 per cent (113 staff) provide support for child protection services.
[7] Of a total of 29 staff in Non-Government Service Delivery, 23 per cent (7 staff) provide support for child protection services.
[8] According to the department, there are 17 staff in Operations, of whom 23 per cent (7 staff) provide child protection services.
[9] Of a total of 19 staff in the Review and Evaluation Branch, 67 per cent (12 staff) provide support for child protection services.
[10] All 9 staff in the Quality Assurance Branch provide support for child protection services.

The department also provided the following caveats to the data provided above:

- These are 'head count' (rather than FTE) data.
- The information provided is notional. This data have not previously been presented in this format, so the figures should not be compared to other collations.
- Staff counts are effective at that time only, and vary weekly.
- Child Protection Branch figures, within the Policy Directorate, include 16 on CPIS and 9 project workers at that time (elsewhere after June 2003).
- The data do not include staff at the Corporate Services Centre. (These are shared services.) In the directorates whose core business is not child protection, the proportion will vary according to priorities.
- Child protection is also a significant issue in other areas that are not included in the count such as domestic violence, homelessness, youth detention and youth justice centres.
- The regional totals do not include Community Services Support staff or new child protection service delivery staff who commenced under Future Directions (31 foster relative care support workers, 15 family service officers (regional relief), 9 reconnect workers, 15 family and community workers (prevention and early intervention).

important social policy legislation. The following graphs (Figures 1.4–1.6) show staffing by age, gender and tenure and depict the majority of FSOs as female and of less than three years' tenure. About one-quarter are under 26 years of age.

The apparently high turnover of child protection staff suggests that employees of limited experience are obtaining supervisory and management positions. At least one area manager interviewed by the CMC was the senior officer at her workplace after a week of service, and held an acting supervisor's position within months. A closer examination of staff turnover at the area office level suggests that turnover does not necessarily occur because of attrition; it may occur because staff are acting out of their role in temporary positions resulting, for example, from the absence of the team leader or their engagement in a trial project. Further analysis suggests that area office staff most heavily engaged in the notifications process have the highest turnover, as well as the least on-the-job experience, when compared with staff in family support and casework roles.

Example:

The Stones Corner area office has five staff in its Intake and Assessment Team, which contains two part-timers each with more than 15 years' experience. All other staff in the team (including the team leader) have between six months and three years experience. In contrast, the Child and Families Team has nine full-time staff with a third of the positions filled by officers having over 15 years' experience each. Other team members have considerable service and the team has been relatively stable for some years. (CMC interview with Department of Families employee, 19 September 2003)

Financial resources

The Department's Ministerial Portfolio Statement 2003–2004 (Queensland Government 2003a) shows that the estimated actual total expenses from ordinary activities excluding borrowing costs were $404.015 million in 2002–03, and in 2003–04 this figure was $408.631 million. Of this, $196.678 million is for grants and subsidies supporting community groups and community projects (see Figure 1.7).

Tables 1.2 to 1.5 (on pages 32 and 33) are extracts from the department's Ministerial Portfolio Statement 2003–04, detailing how its outputs are structured, and its financial summary.

Funding reported by the department to be specific to foster care and the meeting of child-related costs is shown in Table 1.6 (page 33). It shows a significant growth in expenditure since 1992.

In 2002–03 a total of $26 381 million was spent on foster care, $711 000 on foster care crisis services, $18 693 million on child-related costs, and over $42 million on grants to community agencies.

Table 1.6 shows that funding for all of these, except foster care crisis services, increased between 1992–93 and 2002–03.

Figure 1.4. FSOs by age (2000–03)

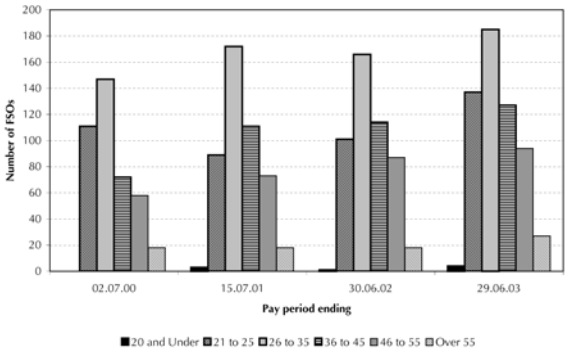


Figure 1.5. FSOs by gender

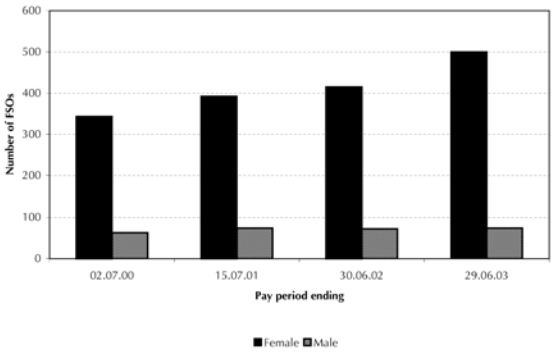
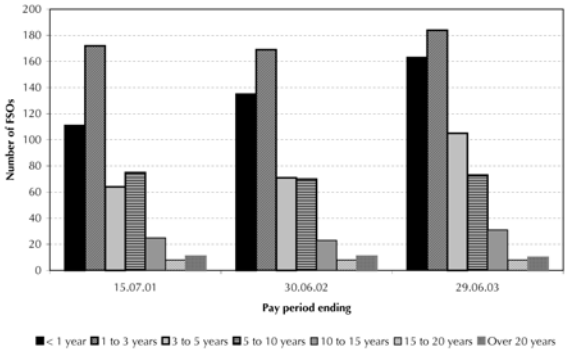


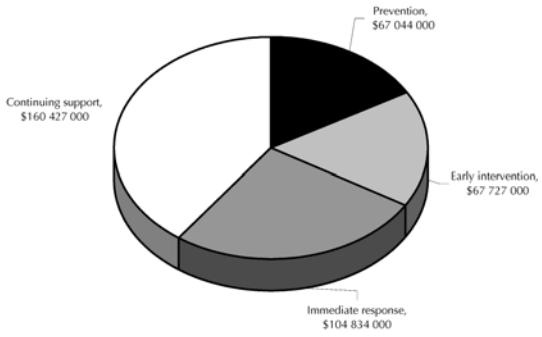
Figure 1.6. FSOs by tenure



Source: Information Services Branch, Department of Families, September 2003.

Note: Tenure data are from the date of commencement in the public service, not from commencement in the role the officer currently holds. However, HR Branch advises it is reasonable to assume that, for FSOs, commencement in the public service is commensurate with their commencement as an FSO. These data cannot identify whether there has been a break in an officer's period of service.

Figure 1.7. Department of Families expenditure on services 2003–04



Source: Queensland Government (2003a).

Table 1.2. Output linkages with government priorities

Output name	Government outcome/ strategic governance	Government priority
Prevention services	A fair, socially cohesive and culturally vibrant society	Community engagement and a better quality of life
Early intervention services	Safe and secure communities	Safer and more supportive communities
Immediate response services	Safe and secure communities	Safer and more supportive communities
Continuing support services	Safe and secure communities	Safer and more supportive communities

Table 1.3. Financial summary

	2002–03 Budget $'000	2002–03 Est. Act. $'000	2003–04 Estimate $'000
CONTROLLED			
Revenue			
Output revenue	350 245	352 123	360 047
Own source revenue	44 985	51 892	48 584
Total revenue	395 230	404 015	408 631
Total expenses	395 230	404 015	408 631
Operating result	…	…	…
Net assets	137 190	137 733	141 267
ADMINISTERED			
Revenue			
Administered item revenue	122 780	121 609	128 570
Other administered revenue	541	486	488
Total revenue	**123 321**	**122 095**	**129 058**
Expenses			
Transfers of administered revenue to government	541	486	488
Administered expenses	122 780	121 609	128 570
Total expenses	**123 321**	**122 095**	**129 128**

Table 1.4. Staffing[1]

Output/activity	Notes	2002–03 Est. Actual	2003–04 Estimate
Prevention Services	4	250	250
Early Intervention Services	4	358	358
Immediate Response Services	4	542	542
Continuing Support Services	4	1 072	1 072
Total outputs		**2 222**	**2 222**
Corporate services provided to other agencies	53	53	
Total	**1, 2, 3**	**2 275**	**2 275**

Notes:

1 The estimated actual for 2002–03 is based on a point-in-time FTE staff count effective as at 20 April 2003.

2 The point-in-time FTE count is obtained in accordance with the minimum obligatory human resources information (MOHRI) standards used across the Queensland public sector. However, the count excludes external non-staff people such as representatives on committees and staff who are on long-service leave.

3 Point-in-time FTE counts vary from fortnight to fortnight as new staff are employed (on a permanent, temporary or casual basis), existing staff take leave and are temporarily replaced, staff return from leave, and staff resign or retire.

4 Corporate FTEs are allocated across the outputs to which they relate.

Table 1.5. 2003–04 output summary

Output		Total cost $'000	Sources of revenue			
			Output revenue $'000	User charges $'000	Cwlth revenue $'000	Other revenue $'000
Prevention Services		67 044	65 038	221	496	1 289
Early Intervention Services	67 727	63 606	226	1 942	1 953	
Immediate Response Services	104 834	75 765	352	25 798	2 919	
Continuing Support Services	160 427	155 638	1 948	…	2 841	
Total		**400 032**	**360 047**	**2 747**	**28 236**	**9 002**

Notes:

1 Explanations of variances are provided in the financial statements and output statements of financial performance.

2 The total revenue sources do not equal the operating revenue in Table 1.3 because the department provides corporate services to the Department of Aboriginal and Torres Strait Islander Policy and Disability Services Queensland.

3 Corporate services provided to other departments are excluded from the 2003–04 output summary because they are unrelated to outputs produced.

Table 1.6. Cost of foster care and child-related costs from 1992–93 to 2002–03

	Subsidies personal benefits $'000	Foster care (1) $'000	Foster care crisis (2) $'000	Child-related costs (3) $'000	Grants to community organisations (4) $'000	Total $'000
1992–1993		7 304		1 534	10 879	19 717
1993–1994	9 610				13 233	22 843
1994–1995	11 043				14 787	25 830
1995–1996	11 733				15 390	27 123
1996–1997	17 044				17 839	34 883
1997–1998	19 213		460		21 730	41 403
1998–1999	19 443		444		26 746	46 633
1999–2000		15 569	510	5 335	29 132	50 546
2000–2001		18 417	586	7 222	33 374	59 599
2000–2002		19 433	750	13 807	34 526	68 516
2002–2003		26 381	711	18 693	42 398	88 183

Source: Annual Reports from 1993–94 to 2002–03.

Notes:

1 Foster carer includes high support needs but excludes emergency placements.

2 Foster care crisis refers to emergency placements expenses.

3 Child-related costs includes all other direct expenses.

4 Grants to community organisations includes payments made to non-government organisations.

Funding for non-government organisations

The department distributes grants in the following nine areas (Department of Families 2003c, Appendix 4):

- child care
- child protection and family support
- community support services
- domestic and family violence prevention
- future directions
- homelessness
- older people
- youth development and youth justice
- contributions and sponsorships.

In 2002–03 total funds of $142.57 million were allocated to these areas and used to support 1030 organisations and 1717 services. The department reports that 13 per cent of these allocations were devoted to supporting services for Indigenous people. Between 54 per cent (Caboolture and Redcliffe Peninsula) and 73 per cent (Brisbane City) of a region's budget is allocated to funding non-government organisations (Department of Families 2003c, Appendix 4).

Table 1.7 shows the allocation of funding by the department to community organisations providing child protection and family support services since 1992–93. The table shows that the department dedicated $35.25 million in services to child protection and family support in 2002–03. The grants report for 2002–03 (Department of Families 2003c) shows that these funds supported over 240 services or organisations; seven of these received over half a million dollars, and one received over $2.16 million.

Table 1.7. Grants to community organisations

	Intervention & placement Services & RAPT & Refugees & CWIDIC 98–99	Child abuse prevention	Emer. 24 hour care operating & subsidy	Family & indiv. support later community & indiv. support (not added)	Estimated family-support component only based on 17% of FISP/CISP (this is added)	Family care & support Family-support Family Support Worker	Rural family support	Child protect & family support New Key Funding Area	Future Directions	TOTAL
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
1992–1993	8 813	158	316	6 894	1 172		420			10 879
1993–1994	10 623	210	279	8 166	1 388		733			13 233
1994–1995	10 890	318	232	8480	1 442		1 905			14 787
1995–1996	11 912	395		9 480	1 612		1 471			15 390
1996–1997	13 189	463	82	10 005	1 701	1 232	1 172			17 839
1997–1998	16 000	615	62	9 375		3 864	1 189			21 730
1998–1999	20 033	780	51	11 083		4 580	1 302			26 746
1999–2000								29 132		29 132
2000–2001								33 374		33 374
2000–2002								34 526		34 526
2002–2003								35 247	7 151	42 398

Source: Department of Families annual reports from 1992–93 to 2002–03. All amounts shown, except column headed 'estimated family support' are published figures.

Key: RAPT Receiving, assessment, placement & therapy
CWDIC Children with disabilities in care
FISP Family and individual support
CISP Community and individual support.

The Inquiry received one submission suggesting that the sizeable disbursements being made to community organisations could have future consequences if, at some point, the grants were reduced. Any reduction in funding, or cessation, could also have significant implications for local communities through decreases in employment opportunities and consequently in support for the immediate community and its businesses.

FOSTER CARE IN QUEENSLAND

An approved foster carer is a person to whom the Department of Families has issued a certificate of approval as an approved foster carer (*Child Protection Act 1999,* Schedule 3, s. 3).

The Child Protection Act allows the department to place children with approved foster carers or an 'other person the chief executive considers appropriate' (s. 82). This definition includes people classified by the department as 'relative carers' and 'limited approval carers', which are categories created by departmental policy. The department defines a relative carer as a person related to a child or young person, or a member of a child or young person's community, and considered as family or a close friend (policy no. 293-1, The Assessment and Approval of Relative Carers).

The department defines a limited approval carer as a person who has not been fully assessed or trained but is approved to care for a particular child or young person, for a specific purpose, for a defined period of time (policy no. 293-2, The Assessment and Approval of Limited Approval Carers).

As at June 2003 there were 1485 approved single or dual foster carer families in Queensland (data provided to the CMC November 2003). Of these individuals 133 were male and 1352 were female; 107 foster carers identified as Indigenous. Of these approved foster families, 869 had child placements. Additionally 317 children were placed with 183 limited approval carers, and 1094 children were placed with 615 relative carers.

There has been some variance in the number of approved foster care families in the last 10 years. From a low of 1140 in 1996, the number of approved foster care families has increased every year but has yet to reach the peak of 1612 approved foster care families that were available in 1995. A more marked increase is noticeable in the percentage of approved foster care families with whom children were placed — from just one-third in 1993 to a little under 60 per cent in 2003 (see Table 1.8 and Figure 1.8). It is not apparent why there are consistently so many approved foster care families that do not have children placed with them. The actual number of children placed with approved foster care families more than doubled in the last 10 years — from 1071 in 1993 to 2568 in 2003. With the rate of children being placed with approved foster care families increasing at a greater rate than the number of approved foster carers entering the system, the average number of children placed with an approved foster care family is up from 2.05 children in 1993 to 2.96 children in 2003.

As at June 2003, over 70 per cent of the 1667 individual or dual foster, relative or limited approval carers had only one or two children placed with them (see Table 1.9).

Foster carers are paid between $151.84 and $293.24 per child per fortnight, depending on the age of the child; they are also paid an incidental allowance of $35 per fortnight and $50 for each new placement lasting more than five nights. The department has the discretion to pay an additional allowance of $60 per fortnight to carers who care for children with extraordinary health, behavioural or other needs. Additional financial assistance is also available for certain travel, health and other costs. Base payments made per child are:

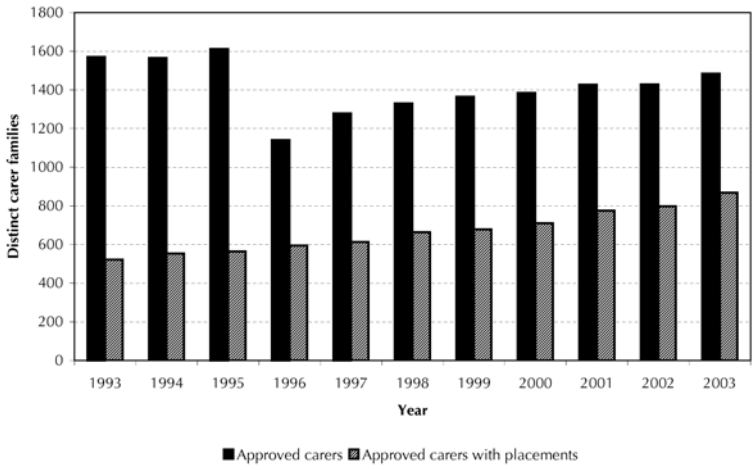
- up to 1 year — $151.84 per fortnight
- 2–5 years — $185.12 per fortnight
- 6–10 years — $228.80 per fortnight
- 11–15 years — $293.24 per fortnight
- 16 and over — $273.39 per fortnight.

Table 1.8. Proportion of approved foster carer families with placements, and children per family

	Total foster care families	Foster care families with placements	Proportion of foster families with placements (%)	Number of children with foster care families	Children per foster care family
1993	1 571	522	33	1 071	2.05
1994	1 565	554	35	1 200	2.17
1995	1 612	565	35	1 215	2.15
1996	1 140	596	52	1 344	2.26
1997	1 278	613	48	1 490	2.43
1998	1 330	664	50	1 529	2.30
1999	1 365	678	50	1 691	2.49
2000	1 385	710	51	1 791	2.52
2001	1 427	776	54	2 062	2.66
2002	1 429	798	56	2 226	2.79
2003	1 485	869	59	2 568	2.96

Source: Annual Reports from 1993–94 to 2002–03.

Figure 1.8. Approved foster care families, and those with placements



Source: Annual Reports from 1993–94 to 2002–03.

Table 1.9. Number of families and number of children placed at 30 June 2003

Number of children	1	2	3	4	5	6	7	8	9	10	11	12
Number of carers	779	424	214	117	62	41	18	7	3	–	1	1

Source: Department of Families (2003c).

Allowances and financial support for carers are provided on the basis that carers are volunteers and reimbursements are a contribution towards the direct costs associated with providing care for children and young people (CMC 2003).

At present, the care allowance does not increase in line with inflation. However, assuming care allowances were increased by 1.9 per cent a year,[21] the total payments that would be made for a child taken into care at 0 years of age in 2003 until the child turned 18 years of age would be $101 287.07. This amount does not include incidental and other payments.

In 2000 the Queensland Supreme Court calculated the cost of raising a child in Brisbane in the case of *Melchior & anor v. Cattanach & anor* [2000] QSC 285. In awarding the Melchiors $105 249.33 for the cost of raising their son, Justice Holmes said:

> An extraordinarily detailed schedule was prepared by Mr Melchior, setting out the anticipated costs of raising Jordan until he completes secondary school. There was scope for argument as to some of its contents; there was for example an assumption that GST would be imposed on food which, one is assured, will not be the case. One would also rather hope that Jordan will not necessarily have to watch the one video per week for which Mr Melchior has budgeted until he reaches the age of eighteen. On the whole, however, the schedule is a reasonable representation of the costs of raising a child.

Commenting on the subsequent decision by the High Court to uphold the judgment, Dr Paul Henman of Macquarie University, who has done some research into the cost of raising children in Australia, commented that his research had found the cost of raising a first child from birth to 18 years for a Brisbane couple who both worked would amount to around $205 600 (Henman 2003).

It can be assumed that there would be economies in caring for more than one child over time. Various different methods have been used to calculate how much children actually cost, and the cost is in part a function of the method used to estimate it (Harding & Percival 1999). An analysis of different methods used to calculate the cost of children has found that:

> the cost of a child is not an objective fact but varies according to tastes and preferences and according to the amount of money that parents have to spend on their children (McDonald 1990).

The 2002 report *The costs of caring*, commissioned by the Child and Family Welfare Association of Australia and the Association of Children's Welfare Agencies, concluded that the level of allowance paid to foster carers in Queensland and other states was substantially below the costs required to meet the basic needs of children. This conclusion was based on the study's finding that the costs of children in care were on average 52 per cent higher than the costs of children not in care.

If a child in need of protection is placed outside their home with the consent of the parents and the placement occurs within the child's family or community network, the parents remain financially responsible for the child's care and are required to make private financial arrangements with the carers. In circumstances where the people providing the placement cannot do so without financial assistance and the parents are unwilling or unable to provide financial assistance, an area office manager may approve the payment of foster allowances to the carers (Department of Families policy no. 345-1, The Placement of Children and Young People with Parental Consent).

Policy no. 345-1 indicates that carers who take a child with the consent of the child's parents are only assessed for suitability if they are to be paid an allowance. There is no statistical information on how many children are the subject of informal arrangements where they are placed with a family associate who is not an approved carer. However, at 30 June 2003 there were 162 children placed with approved relative carers who were not receiving any allowance for caring for these children.

The children in Queensland's care

In Queensland in 2002–03, there were 31 068 notified cases of child abuse and neglect; of the 3966 children under child protection orders, 3642 were granted custody or guardianship to the Director-General of the Department of Families (CMC 2003).

The Inquiry sought information from the department about the children in care. Not all of the information requested was available, and the inability to provide that information is discussed elsewhere in this report. However, some information was provided and appears below. (A full account of this material is provided in Appendix C of this report.)

- Between 1993 and 1999 there were considerably more male than female children in care (56% and 44% respectively), but in recent years the gap has closed; there are now only slightly more males than females in care.
- Compared to the other regions, the Ipswich and Logan Region has the most children in care: an average of 680 children per year. Brisbane City Region is next, with an average of 538 children per year.
- The overall number of Indigenous children in care as at 30 June each year has remained relatively stable since 1992–93 at just under 1000 children per year, while the number of non-Indigenous children has increased by 67 per cent during the same period.
- Around 45 per cent of children ceasing care each year have spent between one and six months in continuous out-of-home care. A smaller proportion (between 10% and 15%) had spent five years or more in care.
- In the last two years there has been a significantly higher proportion of children leaving the system after only one month in continuous out-of-home care. In 2000–01, for example, fewer than 500 children spent less than a month in care, but that number rose to more than 1300 in 2001–02 (an increase of 170 per cent).
- Most children leaving the system seem to be aged six years or older; in 2002–03, for example, 61 per cent of children fell into this category. In recent years about 8–10 per cent of children have ceased care when less than one year old.
- The number of notifications about children in care increased considerably between 1992–93 and 2002–03, from 61 to 605 respectively. In 2002–03 about 75 per cent of the notifications investigated were substantiated and 24 per cent of the substantiated notifications were against carers.
- Male children were more likely to be victims of physical abuse and neglect while in care, whereas female children were much more likely to be victims of sexual abuse while in care.

THIS CHAPTER IN CONTEXT

The purpose of this chapter has been to provide a detailed profile of the child protection system in Queensland and the statutory framework within which that system operates. The focus sharpens in the chapters that follow, which consider in more operational terms how the child protection system gives effect to its responsibilities in terms of actual policies and practices.

In Chapter 2 the department's responses to children at risk of harm are scrutinised, through a number of investigations that highlight substantial and significant practice failures.

Endnotes

1 In some cases, a family meeting may also be attended by the child or other family members and, if the child is an Indigenous child, by a recognised Indigenous agency. Note that the requirement to convene a family meeting is not confined to those cases where the department decides to apply for a child protection order. Section 96 requires a family meeting to be held in all cases where the director-general is satisfied that a child is in need of protection and that 'action' should be taken to ensure the child's protection.

2 During the year ended 30 June 2003, 95 per cent of all guardianship and custody orders were made in favour of the director-general. Note that this percentage is slightly lower than in the two previous years: 96 per cent in 2002 and 98 per cent in 2001 (Department of Families 2003c, p. 79).

3 The CMC understands that there are no agencies currently operating in Queensland that provide care only to children who are the subject of a voluntary placement.

4 Department of Families, Response to CMC request about the licensing of care services under the *Child Protection Act 1999*, November 2003, p. 2.

5 Ibid., p. 1.

6 Ibid.

7 Ibid.

8 Before 21 November 2003 (when amendments to the Act made by the *Child Protection (International Measures) Act 2003* came into operation), the director-general had only to be satisfied about the suitability of the people responsible for directly managing the service.

9 The nominee is responsible for ensuring that the standard of care provided by the service complies with the statement of standards set out in s. 122, and that all people who work for the service (including on a voluntary basis) are suitable.

10 Under s. 126 the director-general must not grant the application unless satisfied, among other things, that methods for the selection, training and management of people engaged in providing the services are suitable.

11 The definition of a person who is suitable to be a director of an applicant for a licence or a director of a licensee is very similar (see s. 9[4] of the Child Protection Regulation).

12 Note that this definition also applies to a person who applies for a certificate of approval as an approved foster carer (s. 9[9] of the Child Protection Regulation).

13 Before 21 November 2003 (when amendments to the Act made by the Child Protection (International Measures) Act came into operation), the director-general could only carry out background checks on the person responsible for directly managing the service and on anyone directly engaged in the care of children for the service.

14 This final ground for suspension or cancellation of a licence was added to the Act as recently as 21 November 2003.

15 The definition of 'a person who is a suitable person for having the daily care of a child' applies to a person who applies for a certificate of approval as an approved foster carer. This definition is given within the section 'Current legislative framework' in this chapter.

16 This final ground for suspension or cancellation of a foster carer's approval was added to the Act as recently as 21 November 2003.

17 For example, policy no. 345-1, Placement of Children and Young People with Parental Consent, August 2003; and policy no. 343-1, Intensive Family Support with the Consent of Family, August 2003.

18 Department of Families, Ministerial Portfolio Statement 2003–04 State Budget (Queensland Government 2003a).

19 A court assessment order granting temporary custody of a child to the director-general can only be made if the consent of the child's parents could not be obtained (s. 38).

20 For the period 21 August 2003 to 28 November 2003, there were only 45 applications. Eight of these applications involved an application for a third or fourth extension. There are no figures available for any period before 21 August 2003, but the department's estimate is 150 applications per month (Acting Manager of the Alternative Care Unit, personal communication 2003, 28 November).

21 The all groups consumer price index (CPI) recorded an average annual rate of growth between 1991–92 and 1999–2000 of about 1.9% (Australian Bureau of Statistics 2003, *Measuring Australia's Economy. Section 6. Prices and Income. Consumer Price Index.* edition 7).

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THE INVESTIGATIONS

This chapter considers a number of investigations into circumstances where there were adverse outcomes for children in care and the response by the Department of Families to these matters. The chapter begins by considering in detail the case that triggered the CMC Inquiry, namely the alleged abuse of children occurring within one particular foster family over a period of many years (referred to in this report as 'family X'). This is followed by a brief consideration of new investigations into another foster care family ('family Y'), initiated at least partly as a result of the investigation of family X.

The chapter also contains a summary of the findings of the recent investigations carried out by the Queensland Ombudsman into two child deaths: Brooke Brennan and Baby Kate. The independent audit of departmental files commissioned by the Department of Families is then considered, and the chapter concludes by identifying systemic failures within the department.

CMC INVESTIGATION: OPERATION ZELLOW

Background

The CMC's Operation Zellow investigated the circumstances surrounding the placement of children with a foster care family (family X) and alleged failures by the Department of Families to act upon notifications of abuse of those children. The CMC investigation sought to determine whether there was sufficient evidence to support criminal charges or disciplinary action, including for official misconduct or police misconduct, against any person. The investigation considered two specific allegations:

1 that departmental officers failed in their duty to protect children placed in the care of family X

2 that successive ministers and directors-general failed to act appropriately to protect children placed in the care of family X.

In addition, the investigation sought to obtain a clear picture of the child protection system in Queensland.

After extensive media publicity about family X, the Department of Families commissioned an independent external review of the circumstances of this family and the actions of departmental officers. The CMC worked closely with this independent review team in order to expedite the investigative process and avoid any unnecessary duplication of effort.

In its initial work, the review team identified six 'flashpoints' in the history of family X; a further three were identified during the course of Operation Zellow and the media coverage. 'Flashpoints' were defined as incidents where issues came to light that:

- should have generated concern on the part of relevant departmental officers or other relevant people about the welfare of the children placed with family X
- required addressing and appeared, on the information available to the review team and the CMC, not to have been satisfactorily addressed.

The department also engaged the services of Ms Gwenn Murray to conduct an independent external audit of notifications of harm in respect of current foster carers. The CMC kept in close contact with Ms Murray, who provided much valuable

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assistance to the investigation. (See Appendix D for the recommendations of her audit, published December 2003.)

Methodology

Operation Zellow involved a number of concurrent lines of inquiry.

The investigating CMC officers had access to all original files relating to family X and the children fostered by them, and were assisted by the independent review team in identifying all relevant additional documentation. The department's Child Protection Information System (CPIS) was also drawn upon where necessary. The CPIS is a case-management system, individual to each area office, and is not statewide. The department acknowledges that the system is a cumbersome 'legacy' database, poorly suited to meet the requirements of an efficient child protection system. For example, CMC investigators found that one child relevant to some of the matters investigated was recorded in the CPIS under three different names.

The Families Youth and Justice database (FamYJ) of child protection notifications, initial assessments and outcomes was also queried.

E-mails transmitted between some departmental employees and some carers were examined and forensic computing inquiries were pursued in relation to some documents of particular interest to the investigation.

Given the publicity surrounding the matters under investigation, media databases were interrogated and Hansard was monitored for pertinent information. The relevant legislation, current and repealed, as well as current and former policies and procedures of the department, were considered.

Over 80 personal interviews were conducted with people who had information relevant to particular flashpoints and/or systemic issues. Inquiries were made in Queensland regional areas and Sydney, as well as a telephone interview conducted with a former key family services officer (FSO) currently residing in the United Kingdom. The relevant ministers and directors-general were interviewed, as well as numerous FSOs and health and education officials, and relevant officers from an Aboriginal and Islander Child Care Agency (AICCA). Some children who had been in the care of family X were also interviewed, as was one natural parent.

In relation to an incident where foster children in the care of family X contracted gonorrhoea, the CMC sought specialist medical advice into how such a disease could be contracted (other than through sexual transmission).

Information tendered from the Commission for Children and Young People (CCYP) was considered, and further information was sought.

Through notices to discover issued under the *Crime and Misconduct Act 2001*, CMC investigators obtained and examined relevant information from the QPS and also files from Education Queensland and Queensland Health.

Challenges

Although the CMC received cooperation from witnesses and relevant agencies, the investigation of the flashpoints still presented many challenges. Some arose from the age of the matters investigated. The passage of time had affected the memories of many witnesses and hindered the identification and location of documentary evidence.

For each child placed in the care of family X (there were at least 56 children), one or more separate files had been created. Each carer also had a separate file. This meant that in total there were more than 100 separate files with little or no cross-referencing. Generally, the note-taking on each file was idiosyncratic, making it difficult to identify exactly who had made the notes. Many were of poor quality with handwritten notes frequently proving difficult to interpret, and many reports were neither signed nor dated. Files often contained little in the way of explanatory notes as to the basis upon which important decisions had been made. There were long periods where there appears to have been little activity, at least as reflected in the files.

Further complicating the investigation was the rapid turnover of departmental staff and the many occasions where officers performed higher or relieving duties for relatively brief periods. There was also little evidence on the files of any formal staff handovers.

The cumulative effect of these challenges was that it was often difficult for the Commission to establish the facts of a matter.

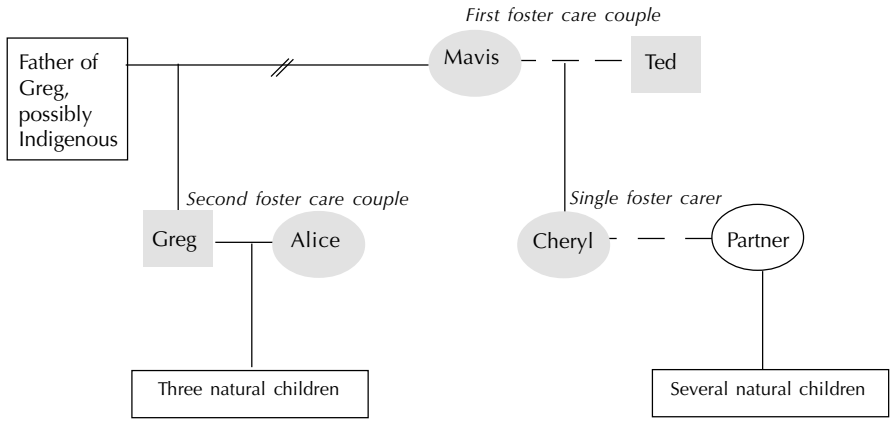
An observation

The Commission understands that the work undertaken by departmental officers is often difficult and confronting. Frontline staff work in a stressful environment and make complex and important decisions amidst the pressure of heavy workloads. In reaching conclusions about the matters under investigation, the Commission acknowledges that it has the benefit of hindsight, which the family services officers and other relevant staff did not have.

Fostering history of family X

The relationships of the extended family referred to in this report as 'family X' are shown in Figure 2.1. (The personal names used here are not the real names of the people involved, but pseudonyms.)

Figure 2.1. Members of family X



Mavis became an approved foster carer in 1979. Since then, family X has fostered at least 56 children, who were formally placed with it by the Department of Families. It appears that other children were also informally placed with various members of family X from time to time. In addition, there is evidence suggesting that large numbers of people intermittently resided in family X's households.

The first couple (Mavis and Ted)

Mavis was approved as a foster carer in September 1979, in accordance with the legislative requirements contained in the now repealed *Children's Services Act 1965*. That legislation required an applicant to satisfactorily complete a medical examination and to be a 'fit and proper person'. The department also undertook a criminal history check.

Her partner (Ted) was not separately assessed during this process, because the couple were in a de facto relationship, but his position in the household was considered.

The department's Manual of Practice and Procedures (drafted in April 1983 when the department was called the Department of Children's Services) provides clear guidelines for work concerning foster carers and the placement of children. It appears from perusal of this manual and from file notes relating to the couple that there were

no breaches of significance relating to the department's early casework with family X and the placement of children in their care. However, given the scarce case notes and documentation in the files, it is difficult to tell how well Mavis's status was reviewed, and what degree of monitoring and evaluation took place.

It should be noted that, while the relevant policies indicated that there should be 'care provider reviews' of approved foster carers on a yearly basis (Manual of Practice and Procedures, s. C.A.6.4[o]), there was no formalised system for this, nor was there any statutory regime for 'reapproval' as exists now under the *Child Protection Act 1999* (Part 2, Division 3 — Licensing of care services and approval of foster carers). It appears that family X was caring for at least one child prior to the original approval, as there are records indicating that the foster child ('Jane') who ultimately made the disclosure of abuse that triggered the CMC's investigation was placed with family X in July 1979.

Mavis had a son (Greg) from a previous marriage and a daughter (Cheryl) from her de facto relationship with Ted.

The second couple (Greg and Alice)

Greg and Alice, who married in 1981, had three children of their own. They applied to the department in October 1991 to become foster parents but were not approved until January 1993. The reasons for this delay are unclear from the files. It does not appear that the department requested a current criminal history and current medical records at the time of the eventual approval in January 1993. Some file notes indicate that in May 1992 the couple was accorded the status of 'approved persons' by the department, specifically to enable them to provide care to a foster child of Mavis and Ted's, while Mavis and Ted were away.

Other records establish that two foster children were placed with the couple two months prior to their approval as foster carers. After their formal approval, other children, some of whom were involved in the flashpoints investigated, were placed with this couple.

Greg and Alice were deregistered as general foster carers in 1998 after the department substantiated allegations of abuse by Greg upon two of the female children. Their status was altered to that of 'relative carers' for the two boys who were left in their care.

There is no evidence that any routine reviews were ever undertaken of this couple's ongoing suitability as foster parents before the events leading to the revocation in 1998 of their approval as general foster carers.

The daughter (Cheryl)

Mavis and Ted's daughter Cheryl was approved as a foster carer in September 1996 and over the following years 10 placements at least were made with her. She was approved as a single person; however, it was reported that she was residing with a friend at the time of her assessment. No corresponding assessment appears to have been made of this person. Cheryl has since revealed that she has been involved in two long-term relationships while approved as a foster parent. The files contain no evidence that either of her partners was ever formally assessed.

On 12 May 2003 the department placed a male foster child (Michael) with Cheryl. The child's mother — Sarah — was a former foster child of Mavis and Ted's. At the time, Cheryl was also caring for the infant child of Marie (also a former foster child of Mavis and Ted's) and another child.

Cheryl was reapproved as a foster carer in January 2002 under the requirements of the Child Protection Act. No major obstacles were found by the department during this process. There is no evidence that her suitability as a foster carer was ever reviewed until such a process was mandated by the Child Protection Act. She has been the subject of only one formal child protection notification, relating to allegations of physical abuse made by a foster child in her care. Despite the child's clear disclosures, this allegation was assessed by the department as being unsubstantiated.

An observation

The evidence indicates that the placement of a child by the department with any one of the members of family X was no guarantee that the child would reside with, or be cared for by, the nominated foster parent(s). There were frequent movements of children between households and all the children would have contact with all the carers. The department was often not aware of these movements. For lengthy periods all families lived in the same general locality. Area office responsibility was also difficult to determine, owing to the movements of some family members over the years. In one instance files were retained by an area office for some time after family X relocated. Files relating to some of the foster children were then sent to another office, where they remained unallocated until a child protection notification was recorded seven months later.

Indigenous status of the family

The evidence indicates that family X was formally accepted by the department as having Indigenous status. How this came about and whether the family is, in fact, Indigenous were contentious issues in the investigation.

The assessment of Mavis and Ted indicated that they would be 'a valuable resource' for Aboriginal children due to their experience. The precise meaning of this statement was not, however, explained.

One FSO clearly recalled Mavis and Ted telling her in 1994 that they were not Indigenous. However, further information in the files indicated that Mavis's ex-husband (and father of Greg) was Indigenous.

The files also disclosed that in 1994 confirmation of 'Aboriginal' status was granted to the family by a local Indigenous organisation. While some people consulted during the investigation expressed reservations about the validity of this accreditation, its outcome, as far as the department was concerned, was that Mavis and Ted became Aboriginal carers. However, it appears that not only were children of Aboriginal descent placed with them, but all children placed with them were treated as being of Aboriginal extraction regardless of their origins. The evidence suggests that some of the children placed with family X were confused about their cultural identity.

When asked about her cultural background during her 'leaving care' assessment, one of Mavis and Ted's foster children said she thought she was Aboriginal but had no further details. She added:

> All children who stay at Grandma and Grandpa's become Aboriginal when they stay there.

It should be noted that there are particular and important statutory provisions and procedures that must be observed when considering the placement of Indigenous foster children.

Experiences of the children

Seven people who had been fostered by different arms of family X were interviewed by the CMC about their perspectives on the broader issues relevant to the CMC's Inquiry. Three of these people are still in the care of the department; four have left care. Their length of placement with family X ranged from a number of months to approximately 13 years.

Owing to the delicate nature of the subject matter of these interviews and to the youth of some of the interviewees, CMC investigators did everything possible to minimise any negative impact. Interviews were reasonably relaxed and conducted in a neutral or non-threatening environment and in the presence of a support person suitable to the interviewee. All of these witnesses voluntarily participated in interviews, which primarily related to their experience of the standard of care provided by their foster families and the level of service and interaction provided to them by departmental officers. Their evidence proved to be of great assistance in enlightening the Commission about many issues relevant to its Inquiry.

Following the events outlined in the Introduction of this report, on 6 June 2003 the Department of Families and the Queensland Police Service took joint action to remove all children residing with all branches of family X and to place them in alternative care arrangements.

Consideration of possible disciplinary or criminal action

The CMC's investigation specifically considered allegations that departmental officers failed in their duty to protect children placed in the care of family X. For many of the flashpoints investigated, it must be concluded that they did so fail. However, having considered the evidence, the Commission considers that there is no basis to support it recommending the consideration of a criminal charge (such as under section 204 of the Criminal Code — Breach of statute law) against any officer over such failures.

Some of the evidence raises the possibility of official misconduct or other disciplinary action; for example, there was evidence of officers failing to act appropriately to record or take action on information directly alleging that children were being abused. Departmental officers are officers of the public service. Section 87 of the *Public Service Act 1996* sets out the grounds for which an officer of the public service may be liable to disciplinary action:

> **87 Grounds for discipline**
>
> (1) The employing authority may discipline an officer if the authority is reasonably satisfied that the officer has —
>
> (a) performed the officer's duties carelessly, incompetently or inefficiently; or
>
> (b) been guilty of misconduct; or
>
> (c) been absent from duty without approved leave and without reasonable excuse; or
>
> (d) contravened, without reasonable excuse, a direction given to the officer as an officer by a person with authority to give the direction (whether the authority derives from this Act or otherwise); or
>
> (e) used, without reasonable excuse, a substance to an extent that has adversely affected the competent performance of the officer's duties; or
>
> (f) contravened, without reasonable excuse, a provision of this Act or a code of conduct.
>
> (2) In this section—
>
> 'code of conduct' means a code of conduct —
>
> (a) approved under the *Public Sector Ethics Act 1994*; or
>
> (b) prescribed under a directive of the commissioner.
>
> 'misconduct' means —
>
> (a) disgraceful or improper conduct in an official capacity; or
>
> (b) disgraceful or improper conduct in a private capacity that reflects seriously and adversely on the public service.

The Commission has in each instance given careful consideration as to whether it should recommend that the Director-General of Families consider disciplinary action against any departmental officers, or whether the Commission itself should institute proceedings for charges of official misconduct against any officer. With the exception of one case where the evidence, if accepted, indicates a more recent and particularly blatant instance of duty failure (see flashpoint 4 below), the Commission has not been able to recommend disciplinary action against specific officers.

There are several reasons for this. The evidence about the department's dealings with family X over many years indicates that many officers were involved in the relevant casework. Some of these officers have now left the employment of the department and the public service, and cannot be subjected to disciplinary action.

As many of the contentious decisions and acts occurred years ago, the passage of time makes prosecution of disciplinary charges difficult. This problem is compounded by

the situation that in some cases the facts constituting the possible disciplinary breaches were well known to more senior departmental officers, who by their own inaction effectively condoned the actions of their subordinates.

For many of the flashpoints, the department's standard of record-keeping was wholly inadequate. In these cases the evidence is not sufficient to establish, to the standard required for any charge, exactly who was responsible for the acts or omissions in question. As unpalatable as this may seem, these officers have been afforded protection from disciplinary action by the absence of records of a kind that might ordinarily be expected to have been kept by any public servant dealing with such important issues. The problems of poor record-keeping and the related lack of accountability for casework decisions are recurring themes in the Zellow investigation. These problems are acknowledged by the department and are the subject of further comments and detailed recommendations in later chapters of this report.

Some departmental officers advised in their interviews that at the time of these events they were labouring under heavy caseloads, and that they lacked resources or alternative placement options for foster children. One officer readily admitted that the decision she made about a particular flashpoint, at a time when she was new to the FSO role and consequently very inexperienced, was clearly wrong and that if similar circumstances now arose she would act differently. There is evidence that, owing to short periods of multiple officers acting in relieving roles and a general lack of handover planning for cases, the supervisory structure in the relevant area office was often confused and did not operate as an adequate check or balance for junior staff. Such factors do not in themselves excuse inaction or other inadequate decision making upon serious allegations of child abuse, but they go some way to explain how these events occurred.

The collective evidence arising from the Zellow investigation pointed to organisational failures on the part of the department. These organisational failures were reflected in the various acts and omissions of many officers across a range of levels in their dealings with children who had been taken into the 'care' of the state.

For all of these reasons, it is considered that the many problems surrounding the interrelations between family X and the department can be better addressed through wide-ranging systemic reform, rather than through individual recommendations for disciplinary action, which would, in effect, focus disproportionate blame upon individuals when the system itself has failed.

For completeness, it should be noted that the Director-General of Families can institute disciplinary action independently of the Commission. There may well be other cases, outside the Zellow flashpoints, that warrant disciplinary action being so considered.

The flashpoints

These incidents occurred at different times and involved different foster children and officers. They occurred under various administrations, as well as two different legislative regimes. They are discussed here in chronological order, starting with the most recent.

Flashpoint 1 — removal of the children (May to June 2003)

All children residing with family X, whether under care orders or not, were removed by departmental and QPS officers on 6 June 2003. The local AICCA was not involved in that removal, even though there was at least one Indigenous child with the family at that time.

The removal was precipitated by a disclosure made by a foster child of Mavis and Ted's (Jane), who alleged sexual and physical abuse of children residing with the couple (see also Introduction). This information was initially provided to an AICCA worker, then to the QPS, and later formally relayed to the department in two separate notifications recorded on 29 May 2003. The two notifications were recorded for administrative purposes, to accurately reflect the children's placements and details of the alleged perpetrators of the abuse.

CMC investigation

The evidence indicates that a departmental officer first received information about the disclosure on or about 22 May 2003 from the AICCA staff member. No notifications were recorded by the department until one week later, although the department did record that Jane was first interviewed by the QPS on 29 May 2003.

A meeting attended by senior departmental officers, including a team leader, the regional director and the area office manager, was held on 23 May 2003. There is conflicting evidence as to what was decided at this meeting about whether the children should be removed, and when. The manager subsequently advised that the department had some difficulties in obtaining required information from the QPS. On 5 June 2003 the police advised that as a result of the disclosure they intended to remove the children the following day. This caused the departmental officers some planning dilemmas, as they were faced with finding alternative placements for the children. They sought to have the QPS delay its intended action, but the police were opposed to leaving the children with family X any longer. The regional director decided on 6 June 2003 that staff would help police remove the children that day.

The AICCA officer who received the original disclosure was interviewed on an episode of the ABC television program *The 7.30 report*, aired on 19 June 2003. The officer told the program that the 'case' had been brought to the attention of the Department of Families in February 2003.

As will be shown below, there is evidence that certain information about Jane had been known to the department since 1999, when some statutory declarations about issues involving the children in care with family X were created. Our investigation did not establish any other specific evidence to support the proposition that information about Jane had been passed to the department in February 2003, although the possibility that information about other aspects of family X or its foster children was given to the department cannot be excluded. The AICCA officer did not repeat this specific assertion when interviewed by the CMC.

In a letter dated 5 November 2003, the State Opposition provided information suggesting that 'persons' were reprimanded for making inquiries about the 'case'. In the above episode of *The 7.30 report*, the AICCA officer said:

> I contacted the area office. We were reprimanded — myself and the other Indigenous worker — for making inquiries in regard to this case, and it didn't go any further.

The officer further asserted that her actions had 'put her career on the line'. CMC investigators explored this issue. The officer and other AICCA staff members were interviewed. The crux of their evidence was that, following the disclosure, they perceived that the relationship between the department and their agency became more antagonistic, with departmental officers referring to the AICCA's funding dependency upon the department and the department's licensing function. Departmental officers also expressed some reservations about whether AICCA officers had provided all relevant information about Jane's disclosure and the fact that Jane herself was not available for interview by departmental officers (she had been very clear in her disclosure to the AICCA that she did not want to have direct contact with the department). Both agencies acknowledged that dealing with the disclosure was difficult for all parties and that there were some communication difficulties. Each perceived that the other agency did not fully understand their perspective or role, and that this affected the agencies' respective abilities to continue to work together in a child-focused and productive manner. Both agencies acknowledged that, historically, there had been some problems in working together.

AICCA staff expressed concern about the level of consultation on this case and others. As noted in Chapter 1, the Child Protection Act has provisions relevant to Aboriginal and Islander children, and these require that the AICCA be involved in placement decisions. At the time of the removal on 6 June 2003, there was at least one Indigenous child placed with family X, which was itself recognised as Indigenous. The evidence, including that of the relevant departmental officers, indicates that the department did not consult the AICCA before deciding to take action on the disclosure, and that it did not consult the AICCA once that decision had been made.

Section 14 (1) of the Child Protection Act provides:

> (1) If the chief executive becomes aware (whether because of notification given to the chief executive or otherwise) of alleged harm or alleged risk of harm to a child and reasonably suspects the child is in need of protection, the chief executive must immediately —
>
> (a) have an authorised officer investigate the allegation and assess the child's need of protection; or
>
> (b) take other action the chief executive considers appropriate.
>
> (2) If the chief executive reasonably believes alleged harm may have involved the commission of a criminal offence relating to the child, the chief executive must immediately give details of the alleged harm to the commissioner of the police service.

The relevant departmental policy (no. 273-1, Child Protection Notification Response — Initial Assessment), which was implemented on 19 November 2002, also outlines clear policy and procedures relating to the assessment of allegations of harm or risk of harm to a child (see also Chapter 1).

The notification arising from the disclosure was prioritised as 1 (high) under the department's notification priority-rating system. Such a rating requires action to be taken within 24 hours to secure the child's safety.

Although the notification is recorded as being received on 29 May 2003, other evidence indicates at least some relevant information was received by the area office earlier, on 22 May 2003. The officer who received this information has stated that he took appropriate steps and notified his team leader, manager, and even regional director.

The policy also outlines that before contacting the family the department should plan what to do. Staff interviewed said that they were complying with this directive. There is evidence that officers decided to wait for a formal police statement to be taken from the person who made the disclosure (this happened on 29 May 2003), rather than have the department itself undertake an 'immediate' investigation and assessment of the risk to the children still in foster care.

Conclusions

The evidence about how departmental staff approached this matter is disconcerting.

There is evidence indicating that information relevant to the basis on which the department finally acted with the police to remove the children was available for at least one week, and possibly as long as two weeks, before the department took that action. There is also evidence suggesting that the removal of the children on 6 June 2003 did not follow any independent assessment and decision by the department, but came about because of the desire of the QPS to act to remove the children. One can reasonably question just when departmental officers might have acted, had it not been for the pressure coming from the QPS.

The Commission acknowledges that the initial information possessed by the department was based on an oral report. There was also evidence from departmental officers as to how the department's actions were to some extent considered by them to depend on the progress of the police investigation. The department was not provided with the written documentation held by the AICCA that supported the abuse allegations until 5 June 2003.

Even after sighting this documentation, the manager said that she still thought further 'planning' should take place before any decision was made to remove the children. While the manager and other officers maintained that they wanted to plan for removal of the children, including finding alternative placements, there is nothing in the files reflecting that such planning was under way. The AICCA was not consulted about the placement of the children.

There is also no information in departmental files to support the assertion that any assessment of risk to the foster children in care occurred. There is no evidence that any departmental officer contacted the children or the foster carers after receiving information about the possible risk to the children.

Further, our inquiries revealed that the information received in May 2003 relating to Jane's disclosure, which in turn led to the removal of the children, is very similar to other information provided to the department in 1999 and again in 2002 (see flashpoints 3 and 4). No notification of possible harm or risk to the children was recorded on either of these earlier occasions.

In light of the evidence and the considerations set out above, the Commission does not intend to recommend that specific disciplinary action be considered against any officer of the Department of Families for this flashpoint. However, it is clear that the disclosure was the last in a long series of reports suggesting that children in care with family X were at risk of harm and needed protection. On this occasion, as will be seen for many earlier occasions too, more should have been done by the department, and done sooner.

Flashpoint 2 — fostering of baby Michael (January to May 2003)

One of the documents released to the media was an affidavit concerning the circumstances in which a baby boy — born to 'Sarah', a foster child in the care of family X — came to be placed with Cheryl.

Subsequently, the Commission for Children and Young People referred information to the CMC that it had received from a hospital in the area where family X resides. The information highlighted concerns about the number of 'under age' children giving birth at the hospital. There was unease about the fact that family X was caring for a baby recently born to a child in care. The CMC was told that various agencies had queried these arrangements and the action, or apparent lack of action, taken by the department in response. Nurses from the hospital later contacted the CMC directly to provide further information about these matters. The Commission acknowledges the assistance of the hospital staff.

CMC investigation

The information gathered from hospital files and the department disclosed that between March and May 2003 three females, all of whom had been fostered with family X at various times, had given birth to children who were now being cared for by Cheryl. Two of the mothers were aged 19 and 22 at the time of the birth of their children and so were not under age. Neither of their children was in the care of the department — the arrangement for Cheryl to care for the children appears to have been a private, consensual arrangement.

The third mother, Sarah, was just 16 and in the care of the department herself at the time she gave birth. An attempt was initially made to have her baby ('Michael') released to the care of Cheryl. The hospital staff refused to release the child. This request was renewed, supported by a letter from an FSO. A care order was applied for some days later and Michael was placed with Cheryl and her partner.

The basis for the care order was that Sarah had purportedly told Mavis and Cheryl that she did not wish to parent the baby and that she would harm him if compelled to do so. Following the removal of all the foster children (including Sarah) from family X on 6 June 2003, Sarah stated that she wished to care for her baby, that she had never expressed any intention of harming him and had always wished to parent him. There is no evidence in the files that, before the removal of the children on 6 June 2003, any independent assessment was ever made of Sarah's likely ability to parent her own baby, or of the suitability of placing that child with Cheryl. Although Cheryl was an approved foster carer, she was at that time already caring for two other infants under the age of two months as well as other children.

The hospital staff explained that they had held concerns about the safety of both Sarah and her unborn child from the time of their initial presentation at the hospital. They also expressed concerns about the other two babies in the care of Cheryl. They informed departmental staff of these matters and meetings were held. There is evidence that, on one occasion, a paediatrician contacted the department directly by telephone to give his views. There is evidence that the hospital staff collectively considered that departmental officers were dismissive of their concerns and reluctant to share information, citing confidentiality considerations.

In response, departmental staff stated that they had completed an assessment regarding the placement of Michael with Cheryl, bearing in mind the concerns about the number of children in the household and the wishes of the mother. They determined that this was a suitable placement, given that Cheryl was an approved carer, she was part of the mother's family network, and this placement would allow Sarah an opportunity to have a role in parenting the child if she chose to do so. The officers also stated that they wanted the hospital staff to be aware of the child protection concerns they held in relation to the mother caring for her baby. They indicated that, as there were no similar specific issues in relation to the other babies then residing with Cheryl, the department could do nothing about the apprehensions held by hospital staff.

Conclusions

While hospital staff maintained that they were worried about Sarah, these worries were never documented by the department as a case note, in the form of an intake or as a notification.

Although there is evidence that the department assessed the placement of Michael into the care of Cheryl, in the form of determining the benefits to both the baby and his mother, there does not appear to have been any documented assessment to determine Cheryl's suitability to care for another baby, or the facilities at her residence. An inspection completed when the children were removed on 6 June 2003 revealed that the three babies were sleeping in one small room.

The evidence also suggests that during Sarah's pregnancy, few attempts were made to fully obtain her views and wishes for her child. Discussions and meetings that were held with Sarah regularly included Cheryl and/or Mavis, causing a doubt as to whether Sarah was influenced by these people in her purported views. There seems to have been little inquiry carried out independently of Cheryl and Mavis, despite some departmental officers acknowledging that they were aware of the apparent control these women had over Sarah.

It should be remembered that Sarah was in care at this time and the department had a responsibility to assess her needs.

The evidence about this flashpoint does not provide a basis for recommending specific disciplinary action, but it does draw attention to flaws in the department's casework that occurred here and in other Zellow flashpoints. They are:

- the omission to record reported information appropriately
- a lack of direct and independent contact with a child in care (to ascertain their wishes), and
- the limited nature of the inquiries made by the department with the foster carers.

Flashpoint 3 — unconditional reapproval of Mavis and Ted as foster carers (2000–02)

The *Child Protection Act 1999* requires all general foster carers who wish to continue caring to apply for reapproval. Mavis and Ted so applied, although, as noted before, Ted had never been formally assessed. Section 131(3) of the Child Protection Act requires that 'a person living with his or her spouse may only hold a certificate jointly with the spouse'.

Clearly, the reapproval process should have provided the department with a critical opportunity to analyse the couple's fostering history and make appropriate decisions about whether the continued placement with family X was in the best interests of the children and whether the pair were appropriate foster carers generally. The assessment made after their application for reapproval revealed a number of anomalies, extending over a considerable period, which should have given rise to serious doubts about the couple's suitability to be or remain as approved foster carers. Instead, they were unconditionally reapproved by the department. No strategies were implemented to address any of the problems identified in the reapproval process.

Reapproval process

When the Child Protection Act was introduced, all current carers were given automatic reapproval as carers for at least two years. The CMC has calculated that,

under the transitional arrangements set out by the Act, Mavis's original approval would have expired on 28 September 2001. The reapproval process is outlined in the Act. Under section 143(2), if a reapproval application is properly made (by being lodged before the initial approval expires), the approval is taken to continue to have effect until the application is decided. This is opposed to the situation where a person applies for an initial approval to be a carer; such an application is taken to have been refused if the chief executive fails to decide it within 90 days. There was evidence obtained indicating that some of the departmental officers involved in the assessment of Mavis's application for renewal of her approval thought that the 90-day limit also applied to such reapproval applications.

The preliminary aspects of the renewal assessment process involve the completion of criminal, domestic violence and traffic history checks and a review of CPIS. Following these inquiries, departmental forms described as Assessment for a Certificate of Renewal for Foster Carer (Part A) and Department Report Assessment (Part B) are completed. Once this has been done, an Evaluation for the Granting of a Certificate of Approval/Renewal as a Foster Carer is completed by the area office manager, who has delegated authority to approve a foster carer for one or two years as a general carer, a relative carer or a limited carer.

The reapproval process for Mavis and Ted began in July 2001 when a pro-forma letter was sent by the department advising the couple that their tenure as approved foster carers was due to expire on 28 September 2001. This letter outlined the process to be followed should they wish to be reassessed, and informed them that a completed application form was to be received by the department before that date. The completed application form was duly received by the department on 1 August 2001.

CMC investigation

CMC investigators sought to identify the departmental officers involved in the reapproval process and to interview them. This was an area where, as noted above, the state of the department's record-keeping affected our ability to draw reliable conclusions. The relevant ministers and directors-general were also interviewed to ascertain if there were any specific policies concerning the reapproval of existing foster carers.

The officer who undertook the preliminary checks was identified. Investigators also established that the department's Regional Alternative Care Team helped complete reapproval assessments from the area. Investigators identified the primary assessing officer tasked to complete the reapproval assessment on Mavis and Ted, and another officer who helped her. (The primary assessing officer is no longer employed by the department.)

The available information indicates that the primary assessing officer started the outstanding components of the reapproval assessment, namely the review of the file and the completion of the forms described above, in late December 2001 or early January 2002. This was at least four months after the application had been lodged.

While completing the Part A form, the two officers spoke with a notifier, who informed them of allegations of sexual abuse made by a former foster child against Mavis's son, Greg. The abuse had allegedly occurred while the child was in Mavis and Ted's care. The child was no longer in care at the time the disclosures were made and Greg was no longer a general carer. (He was still a relative carer.) Other children remained placed with Mavis and Ted, and Greg still had access to these children. Despite what would appear to be an undeniable possibility of risk to these children, no formal notification of harm was recorded.

The Part B form was submitted on 25 March 2002 and recommended that Mavis and Ted be reapproved as general carers without conditions. The next phase — the formal evaluation — was completed by an acting manager, who ratified the primary assessing officer's decision to reapprove and back-dated this approval to 28 September 2001. The acting manager signed the approval certificate on 24 April 2002.

During the assessment process, the primary assessing officer completed two memoranda, one dated 26 March 2002 'Summary of Child Protection and Quality of Care Issues re [Mavis and Ted] — Approved Foster Carers' and another dated 27 March 2002 '[Greg], Relative Carer'. One memorandum outlined the author's concerns about Mavis and Ted's child protection history, which included two substantiated notifications, one for possible sexual harm and neglect dated 30 September 1994 and the other for emotional and physical harm and neglect dated 5 October 1994. The second memorandum related to concerns about Greg sexually harming children in either his care or the care of Mavis and Ted, including allegations by the foster child Jane.

The memoranda recommended that a new carer agreement be negotiated and that this new agreement restrict the children placed with Greg and Alice to boys over the age of 13 years. The memoranda were sent to a senior officer who then forwarded them with a covering memorandum to the acting manager, who received them on 26 April 2002 — two days after the couple had been unconditionally reapproved as general carers.

There are clear inconsistencies between the reapproval recommendation made in the Part B form submitted on 25 March 2002 and the recommendations made in the memoranda of 26 and 27 March 2002. Despite these three documents being written by the same author, apparently within days of each other, there are major and glaringly obvious inconsistencies in their content and recommendations. During their interviews, the relevant departmental officers could not satisfactorily explain the reasons for these discrepancies. All expressed the view that the assessment had been very thoroughly conducted. The primary assessing officer stated that while she had misgivings about the suitability of Mavis and Ted as carers, there was little hard evidence to support her feelings. She also considered that, as a result of the concerns she had outlined in Part B, Mavis and Ted would not be recommended for reapproval, despite her contemporaneous recommendation that they be so reapproved. Such an approach to an important decision-making process, affecting the welfare of vulnerable children, is clearly irresponsible.

There was evidence that some officers felt that to deregister the couple as carers might cause more harm to the children, because they would have to be removed and that in itself would be traumatic for them. Large sibling groups are generally difficult to place in foster care; however, this reasoning was never documented by the officers.

One senior officer, in apparent seriousness, put forward the view that to deregister the couple would have had serious staffing implications, because of the amount of 'extra work' involved for staff if the carers appealed.

Some officers suggested that there was an unspoken consensus among the staff to the effect that no further children would be placed with Mavis and Ted, in apparent recognition of the concerns that these staff held about the carers. Again, this view was never documented. No officer accepted responsibility for putting forward this strategy. Any such strategy ignored the possible risks faced by the children then in care and was clearly fraught with pitfalls, given the high turnover of departmental staff and the recognised shortage of foster carers. Departmental records indicate that another child was placed with family X in February 2002, while their reapproval application was being assessed. Yet another child was placed in November 2002.

The primary assessing officer stated that she thought there had been consideration given to Mavis and Ted being reapproved only as relative carers for the children who were then placed with them. Another officer was of the view that a more appropriate course of action would have been to inform the couple honestly that children were no longer going to be placed in their care and that the children currently in their care would be subject to very close monitoring, rather than just restricting their carer status with conditions. This was never formally documented anywhere.

The investigation found no evidence that there was ever any policy to favour the reapproval of existing foster carers. The relevant ministers and directors-general denied that any such policy existed, or that it was ever accepted that the 90-day period could be disregarded.

There is also no evidence that the contentious Indigenous status of Mavis and Ted influenced the process.

Some specific allegations

During the CMC investigation, the State Opposition passed on information suggesting that a Department of Families officer (later identified by name) involved in the reapproval process was a personal acquaintance of family X and that this relationship may have improperly influenced the final decision. Further, information was received from AICCA officers suggesting that this same officer was a long-term friend and former schoolmate of Greg's.

This information was examined during the investigation, particularly in light of the other evidence that arose about the approaches adopted by departmental staff and the apparent inconsistencies in the reapproval documents. In addition to questioning relevant witnesses, the investigators examined e-mails that had passed between the parties. However, no evidence was found to substantiate the concern that any officer had an inappropriate personal relationship with family X. The named officer denied that he had any personal relationship with Greg. Inquiries established that the two had not attended school together, as had been alleged. This officer had only a minimal role in the reapproval process and was not involved in making the final decision.

Conclusions

It is stating the obvious to say that only suitable people should be approved as foster carers. Here, the reapproval process should have provided an opportunity for the department to take action to address the doubts they had about Mavis and Ted, by either declining the application for reapproval or allowing it subject to appropriate conditions.

The department's assessment process was unsound, as was the consequent unconditional reapproval decision. The Commission's views accord with the views of the independent review team. Section 5 of the Child Protection Act provides that the Act is to be administered under a number of principles, including:

(a) every child has a right to protection from harm

(b) the welfare and best interests of a child are paramount.

In important respects, the evidence about how the relevant officers approached the reapproval task sits uncomfortably with these fundamental principles.

The flaws in the process and the decision are exacerbated by the apparent failure of staff to take appropriate action upon the disclosures made during the assessment process about the alleged sexual abuse of the foster child Jane. As a whole, the evidence from this flashpoint suggests that key officers were reluctant to confront the carers about the concerns that those officers undeniably held. Another opportunity to take action was missed.

The primary assessing officer no longer holds a position in a unit of public administration and therefore is no longer subject to any possible disciplinary action under the Public Service Act.

Flashpoint 4 — ministerial correspondence and statutory declarations (1999)

We investigated what action, if any, was taken by the department in response to some statutory declarations that contained complaints about the welfare of the children then in the care of family X. Earlier, similar matters had been raised in ministerial correspondence. Specifically, it was suggested in the media that the Minister for Education and former Minister for Families, Ms Anna Bligh, had received direct information about the plight of the children and had failed to act.

CMC investigation into ministerial correspondence

Our investigation confirmed that two letters directly concerning family X were sent to Ms Bligh, the first dated 28 January 1999 and the second 2 June 1999.

The first letter was written by Mr Ted Malone, the Member for Mirani, on behalf of a constituent who was the biological mother of some of the children then in the care of

family X. This letter set out the mother's complaints about her perceived lack of contact with her children. It contained no direct allegations of abuse by the foster carers.

The second letter was written by Mr Darryl Briskey, Member for Cleveland, and was received in the minister's office on 7 June 1999. The letter outlined direct complaints by a local resident (who knew Mr Briskey personally) about the welfare of the children placed with family X. Those complaints included that the children were not being fed properly and that they were being abused, including sexually. The informant was also worried that the children received no affection, were 'farmed out for money', that there were unsecured firearms in the premises where they lived, and that there were up to 14 children in the placement at once.

This correspondence was sent to the office of the director-general, where it was received on 8 June 1999. The evidence indicates that, in accordance with the usual procedures, it was then sent to the relevant regional office, which forwarded it to the manager of the responsible area office on a date unknown. The area office was then responsible for preparing a background brief and a draft letter from the minister to Mr Briskey (a 'ministerial').

Statewide guidelines require that such briefs contain information about the ages of the children, the structure of the family, and any action taken in relation to the allegations contained in the correspondence. All such briefs were required to be approved by the regional office and then sent to the office of the director-general. Once approved by the director-general, they were forwarded to the minister's adviser before going to the minister. Timelines for responding to ministerials were laid out. All correspondence was tracked by both the minister's office and the office of the director-general to ensure that it was responded to.

Each region, while adhering to the abovementioned statewide guidelines, had their own regionalised system for monitoring and responding to ministerials. At least one region had an appointed executive officer whose responsibility was to monitor and coordinate all ministerials. This officer processed the incoming letter and forwarded it to the relevant area office, checked that office's brief and forwarded it to the regional director.

Departmental officers the CMC interviewed stated that in 1999 there was no overarching or department-wide written manual or policy on what information should be included in a brief responding to a ministerial. There were some 'guidelines', which varied from office to office. At the time of our investigation there was still no such policy.

The evidence disclosed that in 1999 the relevant region had a set format for such briefs, including provision for the manager's name as the 'action officer' and also the regional director's name at the bottom of the page. Evidence provided by FSOs during the investigation indicated that it was usually the primary responsibility of the manager to ensure appropriate briefs were prepared in response to ministerials. This would usually be effected by forwarding the ministerial to the relevant team leader, who would prepare the brief and provide all the relevant information to the manager, who would then ensure that it was correct and in the appropriate format. The brief was then forwarded to the regional office.

There is evidence that on 25 June 1999 a letter was written to the informant by an acting manager. The letter requested contact to discuss the informant's concerns. Other records indicate that the brief was completed on 30 June 1999. The 'action officer' was recorded as being the then manager. No signature appears on the brief. A letter, consistent in content with the information in the brief, was sent to Mr Briskey on behalf of Ms Bligh on 22 July 1999.

The specific brief prepared by the area office contained general information about the carers and details of the children placed with them. It stated that the department was having regular contact with the children and the carers, and that it held no current concerns for the wellbeing of the children. In the brief, the department undertook to complete a thorough assessment of the children's protective needs. The brief did not specifically respond to the issues noted by the informant and it is open to conclude

that it contained a less-than-thorough reflection of the concerns that have been documented on the carers' and children's files since 1979, and that it was in this effect misleading. Specifically, it contains no information about the history of sexual abuse notifications, the deregistration of Greg and Alice as general foster carers, the notifications relating to children having sexually transmitted diseases (see flashpoint 7) or other notifications relating to alleged physical abuse. There was also some misinformation recorded; for instance, the brief stated that Greg and Alice were still approved as general foster carers.

Some of the departmental officers interviewed suggested that many of their anxieties about family X were based on 'feelings' or 'assessments', as opposed to facts, which may have led to these views being omitted from the brief.

There was nothing on the face of the brief to indicate who wrote it. We attempted to find out. All of the officers denied contributing. The manager stated that an acting manager would have drafted it, as she was seconded elsewhere at the time. We inquired into the dates of that secondment. They did not resolve the issue. The acting manager denied drafting the brief, attributing responsibility to the manager. The regional director stated that she would not have necessarily seen the brief and had no recollection of doing so. The relevant FSO could not recall being consulted about the brief.

We made some forensic computing inquiries in an attempt to identify any officer responsible for drafting the brief. We found that no backup tapes, from where a document of this type might be extracted, now exist. The computing hardware the department used in 1999 has been replaced and sold.

Conclusions re the brief

The evidence is not sufficient to identify reliably (to the standard required to support disciplinary action) just who was responsible for drafting the brief. The only conclusion that can be reached is that the brief was a less-than-adequate account of the relevant information then known to departmental officers. We could not establish whether this occurred intentionally or by genuine oversight.

We interviewed Ms Bligh. She noted that information about issues within her portfolio was brought to her attention in various ways. She said that as the minister she received voluminous correspondence:

> I received literally thousands of letters during my time in that portfolio. Allegations of concerns about children came to me not only through correspondence but through briefs from the department, from Community Cabinet meetings, all sorts of sources so, no I have very little recollection of any of the specifics of any of the cases …

Ms Bligh said that, while she accepted that the correspondence from Mr Briskey and Mr Malone had been sent to her and she had responded, she did not have any independent recollection of the correspondence. She said that she had introduced a system when she came to the portfolio whereby all relevant correspondence was referred to the department for an appropriate response. The format of the response consisted of a briefing note attached to a draft response. Ms Bligh's policy was that any correspondence relating to child protection issues was answered by her in her role as minister, because she regarded such information as important. She stated that she would check the drafting of the letter against the information contained in the briefing note and, where she was not satisfied with the response, would call for clarification. The correspondence was to be tracked and handled by the Cabinet Policy and Coordination Unit.

When asked whether she thought that the ministerial briefings she received about the concerns raised by Mr Malone and Mr Briskey were accurate, she responded that in her view the correspondence from Mr Malone went entirely to a complaint by his constituent about that constituent's level of contact with her children. She further said that 'there was no complaint in Mr Malone's correspondence about the standard of care the children were receiving in foster care' or any information to indicate that the

children were at risk. Ms Bligh noted that receiving requests from natural parents to have more contact with their children was not unusual. She said that, while the letter outlined that one of the children had allegedly been the subject of sexual abuse, this abuse had allegedly been perpetrated by the child's natural father and not within the foster care environment and that the department's response indicated that all contact with the father was being supervised. Ms Bligh maintained that, given the matters contained in the letter, she was satisfied that a proper response had been made.

Turning to the letter written by Mr Briskey, Ms Bligh said that the advice she received from her department was that some of the matters raised by Mr Briskey were not accurate, that there was regular contact between family X and FSOs, and that a thorough assessment would be made of the children's needs. She said:

> The advice I was given at the time I think is quite unequivocal in the sense that I was, I could be satisfied that an allegation had been made and appropriate action was being taken to pursue that allegation and to investigate it.

She further pointed out that as minister she was entitled to rely on the advice presented to her by her department.

Ms Bligh said her expectation was that when she was told that a comprehensive investigation would take place, this would occur. She explained that in a portfolio such as Families it was important to recognise that the issues of placement and other matters involved the exercise of professional judgment and that it would, in most circumstances, be inappropriate for the minister to intervene in those decisions. Ms Bligh noted that a distinction needed to be drawn between the role of the minister and the role of the director-general and said that, in her view, the role of the minister was:

> to ensure that the agency has the resources it requires, to ensure that it has the legislative framework that is necessary for it to pursue its functions and that it has the programs and policies in place that can ensure that it meets the public expectations of the public investment in it …

Conclusions re the ministerials

The media comments suggested that Ms Bligh had direct knowledge of concerns about children in foster care at risk and had improperly failed to intervene.

The letter from Mr Malone did not make any allegations of abuse. The letter from Mr Briskey did.

In responding, Ms Bligh relied on the brief put together by the department, which contained assurances about the protection of the children. Given the information contained in the brief, that response was justified. As noted, the evidence now available supports a view that the content of the brief was not a complete picture of the relevant circumstances. Had it been, one might reasonably have expected that Ms Bligh, or any other minister, would have made further inquiry.

Obviously, the omission of relevant information from such material inhibits a minister's ability to ask the right questions or ensure that the appropriate follow-up is occurring by departmental officers.

The steps for responding to ministerial correspondence need to be properly incorporated into policy to ensure that a consistent approach is taken by all staff and regional offices and that an accurate account is provided to the minister. Specific recommendations to this effect appear in Chapter 5.

CMC investigation into statutory declarations

Commendably, Mr Briskey's informant would not be deterred. After the episode of the ministerial correspondence, the informant collected four statutory declarations and a letter from various members of the public in the locality where the children resided. He delivered them to the area office. They outlined complaints about family X and the level of care that the authors perceived was being afforded to the children. The complaints expressed in these documents were similar to those raised in the ministerial correspondence. They related not only to children who had previously been in care with family X, but also to children still in care.

These documents were written in July and August of 1999. An e-mail was sent by the manager to a team leader on 23 September 1999, summarising the documents and directing that officer to take action.

Despite the disturbing information contained in these documents, there is no evidence in departmental files to demonstrate that the concerns were formally assessed or actioned. There is no evidence that a notification was ever recorded. Our investigation established that the documents were not correctly filed. They were finally located in July 2003 — some four years after their delivery to the department and after the removal of the children on 6 June 2003 — in a green folder in a drawer at the regional office.

The informant stated that he had made a number of appointments with a particular officer at the area office, in an endeavour to discuss his concerns. All of these appointments, he said, were cancelled by the officer. On one occasion he went to a scheduled appointment, which was again cancelled, and handed the declarations and the letter to this officer. He heard nothing in response. The authors of the documents were interviewed by the CMC. None was ever contacted by the department.

The officer nominated by the informant was interviewed and could not recall being given the documents, but eventually conceded that this could have occurred. She could not recall ever meeting the informant but did recall that the documents came to the area office around the same time as the ministerial.

The manager stated that she e-mailed her subordinate about the documents, in order to refer the information to the intake team for formal assessment. The manager thought she returned the documents, with a hard copy of the e-mail, in a green folder. Another officer recalled that in February 2002, when the reapproval process was under way, the officer tasked with the documents in 1999 referred to a green folder, which she took out of a drawer in her office. The officer purportedly said that the documents would be needed in the reapproval process. This officer provided the folder to the primary assessing officer (who, as previously noted, is no longer employed by the department).

Conclusions re the statutory declarations

It is apparent that the action requested by the manager did not take place. There is no evidence that any appropriate action was taken by the tasked officer to respond to the serious complaints listed in the statutory declarations. This flashpoint is another example of a gross failure to respond adequately to serious allegations of harm to children. The apparent failure of the tasked officer to take such action was not detected by her manager or noted by any officer involved in the reapproval process at the time the statutory declarations resurfaced. The system had no way of monitoring or following up the matter.

In the Commission's view, the available evidence is sufficient to warrant the consideration of disciplinary action against the tasked officer, on the basis that her conduct may have contravened section 87(a) and (d) of the Public Service Act.

Flashpoint 5 — termination of a foster child's pregnancy (June to July 1999)

Another matter given prominent media coverage, and which was the subject of specific concerns noted by the State Opposition in Parliament and with the CMC, were the circumstances in which a foster child ('Kylie') placed with family X underwent a pregnancy termination while subject to an order under which the director-general was her guardian.

It was suggested that the fact that a child had become pregnant indicated the level of possible abuse within family X, and further that the action of the director-general in allegedly consenting to the procedure was inappropriate.

CMC investigation

At the time of the termination, Kylie was the subject of a care and protection order. Her placement with family X broke down in September 1997, when she supported two

other foster children who made allegations of sexual abuse against their foster carer (Greg). She was then placed with other carers. On 15 June 1999 her carer told an FSO that Kylie, then aged 16 years, had recently attended her GP, was pregnant and wanted to terminate her pregnancy. It was further reported that the pregnancy was unplanned and that the girl thought she was too young to cope with an unwanted pregnancy, as she wished to continue with her education.

The department has a clear policy where children, who are the subject of care orders (with guardianship vested in the director-general) request terminations. The policy is outlined in the Child Protection Policy and Procedures Manual, directive 38.6 (viii), and effectively states that the director-general may consent to a termination of pregnancy only in circumstances where a doctor has ordered a termination 'on specialist grounds'. The CMC was advised that the policy was not designed to facilitate terminations but to ascertain if the child in care is 'Gillick-competent'[1] (and therefore able to make an informed decision to consent to the procedure) and to ensure that the child is supported by the department in any decision she makes.

Departmental staff and the carers cannot themselves, however, arrange the termination.

The Foster Care handbook advises carers to consult with an FSO and to help the young person in consulting a GP and attending a family planning clinic for appropriate counselling if requested, and to provide any necessary assistance for the health and wellbeing of the young person and the unborn child.

The investigation established that the child attended two GPs and received counselling from a recognised organisation. The counsellor advised that the relevant service 'offers women-centred decision-making counselling, which explores all options (parenting, abortion and adoption) available to a woman who is experiencing an unplanned pregnancy'. The counsellor concluded:

> I feel confident that [Kylie]understood the aspects of her decision and that she made a responsible choice. As a result of our discussion, I referred [Kylie] to a number of clinics that will perform a termination of pregnancy.

The girl's GP referred her to a clinic to 'see, assess, advise and treat as necessary'.

An inter-office memorandum dated 30 June 1999 was prepared by senior staff in the area office, outlining the action taken in the matter. It was forwarded to the operations manager for Brisbane North, Department of Families. This memo requested:

> … that consideration be given for a termination for [Kylie] in order for her to meet her expressed wish for this procedure to occur.

The child was seen at the clinic on 1 July 1999. The relevant officer reported that:

> [Kylie] makes this choice of her own free will. I have found her well prepared and considered of her decision.

This information was provided to the regional director of Brisbane North Region. A memorandum signed by that officer and the deputy director-general and dated 1 July 1999 was supplied to the then director-general, Mr Ken Smith, seeking his consent to the procedure. Prior to then, a principal legal officer in the department prepared an advice which, among other things, addressed sections 224[2] and 282[3] of the Criminal Code and cited the case of *Re Bayliss*[4] as authority for the proposition that a termination of pregnancy was lawful where the termination:

(i) was necessary to preserve the woman from serious danger to her life or her physical or mental health (not merely the normal dangers of pregnancy and childbirth) which the continuation of the pregnancy would entail; and

(ii) in the circumstances was not out of proportion to the dangers to be averted.

The lawyer opined that the decision to consent to the procedure was one for the child if she was Gillick-competent. He ventured the view that, given her age and the counselling she had received, she was so competent. He advised that these issues should be included in the brief to the director-general. An amended memorandum

was sent to Mr Smith on 2 July 1999. It contained a recommendation of the regional director to the effect that the child was well informed and competent to make her own decision regarding her pregnancy and that Mr Smith:

> approve that departmental officers have taken into consideration all the circumstances and acted appropriately in supporting [Kylie]. Further that [Kylie] is sufficiently competent to make her own decision in this matter.

The memorandum was endorsed by the acting deputy director-general and Mr Smith signed it as 'approved' on 5 July 1999.

An internal e-mail between relevant area office staff emphasised that the choice of what to do was the child's, that she needed to know that the department would support her following her decision, and that no departmental officer was to be a party to taking the child to the clinic for a termination. The child proceeded with the termination in the following week.

Conclusions re termination

Some of the reports in the public domain intimated that the child underwent the termination while she was placed with family X. This is not the case. The placement had ceased some twenty months earlier. Given that the child was almost 17 at the time of the termination, her pregnancy does not of itself give rise to any suggestion of the commission of a criminal offence. There is no evidence that the child has ever suggested that any of her approved foster carers were the father of her child or that the pregnancy arose from any criminal act.

The fact that a child in the care of the director-general underwent a termination, with the knowledge of the director-general, was portrayed in the media as one of the critical incidents indicating failure on the part of the Department of Families to protect children in care.

One might expect that the handling of such matters will often be difficult, and that people's opinions on the issue of pregnancy terminations will vary widely. Here, the investigation established that there is a clear departmental policy to be followed in such circumstances and that, significantly, the policy was strictly followed in this case. The matter was the subject of legal advice and considered by a number of senior officers in the department. There is no evidence that any departmental officer ever sought to influence the child in making her decision.

The investigation of this flashpoint has disclosed no evidence of official misconduct by any person.

Flashpoint 6 — deregistration of Greg and Alice (1997–98)

On 7 July 1997, the Department of Families received a complaint from a foster child then in the care of Greg and his wife, Alice. The child alleged that Greg had encouraged her and another foster child to shoplift goods for him, and that both children and been physically and emotionally abused by him. A notification was registered, in relation to the categories of emotional and physical harm and neglect.

A second notification was raised, based on information provided two days later by the other child, who had by that time left her placement and would not return. She made allegations of physical, verbal and emotional abuse by both carers, against both herself and her brother, who was also then in the care of the couple. She also made an allegation of sexual abuse.

A joint assessment of the two notifications was begun on 10 July 1997. The CMC was advised that this process included an assessment of the risk to the couple's natural children. The matter was referred to the Caboolture SCAN team on 15 July 1997 and to the QPS Child and Sexual Assault Investigation Unit (CSAIU) on 4 August 1997.

The QPS investigation centred on the sexual abuse allegations and the complaint that the couple had encouraged children in their care to shoplift. Both girls alleged that Greg procured them to steal and acted in a sexually abusive manner towards them, spying on them in the shower and exposing himself to them. The investigating police executed a search warrant on the couple's residence and interviewed them. They denied all allegations.

On 14 October 1997, another notification was received in relation to the possible sexual abuse by a male foster child (around Christmas 1996) of a boy then in foster care with the couple. The alleged abuse was said to have been witnessed by another boy who was a relative of family X. It was further alleged that Greg was aware of the alleged abuse and did nothing about it. The matter was investigated jointly by the department and the CSAIU. The investigation found that Greg had acted appropriately. It was noted that the alleged victim who was in care demonstrated no fear of the alleged perpetrator and it was determined that the boy could remain in placement. The outcome of the notification was recorded by the department as a 'substantiated risk of sexual abuse' to this boy, from the other foster child. It was noted that this risk 'needed to be addressed.' The alleged perpetrator of the abuse and the child said to have witnessed it were not interviewed in this investigation. There is a suggestion in the material that Mavis refused to allow this.

In January 1998, the QPS completed its primary investigation, recommending that no charges be laid in relation to any property offences, as there was little corroboration for the versions of the complainant children. The investigation also concluded there was insufficient evidence to charge Greg with any sexual offences, due to difficulties in particularising the incidents and as the alleged act of looking at the children in the shower did not, at the time, constitute a criminal offence.

In June 1998 the QPS provided the department with a report to help it decide whether Greg and Alice were suitable to remain as foster carers. After receiving this information, departmental officers met with the couple, who denied all allegations. However, the department recorded an outcome of 'substantiated neglect' in respect of the initial notification and an outcome of 'at risk' against Greg in relation to the allegations of physical and emotional abuse of the children.

The couple indicated that they wished to continue as general carers. The department did not support this but did consider allowing them to continue as 'relative carers', specifically for the two boys then in their care. This required a separate assessment of their suitability. Both boys remained placed with the couple while these assessments were completed. The assessment of one child's needs was completed in September 1998 by a private practitioner, who recommended that the couple be approved as relative carers for this child. The boy apparently expressed a strong desire to remain in the placement. The assessment of the other child, undertaken by another office, was not completed as the child left the placement. The file records no reason as to why he did this, and no information about where he went.

Conclusions

The deregistration process for these two carers took some 13 months. However, it should be noted that this was in part because the department awaited the outcome of the police investigation. During this time, the notifying children had left the placement and no further children were placed with Greg and Alice. Assessments were done of the children in placement; however, there is little information recorded in the files as to why the couple's own children or the boys in care were not perceived by the departmental officers to be at risk, given the substantiated notifications concerning the girls' disclosures.

The couple was deregistered as general carers on 14 August 1998 and not formally approved as relative carers for one of the boys until 22 October 1998. It is apparent that for at least this period they were acting as carers for this child without any formal approval.

The decision to approve the couple as relative carers was based on the recommendation of a private practitioner, who felt the best interests of the child were met by leaving him in this placement. This recommendation was supported by the department, which had documented that the couple had done good work with this boy.

A further procedural issue was detected in this aspect of the investigation, namely that two different area offices carried out Greg and Alice's assessment. This appears to have come about with the opening of a new office. Clearly, the allocation of files for different members of the one foster family to different area offices might readily result in confusion, possible problems in ensuring relevant information is brought to the attention of staff and possibly inconsistent decisions, which might in turn affect children in care.

The evidence for this flashpoint does not warrant any referral for possible disciplinary action, but it does point to casework issues such as the procedural matters noted above and, again, the less-than-complete keeping of records. However, the evidence does not support a view that any officer should now be disciplined for their role in this matter.

Flashpoint 7 — sexually transmitted diseases (1994)

In 1994, the department was informed that three girls being cared for by family X had contracted gonorrhoea. One of the girls was the natural daughter of Greg and Alice. Only one was then the subject of a formal care order.

CMC investigation

When the department received information regarding child protection concerns (such as, obviously, a report that a child in care may have contracted a sexually transmitted disease), it assessed the matter using the guidelines in the Assessing Harm handbook. The information is initially assessed on face value. On the basis of this assessment, it is decided whether an intake or notification response should follow. Those responses are as follows:

> Intake — no harm or risk to the child the subject of the notification
>
> Child Protection Notification Protective Advice — harm or risk of harm to a child
>
> Child Protection Notification Initial Assessment — significant harm or risk of significant harm to the subject child

The concerns about the children were first brought to the attention of one area office on 7 September 1994, through the children's primary school. The notifier stated that one of the girls, then aged 5, had complained of 'sore rude parts'. The school expressed similar concerns on 13 September 1994.

An FSO at the receiving office assessed this information as only an 'intake', and not a 'notification', apparently on the basis of a perceived lack of 'specific allegations'. On 30 September 1994, the area office that had responsibility for the children at that time received further information from a doctor, who informed the intake officer at 5 pm that two of the girls had presented at a medical centre on 23 September 1994 with vaginal discharge. Test results indicated that both had gonorrhoea. The doctor stated that the nature of the disease indicated possible sexual abuse, but noted that the children had not made any disclosures. A notification was recorded.

The third girl also tested positive for gonorrhoea. This was recorded as a separate notification as she was residing in a separate household to the other two girls.

The department's investigation into the notification concerning the first two girls was conducted by an FSO and was commenced on 3 October 1994. During the course of the investigation the three children, as well as Mavis, Greg and Alice and two doctors, were interviewed. The matter was referred to the area Suspected Child Abuse and Neglect Team (SCAN), a multidisciplinary body comprising representatives of the Department of Families, Queensland Health and the QPS.

According to the files, Mavis said she believed the children caught the disease from a young woman who had stayed with family X, and that she thought that the children had used a face washer used by this woman.

The interviews of the children appear to have been conducted separately from each other. No disclosures of sexual abuse were made. One girl stated that no-one had touched her and that she had never shared a bath or shower with anyone else. She also stated that she had never used anyone else's face washer to bathe with. Another girl initially denied being touched by anyone and denied sharing baths with anyone. However, when Mavis sat with this child in the interview the girl changed her version and stated that she did bathe with her sisters.

Investigations revealed that family X would often have different people staying with them, but neither Mavis nor Ted were able to further identify the girl who was, on Mavis's version, the probable source of the disease. They could not provide contact details for her. The department recorded that there had been neglect by Mavis and her

husband, on the basis that they had not adequately supervised the children (because they had contracted gonorrhoea while in care). It was further recorded that because the children had contracted a sexually transmitted disease while in care, an outcome that they were 'at risk of sexual abuse' should also be recorded. However, a further and incongruous outcome of 'not substantiated' was also recorded in respect of the possibility of sexual abuse, owing to the undue weight departmental officers placed upon the scenario advanced by the carer as to how the children could have contracted the disease. This issue is addressed below.

The departmental investigation into the circumstances as to how Greg and Alice's daughter contracted the disease was conducted at the same time. This girl stated that she had not been sexually abused and that she would have caught the disease from one of the other foster girls, as she had used her face washer. The assessment noted that medical advice given to the department was that the bacteria would be able to survive on a wet face washer. We interviewed the doctor who was recorded in the material as providing that advice. The doctor recalled the matter and noted that she was highly concerned for the children at the time. She recalled that she had made inquiries with an experienced microbiologist and had accessed research on the subject of how the disease may be transmitted. The cumulative effect of her inquiries was that it was possible, although highly unlikely, that gonorrhoea could be contracted from a face washer used by an infected person. The doctor stated that she did not necessarily believe that this was the case here, and had said so when advising the department of her views.

We obtained specialist medical advice during our investigation, which confirmed that contracting gonorrhoea in such a way, particularly given that three cases were diagnosed, is extremely unlikely.

Greg and Alice were interviewed in the departmental investigation. The department determined that the allegation of sexual abuse in relation to the couple's daughter was 'unfounded'. We found no evidence to reflect any consideration by the department of whether the child was at risk of neglect by her parents or at risk when staying with her grandparents.

In summary, despite the two notifications that three young girls had contracted gonorrhoea around the same time, the department found that in one case the possibility of sexual abuse could not be substantiated, even though this finding sat alongside a contemporaneous one that the children were 'at risk of sexual abuse', because they had contracted a sexually transmitted disease. In the other case, the department found the possibility of sexual abuse was 'unfounded'.

About this time, a further notification was recorded by an FSO, in relation to allegations of sexual abuse upon two other girls then in the care of Mavis and Ted. Another child being cared for by Greg and Alice reportedly told the FSO that one of the girls had told her that she and the other girl had been touched by a man who resided with family X. Further complaints were recorded that one of the girls had disclosed this to Mavis and had not been believed, and that the children were being censored in their disclosures to the department.

Another notification of harm was raised. The files reveal that the investigation of that notification was commenced on 4 October 1994 by the same officer who undertook the assessment of the gonorrhoea notifications. The new investigation focused on possible sexual abuse. Both girls denied the allegations. Mavis said she had never been told about the man touching the children and, if she had, she would have notified the police. No interview was conducted by the department with that man, for the apparent reason that he no longer lived with family X. An outcome of 'unfounded' was recorded by the department for the later notification, because no disclosures of abuse were made.

Involvement of the SCAN team

The department's files indicate that both of the gonorrhoea notifications and the later notification about the alleged touching by the man were referred to the relevant SCAN team on 11 October 1994. SCAN minutes indicate that only the issues in relation to

the first notification (concerning the two girls contracting gonorrhoea) were discussed. Why the SCAN team did not address the other two notifications is unclear.

SCAN team members were an officer of the department, a doctor from Queensland Health and representatives from the QPS and Education Queensland. The minutes indicate that the concerns held by the SCAN team for the children were the possibility of sexual abuse, the care providers' ability to protect them, and physical neglect of the children. At the first meeting recommendations were made for action to be taken through further medical examinations and further interviews of members of the household.

The next meeting was held a fortnight later with the same representatives. Health verified that the children contracted the gonorrhoea from the same source and there was no similar pattern reported (gonorrhoea is a notifiable disease under the *Health Act 1937*, which means that information about an outbreak of the disease must be notified to Queensland Health). The notes reflect that the team decided that the doctor should see the two girls, that departmental managers should meet with the two foster care couples, and that health checks should continue. The team recorded ongoing concerns about the possibility of sexual abuse and neglect of the children.

The next documented SCAN meeting occurred on 20 December 1994. The minutes state that the source of the gonorrhoea was still unknown, that family members said they had all had health checks and that the manager was to meet with Mavis and Ted regarding concerns for some of their foster children, with the allegations of neglect to be addressed in this meeting. Ongoing concerns were recorded about possible neglect of the children, in terms of hygiene issues and their exposure to the risk of sexual abuse. On 10 January 1995 the matter was again considered by the SCAN team. The final SCAN meeting about this matter was held on 21 February 1995. The notes state that there had yet to be a meeting between the two relevant area offices, although one was planned to discuss 'case-planning' issues. The matter was then 'closed for SCAN'; that is, the SCAN team did not further consider these matters. There was no evidence as to whether SCAN made any final recommendations about what should be done for the welfare of the children.

Beyond indicating the above matters, the minutes and other records of the SCAN team provided little other information, particularly in respect of why the team 'closed' its interest in the matter. We sought to locate the primary QPS officer who was on the team; however, at the time of our investigation this officer was on extended leave and uncontactable. No other witnesses could amplify the reasons why the SCAN team did not further address the concerns that it had identified about possible sexual abuse and neglect of the children.

A further relevant notification

A fourth notification was raised on 5 October 1994 relating to physical and verbal abuse of the children in the care of family X. This followed disclosures by two foster girls who alleged that the children had been subjected to excessive physical discipline (being hit with a 'green stick'), verbal abuse and excessive control, in that the children were coached on what they were allowed to say to departmental officers.

The department started an investigation, which was conducted by the same FSO who conducted the above inquiries. The evidence shows that the investigator interviewed the children and their carers. The assessment stated that all children were seen but did not want to talk to the department or the Juvenile Aid Bureau (JAB). The carers denied the allegations, but an outcome of 'substantiated' was recorded by the department, on the basis of the child's initial disclosure, which was supported by another child. During a meeting with the department on 21 December 1994, where the concerns were further raised, the carers maintained their previous denials, but stated that they acknowledged the concerns and would work towards addressing them. The children remained in their care.

Clearly, much of the information comprising this later notification, such as the allegation that the children were coached on what they said to departmental officers, should have been viewed by the department as being of obvious relevance to the

earlier gonorrhoea notifications and the further specific allegation of possible sexual abuse.

Issues highlighted during the course of the investigation

This aspect of the investigation highlighted a number of serious issues about how the department had dealt with the notifications furnished to it, and the circumstances surrounding family X at this time. These issues are:

Unallocated file — the file relating to the children had been sent on to the relevant area office (after family X had moved) in about February 1994. It remained unallocated until receipt of the notifications in October 1994. Accordingly, no casework was completed with the children between February 1994 and October 1994, despite there being a previous noted history of failure of the carers to engage with the department and the existence of a case plan which specifically stated that departmental officers were to work with Mavis to ensure she had the capacity to protect the children. No case officer was allocated to the children until January 1995.

Lack of file reviews — the interviews with departmental officers indicated that the assessments following the notifications were conducted somewhat in isolation, in that there does not appear to have been full consideration of the case as a whole, or of previous concerns. There is evidence that some officers involved in aspects of the various assessments were unaware of some of those matters. As noted above, the later information alleging that the children had been coached on what they said to departmental officers should have been regarded as highly relevant to the earlier gonorrhoea and abuse notifications, particularly in view of the evidence that was then available about at least one child altering her version of events when Mavis sat in on her interview. The information that generated each notification was in itself serious in terms of the children's level of risk. When all of the notifications (which arose over a period of only a few months) are viewed together, a clearly alarming picture emerges.

Risk assessment — despite receipt on Friday 30 September 1994 of a notification that three small children had been diagnosed with a sexually transmitted disease, the department's investigation was not launched until the following Monday. The CMC investigation could not establish whether any assessment was made to determine the immediate risk of harm to the children. There was clear information from the notifier, who was a doctor, that due to the nature of the disease the children were at possible risk of sexual abuse. As noted, there was also no evidence that any full risk assessment of issues of possible neglect was carried out for the child of Greg and Alice.

Record-keeping — the evidence disclosed a severe lack of documentation of the officers' decision-making processes, concerns and recommendations. At the time, notifications were recorded on A3 pages and were usually handwritten. The forms provided little space for documenting concerns, methodologies, outcomes and recommendations and, as a result, little information is recorded on the notifications themselves. The main assessing FSO took some handwritten case notes during her interviews, but as these were not typed, or put in the form of an assessment, they proved of little worth when the CMC attempted to investigate the process nine years later. This FSO stated in her assessment that she held serious doubts about the ability of Mavis and Ted as carers, but the files contained no recommendations based on such doubts. When interviewed, the assessing FSO stated that she had recommended the removal of the children from their placement with family X, but this recommendation is also not contained in the documentation, nor noted anywhere in the outcome of the investigation. The children, including the ones then suffering from gonorrhoea, remained placed with family X until they left care, or were removed in 2003.

There was evidence that at a meeting of senior departmental officers on 21 November 1994, discussion took place about an Adolescent Resource Worker working with some of the foster children. However, there is no record of this ever occurring. The notes of the joint area office meetings, internal meetings and SCAN meetings were generally not detailed. Several officers provided evidence that they were either present at, or knew about, a meeting where the removal of the children (as a result of the notifications) was discussed, but there is no record of this meeting taking place, or of any discussion about such significant issues.

The recorded information was sometimes placed on wrong or inappropriate files. For example, a copy of the notification that resulted in an outcome of 'substantiated neglect' by Mavis and Ted was not placed on their file. Minutes of meetings in relation to these notifications were not routinely filed.

Failure to interview all household members — the investigation disclosed no evidence that interviews were conducted, or that they were sought, with all other relevant members of the household, including those who could have been the possible cause of the infection. This was a major gap in the investigation process.

Failure to confront Mavis and Ted and lack of follow-up — when the department interviewed this couple, they offered the face washer scenario as a possible explanation as to how the three girls had contracted gonorrhoea. The evidence of the doctor indicates that while she acknowledged this was 'possible', she found such a cause extremely unlikely. However, on the basis of that evidence, staff appear to have accepted the face washer scenario as their preferred explanation as to how the girls contracted gonorrhoea and to determine what further investigation or action should follow. The files contained other evidence that there had been difficulties experienced by officers in communicating with the couple. When they stated that they would in future cooperate with the department, this was accepted with no strategies to achieve this or intended follow-up action noted. There was some mention from witnesses of plans to monitor and follow up, but this is not documented and there is no evidence that it ever occurred.

Lack of handover — the investigation has disclosed that two of the key officers involved in the assessments intended to leave the area office at the end of 1994. There is little material in the file reflecting any preparation for their departure, such as provision for a handover to the staff who would assume responsibility for their casework. An incoming officer indicated that she received no formal handover when taking up her position.

Conclusions

As noted above, specialist medical advice obtained during the CMC investigation indicated that contracting gonorrhoea by the face washer scenario was extremely unlikely, particularly in view of the fact that not just one but three persons contracted the disease. Gonorrhoea is classified as a sexually transmitted disease. Here, the evidence is that three young girls contracted it around the same time and from the same source of infection. The only reasonable conclusion that can be drawn as to the face washer scenario being the cause of that infection is that such a possibility was extremely remote. In the Commission's view, the face-washer scenario should have been rejected by the department for what it was — remote to the point of being fanciful, and an absolutely unsatisfactory response in the circumstances. That trained officers working in the area of child protection could have placed such weight on such a scenario, when determining what action should be taken (or not taken), is, in the Commission's view, disgraceful and indefensible.

Leaving aside other equally remote explanations that someone might ever conceive as to how the disease may be transmitted, obviously the compelling alternative explanation for why the children contracted gonorrhoea is that they were sexually abused. All of the children were young at the time and any sexual contact would therefore necessarily have involved the commission of serious criminal offences against them. Even though the young girls did not make any specific disclosures of sexual abuse the gonorrhoea notifications, in themselves, indicated indisputably that all of the children then placed with family X were in a position of clear and immediate risk.

This picture was further illuminated by other information given to the department around this time. When the department was assessing the gonorrhoea notifications, it received a further report about the possible sexual touching of another child in care, by a person then residing with family X. The face-washer scenario arose from a suggestion advanced by the carer. There was a considerable body of information about a history of difficulties experienced by the department in dealing with this carer on various matters and a further report alleging that she coached the children in what to say to officers. There was evidence of a conflict in one girl's evidence between the versions she gave in and outside her carer's presence, about whether she had in fact shared a bath with the other children and was ever in a position to be exposed to any supposedly infected face washer.

The likelihood that the children had been sexually abused demanded that a thorough and immediate investigation occur. The department's response was neither. Why the SCAN team did not pursue the matter is unclear. What is clear is that the processes of the SCAN team also did not satisfactorily address the grave issues involved.

This flashpoint is a most graphic and disturbing example of how the system totally and inexcusably failed the children it was supposed to protect. Given the passage of time, the inadequate recording of actions and decisions and the multiple instances where the system so miscarried, it is difficult for the Commission to now fairly apportion blame in terms of recommendations for disciplinary action against individual officers. The Commission notes that the independent review team is (at the time of the CMC preparing this report) undertaking some more detailed analysis of particular casework decisions and issues, and it may be that the further inquiries of that team and its members' professional expertise may clarify the situation further.

However, the difficulty in allocating fault among officers should in no way be taken as detracting from the Commission's primary conclusion in this matter: there undoubtedly was grievous fault.

Flashpoint 8 — alleged sexual abuse of foster children in 1992 and 1995

The 1992 disclosures

On 12 December 1992 an area office recorded a child protection notification in respect of allegations made by a foster child then residing in family X's household. The child had previously, by formal order, been removed from her home environment where she had resided with her natural mother and stepfather. The file indicates that there were concerns about the risk of possible abuse to her, should she continue to reside in that environment.

Some days later the child was interviewed by a JAB police officer about her disclosure. There is evidence that the child made clear disclosures during this interview of sexual abuse by her stepfather, *who was recorded as then residing in the same household with family X*. This was one of the very persons from whose care the child had been removed some time previously, because of concerns about the risk of abuse.

The outcome of this notification was recorded by the department as suspected sexual abuse upon the child by the suspect. The matter was referred to a SCAN team.

The stepfather was interviewed by the QPS as part of its investigation. He denied the allegations and his version of events was recorded as 'believable' by the interviewing officers. No criminal charges eventuated.

CMC investigation

There is evidence in the files that, during the departmental assessment, Mavis was aggressive towards the inquiring FSO and protective of the suspect. She asserted that the child who made the disclosure of alleged sexual abuse was lying. Concerns were expressed in the case notes about the suspect remaining in the house.

On 22 December 1992, 12 days after the initial allegations came to the attention of the department, there was a case note written by an FSO documenting a telephone conversation with the child. During this conversation, the child told the FSO that family X had decided that, in the following year, three of the children would reside with Cheryl and the suspect would also reside there. The department apparently made no objection to this unilateral placement decision by the foster carers.

The SCAN referral of January 1993 states that Mavis and Ted were asked to ensure that all contact between the disclosing child and the suspect was supervised. A further SCAN review on 9 February 1993 reported that the child's medical examination was consistent with sexual abuse, although the timing of the abuse was difficult to ascertain.

A case review was conducted at the area office on 8 February 1993. The following points of interest were recorded:

- The Department of Families requested that the suspect reside elsewhere and that his access to the child be supervised.

- The foster parents were asked to support the child.
- Contact with the children's mother was to be explored.[5]

There is no further documentation to show whether any of these matters were followed-up.

The records indicate that another meeting was held on 21 February 1993 between departmental officers to discuss the couple's suitability as foster carers. The details of the meeting were recorded in a memorandum dated 1 June 1993, which also stated that an FSO had contacted Mavis on 29 March 1993 to inquire after the children's welfare. It outlined that during this contact the FSO asked who was residing in the household and was told that family X did not want 'to be spied on' by the department. The family was not visited for some two months.

The memorandum also outlines a list of 'negatives and positives' relating to the placement of the foster children with the carers. Four positives and 14 negatives were given. The case plan indicated that there was to be a placement meeting with the carers to discuss these negatives with them. Planning meeting minutes dated 30 July 1993 report that the departmental case officer was still not having any contact with the children.

Of further concern are repeated references in the file to the disclosing child being sexually abused by another named male person (related to the carers but not to the child) from as early as April 1992. A case note dated 27 January 1993 also documents a disclosure by the child to this effect. We found no evidence of any child protection notification ever being recorded. A case note recorded on 29 March 1993 documents an FSO's assessment that the children's placement was, at that date, unsuitable. There is no further action or documentation relating to this assessment. When interviewed, the FSO said that, while she did record her concerns, she did not record a notification about these allegations because she saw the nominated perpetrator 'as a child himself' and that he had an intellectual disability. The FSO stated it was difficult to discuss these issues with the carers, who were defensive and of the view that such things did not happen in their family. This FSO stated that she had significant concerns about the children's placement and felt that they should have been removed.

Conclusions re the 1992 disclosures

The disclosing child had been removed from her parent and step-parent under a formal care order and placed in alternative care with family X, because of concerns about possible harm to her if she stayed in her home environment. It is of grave concern that a person from whose care the child had been so removed then came to reside again with the child in the foster carers' home. The department was aware of this but it seems little was done. One is entitled to ask what the point of the formal care order was, when it was effectively circumvented in this manner without any meaningful intervention from the department.

There is evidence that one carer formed an adverse view about the child's disclosure. Despite this, the department assessed that these carers were still able to protect the child and adequately supervise her contact with the suspect.

When further concerns were brought to the attention of the department relating to sexual abuse of the same child by another man in the house, the department took little action. No notification was raised. Despite clear notes reflecting an FSO's view that the placement was unsuitable, it continued.

Again, given the passage of time it is difficult to now sustain any possible disciplinary charges against individual officers. While there is clear evidence that an FSO did not record a notification of alleged sexual abuse, that officer did document her concerns about the children and her view that, at that time, their placement with family X was unsuitable. Unfortunately, her warning was ignored.

The 1995 disclosure

In November 1995 a further child protection notification was raised in respect of allegations made by two foster children of improper advances made to them by the suspect described above. The outcome of this notification was recorded as

'substantiated for risk of sexual abuse' and for suspected 'other emotional' abuse. By this time, the suspect was no longer residing under the same roof as the children. Formal orders were sought in respect of the children, in order to vest their guardianship in the director-general.

Conclusions re the 1995 disclosure

This later report resulted in the department recording substantiated outcomes in respect of the risk of sexual abuse to the children at that time. Had the department acted more effectively in responding to the earlier disclosures regarding this same suspect, the children would not have been subjected to this further risk and possible harm. Again, the system failed to protect the children.

This 'flashpoint' demonstrates once more a number of problems that recur throughout the fostering history of family X. The evidence identifies failings in the casework, such as the incongruous placement of a child taken into care in a residence where her step-parent came to live shortly afterwards. Serious allegations about sexual abuse were not responded to adequately in 1992. There was a reluctance, again, to confront the carers about issues of real concern. The department's inadequate response in 1992 created a situation where it had to acknowledge, some three years later, that the children with family X had been exposed to continued risk from the same suspect.

Flashpoint 9 — alleged sexual abuse of a foster child (1985)

The child for this flashpoint was placed with family X early in its fostering history. In 1985 the placement broke down and the child was removed.

CMC investigation

An inspection of departmental files revealed a case note written by an FSO in November 1985, just before the placement broke down. The notes record that the child went to say goodbye to the neighbours and then accused a family member of 'trying to do something to [her]'. This is the first and last mention of this matter. The next file note is a letter to the carers thanking them (and their children) for the care that they provided to the child over the seven-year placement. The child later left the care and protection of the department. A memorandum prepared at that time made no reference to the allegations but did state there was no satisfactory resolution to the reasons for the sudden breakdown of the placement.

Another FSO became the child's case officer in 1987. File notes of this FSO reflect that the child made disclosures of sexual assault by a member of family X. There is no evidence that a notification of harm was recorded, as it should have been. The FSO completed a comprehensive report for the child's discharge from care, outlining the child's case history. The report included details of this disclosure. The report moved through all levels of supervision, to the district manager, without any direction to raise a notification, or to instigate an investigation. The alleged offender remained in a situation of unsupervised access to other children in care and notifications of alleged abuse, including sexual abuse, were to result in the years following.

Conclusions

Again, despite a disclosure of a very serious nature being made, little effective action was taken. No notification was recorded and no investigation followed. While at the time of the 1987 disclosure the child making the allegations of abuse was leaving the department's care, other foster children remained with family X and dozens of children were later placed with it. There is no evidence that the risk to these children was ever evaluated, or even appreciated, at that time. As set out at length above, many more disclosures followed. An early opportunity to protect the children was missed.

However, 18 years have passed since these events. The majority of the employees involved in this flashpoint have left the department and so cannot now be disciplined.

The involvement of ministers and senior departmental officers

On 30 July 2003 the article 'Collective amnesia on abuse' appeared in the *Courier-Mail*. The article asserted that various former departmental ministers were refusing to accept responsibility for the plight of the children placed by the Department of Families with family X. It spoke of a 'collective amnesia' that extended to the directors-general of the department.

Ms Bligh's actions in relation to two specific issues have been explored above, in the discussion about flashpoint 4. We also made inquiries with other relevant ministers and directors-general. We sought to establish whether any such alleged failures of these individuals to intervene, or otherwise act to protect the children, involved official misconduct, or whether there was any evidence arising that would help the Commission make recommendations about systemic and procedural issues.

The following ministers and their directors-general were identified:[6]

- The Honourable Anne Warner was minister at the time that the three children contracted gonorrhoea. Ms Warner was also minister at the time that some disclosures of sexual abuse were made. Ms Ruth Matchett was then director-general.
- The Honourable Kevin Lingard was minister at the time that Greg was deregistered as a general foster carer but approved as a relative carer. The Reverend Allan Male was then director-general.
- The Honourable Anna Bligh was minister at the time the foster child underwent a pregnancy termination while in care and Mr Ken Smith was director-general.
- The Honourable Judy Spence and Ms Bligh both held the Families portfolio across the time of the reapproval of family X as foster carers.
- Ms Spence was minister as of 6 June 2003 when all foster children were removed. Mr Frank Peach was director-general. They held the same positions at the times relevant to flashpoint 2.

During the investigation, information arose which indicated that other ministers and directors-general had also received correspondence raising concerns about the welfare of the children with family X. The handling of that correspondence is dealt with below. Perusal of the relevant files has disclosed no evidence, other than this correspondence, that any of the ministers or directors-general were directly notified by members of the public about family X. Liaison with the independent review team confirmed that it too discovered no such information during its work.

The ministers and directors-general were asked about the incidents that occurred during the period they held responsibility for the department and, where relevant, the correspondence received by them. Also, the following areas were covered:

- what action would have been implemented had they been aware of the situation within family X
- whether they should have known about family X
- by what mechanisms would they have received such information
- any systems to facilitate the receipt of such information
- whether such information was sought proactively
- whether there was any follow-up system when information was received.

The ministers

The Honourable Anne Warner (minister from 7 December 1989 to 31 July 1995)

Ms Warner stated that during her time as minister she received 'huge amounts' of correspondence and that the department traditionally was a department that received a high volume of complaints. Ms Warner stated, however, that 'in the main matters of practice were not brought to the minister's attention unless there had been somebody writing from the outside …'

Ms Warner stated that prior to the recent media attention she did not have any specific knowledge of family X. The investigation established that she had received three items of correspondence in 1992 and 1993 from the father of some of the children in the care of family X. He was then serving a term of imprisonment for sexual offences against other children. Ms Warner had no independent recollection of this correspondence, or of the responses, copies of which were provided to her.

The first letter cited issues about the whereabouts of the children, the reasons why they were in foster homes, why the case officer had allegedly not returned the father's calls and why the father was allegedly not notified when something happened with his children, or of his legal rights as the children's guardian. This letter did not raise any direct concerns about the standard of care received by the children.

The second letter did so. It alleged that two of the children had been assaulted and that others had to go to the toilet in a bucket. There was a further complaint that drugs were used in the premises and that a 'child molester' resided there. The third letter requested a response to the previous communications. These later letters were responded to by the director-general (see below).

The records reveal that a briefing note was provided to Ms Warner addressing the issues outlined in the first letter and correspondence was forwarded in accordance with this briefing note.

Ms Warner advised that her usual action was 'to send the letter to the department for a brief and suggested response'. Ms Warner also stated that she would have accepted the information provided in briefing notes, in the absence of any other information. She would consider the information provided to her and, if she did not have concerns, would sign the letter on that basis. Ms Warner stated that on occasions she would call for additional information if:

> [the information] appeared to be inconsistent or unnecessarily harsh or there was something in it, the response or in the brief, that I thought didn't make sense and then I would ask further questions.

Ms Warner stated that she was always very concerned to maintain the separate functions of minister and caseworker. In her view, the role of the minister was to formulate and implement policy and to obtain requisite funding. As she was not a trained social worker, Ms Warner thought it important that she did not get drawn into casework or substitute her decisions for those of the FSOs. Ms Warner could not recall if there was any proactive regime of reviewing departmental files so that any problematic placements could be identified, stating that she relied on the professionalism of the FSOs for this. Ms Warner stated that she visited many area offices during her time as minister and that she hoped FSOs would have felt comfortable in raising any issues with her or the director-general.

Ms Warner was minister at the time that the three children residing with family X contracted gonorrhoea. She said that she had not been advised about this incident and that she would not necessarily have expected to be so advised. Ms Warner was asked what her response might have, had she known of the matter:

> Take the kids out. I mean if any of that kind of information, or even if the kids even whispered that 'these people are abusing me' — in [my] experience there wasn't much policy debate on that; they'd get out. The kids come out.

When advised that the children were left in the placement with no change to the casework arrangements, Ms Warner stated, 'Well, I'm horrified if that was the case.'

Ms Warner was asked about the general circumstances of a foster child undergoing a termination of pregnancy. She said that it was not her role to 'approve' such procedures, although she would have been informed of them by her director-general. She stated that she was aware that there was a very strict policy in relation to such matters, and that as far as she was aware this policy had always been followed. She was not able to recall a specific instance where a termination had occurred.

The abovementioned correspondent (who wrote to Ms Warner) also wrote to the Ombudsman about the same issues that he had set out in his second letter to the

minister. That letter was forwarded to the director-general, Ms Matchett, who was provided with an adequately detailed briefing note. Ms Matchett responded to the Ombudsman by way of a letter based on the briefing. This letter also dealt with the concerns addressed directly to the minister.

The Honourable Kevin Lingard (minister from 26 February 1996 to 13 February 1998)

Mr Lingard stated that when he assumed his portfolio in February 1996 he was concerned about the level of complaints involving the department that he was receiving from the public. He made a decision that he would be more 'hands on' in his approach to his portfolio. Each morning he took direct phone calls from people with concerns, and recruited a team of experienced staff to respond to these concerns and to keep him informed. All letters in response were personally signed by him. As with the other ministers, Mr Lingard also received correspondence from the public. Follow-up was conducted where it was considered necessary.

During the course of our investigation information was received alleging that Greg was personally known to Mr Lingard and his director-general, the Reverend Male, and that they had intervened on his behalf in relation to the deregistration process. Mr Lingard stated that he did not recall ever receiving any direct information about family X. The circumstances of Greg's deregistration were outlined to him and he confirmed that he had no knowledge of this event and that he had not intervened in this process. He said he did not know the carer and could not recall any direct correspondence or contact from him, although the man could have contacted him during his morning telephone sessions.

Mr Lingard stated that had he known of the circumstances in which the children placed with family X were residing he would have intervened. Mr Lingard was not aware of any pregnancy terminations being performed upon children in care while he was minister.

The Honourable Anna Bligh (minister from 29 June 1998 to 22 February 2001)

Ms Bligh stated that during her tenure as minister she attempted to ensure that she was approachable. She visited departmental offices on a regular basis where she would talk to staff about issues. She stated, however, that staff who 'had the ear' of the minister would tend not to discuss individual cases but broader issues such as caseloads. She said staff were always deeply concerned about issues of confidentiality, particularly prior to the *Child Protection Act 1999*.

Ms Bligh stated that she was not aware of any systemic or cultural reasons that would have caused staff to have deliberately hidden concerns from her, although she was aware of what she termed a 'culture of secrecy' within the department.

Ms Bligh was minister at the time the reapproval process for Mavis and Ted was commenced, but not at the time that they were reapproved. She stated that the approval/reapproval process was one of the most significant reforms in the Child Protection Act. (Ms Bligh was the minister responsible for the passage and implementation of that Act.)

She acknowledged that, given the concerns outlined in the Assessment of Protective Needs (APN), the reapproval should have been a good opportunity to reassess the suitability of family X as foster carers. She stated that she could not speculate on the reasons why the people conducting the reapproval assessment recommended that reapproval be given. When questioned as to whether there was any presumption that foster carers should be reapproved, Ms Bligh stated that there was no such presumption and that the process was one that should have acted to rid the system of foster carers who were not appropriate.

Ms Bligh was also minister at the time the foster child underwent a termination of pregnancy. Ms Bligh advised that under the departmental procedure in relation to such matters she was not part of the decision-making process and that such issues were within the responsibility of the director-general, as the guardian of the children in

care. She stated, however, that as with other sensitive issues she would have been advised of terminations in 'verbal briefings' with the director-general and can recall being advised that terminations had occurred, although this was 'very unusual' and 'highly sensitive'.

The Honourable Judy Spence (minister from 22 February 2001)

Ms Spence, who is the current Families minister, stated that she was first informed about family X on 6 June 2003, when the children were removed, and not before. She said she was disturbed by the information disclosed in the media about the circumstances of the children. She stated that had she been aware of the situation she would have intervened and that she would have hoped that the case had received better attention at a more senior level and that better decisions had been made in the department.

Ms Spence was questioned about how information relating to such a family would come to her. She stated that she would receive such information from members of the public approaching her directly, or during Community Cabinet meetings. She added that she would also receive information from her parliamentary colleagues, including backbenchers. The minister was questioned about whether there was any independent way in which she would have obtained such information. While there were no such mechanisms prior to this matter, the minister outlined some steps that she has since commissioned, including the independent audit conducted by Ms Gwenn Murray.

The minister was also questioned about what processes she followed in addressing concerns that might be forwarded to her. She stated that:

> … the correspondence is received by this office, it goes to the department for a response, a briefing note is prepared and a letter is prepared for me to sign. So that, the briefing notes and the letters will then come to this office … on July the 1st last year we established an operations directorate in the department and that … operations directorate now receives all correspondence … [this] offers some quality assurance and some quality control over the correspondence that is prepared for the minister. Since this case has come to my attention I have given now the directive that the director-general should also receive any correspondence, should also read any correspondence before it comes to my attention. That hadn't been the case.

The minister stated that if she was not happy with the information that came through briefing notes she would send it back for further information or action. Given the number of notifications, she would not herself seek out information on a particular family. Ms Spence stated that if she had concerns about a family:

> I might, for example, ask for further information on a particular family if I'm given a briefing on that family and I'm keen to ensure, keen to find out further particulars about the family or I might ask the director-general to review the decision-making about a particular family that's been brought to my attention and have ongoing briefings about a family. And there have been a number of cases where that's occurred.

She stated that she perceived the role of the minister as being one of ensuring:

> that the departments they administer have … sufficient budgets, sufficient processes in place to ensure that the government's policies are being carried out and, indeed in terms of child protection, that good and sound decisions are being made to protect Queensland's children.

Ms Spence differentiated between the role of the minister and of the director-general, who was responsible for the running of the department. When questioned about whether practitioners within the department felt confident in bringing concerns directly to her, she said:

> … it's not been my experience that senior practitioners in the department would bring their concerns directly to the minister or the minister's office. However, I do believe that they have the capacity to bring their concerns to the attention of the director-general and you know I think you need to talk to him about how frequently that occurs.

Ms Spence was minister at the time Mavis and Ted were eventually reapproved. She had no knowledge of their reapproval but agreed that 'there is concern about the fact that this family got reapproved.' The minister stated that she was not able to comment on the reasons why family X was reapproved, but was of the view that the scarcity of foster carers as a resource did not affect the department's decision.

Reassignment of Minister Spence's media adviser

It was suggested to the CMC during the investigation that Ms Spence may have had earlier knowledge of family X and that her then media adviser may have had knowledge of this. It was also suggested that this officer did not return to her position as Ms Spence's media adviser, upon her return from sick leave, but was reassigned.

We interviewed the adviser, who stated that the first she knew about family X was when the documents (the APN and the affidavits) were initially leaked to the press. She considered that the minister was told at the same time and, as far as she was aware, had no prior knowledge of the foster family.

She explained that her reallocation was a mutually agreed decision between herself and the minister, for personal reasons, and unequivocally stated that the decision was not related to the foster family issue.

The directors-general

The position of Director-General of Families carries with it the role of guardian of children in care.

Ms Ruth Matchett (1989–95)[7]

Ms Ruth Matchell said that, in general, information about a specific family would come from external correspondence. She said that she always tried to ensure that staff were able to approach her about issues.

She said she had no personal recollection of family X.

When correspondence was received in relation to these issues there was a process for dealing with it, which involved obtaining a briefing on the matter. Ms Matchett stated that she was of the view that she was entitled to rely on the information received from the area office, but would question the information if she did not agree with it or did not follow the reasoning of the officer providing the briefing. There was no department-wide audit process at this time.

As noted, Ms Matchett was the director-general when the father of some of the children in care wrote letters in 1992 and 1993 to the then minister, Ms Warner. That father also wrote to the Ombudsman about the issues he had set out in his second letter to the minister. That letter was forwarded to the director-general, Ms Matchett, who was provided with an adequately detailed briefing note. Ms Matchett responded to the Ombudsman by way of a letter based on the briefing.

Ms Matchett stated that she did not recall being advised about children in the care of family X being diagnosed with any sexually transmitted disease. She stated that had she known of the full extent of the alleged situation in which the children were living she would have been of the view that the children should have been removed.

Ms Matchett acknowledged that in her position she dealt with issues about terminations performed upon children in care and that they were always conducted in accordance with the policy.

The Reverend Allan Male (1996–1998)

The Reverend Male was director-general during the time that Mr Lingard was minister. He confirmed that in common with his minister he adopted what he described as a 'more open' approach to the department, which he described as a 'closed department.' He stated that he personally was very hands-on in his approach and in intervening in matters.

The Reverend Male said that, to his knowledge, a lot but not all ministerial correspondence went through his office. He said that had he been aware of the particular foster family and the allegations about the treatment of the children he would have intervened. He said that he issued a directive stating that every foster child in care had to be spoken to alone by an FSO every six months, to ensure that they were happy in their placement. He noted that this clearly did not happen.

The Reverend Male stated that he had no knowledge of family X and had no relationship with Greg. He said that the first knowledge he had of family X was through the media articles.

He could not recall any terminations upon a child in care while he was director-general.

Mr Ken Smith (1998–2001)

Mr Ken Smith is currently Director-General of Education Queensland and was Director-General of the Department of Families from August 1998 until February 2001. Ms Bligh was his minister.

Mr Smith was of the view that the role of director-general was as the accountable officer for the functioning of the organisation. He stated that he was:

> … responsible through the minister to the Parliament for the proper expenditure of funds and the administration of programs…, and 'has responsibility for the operations of the agency' and to carry out legislative responsibilities.

Mr Smith was clear that it was not his role to directly intervene, in the absence of exceptional circumstances, in the casework of departmental officers.

Mr Smith stated that he would receive information through letters sent to him from the public. Such letters would be referred to regional directors for a briefing and response. He said that, depending on the nature of the issue so referred, the response would be returned to him or he would give direction as to what further action would be taken. In such circumstances 'he would rely on the professional capability of the staff in the system to deal with those issues'.

Mr Smith said that, while there did not appear to be any formal follow-up system, the director-general had the capacity to do this where it appeared warranted. He noted that the community was the primary avenue for information about notifications of abuse and neglect. There was no department-wide audit process.

Mr Smith stated that FSOs would approach him to raise issues. He said he wanted to ensure 'a degree of openness for people to raise issues and any concerns that they might have as necessary'.

Mr Smith, who was the director-general at the time the reapproval process for family X first commenced, said that there was no presumption that foster carers should be reapproved.

Mr Smith was also director-general at the time the foster child underwent her termination. He stated that he had signed a memorandum acknowledging that the child was 'Gillick-competent' to make a choice about whether she wished to proceed with the termination, but that he did not have a specific recollection about the full circumstances of the matter. He said that this was not a common occurrence, and in relation to advising the minister, stated:

> Either myself or the deputy director-general would have from time to time briefed the minister verbally but not necessarily consistently on individual terminations. But going back to the previous point, the responsibility in a clear legislative sense was with myself, so the minister has no statutory responsibility in terms of approving those items, which is different from being informed.

Mr Frank Peach (2001–)

Mr Frank Peach is the current Director-General of the Department of Families and has held this position since February 2001.

He stated how he received the first information about family X:

> Mid-afternoon in the Qantas lounge of Melbourne Airport on 6 June I got a phone call from the Executive Director of Operations ... who phoned me and said that ... he'd become aware of the case and that it looked really bad.

The investigation has not disclosed information that would indicate that Mr Peach had any prior knowledge of family X.

Mr Peach was very clear that he saw the role of director-general as strategic; that it involved trying to best position the department for the future and to improve the organisation so that it is viable and successful. However, Mr Peach added that had he been aware of the situation in which the children in the care of family X were allegedly living he would have ensured that appropriate action was taken to address it.

Mr Peach explained that he received information from members of the public through correspondence and through departmental channels. He said that it would not be common for him to receive information directly from an FSO. He acknowledged that communication in the department was difficult and that he was developing strategies to address this issue. Mr Peach noted that he was also involved in developing strategies to identify problematic foster carers in the future. He said that the department was facing great challenges in its delivery of services and that he was endeavouring to meet these challenges.

When asked about the process leading to the reapproval decision, Mr Peach stated that he found the relevant decisions, as he understood them, to be 'inexplicable'.

Mr Peach acknowledged his role in the process regarding pregnancy terminations of children in care, and admitted that he found it a difficult one. He stated that he had been involved in such decisions on two occasions and that each had been the subject of great thought and consideration.

Conclusions about the ministers and directors-general

The investigation did not establish any evidence of official misconduct on the part of any minister. There is no evidence that any minister committed a criminal offence. It is also considered that there is no evidence to support any possible case of official misconduct against any director-general.

All of these witnesses acknowledged the difficulties of their roles and the challenging nature of the foster care area in particular.

None of the ministers or directors-general (with the exception of Ms Spence and Mr Peach, as discussed further below) had any formal policy or practice to identify concerns about specific foster families, other than waiting for such concerns to be conveyed to them by members of the public. These concerns would then be addressed by way of the ministerial briefing process or, in the case of Mr Lingard, through his special team of experienced officers. When specific concerns about family X came to light, they were responded to in the ways described above. That action did not lead to the effective identification of problems that staff have acknowledged as existing in respect of this family, at the relevant times. However, it must be noted that the various ministers and directors-general responded reasonably on the basis of the information furnished to them by departmental staff.

It must be acknowledged that Ms Spence and Mr Peach have implemented some initiatives, such as the foster care audit and the establishment of review and evaluation teams, which the CMC was advised are designed to identify problems in a proactive and systematic way. These initiatives are all of relatively recent origin.

There was no other systematic process of follow-up for any of the ministers or directors-general, and they were all of the view that in such circumstances they were entitled to rely on the information that staff, who had a more detailed knowledge of the case, had given them. All the ministers, with the possible exception of Mr Lingard who had a more 'hands-on' view of the role of the minister, expressed the view that their role did not of itself dictate intervention on a casework level in the absence of compelling information to the contrary.

A consistent view now adopted by the ministers and directors-general was that, had they been in receipt of accurate and thorough information about the situation of the

children placed with family X, they would have intervened to protect the children. The question remains: why were they not so informed?

Clearly, ministers and directors-general have very important roles to play in safeguarding the administration of their departments. To perform those roles properly there must be adequate systems to ensure that they are provided by their departments with full and accurate information about relevant issues. Such systems must include auditing and monitoring processes. There is an obligation on staff to provide their senior officers with a complete picture of the available and relevant information, so that informed decisions can be made. The department needs to have a culture encouraging transparency and accountability, rather than one of understating or hiding pertinent information from senior officers.

The new child protection system and the specific recommendations that are outlined in the following chapters of this report are designed, at least in part, to ensure that the circumstances outlined in this chapter do not recur. In the future, the roles of ministers and directors-general will be enhanced and supported by the new system.

CMC INVESTIGATION: OPERATION GHOST

Background

Following the public disclosure of some of the circumstances surrounding family X relevant to Operation Zellow, an independent audit (led by Ms Gwenn Murray) was commissioned by the Families minister. This audit commenced an examination of how the Department of Families had responded to notifications of abuse against current foster carers. Further information about the work and conclusions of this audit team follows in a later section of this chapter.

On 2 October 2003 the director-general, Mr Peach, formally referred to the CMC some information disclosed by this audit. Under section 38 of the Crime and Misconduct Act, public officials[8] are obliged to inform the CMC if they suspect that a complaint, information or matter involves, or may involve, misconduct. The information referred by the director-general involved another foster family ('family Y'), in a different region of Queensland from where family X resided. The work then undertaken by Ms Murray's team had given rise to significant concerns about the casework undertaken at the relevant area office in relation to two foster carers (a married couple).

The CMC was advised that the independent audit team had raised its concerns with the relevant departmental area office and had requested that — due to the existence of a number of notifications that had been raised in relation to possible sexual abuse of foster children by a foster parent — the risk to the children in the couple's care be assessed immediately. In response the department completed a written assessment, which was submitted to the audit team. In this assessment the area office did not recommend the removal of the children. The CMC was advised that the audit team and senior management within the department did not consider this outcome to be acceptable. A second assessment was requested, which was conducted by a senior practitioner from another region. Her assessment was that the situation warranted the immediate removal of the children in the care of family Y. This was done.

The director-general subsequently referred the matter, on the basis of suspected misconduct, to the CMC. The CMC determined to undertake a misconduct investigation into this matter as a separate operation called 'Ghost'.

Investigations to date

Preliminary investigations in Operation Ghost began at the same time as Operation Zellow was progressing. With the completion of Zellow, the same multidisciplinary team is continuing inquiries in relation to Ghost. Again, relevant files have been gathered and CPIS interrogated. Interviews with departmental staff began in November 2003 with CMC investigators following similar investigative methodology to that employed in Zellow, given that the family history and casework decisions made in the Ghost matters display many of the same features as arose in the circumstances investigated in Zellow.

Issues identified to date

Although the investigation into the Ghost matters was at a preliminary stage at the time of preparing this report, sufficient information had come to light to identify a number of concerns. At the time of preparing this report, the CMC had not had the opportunity to validate these initial issues through further investigation and evidence.

The preliminary evidence indicates that:

1 Notwithstanding the audit team's clear identification of problems during its audit and the direction to the area office to address the issues, the office produced an assessment that did not contain a recommendation for the removal of the children. As a result, an independent officer of the department had to make a further assessment.

2 The assessments done by departmental officers as part of the approval and reapproval process for the foster carers failed to consider all relevant material, including disturbing information about the history of family Y.

3 Despite a number of foster children making clear disclosures of sexual abuse, it appears that the foster carers' versions of events, as obtained by departmental officers, were preferred to those of the children and the notifications had outcomes of 'not substantiated' recorded.

4 There may have been instances of poor decision making by departmental officers and inconsistent outcomes in respect of placement decisions and the recording of notifications of abuse. There is a significant body of evidence of poor record-keeping generally.

As can be seen, these issues are similar in many respects to the circumstances investigated in Zellow and the problems identified regarding the way in which the department handled many matters relating to the children in the care of family X.

More matters of serious concern

As a result of the problems arising over the management of casework decisions in the regional office relevant to Operation Ghost, the director-general arranged for a senior departmental officer to conduct an audit of the decisions made by the manager of that office. On 20 November 2003 the Director-General of Families, Mr Peach, forwarded to the CMC a copy of the briefing note arising from that internal audit. That note advised that the audit had examined a random sample of 80 casework matters decided by the manager. It also provided the following 'background' information as to the context in which casework decisions were made:

> To facilitate the provision of quality child protection services within available resources Policy memorandum PM 00/03 Child Protection Initial Assessment response and Specific Workload Management Strategy was introduced 6 March 2000.
>
> This provided a framework for:
>
> — prioritisation of responses to child protection notifications
>
> — management of those notifications that could not be responded to in a timely manner given workload demands.
>
> All notifications requiring initial assessment are prioritised for commencement and completion according to the assessment of immediate danger and risk of future significant harm:
>
> — Priority 1 matters should be commenced within 24 hours and completed within one month of commencement
>
> — Priority 2 and 3 matters should be commenced within 14 days and completed within one month of commencement
>
> It should be noted that team leaders approve notifications and initial assessment outcomes and that it is only managers who could approve Workload Management. The majority of the decisions for 2000, 2001 and 2002 as listed in the material provided by CPIS [Department of Families Child Protection Information System] relate to Workload Managed decisions by [the Manager].

By way of explanation, it should be pointed out that 'workload management' was a

strategy implemented by the department in 1999–2000 to help area offices manage high workloads. From the information gathered by the CMC, it seems that essentially the strategy gave area managers, on the recommendations of team leaders, an option of 'writing off' child protection notifications where high workloads meant that a full assessment could not be carried out. The policy is no longer in force.

Under a heading 'Use of workload management to "write off" notifications', the briefing note cited the following instances of randomly sampled harm notifications that had been workload-managed and the auditor's views (in italics):

1. Received 19/5/00 and submitted to Supervisor 10/11/00. Approved by Acting Team Leader as notification on 6/3/01:
   - Notifier states eldest subject child has moved out of family home due to allegations of sexual abuse by her stepfather. Child told notifier that stepfather had been making sexual advances for 4 months etc etc. Both mother and child confronted him and he admitted touching child. He denied he had ever touched the younger child. Notifier concerned about younger child.
   - Previous history noted that subject child and elder sibling had been previously subject to CP [child protection] application in 1996 due to sexual and emotional abuse by their stepfather.

   There is no record of referral to police [or] of any action taken prior to workload managing the notification 30/7/01.

2. Received 9/8/00, notification created 24/4/01 and submitted to Supervisor on that day. Approved as a notification … on 19/6/01 and workload-managed 21/6/01.
   - The notifier was a teacher and stated that mother had found out that child had told lies about his misbehaviour and came to school and put child in headlock, slapped his face and pushed him to the ground and kicked him. Child already had bruise on the knee. Child told teacher that this happens at home. The child's teacher witnessed this abuse occur.

   No material recorded and workload-managed 21/6/01.

3. Notification received 21/12/98 from JAB about a child who stated that her brother was sticking his 'wee wee' in his sister's bottom.
   - Approved as a notification 19/3/99 and rationale for unable to commence workload reasons is that FSO allocated this work and only stayed 6 weeks, notification now over 12 months old and unable to be completed. As notifier was police officer JAB officer would have followed it up.

   Outcome approved 20/1/00

4. Notification received 22/6/98 and approved 22/6/98. The notifier was the [local] police. Notification related to significant domestic violence and the refusal of a child to return home. The initial assessment commenced on 22/6/98 and after 2 visits where no-one was at home a letter was written to the family.
   - The family did not respond. The FSO writes that 'after consultation with Acting team leader [now the manager] it was decided not to have further contact with the family as they were not prepared to talk to us and the child had made her own decision to return home'.

   Outcome — unable to commence workload reasons.

5. Notification received 4/6/01 approved as notification 28/6/01 by [Manager]. Notifier very concerned about violence in the home and the risks to the subject children. Assessment commenced 5/6/01 and interviews undertaken. These disclosures by the children were made against the grandparents with whom the family had lived. The original notification had grandmother as the notifier and the mother was the perpetrator. Both children stated that they:
   - were hit with a stick (grandparents)
   - had food forced down their throats (mother and grandparents)

— had a cigarette lighter pressed against their skin (by mother as punishment for doing this to someone else)

This outcome was unsubstantiated … approved 9/7/01. This outcome is questionable given the disclosures by the children about their mother and grandparents. A second notification should have been raised with the grandparents listed as perpetrators. Given the disclosure about both the grandparents and the mother both notifications should have been substantiated.

6. Notification received 15/1/03 and initial assessment commenced 15/1/03 with approval dated 29/6/03. The notification related to a young person disclosing a long history of sexual abuse by her step-grandfather, involving herself and her siblings. The interviews revealed the perpetrator was no longer living with the grandmother. The outcome is recorded as unsubstantiated because the mother acted protectively in confronting the alleged perpetrator about the abuse, she only hit the child once, and the alleged perpetrator is no longer living at home. There is no record of the matter being referred to JAB or SCAN.

The unsubstantiated outcome is incorrect given the child has stated she was sexually abused and it appears that no interviews were undertaken by police with the alleged perpetrator.

7. Notification received 5/6/00 approved as a notification 20/7/01. Assessment commenced 11/7/00. Notification related to subject child watching parents have sex. Child allowed to touch her mother sexually, kissing her breasts and vaginal area. Stepfather allowed child to touch his penis.
   — The notifier was a medical doctor and he stated he was concerned about the inappropriateness of this behaviour. The child would be seen by a paediatrician in a couple of weeks. Child then aged 10 years.

Approved to be workload-managed 30/7/01. No action taken.

8. Notification dated 24/9/99 approved as a notification 21/2/00. Allegations of sexual abuse of child by sibling who claims she was sexually abused by father. The initial assessment was listed as 'unable to be completed', as address details were incomplete. The street name and town were provided but not the number. No record of contacting police. In the concerns expressed in the notification it is noted that there has been previous involvement with the family and this warrants a full assessment.

Outcome approved 21/2/00.

9. Notification received 12/98 regarding serious physical abuse of a two year old child by her mother. The matter was assessed on 4/1/99 and one line is recorded — family have moved. No person living at address. Outcome unable to complete client reasons. There is no record that attempts were made to recontact the notifier and establish where the family may be residing.

10. The concerns stated are that the child then aged four years stated that 'Daddy sexed me. He put his doodle up my bum and I screamed.' Caller has seen child acting out sexually. Child has bruises everywhere. Child swears the entire time etc.
    — 17/10/02 FSO telephoned JAB — interviews arranged for 23/10/02
    — 23/10/02 a higher priority matter arose and interviews set for 29/10/02
    — 29/10/02 a higher priority matter arose and interviews did not occur on that date.

Outcome was workload-managed 3/12/02.

The briefing note also said:

> there are a number of notifications that relate to significant domestic and family violence. The connection and interrelationship between this and child protection is often absent in the work undertaken in the area office.

A number of practice and follow-up issues were identified. They are in many respects the same as those arising from Zellow.

In reporting these matters to the CMC, the department advised that it was undertaking urgent action to ensure that none of the children remained in a situation of risk. Such steps included arranging necessary follow-up action, completing initial assessments and changing recorded outcomes. Mr Peach also directed that the manager be asked to show cause why disciplinary action should not be commenced against her.

Given the recent receipt of these matters, at the time of preparing this report the Commission has not had an opportunity to fully assess the information reported to it and is obviously not in a position to express any conclusions. However, the nature of this information, if it is accurate, suggests that the cases investigated in Operations Zellow and Ghost are not isolated occurrences.

The above 10 cases were extracted from a random sample of 80. The briefing note outlined how the department's CPIS manager had produced a list of 1000 casework decisions this manager had approved, across nine area offices, from 1997 to 2003.

OMBUDSMAN'S INVESTIGATIONS

In the last two years there have been two highly publicised cases about the deaths of children while in the care of their parents. The Queensland Ombudsman conducted investigations and released public reports on each child's death. These two reports:

> Queensland Ombudsman May 2002, *An investigation into the adequacy of the action of certain government agencies in relation to the safety of the late Brooke Brennan, aged three* [the Brooke Brennan report].
>
> Queensland Ombudsman October 2003, *An investigation into the adequacy of the action of certain government agencies in relation to the safety, well being and care of the late baby Kate, who died aged 10 weeks* [the Baby Kate report].

are relevant to the CMC's Foster Care Inquiry because of the extent to which the issues highlighted by the Ombudsman align with the issues identified by the CMC in its investigations.

The following details are taken from the Ombudsman's public reports.

The Brooke Brennan report

At the time of Brooke's death on 25 July 1999, she was living with her mother (Ms A) and a Mr Self in a unit at Back Street, Biggera Waters, on the Gold Coast. Brooke was then three years old. On the morning of 12 July 1999, Ms A took Brooke to see a Gold Coast general practitioner about a sore finger, episodes of vomiting and hair loss. The doctor also noticed bruises on Brooke's body and he referred her to the Emergency Department of the Gold Coast Hospital for further investigations. He advised the hospital that some of Brooke's problems could be related to 'non-accidental' injuries.

Brooke was reviewed in the Emergency Department by the emergency and paediatric registrars, both of whom noted multiple bruising to her body as well as a swollen and bruised little finger, which was later confirmed through X-ray as fractured. The records reflect that both doctors discussed the likely cause of Brooke's injuries with her mother. Brooke was admitted to the paediatric ward of the hospital overnight and a doctor specialising in child abuse, who was a member of the Gold Coast SCAN team, was contacted and arrangements made for him to review Brooke's case the following morning. Ms A remained with Brooke at the hospital that afternoon and evening, leaving around 7.30 pm, after Brooke had settled for the night.

Ms A returned to the ward the following morning at about 7.15 am. After a matter of only some minutes, she led Brooke out of the ward, allegedly explaining to a nurse that she was taking Brooke for breakfast at the hospital canteen. The nurse claims that she objected to this course of action and asked Ms A not to remove Brooke from the ward, but Ms A ignored her request. The nurse notified hospital security and some searches were carried out, but Ms A and Brooke could not be found.

The hospital contacted the SCAN doctor who was to review Brooke's case that morning and advised him of what had occurred. The SCAN doctor said he

immediately attempted to contact the Gold Coast Juvenile Aid Bureau (JAB) and the Department of Families, but was unable to contact either agency for some hours. The SCAN doctor and several doctors employed at the hospital had the ability to issue an order under the *Health Act 1937* to have Brooke taken into custody and returned to the hospital to be detained for up to 96 hours (a '96-hour order' under section 76L of the Health Act). However, this course of action was not taken.

The SCAN doctor claimed to have spoken to an officer at the JAB in the early afternoon and requested assistance to find Brooke, but his request was refused. The QPS had no record of the conversation, although telephone records confirmed that the phone call did take place. The SCAN doctor spoke to the department later that afternoon and made a child protection notification in relation to Brooke. After receiving the notification — and in order to assess Brooke's situation — the department immediately sent two FSOs to the Back Street address, given to the hospital by Ms A.

The two FSOs arrived at the address, a unit in a two-story block, at about 4 pm that afternoon. According to the FSOs, they knocked on the front door and called out for any occupants, but no-one answered. They then spoke to a neighbour, who directed them to the back of the units. They found the back door to the unit open and could hear a radio playing. One officer entered the unit to see if Brooke or Ms A was inside, but found no-one there.

The FSO found a note that appeared to be written by Ms A to her partner, Mr Self, indicating she had left him because of her belief that he had injured Brooke. The FSOs left after searching in the vicinity of the units in case Ms A or Brooke remained in the area. They made some efforts to find an alternative address for Ms A or Brooke, but with no success. The FSOs advised that due to their workloads at the time, they did not have time to follow up on the notification regarding Brooke. The regional office had been notified of the high workloads and the impact that this was having on staff and their ability to undertake all required work, in March 1998, but the area office was still under-resourced at the time of Brooke's death in July 1999.

The matter was then referred to the Gold Coast SCAN team for discussion at a meeting on 22 July 1999, nine days after Brooke's disappearance. Neither the SCAN doctor, nor the QPS, nor the department referred the matter to the meeting of 15 July 1999, the next available meeting, as required by the SCAN team manual. At this meeting, the SCAN team recommended that no further action be taken by any of the SCAN participating agencies. The department did not make any further efforts to find Brooke.

On the morning of 25 July 1999, an ambulance was called to the Back Street unit. Ambulance officers found Brooke lifeless, with severe and extensive bruising to her body. Resuscitation attempts were unsuccessful. Doctors later determined that she had died from internal injuries caused by considerable external force.

It was later revealed that Ms A and Brooke had in fact continued to live in the Back Street unit with Mr Self from the day Brooke was removed from the hospital until the day of her death. At the time the FSOs visited the unit on 13 July 1999, Ms A and Brooke were actually hiding in a downstairs laundry. Ms A advised that she had wanted to avoid speaking to the officers because she thought they were police officers.

Although Brooke was removed from the hospital by her mother, Queensland Health retained a responsibility to ensure that appropriate action was taken for her safety. The department also took on responsibility once it received notification. Assuming that the SCAN doctor did request assistance from the Gold Coast JAB, the QPS also had a responsibility to provide an appropriate response. Because of a combination of factors, the responses of these agencies and the involvement of the SCAN team were not sufficient to prevent Brooke from being further harmed.

The Ombudsman made recommendations about:

- the obtaining of 96-hour orders by Queensland Health
- improved communication between Queensland Health, the QPS and Families
- the referral of matters to SCAN teams

- keeping of minutes by SCAN teams
- better record-keeping by the Department of Families
- improved case management within the department
- an independent consideration of resources required to meet the department's statutory obligations.

The Baby Kate report

Baby Kate,[9] aged 10 weeks, died on 10 September 2001, following a decision by departmental officers to leave her in the care of her mother, Lisa, who had an intellectual disability.

Lisa, who was born interstate, grew up in foster care. When her foster parents relocated to Queensland, the responsibility for management of Lisa's child protection case was transferred to the Department of Families. After her long-term foster placement broke down, she was placed with another foster family were she remained until her child protection order expired at age 18. She then left the care of the state. However, the department continued to offer her assistance as a 'support service case' for about a year after its statutory obligations ended.

In February 2001, when Lisa became pregnant, concerns were expressed to the department about her ability to care for her child when it was born. The information recorded in the notification was:

> Lisa's social and intellectual functioning is at a very low level and she is extremely vulnerable — as is her unborn baby. Lisa has difficulty managing her own hygiene, health and daily care and it is unlikely that she will be able to offer a new-born baby an appropriate and safe environment. She has been drinking and also discussed physical domestic violence between her and her partner — it is unknown if this has occurred during her pregnancy.
>
> Lisa's low level of intellectual functioning, her history of abuse and her lack of basic hygiene and self-care skills place her unborn baby at significant risk of possible neglect and/or physical abuse and emotional harm.
>
> Lisa's disinterest in obtaining any prenatal care for her unborn baby suggests a serious lack of insight and understanding of the needs of both herself and the baby. Lisa has indicated that she is in an abusive relationship and has been drinking heavily and this is also placing her unborn baby at risk of physical harm.

This information was referred to an intake officer in the area where Lisa lived. That officer made the following notation in the computer system:

> Expected date of confinement — July 2001. Still do not have an address for Lisa. Apparently, Lisa whose birthday is in July, has said that she hopes to put the child in care for a few weeks so that she can party for her birthday. There is still the belief that the relationship is one of domestic violence and suspicion that this is occurring whilst she is pregnant.

The officer said that she provided this advice to the social worker at the relevant hospital; however, Queensland Health advised there was no record of this advice being provided.

Baby Kate was born at a regional Queensland hospital. Three days after her birth, she and her mother were transferred to a smaller hospital closer to Lisa's then place of residence.

The smaller hospital was told of Lisa's condition and the documents that accompanied her transfer stated that Lisa needed 'a lot of support and encouragement with her parenting skills'. A few days later, nursing staff saw Lisa shake baby Kate and swear at her. The incident was reported to the Medical Superintendent who made the notation '? child at risk' in baby Kate's medical chart.

Prior to the shaking incident, nursing staff had approached the medical superintendent with concerns about Lisa's ability to care for a baby. The medical superintendent

contacted the paediatrician at the larger hospital to discuss his observations and concerns, and those of the nursing staff. The practitioners agreed that Lisa and her baby needed to be transferred back to the larger hospital for further observation and assessment.

Accordingly, on Friday 6 July 2001, Lisa and Kate were transported by the Queensland Ambulance Service to the larger hospital. The medical superintendent's letter of referral to the paediatrician at the larger hospital referred to his concerns about Lisa's ability to care for her child and to his 'global concerns for both mum and baby'. He said:

> Lisa is struggling. This is day 7 post-natally and I have concerns about her ability to maintain the care of the child. She seems to bond minimally with Kate, only doing the minimum for her. Kate's crying irritates her. [He referred to her medical conditions.] She seems willing to learn but is easily frustrated and has very little spontaneous interest. I have global concerns for both mum and baby.

In accordance with the Health Act, the paediatrician made a child protection notification to the local area office of the department. The notification was recorded by FSO1 who, together with FSO2, was tasked to attend the hospital to assess the situation.

Lisa acknowledged that she needed help caring for her baby, especially with night feeding, but she indicated that her partner, John, would help her. The next day, the FSOs returned to the hospital and spoke to Lisa and John. They explained their concerns about the safety and wellbeing of Kate and informed Lisa and John that the baby would not be able to go home unless the department was satisfied that she had a parent who was *willing and able* to care for her. The FSOs asked John to stay at the hospital to enable nursing staff to assess his ability to care for Kate and support Lisa.

The SCAN team was told what had occurred and that John had not, up to that time, participated in the assessment. The SCAN team recommended that the department 'talk to John about committing to Lisa and baby Kate going home', and that the matter be reviewed by SCAN a fortnight later.

The Friday after the first SCAN team meeting, John arrived at the hospital and indicated that he was there to stay for the weekend. Queensland Health informed the department of his arrival. As FSO1 was on leave the following Monday morning, FSO2 was tasked with attending the hospital with FSO3 to receive feedback from the hospital staff about their assessment of the parenting skills of Lisa and John. The FSOs did not review, or seek to review, the observations that had been recorded in Kate's medical chart by the nursing staff and only had minimal discussions with hospital staff.

The FSOs then reported to their manager their assessment, which was that Lisa and John should be allowed to take baby Kate home. A Child Protection Follow Up (CPFU) case was created, which provided for voluntary ongoing departmental intervention with the family unit.

Kate was discharged from hospital into her parents' care that afternoon. Some four days later, the department became aware that the relationship between Lisa and John had ended and that Lisa intended to move to Brisbane with Kate. The department referred Lisa and Kate to a local group home near the smaller hospital, where they remained for about a week before travelling to Brisbane to stay with Lisa's former foster family.

The SCAN team reviewed the matter on the same day. The minutes of the meeting indicate that the SCAN team was advised by the department that Lisa and Kate would be attending the Riverton Early Parenting Centre, which is a Queensland Health facility located in Clayfield, Brisbane. The SCAN team recommended that, once Lisa had been assessed at Riverton, a long-term placement at either Sisters of Mercy or Fatima might need to be considered. The matter was then 'closed to SCAN' (i.e. not to be the subject of any further discussion or follow-up by the SCAN team).

While Lisa was in Brisbane, residing with the foster family, the foster mother maintained a diary on Lisa's interaction with her baby. While the diary recorded some

improvements, it repeatedly reported that she had to be prompted to get up in the night to look after Kate and was upset if she had to look after the baby when she wanted to go and have a cigarette or do something else. This diary was provided to the FSO, but only its favourable aspects were taken into account.

Although the department initially referred Lisa and her baby to Riverton, it later decided not to proceed with this referral. Instead, the department referred them to a residential facility operated by a non-government organisation in Brisbane. That facility provides emergency accommodation for women and their children but does not provide the specialist parenting services available at Riverton. FSO1 advised that the reason she did not send Lisa and Kate to Riverton was that this 'would set Lisa up to fail' and as an intellectually impaired mother, she had the right to have the opportunity to mother her child.

Lisa and Kate resided at this facility for approximately four weeks until Kate's death. During this period, Lisa did not receive the necessary support or supervision, such as that available at Riverton.

On the evening of 10 September 2001, Lisa found Kate dead in her cot. Lisa's subsequent police statement indicated that she had put Kate to bed at around 4.30 pm and that the baby had been crying ('with temper') so she covered her fully with a blanket and some jumpers so that the crying would be muffled — although she left a space between the bed and the blanket so that air could get in to the baby. About half an hour later, Lisa pulled the jumpers off the head, but left them over the body. Lisa then went outside to have a cigarette and completed her chores at the facility, checking on Kate intermittently. Just before 8 pm she returned to the room again and found that Kate had died.

The police were called. One officer completed a form relating to the death. This was provided to a pathology registrar at the John Tonge Centre who carried out the post-mortem on baby Kate. The form stated that the death was 'non-suspicious'. However, a detailed police investigation had not been conducted at that stage.

The next day, a detective constable from the JAB began a full investigation. He interviewed Lisa about the circumstances of the baby's death and took a statement from her. The QPS did not provide the information contained in Lisa's statement or any other information from the police investigation to the John Tonge Centre pathology registrar. The initial finding of the post-mortem was 'not yet determined pending test results'. When the post-mortem was completed some weeks later, the cause of Kate's death was recorded as sudden infant death syndrome (SIDS).

There is doubt about the accuracy of this finding because a finding of SIDS is a 'diagnosis of exclusion'. This means that SIDS should not be recorded as the cause of death unless all other possible causes have been excluded. Significantly, the coroner relied partly on the SIDS finding in recommending that no inquest be held.

Two weeks after Kate's death, the Department of Families commenced an internal review of its management of Kate's child protection case. The review was completed in about three weeks. The department concluded on the basis of the internal review 'that no negligence had occurred in relation to the management of the case by departmental staff '.

In contrast to the departmental findings, however, the Ombudsman formed the view that maladministration had in fact occurred in a number of areas and made the following recommendations:

- better record-keeping and quicker transfer of files between offices
- better communication and cooperation with other practitioners and agencies
- the ability of the department to take prenatal action in respect of children at risk of harm
- SCAN cases being transferred between SCAN teams when a child moves area
- greater consideration of the welfare and best interests of the child and his/her right to long-term alternative care where there is not a parent

- the establishment of an external Child Death Review Committee which included the Commissioner for Children and Young People.

The Ombudsman's conclusions in this matter demonstrate that the response by the Department of Families to the needs of an obviously at-risk child was self-evidently less than satisfactory, in view of the tragic outcome. It is pertinent to note that in scrutinising its own activities the department found no evidence of 'negligence' in the management of the case by its officers. This finding, in view of the matters identified by the Ombudsman, raises the question of the capacity of the department to adequately scrutinise its own activities.

THE EXTERNAL AUDIT OF DEPARTMENT OF FAMILIES FILES

As noted at the start of this chapter, prior to the announcement of the CMC Inquiry, the Director-General of the Department of Families appointed an independent external auditor, Ms Gwenn Murray, to review all departmental files involving notifications of abuse to children in care by any foster carer who currently had a placement. Ms Murray was aided by 10 senior departmental officers with extensive child protection and research experience, together with a representative of the Commission for Children and Young People and senior policy officers from the Social Policy Division, Department of the Premier and Cabinet. CMC officers liaised extensively with Ms Murray and her valuable assistance is acknowledged.

Terms of reference

The director-general set down seven terms of reference for the audit:

1 to determine the accuracy or otherwise of the assessment outcome for each notification

2 to consider whether the action taken following substantiated notifications was appropriate for the circumstances in respect of both the foster carers and the subject children

3 to identify any emerging pattern in relation to foster carers who have been subject to a number of notifications (whether substantiated or not)

4 to comment on the adequacy of statutory requirements, departmental policy, practice and procedures as they relate to notified foster carers

5 to make recommendations for any change to policy, practice and procedures that may be required

6 to refer any relevant information identified through the audit regarding the case which is the subject of the CMC's current investigation (Operation Zellow)

7 to bring to the notice of the director-general any matters relating to actions or inactions of departmental officers that may require a further response.

Methodology

To give effect to the terms of reference, the audit team:

- reviewed all notifications and initial assessments involving foster carers who were currently approved carers for the department
- reviewed relevant legislation, policy and procedural information
- undertook preliminary discussions with community groups
- considered the findings of previous audits conducted by Families, as well as relevant reports from other states and overseas.

The audit has three phases:

Phase 1: Notifications

Phases 2 and 3: Review of foster carers without a current placement.

Assessment tools

The audit team developed a set of criteria to assess the recording of information and the practices and procedures implemented by the department. Quality assurance mechanisms were developed to ensure that the decision-making processes of the audit were consistent and a database was constructed capable of both recording the outcomes of the audit and generating reports from data queries.

Data

Relevant data were requested from both the Information Services and Corporate Services branches of the Department of Families. However (and not surprisingly, in view of the CMC's own experiences), the audit team reported that accessing relevant data was difficult because of the department's very poor data systems. The information required was stored on the Child Protection Information System (CPIS) and the Family and Youth Justice database (FamYJ). A significant amount of relevant information was also stored on paper files in area offices. As there is only limited interaction between these three systems, obtaining the relevant data took three to four weeks before any actual analysis could be commenced.

Several times during the audit, additional notifications against foster carers that were not included in the first search were identified. Additional searches were conducted to ensure that all relevant notifications had been found.

Sample size

As at 20 June 2003, according to the data provided by Ms Murray to the CMC hearings, there were 1579 foster carer families with current placements (although the term 'current placement' is difficult to track because children are moved in and out of the system on a daily basis).[10] Of the active carers identified at 20 June 2003 — phase 1 of the audit — 197 families (28%) had been subject to notifications.

Phase 1 of the audit started off with 883 notifications, which had occurred between 1 January 1997 to 30 April 2003. An additional 39 notifications were identified as the audit proceeded. These were audited accordingly as part of Phase 1. A further 44 notifications were identified after the CMC's public hearings. These notifications related to approved foster carers who had either emergency or unpaid relative placements and were not provided to the audit team in the initial data reports. The director-general asked the team to audit these additional notifications as well because they fell within the terms of reference of the audit. The total number of notifications as at 19 November 2003 was 1022 (see Table 2.1 below).

Table 2.1. Notifications (phase 1)

Source	No.
Number of notifications initially provided to the audit team for Phase 1	883
Number of additional notifications identified during the audit	95
Number of emergency placement notifications transferred to Phase 1 from Phase 2 (see discussion below) of the audit	9
Number of additional notifications for emergency placements and unpaid relative carer placements not previously provided to audit team	35
Total notifications to be reviewed/audited in Phase 1	**1022**

The audit team began by reviewing the most recent and prolific notifications (i.e. multiple notifications against carer families). A total of 596 notifications had been reviewed by the time Ms Murray presented her preliminary findings to the public hearings, including all of the notifications for 2002–03. Analysis is continuing on the earlier cases.

Of those reviewed so far, 348 (approximately 58% of the notifications) — relating to 473 distinct children — fell within the scope of the audit. A further 248 of those notifications were outside the scope of the audit because they related to allegations of offences perpetrated by the child's natural family before they were taken into care or during access visits once in care, or by foster carers against their own children.

In an extension to the audit process, the team reviewed the sample on 20 October 2003, to determine whether there were any carers without a current placement who had had a placement since 1 January 2002. As a result of this procedure, an additional 112 notifications were identified for the 393 carers in this category (see Table 2.2). A review of these carers/notifications will occur in Phase 2 of the audit.

The independent auditor has also recommended that a third phase of the audit be conducted to review carers who have not had a placement since 1 January 2002
(123 foster care families were identified within this group). Although it is a requirement (under the Child Protection Act) that a reapproval process for carers occur every two years, the audit has revealed that this does not always occur and that there may be carers in this category who have not been reviewed for some time. Before undertaking Phase 3, the audit team has recommended, therefore, that departmental staff clarify carer status and/or reassess these carers. Table 2.2 indicates the number of carers to be reviewed in phases 2 and 3 of the audit.

Actions taken about concerns raised by the audit

Where errors in recording or concerns about the decision making for individual cases were identified, the audit team sought an explanation from the relevant area offices. The audit team also called for immediate action by the director-general for all cases that indicated the immediate safety of a child was at risk, including a response to the team within 24 hours of notification and a written report of the actions taken. Any

Table 2.2. Approved fosters carers without a current placement (at 20 October 2003) to be reviewed in phases 2 and 3 of the audit

Audit phase	Year of last placement	Number of approved carers without a placement at 20.10.03
Phase 2	2003	295
	2002	98
Phase 3	2001	50
	2000	24
	1999	22
	1998	9
	1997	10
	1996	4
	1995	3
	1994	0
	1993	0
	1992	0
	1991	1
	Total	**516**

matters thought to reflect some type of criminal behaviour or misconduct were also referred to the director-general and the CMC.

Interim report (August 2003)

An interim report of the project was provided to the Director-General of the Department of Families on 12 August 2003 (Murray 2003a). A copy of that report was also given to the CMC. Ms Murray appeared at the public hearings of the Inquiry at the request of the CMC. The audit at that time was ongoing and the findings reported were therefore preliminary. Nevertheless, Ms Murray reported that the audit had already detected a number of serious concerns regarding practices, procedures and policies within the Department of Families. She also reported that these issues appear to have seriously affected the care and safety of some children in foster care. The results of the audit are particularly relevant to the terms of reference of the CMC Inquiry and are documented below.

Timeliness of response

Notifications about children in foster care automatically receive a priority one notification, requiring action to be taken within 24 hours.[11] Ms Murray reported, however, that only 36 per cent of initial assessments (IAs) reviewed by the audit team were commenced within 24 hours and 21 per cent of them were not commenced within two months.

Recording notifications

In recording a notification, it is important to include information about all subject children and relevant people. Clear statements of alleged harm, the context in which they occurred and the person allegedly responsible need to be clearly identified and recorded. It is also important to conduct a number of inquiries about the history of the child, the family and the carers. The audit team found that the recording of information within notifications was quite comprehensive: clear statements of harm or risk of harm were sufficiently provided in 80 per cent of the cases reviewed. Similarly, the context for the harm was sufficiently provided in 74 per cent of cases and the recorded category was consistent with the child protection concerns expressed in 86 per cent of cases.

However, the review also revealed that children in care are not regularly visited, and if they are the information is not well recorded. It also noted that placement meetings happen irregularly, casework is not documented, and there appear to be carers with a large number of children placed with them at any one time.

In addition, due to the high workload of staff doing child protection work, low priority appears to be given to recording information that will ultimately form the child protection history of the child. The departmental database systems also appear to be cumbersome and not particularly user-friendly, and the audit noted that recording information can be a burden for many workers.

Assessment of harm

The audit processes revealed that outcomes of initial assessments were substantiated in 50 per cent of cases, 42 per cent were unsubstantiated, and the remaining 8 per cent were recorded as a part assessment (for 'client reasons' or 'unable to commence for workload reasons'). However, the assessment of the allegations of harm by departmental officers was considered by the audit team to be problematic and, in fact, inadequate in 55 per cent of the cases reviewed. Many of the essential elements required to ensure the current and ongoing safety of a child were considered to be missing in most of the assessments conducted. For example:

- In 31 per cent of initial assessments, there was no evidence that all of the subject children had been sighted. If one child had been the subject of a notification there was no evidence to suggest that he or she had been sighted by a departmental officer, or if there were multiple subject children there was no evidence that any or all of the children had being sighted (only three out of five

of the children may have been sighted, for example). In most cases where a child was not sighted, they were also not interviewed.

- In 29 per cent of the initial assessments, where the audit team considered the subject children to be both old enough and intellectually able to be interviewed, there was no evidence to indicate that all of the children had been interviewed. If there was only one subject child there was no record of a departmental worker ever interviewing that child, or if there were multiple subject children there was no evidence that any or all of the children had being interviewed (only three out of five may have been interviewed, for example). Some records indicated that telephone interviews had occurred and these were assessed as adequate by the audit team.
- Not all relevant people were contacted:
  - all relevant foster carers were not interviewed in 29 per cent of cases
  - other relevant persons alleged responsible, such as the foster carer's relative or another foster child in the placement, were not interviewed, despite being allegedly responsible in 63 per cent of cases
  - in 65 per cent of cases, information was not gathered from other relevant people to form a holistic assessment.
- In 30 per cent of audited cases, significant contextual factors (such as medical or educational assessments) were not taken into account.
- Practices tended not to include a risk assessment or an analysis of protective factors:
  - in 40 per cent of cases an assessment of harm was not identified and recorded for each subject child
  - in 53 per cent of cases, the assessment of future risk was not identified and recorded for each subject child (demonstrating a lack of understanding about harm and future harm)
  - in 38 per cent of cases, other foster children's protective needs should have been assessed but were not.
- Sexual abuse was not well identified.
- Children were more likely to be believed when they disclosed harm by their natural parents than when they disclosed harm by their foster carers.

The most disturbing findings were:

- The outcomes recorded were not considered by the audit team to have been appropriate in 43 per cent of cases.
- Following a substantiated risk outcome, the audit team considered that in only 67 per cent of cases was the action taken for the child appropriate.
- The actions taken against foster carers was considered appropriate by the audit team in only 47 per cent of cases.
- The recorded assessment was not consistent with the outcome in 32 per cent of cases.
- The outcomes recorded did not often have a clear rationale for the decision making that led to the outcome.
- There was often no clear case plan for addressing protective concerns.
- In 5 per cent of cases subject children were left with foster carers when it was considered by the audit team that they were at an unacceptable risk.
- In 12 serious cases involving allegations of both physical and sexual abuse, Ms Murray was so concerned that she requested the director-general to act immediately, and in a further 19 cases Ms Murray requested that the carer be reassessed.

Overall, therefore, the audit team determined that the assessment of allegations of

harm were inadequate in 55 per cent of cases reviewed.

Policy implications

Ms Murray noted a number of policy implications arising out of her audit to date. These included:

- **The rights of children**. The *Child Protection Act 1999* clearly articulates that a child has a right to be provided with a safe and stable living environment, to be placed in care that best meets the child's needs, and that the child is to be consulted about, and to take a part in, decisions about that child's life. One of the most clear and apparent findings of the audit is that departmental practices are not child-focused and that children's rights are rarely addressed. For example, Ms Murray reported serious concerns that not all subject children were sighted during the assessment of allegations of harm and that many were not interviewed at all. The audit team found that children, when interviewed, were often not believed. Ms Murray also noted that while there appear to be formal support systems for foster carers during interviews about allegations of harm, there are no such systems for the children.

- **Carer's partners**. Ms Murray noted that in some cases the carers' partners had not been approved as carers even though they shared the same household.

- **Official visitors and children's guardians**. Currently the Commission for Children and Young People provides community visitors to attend residential facilities. Ms Murray suggested that a similar scheme should be implemented for children in foster care. She also noted that the New South Wales Office of the Children's Guardian is responsible for all children and young people in the care of the department. The Children's Guardian, among other things, reviews care plans, sets standard of care and responds to complaints by children and young people about their care. Ms Murray suggested that this role could be explored for children and young people in Queensland.

- **Departmental staff**. According to Ms Murray, little attention appears to be given to supporting the professional development and emotional resilience of child protection workers.

- **Inconsistency in decision making**. Ms Murray reported considerable inconsistency in decision making between officers and between area offices.

- **The need for specialist investigators**. During the public hearings the CMC Chairperson queried Ms Murray about a potential role for specialist investigators to review notifications. Ms Murray agreed that the proposal warranted further attention because FSOs do not receive any training in investigations. Ms Murray also noted her concerns about potential conflicts of interest for workers when required to objectively assess allegations against foster carers with whom they may have had long-term or ongoing relationships. She also pointed out that the provision of therapeutic services for children is the primary role of FSOs and this may also limit their capacity to undertake adequate forensic review.

- **Data-management systems.** Ms Murray stated that current data-management systems are a major obstacle to good practice and quality assurance. The audit will provide the department with recommendations for the development of an integrated client-management system to ensure that a worker's day-to-day practices are enhanced and that the data are quality-assured.

The central message drawn by Ms Murray and her team from their audit of departmental files was that the current system is failing many vulnerable children in foster care. She pointed out, however, that in her view this situation did not occur overnight: the child protection system has been for many years heavily burdened by under-resourcing, out-of-date case-management systems and a lack of good placement options. She stated that the department is becoming dangerously like one of the neglected children for whom it has a statutory responsibility. Major reforms need

to be developed and implemented to ensure the safety and wellbeing of children and young people. She suggested that these include:

- better resources for the department and community agencies
- training and professional development and emotional support for departmental workers
- adequate training and financial and emotional support for foster carers
- intensive family support services to help families keep children safely supported at home where appropriate.

Ms Murray stated her opinion that the investigation and assessment of notifications of children in foster care and the following casework are currently unacceptable. She noted that if a child is removed from its natural family because of abuse the department and the child's carers have to promise the child that they will be placed somewhere better, where they will be safe: 'We cannot afford to further fail these vulnerable children' (CMC 2003, p. 307). Ms Murray called for a whole-of- government approach and significant community commitment to ensure the safety of our children.

Limitations of audit

It is important to recognise that, concerning as they are, the findings of the audit conducted by Ms Murray and her team are conservative in their estimation of the level of apparent practice failure by the Department of Families. The audit was limited in its terms of reference and consequently is likely to represent an underestimation of the actual levels of inappropriate decision making within the department. For example, the first phase of the audit only reviewed approved foster carers with current placements. The audit did not include:

- approved foster carers without current placements — it may be that some foster carers who are available for placement have notifications against them that have not been audited and, as such, may pose a potential threat to children in the future; it is understood that phases 2 and 3 of the audit will address these concerns
- licensees and carers who provide care for residential facilities
- allegations of abuse by natural parents during access visits while their children are in care
- allegations of abuse by foster carers against their own children
- allegations made by children who have left the system — the CMC's Operation Zellow revealed evidence that notifications against carers, once a child has left the system, are not necessarily recorded. This has important implications for the safety of children who remain in the care of those carers against whom allegations have been made, and for any future children who may be placed in their care.

The audit team requested data reports by way of 'currently approved carers with a placement' which included relative carers. However, following the discovery of major data discrepancies during the audits, the data were checked against the foster care payment system to ensure that all foster carers with placements were inspected. It is possible, however, that some notifications against unpaid relative carers may have been missed. Information provided by the department to the CMC, for example, indicated that there were 162 children placed with unpaid relative carers as at 30 June 2003.

The audit process also depended upon the identification of carers with notifications against them by using various departmental data systems. These systems have been shown to be inadequate and without a full audit of all foster care files it may be that more children remain at risk.

The nature, process and outcomes of the audit also indicate that the department does not routinely review notifications in any ongoing or systematic way to assess trends, identify children at risk, or deregister carers identified as a threat to the safety of the

children in their care. It also indicates that important information about children and carers is not available to workers on any systematic or routine basis.

In summary, the evidence arising from the independent audit reveals major systemic failings by the department in terms of organisational infrastructure for child protection services, work practices by FSOs, supervision and monitoring by management and an apparently general failure by the department to comply with its statutory responsibilities towards vulnerable children at risk of abuse and/or neglect.

The evidence also reflects, in many important respects, many of the systemic issues identified in Operations Zellow and Ghost and the two child-death investigations reported upon by the Ombudsman.

Final report of phase 1 (December 2003)

On 15 December 2003 (as this report was being prepared for publication), Ms Gwenn Murray's final audit report (2003b) was publicly released and posted on the Department of Families website. As indicated in her interim report and her oral presentation to the Commission's public hearings, Ms Murray identified many areas of great concern in the way that the Department of Families currently handles child protection in Queensland.

For example, Ms Murray wrote:

> The Audit has found a number of serious issues about under-resourcing, outdated information systems, practice, procedures and policy within the Department. These issues have seriously impacted on the care and safety of many children in foster care, with only 15% of audited cases (or one in seven cases) that required no further action. The Audit has also highlighted a range of systemic matters that require addressing. (Murray 2003b, p. 2)

She said in her opening remarks that:

> The Audit findings are serious … Major reforms need to be planned and implemented to ensure the safety and well being of children and young people, and some of these need to be given high priority. They include better resources for the Department and community agencies; training and professional development and emotional support for its workers; adequate training and support for foster carers; and intensive family support services to assist and strengthen families to keep children safely supported at home where appropriate.
>
> The Audit has provided an opportunity for government and community to rethink current systems and approaches to ensuring children are safe, to contribute to their well being and to collaboratively create a range of integrated services and options. It is also an opportunity to reflect on practice in the past and to move towards a more child-centred approach. If a child is removed from its natural family because of abuse, the Department has to promise the child that they have been placed somewhere better and safer. We cannot afford to further fail these vulnerable children. As Desmond TuTu said, 'it takes a whole village to raise a child', and child protection is not just the business of the Department of Families, it requires a whole of government and community commitment and approach to keeping our children safe. (Murray 2003b, p. 6)

Ms Murray's report provides numerous recommendations for reform within the child protection system in Queensland. These recommendations are fully listed in

Appendix D of this report.

The concerns raised by Ms Murray, and the recommendations that she makes, have been derived quite independently of the CMC's Inquiry, albeit in parallel processes. The Commission views Ms Murray's findings as highly complementary to those arising from this Inquiry and is fully supportive of her recommendations. It is the Commission's view that Ms Murray's recommendations can play a pivotal role in the implementation of the CMC's recommendations for reform, which come later in this report (see Chapters 4–9).

SYSTEMIC ISSUES ARISING FROM THE INVESTIGATIONS

The evidence arising from the investigations reported in this chapter demonstrates not only a sequence of poor decision making with respect to one foster care family and the large number of children placed in its care, but, more importantly, the extent to which that poor decision making is clearly systemic in nature. The collective message of the evidence from the Zellow and Ghost investigations, together with the independent audit, the Ombudsman's reports and the new matters most recently forwarded to the CMC, is that these documented failings cannot be solely attributed to deficiencies of individuals, but have to be recognised as organisational failure.

Preventing any repeat of the litany of problems highlighted by these investigations will require concerted attention to the systemic issues that underpin the extent to which the department has failed in its responsibilities to children placed in its care.

It is an unfortunate irony that these investigations and the broader Inquiry processes combine to comprise a methodologically elegant research design. Available for examination and analyses are quantitative system-wide data (the independent audit) and the Ombudsman's reports, tightly focused and detailed 'case study' material (the Zellow and Ghost investigations) along with the very detailed and rich qualitative material provided as part of the public submission/ hearings process.

The capacity to draw upon micro- and macro-level data in the both quantitative and qualitative forms means the Commission is equipped not only to ascertain the reality of child protection services as they are actually provided in Queensland today, but also to identify what the key features of a better model of service delivery ought to be.

The various investigations draw attention to nine areas of departmental responsibility characterised by systemic failures. These are:

1 children in care as the number one priority
2 intake and assessment procedures
3 investigative procedures
4 induction, training and professional development
5 clinical accountability
6 the SCAN process
7 case planning and management
8 caseloads
9 protection of Indigenous children.

While these issues are generally clear from the evidence set out above, and are discussed in detail later in this report, it is useful at this point to make the following brief comments.

Children in care as the number one priority

One of the guiding principles for the administration of the Child Protection Act is that the welfare and best interests of a child are paramount. This commitment was not, however, reflected in the evidence arising from Operation Zellow. In situations where the wishes of the foster carers conflicted with the rights of the children or other interested parties such as biological parents, the weight of the evidence favours the view that the officers consistently gave precedence to the wishes of the foster carers.

For example, there was evidence that at one point one of the foster carers stated that she did not want staff visiting her home and that the staff obliged by curtailing visits, except under terms acceptable to the carer. In Ghost, the preliminary evidence indicates that in response to allegations of abuse the versions of carers have regularly been preferred over those of the disclosing children.

The fostering history of the children in the Zellow investigation also provides repeated examples of little contact being maintained between the children and their birth families. There was evidence that this was so marked that at one time the department considered removing the children; however, no such action eventuated.

On some occasions in the Zellow investigation investigators discovered there was no evidence that officers had spoken directly to relevant foster children about issues of concern. In other instances, children were spoken to by staff in the presence of a foster carer and clearly the possibility arises that their version of events may have been influenced by that circumstance. Such approaches to information gathering had the clear potential to adversely affect the department's capacity to assess the real status and needs of the children.

Intake and assessment procedures

The evidence about the intake and assessment procedures followed in the Zellow flashpoints indicates that the department's approach to such matters was not consistent and was often inadequate. For example, the first information received at one area office about a young child contracting gonorrhoea was assessed as a low-priority intake, despite the fact that that information clearly presented the possibility that the child may have become infected with such a disease through sexual transmission. Given the young age of the child, it is very difficult to envisage how such information could ever be viewed as anything other than 'high priority' by officers of an agency charged with protecting children.

The doctor contacted the relevant area office to advise of the diagnosis of two young children with gonorrhoea at 5 pm on a Friday. The evidence is that no investigation was commenced by the department until the following Monday and no assessment made of the safety of any of the children for the intervening weekend. It would appear that even such a serious diagnosis and its obvious implications did not result in a perceived need by the relevant staff to work outside standard business hours.

Concerns about the department's responsiveness arose in relation to other Zellow flashpoints such as the treatment of the statutory declarations, in the early evidence arising from Ghost about the area office's initial reaction to the concerns expressed by Ms Murray's audit team and in both of the Ombudsman investigations. The details of the most recent referral to the CMC, if substantiated by further investigation, point to an alarming pattern of evidence of inaction or delay in the recording of notifications and undertaking necessary assessment work in a timely fashion.

Investigative procedures

There was little evidence that sophisticated investigative procedures were routinely employed by the department. There is evidence that in several flashpoints relevant witnesses were not interviewed. Contributing to and compounding the unsatisfactory nature of some of the investigations undertaken by the department were the

deficiencies noted already about note-taking and record-keeping. In the Baby Kate report, the Ombudsman concluded that case records were not properly kept and that his investigation indicated that such inadequacies were likely to be widespread. The evidence from the CMC's inquiries completely validates that view. The Ombudsman also drew attention to perceived inadequacies in the department's internal review of the circumstances of Kate's death.

The Commission understands that departmental officers are not trained investigators, at least to the extent of some other professionals such as police detectives. However, given the important assessment and inquiry work required in the delivery of adequate child protection services, it is reasonable that higher standards be expected than those demonstrated in many of these matters.

Less-than-adequate communication between the department and other relevant agencies such as the QPS, which affected departmental investigations, and also those of other agencies, was also a consistent theme in the matters investigated.

As well, it is the view of the Commission, given the evidence arising from the Zellow flashpoints, that it would be preferable for there to be some separation of the roles of investigating harm notifications and making subsequent casework decisions. Many departmental officers spoke of the difficulty in finding alternative placements for children who needed to be removed from a foster family. Where the officers responsible for casework decisions about such placements are the same officers who also investigate notifications and have to decide whether recommendations for removal should follow, an obvious potential for conflict exists. It would be far better if the investigative and casework roles were kept independent. More is said on this issue in Chapters 3 and 5.

Induction, training, and professional development

In addition to the deficiencies identified in departmental investigative methodology, the various investigations have produced evidence questioning the validity of many decisions made by officers. There is evidence of numerous instances of noncompliance with specific policy and procedural requirements and broader child protection policy obligations and principles. The complete evidentiary picture and the comments noted below in relation to issues about accountability of decision making and caseloads indicate that a significant number of officers at the frontline of child protection work were not equipped with the necessary skills and resources to enable them to make the right decisions in an acceptable number of cases. It is accepted that such decisions will often be difficult ones to make. Different officers (and other people) might disagree about outcomes in specific cases. However, it is necessary that decision makers follow appropriate and transparent processes to ensure that in arriving at determinations they have accessed all available and relevant information, taken into account the relevant considerations and policies and procedures, and made a decision that is itself documented and based on reasoning reflected in the relevant records.

The evidentiary picture of current practices that emerged from the investigations points to the need for reform in the areas of training, induction and ongoing professional development of departmental staff.

Clinical accountability

The evidence from some of the Zellow flashpoints, such as the reapproval process, highlighted a widespread lack of 'ownership' of decisions made and the casework in respect of family X. The primary assessing officer in that process gave evidence that although she made a particular recommendation it did not accord with her real view and she expected that the recommendation would not be implemented. The roles and responsibilities of various staff frequently could

not be established with precision during the investigation; for example, there was insufficient evidence available to identify who wrote the inadequate ministerial brief for Mr Briskey's letters.

Factors such as the state of the relevant records and staff turnover rates also affected accountability. There was little evidence found, in any of the investigations, to illustrate that there was any rigorous supervision of casework matters or any productive audit or other follow-up strategies.

The SCAN process

The gonorrhoea flashpoint matter was referred to SCAN. Despite that team's awareness of the possibility of sexual abuse occurring to the children, it cannot be concluded from the available evidence that SCAN intervention effectively addressed all of the concerns that had arisen. Many of the matters outlined in this part involved less than adequate or timely communication of information to SCAN teams and other questionable outcomes. Again, record-keeping problems in relation to the SCAN minutes and recommendations were identified. Communication deficiencies between SCAN teams, the department and other relevant agencies were noted in several matters.

Case planning and management

In the Baby Kate report the Ombudsman noted that the delay in transferring casework and managerial responsibility between area offices might be symptomatic of widespread problems.

In the Zellow investigation different area offices had responsibility for the children at different times. Some children's cases went unallocated for a long period. That matter also produced evidence of a consistent lack of appropriate case planning for the children in care. The files reflect that case management, where it did exist, was reactive rather than proactive and there is little evidence of periodic review (as is now required by s. 88 of the Child Protection Act) or considered case planning. All of these factors meant that at times there appeared to be few officers with an adequate or 'corporate' picture of information about family X, and this, in turn, affected how notifications were handled.

Caseloads

During the Zellow investigation, FSOs indicated that staffing levels seriously affected their capacity to undertake their roles effectively. Exacerbating this problem was the rapid turnover of staff and short periods of staff relieving in higher positions. This also seems to have led to a loss of 'corporate knowledge', which, as noted above, negatively affected case-planning and management processes.

Resourcing shortfalls were noted in the Brooke Brennan report. The Ombudsman also noted a lack of remedial action, in one instance, when departmental management was specifically advised that resourcing constraints were damaging child protection work.

However, it must be noted that it would be extremely simplistic to conclude that merely putting more resources into the department would in itself alleviate or overcome the systemic problems identified in these investigations.

Protection of Indigenous children

The evidence in Zellow as to whether or not family X was Indigenous highlighted how the department dealt with relevant Indigenous issues such as the Indigenous 'placement principle' and the special needs of Indigenous children in care. Specifically, there was evidence about an apparent lack of consultation with the

AICCA about the removal and placement of the children, and also evidence of some communication difficulties between the area office and the AICCA.

Beyond that specific evidence, there was other information provided as to the relationship between the department and the local AICCA, and how that affected the department's handling of the most recent disclosure, which ultimately led to the children being removed from family X. The particular issues identified in evidence suggested that issues such as the above may be systemic and, while the Zellow case was the only specific investigation involving Indigenous children, consultation with stakeholders during the Inquiry process supported the investigators' initial perception about the likely systemic nature of these matters.

FINAL COMMENT

It cannot be said that the adverse outcomes for children highlighted in this chapter derived simply from a few atypical and extreme cases that resulted from an unfortunate series of poor decisions by individual FSOs. Collectively, the evidence indicates organisational failure to equip officers at virtually all relevant levels of the department with the information or skills and resources to make the right decisions in the best interests of children in care in a satisfactory number of cases.

All of the problems identified in the broad audit work of Ms Murray are exemplified by the specific evidence arising from the Zellow, Ghost, Brooke Brennan and Baby Kate investigations, which also illustrated some additional systemic issues. The particular facts of those matters underscore the ultimate effect of these systemic failings: the extent of practice failures and inadequate processes 'tallied' by the independent audit are shown by those investigations to have human costs that should not be tolerated as part of any modern state-administered child protection service.

These issues are of immediate concern to the Commission and should be of similar concern to the department, all other stakeholders in the child protection area and the Queensland public.

Endnotes

1 The English case *Gillick v. West Norfolk and Wisbeach Health Authority* [1986] 1 AC 112 deals with testing the competence of a child or intellectually disabled person to consent to medical and other procedures.

2 Section 224 makes it an offence for a person to unlawfully administer poison or a noxious thing or to use force to procure the miscarriage of a woman.

3 Section 282 relieves a person from criminal responsibility for the performance of a surgical operation upon any person for the patient's benefit or upon an unborn child for the preservation of the mother's life, if the operation was performed in good faith and with reasonable care and skill.

4 Unreported, Supreme Court (Qld) McPherson J, 24 May 1995.

5 This is the woman who later voiced her concerns to Mr Malone MP about her lack of contact with her children.

6 The Honourable Margaret Woodgate was minister from 31 July 1995 to 19 February 1996. There is no evidence that Ms Woodgate received any relevant correspondence about family X or held the portfolio at the time of any of the flashpoints.

7 Ms Matchett was followed as director-general by Ms Jacki Byrne (now deceased).

8 Defined to include the chief executive officer of a unit of public administration — for example, the Director-General of the Department of Families.

9 The names used throughout the Ombudsman's report and repeated here are pseudonyms.

10 The data provided to the CMC by the department's Information Services Branch, independently of Ms Murray's audit, indicated that there were 1667 carers with current placements as at 30 June 2003.

11 A departmental officer recording a notification of harm determines the level of harm or risk of harm and prioritises the case as one requiring a protective advice response or one requiring investigation and assessment. Ratings of one, two or three are applied — one being the most serious and urgent. Departmental policy from 1 December 2001 states that a notification about a child in foster care must receive a priority rating of one, requiring commencement within 24 hours.

3

THE PUBLIC HEARINGS AND INQUIRY SUBMISSIONS

This chapter focuses on the key themes and issues that emerged from the written submissions, from the CMC's consultations with staff of the Department of Families and other interested parties, and in the evidence at the Inquiry hearings. These themes and issues reflect the problems besetting the current child protection and foster care systems and warrant particular attention in the new system, as outlined in Chapters 4–6. Hence, they form the basis of many of the recommendations made later in this report.

The chapter does not exhaustively detail all of the evidence and submissions about each issue. However, the relevant witnesses and other parties can be assured that all of their information has been considered at length in the preparation of this report.

KEY THEMES

The key themes and issues dealt with in this chapter are:

- a child's needs
- workplace issues in the Department of Families
- foster care
- enhancing accountability
- protecting Indigenous children
- transformational versus incremental change.

A CHILD'S NEEDS

In undertaking its investigative functions, the CMC has striven to understand, and respond to, the needs of children. The whole focus of the Inquiry has been upon ensuring that children in foster care are protected from abuse. Hence, in addition to hearing evidence and considering submissions that addressed the needs of children, we conducted research, consulted widely and sought to obtain foster children's perspective on their own experiences and needs.

In evidence before the Inquiry, Ms Nicky Davies from Legal Aid Queensland made the following observation:

> The best interests of children are generally best served by being cared for by their family — whether that's by parents or relative carers — with support for the family, if necessary. This generally promotes the child's identity, including their cultural identity. However, if that is not possible the focus must be on the needs of the child or young person, not any perceived rights of parents or least intrusive options. Decisive and timely action must be taken to protect the child from harm and provide for their long-term interests and stability. There appears to be an over-emphasis at times on short-term orders and proposals to reunify a family when reunification is not a realistic option and the protective needs and welfare of the child would be better served by a long-term stable order. This also places great burdens on foster carers in providing a family environment for the child when there is so much uncertainty in the proposals for the future of the child. (CMC 2003, p. 544)

Case planning

Case planning is an essential tool in developing a strategy for either reunifying a child with their family or managing contact with family members while ensuring stability within a placement. Case planning allows contribution from all relevant stakeholders and sets the ground rules for engagement regarding the child, thus increasing certainty for the child, the parents and the carers. However, the Inquiry was repeatedly told that case planning was often done poorly by departmental officers, if it was done at all.

In respect of initial assessments, on which case plans are based, the Inquiry was told by the Abused Child's Trust:

> When the child comes into care what in most cases doesn't happen is a full evaluation of that child's needs — medical, education, psychological — and then a plan to put in place to support those needs or address those needs and to address the needs — both educational and otherwise — that the foster carers will require to manage that child. (CMC 2003, p. 584)

CREATE also expressed the view that finding a bed for the child was often the primary focus, with workloads preventing any extended assessment being completed at a later time (CMC 2003).

There was evidence that this failure to plan reasonably far into the future particularly disadvantaged those children who required extensive therapeutic assistance through individual packages. Life Without Barriers told the Inquiry:

> What's happened, I guess, also is that because of this drive on reduction of costs with the packages it means that it's very rare for a package to have a case plan that extends beyond a few months, so it's quite incongruous to me that whilst the department is concerned about permanency that they have administrative systems that don't allow a child to have a case plan developed beyond a few months in many instances, in which case that leads to increased disruption, a lack of security for those children, a lack of capacity for community agencies such as ours to develop their infrastructure and plan the kind of service provision that we need to organise. So, again, it is, I guess, an example going back to what the minister was saying where the systems are being created that have been quite at odds with what the philosophy requires and, again, constitutes systems abuse. (CMC 2003, p. 106)

During the CMC's consultations with foster children, the children were asked to tell the Inquiry about their interactions with the department, particularly family services officers (FSOs). They gave the following responses:

> The FSOs don't do handovers. Every new one you get asks you to tell them all about your background. It should be on your file. I've had five FSOs in the space of four to five months, and I never got to know them. I'd ask for a certain FSO and a different one would deal with me. The department don't know you or even who your FSO is; you have to start from scratch each time.
>
> They [FSOs] tell you that they're so overworked with lots of priorities. It means that you can only think 'Am I the last priority?'.
>
> If you ring and say that there is an emergency, you get told that they'll get back to you in 48 hours.
>
> They always cancel meetings. The good kids do not get attention. You have to play up to get attention. It's the good kids who don't get attention who end up worse.
>
> When I would ring my FSO she would only talk to my carer — she refused to talk to me. They never send you a birthday card — you should be able to celebrate something, but they only come when you are in crisis and mostly not even then!

In terms of children and young people having a voice in the case-planning process, the Inquiry was told by the Queensland Coordinator of CREATE:

> Children and young people have reported to us that they do not have case plans and many do not know who their worker is. Many have not seen their worker for a significant period of time. Workers, it appears, do not have the capacity to maintain regular contact with children and young people on their caseloads. If workers are not regularly meeting with children and young

> people on their caseloads, they are unable to know whether these children and young people are experiencing caring and protective environments let alone able to ensure legislative requirements are being met. (CMC 2003, p. 250)

It is evident from the consultations that CREATE has had with children and young people in care that many of them are not being involved in case planning, nor consulted about decisions that affect their lives. Reasons such as staff turnover are likely to contribute to this state of affairs as it is known that 28 per cent of FSOs have been with the department less than 12 months and 60 per cent have been there for three years or less (see Chapter 1). Children often live a significant part of their childhood in the system — much longer than many workers remain within the system (CMC 2003).

Holistic care

Other evidence received highlighted the fact that little attention appears to be given to the 'non-urgent' needs of foster children, such as health care or education, until those needs become critical.

The Inquiry was told that the Department of Families generally does not hold information regarding a child's immunisation records, allergies or health history, and it can take some time before it obtains the child's Medicare number (CMC 2003). Even less of this information is passed on to carers (who are the ones actually taking the child to medical practitioners), making it difficult for them to provide medical practitioners with all relevant information. One can readily expect that such problems might have critical consequences.

The Inquiry heard that each medical visit needs to be approved by an FSO, because the department has guardianship over a child and their medical care is a guardianship decision (CMC 2003). Further, counselling sessions, where they are provided, are on the basis of three to five visits, with the counsellor having to provide a written report to the FSO to justify further appointments. This approval process can lead to gaps of up to three months between counselling visits for the child, despite the fact that the child is still in need of therapeutic assistance (CMC 2003).

Children in care are not oblivious to the limitations of the services they receive, and the impact of the failure to provide such necessities as basic medical care may be long lasting. During consultations one young person said:

> I was diagnosed with a rare heart condition, which I later found out was hereditary, but it was not on the file that the FSOs have. I now have a pacemaker and defibrillator, and they had to go back to my parents to get all the information.

At the hearings a former foster child, Natasha, said:

> I didn't go to the dentist the whole time I was in care in six years and just recently — I won't show you my bad teeth — but just recently I was in excruciating pain, I couldn't work, I was crying, crying, crying, and couldn't be a mother, couldn't be anything except a sook. Someone advocated on my behalf and rang the media adviser for the Department of Families and after going to see a private dentist the next day and sending the quote into the department two days later it was paid for. My teeth now — I've got to go get two root canals done and I had every single tooth that can be filled, filled. (CMC 2003, p. 262)

The following passage from a submission from two practitioners is also persuasive:

> Queensland Health provides some services to assist children in care, but the clinic at the Royal Children's Hospital has the highest failure-to-attend rate within the hospital, meaning that important treatment is not always provided to these children. Further, unless children in care are brought to the attention of Queensland Health through the SCAN process or directly by individual FSOs, Queensland Health has no way of identifying these children and offering the health services to them. (Smith & Drew submission, pp. 3–4)

Stability and support

Children need to feel supported and to have stability in their lives, to feel safe and to receive help as they develop in life. The President of the Children Services Tribunal, Ms Beverley Fitzgerald, told the Inquiry:

> I very vividly remember very early on in working in this area a young child being petrified looking out the window to see his stepfather who was coming to see them at the hospital and being mortally afraid of that particular man who had been abusing him. Within 10 days I was escorting him out to the car of his new family with his foster parents whom he'd only met that day and I was trying to reassure him that these were good people — I don't know if they were good people but I was assured that they were good people — and seeing that little face as he drove out with those absolute strangers was something that has stuck with me for many years.
>
> I do think children deserve the right to meet people. There are emergency situations where they must be placed immediately, but if there were such things as assessment centres, well then perhaps they wouldn't have to fit into a family home to arrive at somebody's home at 10 o'clock at night. For a young child who's old enough to know what's going on, it must be very stressful for them and I see it as emotionally abusive. It's just — I've always had an issue with that. (CMC 2003, p. 457)

The following suggestion was made to the Inquiry by a former carer as way of ensuring that children maintain some of their identity and history while in care:

> The children should come with a package. Every child who enters the system for the very first time they need their important details. They need their medical details. They need their school records. They need their family history details, particularly with the Indigenous children. They don't realise that they've got sisters or brothers or cousins that might exist out there. They could have an aunty, a direct aunty, two streets away and they won't know — they might not know for 10 years — so they need all that sort of thing to come with them. And if they've previously been in schools, maybe those school records could go with them as well and just keep that, sort of, little package with that child and that's the child's possessions. It doesn't belong to the Department of Families. It belongs to that individual child so no matter where that child is that package goes with them. (CMC 2003, p. 417)

During the CMC's consultations with children, one child stated that all of her clothing was lost while in storage and the department refused to replace it. Another said that most foster children have nothing more than a garbage bag to take their things with them. One carer advised that she often had children arrive on her doorstep with a plastic bag with only a few changes of clothes, despite having been in care for a number of years (CMC 2003).

In other consultations, children in care were asked to outline the 'highs and lows' of being in foster care and indicate what could be improved and what they thought was important. A sampling of their comments is given below:

- I am very happy with my current carer. We had a chance to get to know one another a bit beforehand. We went to a local restaurant to meet and get to know each other first. I wasn't just dumped on the doorstep like some other times.
- My carers don't really know anything about me. They have a girl aged 10, so I'm also treated like a small child. They don't think I can handle some things, for example they won't let me enter a marathon. I lived on the streets for three months, I can handle a marathon.
- I've been with my family for five years now and they're now 'my other family'. I've never been left out. My foster sister got exactly the same present as I did at Christmas. I get introduced by (foster) mum as 'one of my girls'. They're now my guardians. It's a very stable family. My two mums get along well and can talk to each other to arrange things about me. My foster mum is very supportive of my real mum.
- I think what could be done better is if they could understand better. My sister and I had to go to a child psychologist, who just didn't understand. The psychiatrist tried to 'fix us' to 'make us normal', instead of trying to help us to understand ourselves.

- In my current placement I'm treated as family. They trust me and that gives me a lot of freedom. If I want to go out, they trust me to do what is right and treat me with respect. They treat me as though they know I'm being good.
- Mum calls me one of 'my boys'…. I did heaps of chores on the holidays. No one made me do them. I did them because they just needed doing.

Not at all surprisingly, it would seem that for those in care what is important is a sense of belonging and a belief that being in care means being respected, valued and supported. For a variety of reasons, especially workload demands, not all children in care see their relationship with the Department of Families as characterised by these attributes.

Contact with family

A child's relationship with their family has significant ramifications for their adult life. Children in care often have relationships of conflict with their families. Yet the evidence was clear that the approach by the department to the maintenance of these relationships has not been consistent. Some children have been denied contact with their natural families, despite their wishes and the rehabilitation of their parents, while in other cases a strong policy of reunification has been pushed by the department even when it is against the child's wishes and not in the child's best interests.

The Inquiry was told that some children will break down even good placements, because they have an unspoken belief that if they keep sabotaging all the placements the department will run out of options and have to send them home. The following example was given to illustrate this point:

> This child had a father with a mental illness. There was documentation suggesting not only was the father depressed and suicidal but that he had articulated a threat to take himself and his child out. The child was removed, placed with good carers, but he continually broke down all the placements. All he wanted to do was be home with dad. At one stage he walked 40 kilometres home. He was 10 years old. (CMC 2003, p. 499)

Max, a foster child who gave evidence at the Inquiry, said:

> When I was seven ... my mum just totally left me for three years and I was left to look after myself in a way ... I would cry and I just needed her so much, but she wasn't there and the department did not look into it and try to get her to come to me because I needed that relationship to build a sense of love. I think that when parents go away and you don't have that sense of relationship, it's just so hard. (CMC 2003, p. 259)

There was also evidence about other foster children who did not wish to see their parents. Some of the children that we consulted said the following:

- It's all crap. My mum just virtually told me to piss off. I felt that the department wanted me to see my mum, so I did. You get this feeling of pressure from them to see your family, whether you want to or not.
- The FSO rang my dad, without letting me know, to see what he thought about the application from my foster parents for guardianship. I was so annoyed. He's had no contact with me and doesn't know anything about me. The FSO said what a 'nice guy on the phone' he was, and put pressure on me to see him, but I insisted on making my own decision. Dealing with him face to face is a lot different from 'the nice guy on the phone'. It was like, 'I'll make you see your dad'!

Foster carers spoke of watching FSOs drag children out to cars or out from under a house in order to take that child to a contact visit with their biological parents. The following comment was made to the Inquiry:

> I guess what we tend to talk about sometimes, as an illustration, is that if a partner in a domestic violence occasion goes and seeks refuge in a refuge, then the people in charge of the refuge don't make them go back home to their abusive partner once a week because it is good for them. (CMC 2003, p. 329)

It will often take some time for biological parents to resolve the issues that led to the child entering care; however, children often do not have five or six years to put their lives on hold in anticipation of resuming a relationship with their parents. Many in that time will have bonded to their foster parents; yet there was evidence that at times the department still pursues reunification attempts with these children and their biological parents without addressing the significant new attachments that the child has made with their foster parents (CMC 2003).

Transition

CREATE told the Inquiry:

> At the age of 18, young people are no longer the responsibility of a statutory authority and sometimes are not equipped and prepared to enter independent living. A young person should have a transition plan developed some time before they are due to transition from care, perhaps two years; however, in practice it has been reported that transition plans are not developed until six months before a young person is due to leave statutory care if, in fact, at that time. (CMC 2003, p. 253)

Clearly, there should be proper planning accompanying a young person's transition out of care. The transition will be a major step in a young person's life and will usually be accompanied by some anxiety about the future. Careful planning is vital to guard against any feeling of 'abandonment' and to deal with practical issues such as housing and career options.

Placement options

The evidence indicates that many foster children experience multiple placements during their time in care. The toll this has on a child's confidence, resilience and sense of worth is significant and may reduce the ability of services to engage with these children and provide them with the assistance they require. Currently, about 20 per cent of children in care in Queensland come from sibling groups of four or more and there is very limited provision to reunite those children. In most instances they are separately accommodated, compounding the trauma of separation from their parents (CMC 2003).

Numerous submissions were made to the Inquiry regarding children having 20, 30, 40 or more placements (CMC 2003). Clearly such a large number of placements for any child must disrupt their sense of stability and reduce the continuity of care that can be provided to the child. It should be noted that the numbers provided to the Inquiry contrast with the numbers provided in the department's annual report. This is because the numbers provided to the Inquiry counted every single change of family, shelter or other form of care that a child experiences, whereas departmental numbers counted every change of type of care. For example, if a child was placed in foster care, moved through five families and then placed in a residential group home, the department would count that as two placements, not six (information provided by the Department of Families, 29 August 2003). In the Commission's view, this is self-evidently a misleading and grossly unsatisfactory counting rule and one that should not be further used.

The Inquiry was also told of cases of families having 6, 10 or even 13 foster children in their home at one time. As one foster child said:

> How can you have 13 abused children and show them all love?

There are many young people who do not wish to live in a family other than their own and would prefer living in a residential setting (Save the Children submission). The Inquiry was told that there was a problem finding placements for adolescents on the Gold Coast:

> We might be able to get them placed in a youth shelter at night. Those children may have to behave in a certain way, like attend school. These are kids that are probably unlikely to attend school, so they can't have conditions placed on them and youth shelters frequently ask children not to be present during the day. So you need to be able to have options available that suit different kinds

> of kids, just as you need to have a diverse pool of foster carers to be able to suit different kinds of kids. (CMC 2003, p. 195)

The Abused Child Trust told the Inquiry that they had a major concern with the fact that:

> There's no continuum of care for children who are abused and neglected and what we see is that, when a child is plucked out at whatever state in the child protection system, hopefully that immediate problem is dealt with, but then we don't — there's no ongoing plan for the child. There doesn't seem to be any overarching strategy within the department ... that comes down to the individual child. (CMC 2003, p. 588)

CREATE told the Inquiry:

> Foster care should not be the only option for children and young people in care. There needs to be a range of placement options that incorporate long-term planning to ensure that long-term individual needs of children and young people entering the system are met. Many young people in care report that they would benefit more from residential settings or supported independent accommodation. (CMC 2003, p. 253)

Often relatives are considered the best option; however, sometimes children reported that they experienced further abuse in these environments and that the department had no further contact when the children lived with their relatives. Clearly, relatives need to be assessed as to their suitability before children are placed with them (CMC 2003).

The Inquiry was repeatedly told that when considering placements for children it was necessary to view the child as the most important priority, and plan responses around the needs of that child while maintaining a degree of flexibility based upon the recognition that different children need different responses at different times. Ironically, the Inquiry was also repeatedly told that, while the Child Protection Act provides that the welfare and best interests of the child are paramount, children are rarely asked what they want and when they do raise concerns or voice objections to planned courses of action they are often not listened to by the department (CMC 2003).

Advocacy for children and young people

When things go wrong with placements or children are not happy with decisions made by FSOs regarding their care, there are few avenues open to them for redress. When complaints are made to the Commission for Children and Young People (CCYP), the commission seeks advice from the Department of Families, which has 28 days to respond. Concerns were expressed to the CMC that this is 'not fast enough' for children who are facing immediate difficulties in a foster home or have an FSO who is insisting that they return home either for a visit or for good, despite the child's desire to remain with foster carers (CMC 2003). This avenue of possible recourse also depends on children in care knowing that the CCYP exists, knowing it has this role, and knowing how to get into contact with it.

At present, many children rely on their carers to be the adult voice in the system advocating on their behalf, which produces an obvious conflict of interest when the child wants to complain about the foster carers.

There was evidence that this apparent lack of access to an independent advocate for their interests leads many children to stop reporting abuse, in the hope of not making the situation any worse. The Inquiry was told by Ms Hetty Johnston of Bravehearts:

> Children usually come from a home situation anyway in the first place, they've come forward and disclosed, they've been torn out of that situation and put into numerous others and then quite often a litany — you know, 30 and 40 different placements. So sometimes it's better to just shut up. You learn that, you know, I think fairly quickly from what we're hearing that you just put up with everything other than the most horrendous stuff because nothing good comes of speaking out. Just nothing good comes from speaking out.
>
> Often children have disclosed numerous times from the family home situation before they're removed and put into the system, they've made — some of them

> have made numerous disclosures, to teachers, to friends, to other relatives and they've still remained in that family situation due to the notification process and eventually they are removed, but they have learnt that making a disclosure doesn't often mean that they're going to be protected; so more often than not they just choose not to make a disclosure. (CMC 2003, p. 413)

WORKPLACE ISSUES IN THE DEPARTMENT OF FAMILIES

Communication and information sharing

The Inquiry was told about many perceived communication problems in the department's internal reporting and in its external relationships with other stakeholders in the child protection system.

There was evidence that some of the department's processes and levels of communication with other important agencies have led to a perception that it is 'reluctant' to work collaboratively. According to Ms Elizabeth Drew of the Royal Brisbane Hospital's SCAN team:

> I see an increasing reluctance to working collaboratively. And that demonstrates itself in ways such as delays in making referrals to a SCAN team, the timing of referrals, so that they're made to a SCAN team well after the investigative process and the assessment is complete, so that there are — and you can see it as we go back and read the minutes — a number of times when the Department of Families in their written recommendations will recommend that a case be closed to SCAN when there are still obviously outstanding issues that need to be addressed. (CMC 2003, p. 436)

There was also evidence that problems in sharing information may further endanger children at risk. The Police Commissioner, Mr Atkinson, noted that there were often delays in police receiving information from the Department of Families, and difficulties in contacting departmental officers about child protection matters outside standard hours:

> A key issue for police officers in this field and Juvenile Aid Bureaus are delays in notification or non-reporting of matters where as a matter of course we would normally initiate a formal police criminal investigation, and we believe particularly that any matter that involves the sexual abuse of a child should immediately be referred to the police service for investigation.
>
> This is entirely in a constructive sense, but one of the issues that Juvenile Aid Bureau officers are encountering is that Family Services officers work a structured 9 to 5 day roster week from Monday to Friday and are generally unavailable after 5 pm on Fridays. What's been found is that notifications regarding child protection matters are being forwarded to police at the end of the working week for family services officers around 5 pm on Fridays.
>
> In many cases some of these have been received earlier in the week, but we don't receive them until about 5 o'clock on Friday and of course they require and need to have immediate action, which can and does alter the planned activity for the Juvenile Aid Bureau officers. So one of the things we'd be seeking for consideration is an extension of hours of Family Services officers and as well immediate notification of matters that clearly will require police involvement. (CMC 2003, p. 521)

Legal Aid Queensland noted that difficulties sometimes exist in the preparation of child protection matters to be presented to the courts. While the following observation was expressed in terms of how resources are directed within the department, it also illustrates an apparently common gap in the department's communication processes with Legal Aid Queensland:

> A further concern for Legal Aid Queensland is the lack of appropriate preparation of cases to be presented to court by the Department of Families. Court material is prepared by family services officers. Frequently they have little experience of the system and, Commissioner, you have received evidence about the experience level and turnover of family services officers … and they are not trained in the preparation of affidavits, the rules of evidence and the like, yet they prepare the material for court.

> The family services officer is often not clear as to the relief they seek from the court. That is, which particular type of child protection order they are applying for and that they feel is in the best interests of the child in the particular case. They don't have a settled case plan for the child nor have they assessed the evidence they will need to support the case. The family services officers are generally expected to conduct all preliminary court matters and procedures up to final hearing.
>
> In our view, this is an example of a badly directed resource. A worker with particular training and skills is used to perform tasks outside of their training and skills and expertise. It is time consuming for them, is often not well done, which can cause delays in the process, and keeps them away from the work they should be doing, which is working with children and families. And this is compounded by the fact that as the case progresses through the court system and after a determination has been made by the court, that same family services officer is expected to continue working with the family often in very difficult and highly emotionally charged circumstances. (CMC 2003, p. 543)

Many submissions and witnesses commented upon the need for the department to fully share information about issues relating to the physical and mental health of children in care. Dr Jennifer Smith of the Community Child Health Service, Royal Brisbane Hospital, commented on the topic as follows:

> We feel there's a need for much greater information flow between Health and the Department of Families in relation to the history, the developmental and medical history, of children who are entering care.
>
> [Re impediments to information flow] Sometimes privacy, confidentiality, that's usually what foster parents will tell us. They say that they've been given no information because they've been told that they're not entitled to the information for confidentiality reasons. But then they're the person who actually presents the child to the paediatrician for assessment and cannot give us any information.
>
> Sometimes we actually see children who've actually been moved from one placement to another and it can just be that the information actually, I think, gets lost in the system. I remember we were presenting a case at Grand Rounds, the weekly medical one-hour lecture series that's run at the hospital, a case series on children in care who presented to our service. And there were people from the Mater Children's Hospital, from other hospitals there to hear that and there were people in the audience sitting there, paediatricians saying, 'I recognise this child, I saw this child and treated them for these sort of conditions. It wasn't the left kidney that was taken out, it was the right kidney'. I think it just gets lost with these kids who move through multiple placements. (CMC 2003, p. 448)

The government submission noted that a protocol has recently been established for the Department of Families, the QPS, Education Queensland and Queensland Health for improved information-sharing practices. At the time of the Inquiry, this protocol was being trialled at various locations.

Perceived problems with respect to information and communication can easily lead to the view that communication with the department is too often a one-way process. It was stated that the department:

> … is less willing to engage with key stakeholders in collaborative policy, service planning and practice framework development. (PeakCare submission, p. 17)

This perceived reluctance to satisfactorily consult with stakeholders also has the potential to isolate the department and leave it reliant on its own understanding of the issues, which may not always adequately reflect 'on the ground' realities. In the evidence before the Inquiry and in the CMC's consultations, staff and outside agencies variously described their perceptions of the department's reluctance to share information as 'organisational arrogance' and 'managerialism', with the department being seen by these people to unilaterally define agendas and priorities. Whatever the merits of these views, it is possible that the processes established by the department to scrutinise the release of information encourage the perception that some delays relate to organisational sensitivity, rather than to the availability of material or other appropriate considerations such as privacy or legislative issues.

It was suggested by Dr Robert Lonne that this perceived sensitivity about releasing administrative data may also derive from a sense that the organisation is widely held in low regard:

> … many staff feel that they are unsupported by the government and held in poor regard by significant stakeholders (e.g. media) and the general community. A climate of defensiveness and a 'victim' mentality are in evidence in some departmental staff … the department needs to get into a position where it welcomes criticism as a fundamental part of the ongoing process of reflection and development. At present it remains prone to 'bunkering down' under sustained media complaint and concern. (Dr Robert Lonne submission, p. 5)

Importantly, it must be recognised that the department's information management systems are not of the calibre normally expected of a large and complex agency (as discussed below) and this may at times impinge on its ability to respond to information requests or to disclose relevant information in a thorough and expeditious manner.

Information technology

The Child Protection Information System (CPIS) is a cumbersome and inflexible system that does little to encourage use. Accordingly, the data contained in the system are often of questionable quality and out-of-date. All too often these data cannot be relied upon by the department itself. One effect of a system that cannot be relied upon is increased demands being placed on FSOs by team leaders to collate manually statistics and other information that ought to be available electronically. These deficiencies are well known to the department, as evidenced by material in the government submission to the Inquiry:

> As a result of the current system architecture, family services officers must access two separate systems to view recorded client information; a considerable amount of information is entered centrally. Because of cycle times this information is not immediately available to family services officers. They must wait to generate a new client record before they can record intakes, notifications, assessments and case notes; some information recorded on local area office CPIS databases (e.g. case notes) is not uploaded to the Family and Youth Justice Information System. Consequently, this information is not available statewide, and the system provides no functionality to record youth justice case management information.
>
> The current system does not allow for statewide access to case notes, placement agreements, Assessment of Protective Needs reports, or family meetings. This is particularly of concern in relation to mobile families. The inability of staff across the state to access relevant client information stored on other area office databases may mean that children who are at significant risk of harm slip through the system, as current information is not available to service-delivery staff. These information management issues have been identified as problematic through some child-death reviews. (Queensland Government submission 2003)

For those staff who choose to avoid using the system, or who are slow inputting the necessary data, there appear to be very few consequences. Discussions held with some area managers in the Brisbane, Ipswich, Logan and Sunshine Coast regions suggested that, due to overall delays in accessing information on the system, at least one manager set an informal target for data to be entered within three months of an event occurring. Given the significance of the data the department manages, this is clearly inadequate (even though it may presently be unavoidable) and could have very serious ramifications.

It must be noted that the Queensland Government and the Department of Families are taking steps to remedy these problems. As part of the Future Directions commitment, $12 million has been allocated to the development of a new Integrated Client Management System (ICMS).

Record-keeping

It appears from the manner in which case records are kept and the difficulties in the use of the electronic recording system that decisions are made first and recorded later, with few written submissions preceding decision making. The Department of Families has relatively few standardised forms for staff to prepare submissions and even fewer that are available electronically.

As noted in Chapter 2, the two recent Ombudsman's reports about the deaths of Brooke Brennan and Baby Kate both stressed the need for better record-keeping by the department:

> Several DoF officers told my officers that record-keeping standards are not monitored by management. All described work practices that relied heavily on verbal communication. Some officers made the point that they were 'verbal people', because their background and training was in social work and not administration. (Queensland Ombudsman [Baby Kate] 2003, p. 99)

Similarly, the Ombudsman observed that:

> These work practices must lead to significant case management difficulties when FSOs become ill, take leave, resign or retire on short notice or are transferred. In such circumstances, DoF is exposed to considerable risk, potential embarrassment and perhaps legal liability if something goes wrong. (Queensland Ombudsman [Baby Kate] 2003, p. 99)

The full extent of these record-keeping deficiencies is uncertain, but the CMC's own investigations and a recent media release (the Honourable Peter Beattie MP, 15 September 2003) announcing the department's recent appointment of staff to address this issue, emphasise that the problem is not an isolated one. During discussions with representatives from the Queensland Public Service Union (QPSU), CMC officers were told that it was common for staff to forgo fieldwork to spend days in the office bringing case notes up to date.

Record-keeping deficiencies present obvious problems of accountability. It is a significant cause for concern that staff record information in a variety of formats, store records in non-standard locations and rely on memory for unrecorded information. The department's files, unlike those in the health system for example, do not use standardised forms, recording techniques or formats. It is obvious these inefficiencies need to be addressed as a priority. The development of proper monitoring processes for physical and electronic records is a critical element of individual and organisational accountability.

Disconnection

Several submissions suggested there was a disconnection between head office and frontline staff and noted that there is no apparent specialised child protection line of command in the Department of Families, as evidenced by:

- the absence of any specialist head office manager outside the director-general who can be held accountable for child protection decisions made in the field, or exercise line control over decision making or professional performance
- the Child Protection Branch in central office being a stand-alone work group that generates policy and advice but cannot exercise any line control
- regional managers who have responsibility for a range of competing responsibilities, one of which is child protection, but have few delegations in respect of that function
- regional managers and area managers who can be 'content free' because of their effective distance from many aspects of the child protection decision-making process ('content free' is a term used by some staff to describe managers who have no or little specific child protection experience)
- team leaders and FSOs are the only logical site of accountability for many child protection decisions because of:
  - the departmental structure, which distances manager from frontline decision making

— the way delegations are structured, with their exercise often resting with FSOs and team leaders alone

— departmental policy that rests the exercise of discretion with frontline staff and team leaders, who typically have modest classifications and little seniority in the department.

As organisational psychologist Ms Penny Gordon told the Inquiry:

> I think that there are poor levels of recognition of the interdependence that is actually required within the Department of Families, and by that I mean those people who work in area offices can't do their jobs properly or well without some of those people who work in head office or environments or in senior management and, conversely, senior management not realising at times the interdependence in relation to those who are service deliverers; again it is the compartmentalisation that exists within the organisation. (CMC 2003, p. 171)

Perhaps adding to such perceptions of 'disconnection' is the way the department's outputs and performance measures are stated in the *Ministerial performance statement [MPS] 2003–04* (Queensland Government 2003a). While the emphasis on four outputs, which include early intervention and prevention, is widely regarded as worthwhile, the specific performance measures stated in the MPS are sometimes difficult to relate to the actual tasks of FSOs performing child protection duties. If the department's performance measures are perceived by child protection workers as only distantly related to their real activities, it becomes difficult to achieve a cohesive workforce. Frontline workers come to believe that they have yet another problematic aspect of their work to deal with that is essentially unrelated to their work in hand.

Workload

Many submissions addressed the issue of the workload of child protection staff. The picture arising from all of the evidence is that the workload of frontline child protection officers is, at least in many locations, at a very high and demanding level — a factor that may explain the significant number of notifications of suspected harm to children that have not been dealt with adequately (see Chapter 2).

There was also much evidence that management within the department has constantly sought to address this matter through administrative arrangements. Indicative comments on caseloads made by a number of parties during the Inquiry include:

> *Legal Aid Queensland*
> Caseloads of Family Services officers are often very high and, for many practitioners, the volume of work means that the majority of their time is spent in crisis management rather than measured case planning and support of parents and children. (LAQ submission)

> *Hilary Lennon, Regional Resource Officer, Child Protection, Department of Families*
> My caseload was 35. It's not rocket science to know if you have a caseload of 35, you can't spend even one hour a week with each of those children, even if you can guarantee they're going to turn up at the office. (CMC 2003, p. 509)

> *Queensland Public Service Union*
> There's the culture of accepting high workloads. One of my delegates recently called that the martyr complex. Staff do work long hours. Staff don't take meal breaks. Staff frequently work back long hours. I've had members complain to me that their area managers direct them to go home at 7 o'clock in the evening. Staff actually want to stay back later. They don't like it when I say, well, I agree with your area manager on that one. Staff don't get paid overtime because they're considered field officers under the directive. So it's not necessarily a great job to be in if you're a field officer. Our members do it because they're passionate and they care about the children that they look after. (CMC 2003, p. 201)

> Browns Plains/Logan have 500 outstanding initial assessments and Logan has got approximately 120 unallocated initial assessments … in the Brisbane region we have 620 outstanding initial assessments with only 8 people dealing with these initial assessments. (CMC 2003, p. 214)

It is somewhat surprising to find that, despite the industrial sensitivity of the workloads issue, the department does not have readily available records on the number of cases held by each employee (Department of Families Human Resource Manager, 30 September 2003). This issue was addressed in the evidence of the Director-General of the Department of Families, Mr Frank Peach:

> **Counsel assisting:** Can I raise with you just how difficult the task may be for FSOs in carrying out their task, and we touched on the burnout factor earlier. Are there any statistics available or is there any data available to suggest what an average caseload is for FSOs?
>
> **Mr Peach:** In Queensland we haven't gone down that path. The reason for that is that the wide range of work that FSOs do makes it difficult to talk about a specific number of cases and that's been an ongoing and very vigorous discussion with the union as recently as last Friday. So we haven't got the statistics. There are statistics from other states but of course, the sorts of work that they do again varies from what we do here.
>
> **Counsel assisting:** Yes. And of course, [there is] no point in comparing apples with things other than apples, but there's been no attempt to extract average caseload data in Queensland?
>
> **Mr Peach:** Not, not caseloads … as such … one of the real challenges in the organisation is getting a good grip on good data to make decisions, and that's been a challenge all along … we have, from about March this year, started to try to get some outcomes data from area offices about efficiency and effectiveness and one of the measures that we have used is the number of initial assessments completed per FSO per month and I'd preface my remarks with the comment that the data is early, that we'd need to get it over an extended period to take account of fluctuations from month to month, but there's no doubt that there is a huge variation from office to office which we don't fully understand, and recently … my Executive Director of Operations has written to area managers asking them to explain their performance in relation to that and the sorts of issues that sit behind counting the number of cases are starting to surface. The discussion we need to have about that has got a long way to go, I think, to understand and get a better way of doing it. Most of our efforts to date have been about two things: one, accepting from the end of April this year that workload management is not on, that the community would find that unacceptable, and attempting to look at a range of ways of doing the work so that we don't just ignore work; and then secondly to improve the work practices. And it may well be that over time as we work through that we still find that we're unable to do everything we're trying to do. If we've got good data then we've got a capacity to go to government and argue for it. At the moment we're arguing without the ammunition that we need, except at that very global level when you look at interstate loads and say it's heavy, heavier here and that doesn't often convince people. (CMC 2003, p. 62)

Staff, through their union, asserted an opposing view about caseloads; namely that they constitute a key indicator of workload.

In any event, there was much evidence about the extent of individual FSO caseloads and the impact of such workloads. During the Inquiry it was asserted that many staff have caseloads of over 35 children or families and that this was unreasonable. In New South Wales, estimates of child protection worker caseloads, measured in terms of a caseworker to child ratio, were typically between 1:26 and 1:30 with the international benchmark said to be 1:10 (Kibble Committee 2003).

Should it be that Queensland caseloads are as high as they appear to be from the anecdotal evidence presented to the Inquiry, it is unlikely that staff are in a position to adequately support the clients for whom they are responsible.

Nevertheless, irrespective of the measure adopted, as Mr Peach noted, informed decisions about the apparent need to increase child protection human resourcing rates, and the extent of any required increase, should flow from the acceptance of a transparent measure used to determine what the ideal or even baseline staffing complement should be. The QPSU asserted that 12 to 15 individual children is a fair caseload for an experienced worker. The Child Welfare League of America recommends a ratio of 1:17 (Barton Child Law and Policy Clinic 2001).

Accountability and blame

In addressing the Inquiry, the current Minister for Families, the Honourable Judy Spence MP, said:

> It has been suggested that there is a culture of blame within this department. I reject that. There is a significant difference between being responsible and accountable for a decision and mere finger pointing. We have a well-educated workforce and I believe that they accept the need to be accountable for their decisions just as we, as a government, must develop the training and support needed to help them do their jobs. (CMC 2003, p. 788)

In similar vein, the Director-General of the Department of Families, Mr Peach, said:

> I don't agree that there is a culture of blame in the organisation, in a real sense. There is — you are undoubtedly right that that perception is very high and as recently as last week we were speaking with union representatives about this very issue in relation to the CMC hearings. They explained, at great length, the fear that's in the organisation at the moment that people are being hunted out and blamed.
>
> The reality is that that doesn't happen. In the three years, almost three years, I've been here I don't see that retribution and that blaming of people by the organisation. But it is a fear that's there, there's no doubt. (CMC 2003, p. 41)

And further, on the last day of hearings:

> The union may see some of the changed processes as resulting in blame and I guess that's indicated in an e-mail to union members on Wednesday the 15th of October when one of the union delegates says, 'I see over and over again that departmental workers are being blamed for inappropriate practice'. However, I have said many, many times in the last three years that what we're on about is not about blame but about transparency and about accountability. (CMC 2003, p. 740)

Offering the view that a blaming culture does in fact exist within the department were comments from representatives of the QPSU as well as various other submissions. Dr Jennifer Wiltshire and Ms Julie Clarke said:

> You need to develop a culture other than a culture of blame because that culture ultimately rebounds on the people that you're seeking to serve — the client group for children, young people, families — and as workers experience symptoms of burnout, emotional exhaustion, depersonalisation and feeling undervalued they're less able — they have less of a capacity to meet the demands of the role that they have with children and families. (CMC 2003, p. 274)

Legal Aid Queensland pointed out:

> The family services officers often take the view that they are professionally under attack in some way and therefore they approach the process of the tribunal in a defensive and closed manner rather than engaging in an independent review of decision making in the interests of the child or young person. (CMC 2003, p. 543)

The Commission is convinced that an unfortunate feature of the department's workplace environment is a widely held perception on the part of staff that a 'blame' culture, as opposed to one that promotes openness and accountability, exists. This perception led to some departmental staff who were assisting the Inquiry requesting to view the proceedings in a separate room, so as not be seen by departmental management who attended the hearings. These staff indicated their request was based on their wish to ensure they avoided criticism or retaliation from management for attending the hearings.

In another instance the QPSU advised staff, via e-mail and during the Inquiry hearings, not to cooperate with departmental management seeking information on the use of students in area offices to undertake casework. The rationale supplied by the union was that staff providing information could expose themselves to criticism or disciplinary or other action, should management deem their conduct questionable.

Partly as a result of that e-mail, the director-general was at an obvious and admitted disadvantage when responding to questions on this issue on the last day of hearings.

Clearly, if there was evidence that students had been allowed to accept a significant level of responsibility for casework that would otherwise be undertaken by qualified and experienced FSOs, there would be resourcing and supervisory issues of a type that would normally warrant a director-general's attention and some management response. The evidence before the Inquiry about the way this particular issue was addressed illustrates the problems that can arise when communication difficulties and perceptions about the existence of 'blaming' or overly reactive management responses affect the free flow of necessary information between levels in the Department of Families.

A reactive culture

During consultations with departmental officers and in many submissions reference was made to the department being in a constant reactive, rather than proactive, state in responding to child protection issues. Repeated reference was made to FSOs and team leaders being 'crisis driven'.

The evidence that the department is overly reactive in its approach arises in the main from the evidence about aspects of the work of FSOs revolving around crises occurring with clients and children (consultations with area managers in Brisbane, Ipswich, Logan and Sunshine Coast regions). One area manager advised that a survey undertaken within his office revealed that the most stressful event experienced by FSOs and team leaders is the breakdown of a foster care placement. This situation arises as breakdowns often occur suddenly, usually involve a dramatic episode, require the placating of both the child and the carer, and call for an immediate response to place the child elsewhere as well as maintain the previous carer's services.

The prevalence of such crises and the evidence of a 'reaction-driven culture' were apparent in many submissions. For example:

> The work of the department appears to be driven by crisis management rather than planned and measured support of families to care appropriately for their children. There is a perception that the Department of Families intervenes only when they have to act to remove a child from the family's care, rather than working to support the family. Further, once removal has occurred the department does little to work with the family towards reunification of the child in the family's care. (LAQ submission, p. 3)
>
> Another feature of departmental culture that is important to understand is the inherently crisis-driven nature of child protection work and its resultant effects on work practices and relationships. In many cases, people who abuse and neglect their children are in a crisis state or have chaotic lifestyles (e.g. substance abuse, domestic violence). When authorities intervene to investigate and assess allegations of abuse a heightened state of crisis often results, which paradoxically can increase the risk of further harm. (Dr Robert Lonne submission, p. 8)
>
> A 'crisis culture' typifies most area offices and many regional and central offices that deal with high-profile cases. Over time the office systems tend to be driven by these incidents rather than respond to them. In short, the office systems tend to go into overdrive with difficult cases, which tend to receive major amounts of staff time and energy until they are resolved and quieten down, whereupon the next complex and stressful case takes over and gets the staff attention and resources. A net effect is that 'quieter' cases or matters of lower priority tend to slip out of sight and not get attended to because the culture is to quickly tend to the crisis and chaotic cases. The staff are drawn into a culture that appreciates crisis work, albeit stressful cases. This is an important process because it directly contributes to a culture that downplays the importance of alternative care and, hence, attending to the needs of children in care and foster placements. (Dr Robert Lonne submission, p. 8)
>
> Programs also need to be measurable and are best done by agencies, not the department, as the department is always in crisis mode and does the most important things first, so early intervention would just not get done if left to the

local area office. (confidential submission)

PeakCare submitted to the Inquiry:

> Because we've got a queuing type arrangement and we've got an excessive demand coming in to the system and staff in the field then have to process a larger number of notifications than they can reasonably handle in a normal flow of work, the emphasis is on creating that instant reaction to the circumstance and the only way to intervene in the circumstance without creating further harm is to withdraw the child from it. (CMC 2003, p. 144)

Overcoming this aspect of organisational dysfunction is vital but difficult. As suggested by Dr Lonne in his submission (p. 8):

> Turning the crisis culture around is a formidable task, and it may be a better strategy to change the system to better meet the needs of children in care rather than tackle front on the crisis culture because, despite its drawbacks, it also enables many crisis situations to be relatively well addressed despite the chronic underfunding that plagues the department. Structural and programmatic changes can partly redress the negative effects of the crisis culture.

In addition to this intrusion of a 'reactive' mentality into day-to-day operational decision making, there were also frequent references to the department itself being an organisation in crisis. Comments were made such as:

> The reliance on foster care and the lack of reform of family-based care to cater for the increasingly complex needs of children and young people has led to a system in crisis. (PeakCare submission, p. 36)

In context, it should be noted that various recent studies and inquiries in South Australia, New South Wales, New Zealand and the United Kingdom have all identified aspects of comparable organisations and child protection systems that are, or have been, dysfunctional and in need of major reform. New South Wales alone has recently promised to achieve a $391 million increase in recurrent funding by 2008 in an attempt to remedy its perceived problems in the area of child protection (Department of Community Services NSW 2003a).

Change management

The Inquiry was told that the Department of Families has a range of initiatives and trials in place which reflect that substantial efforts are being made to find new and better ways of working. The Commission acknowledges these initiatives. The minister told the Inquiry that the department had recently established 31 trials relating to non-government agencies, appointed 70 new staff, increased payments to carers, initiated the development of an integrated client information system and increased funding to the non-government sector (CMC 2003).

Many of these initiatives relate to the department's Future Directions statement of 2002, as a result of which 20 initiatives are being taken across all departmental outputs and client delivery services. However, there was also evidence indicating that, taken together, the many organisational changes, coupled with high staff turnover and generally negative publicity, underpinned a perception on the part of some that the department's operations were 'chaotic'.

The director-general clearly saw the rate and magnitude of change occurring in the department as being manageable and organised, stating:

> My comment at the beginning of the Inquiry was that should Education Queensland or the police have been operating under the same level of stress with a workforce of a similar profile to ours — namely, 60 per cent of staff in their first three years — that those departments would be in chaos. My point was that it's a great achievement of my staff that given the experience of many staff and the difficult and complex circumstances under which they work we are not in chaos. That appears to have been distorted quite horribly. (CMC 2003, pp. 738–739)

Over the last ten years the department has had in the order of five different directors-general responsible to five different ministers. In the most recent change the emphasis

on strengthening management has seen the occasional appointment to senior positions of staff from outside the department.

The QPSU, in particular, raised issues about the consequences of regular changes in management personnel and head office intent on introducing new initiatives. It suggested that each new minister and director-general brings a new perspective and initiates change as a consequence, but, because there has been a high turnover in these positions, there is insufficient time for the initiatives to take root and be evaluated before they are replaced or superseded. It was reported in several submissions that some initiatives had not been followed through and the results of some trials and evaluations, or reasons for the termination of those trials or evaluations, had not been disclosed to staff. This was reported as being particularly dispiriting for staff optimistic about the promise of some of the initiatives, and contributed to a pervasive sense of 'change fatigue' (QPSU submission).

From the evidence, it was not obvious to the Inquiry that the department has an appropriate change management system in place. It is understood that the department has recently sought to appoint a change expert at a senior level.

FOSTER CARE

Client focus

Submissions to the Inquiry regularly stressed that FSOs engaged in child protection often had minimal contact with children in care and tended to focus on communication with foster carers and other adults. This situation was revealed by the CMC investigations related in Chapter 2 to be a systemic problem.

It is possible that such a deflection of FSO attention occurs because not all FSOs are skilled or trained in communicating with children. Many find it easier and quicker to communicate through adults. Whatever the cause, this situation has the potential to generate confusion in staff about who the client actually is, and to contribute to adverse outcomes for children in care.

The confusion regarding clients was described by the Abused Child's Trust during the hearings:

> All too often decisions are made based on what the adults are wanting, what the adults are saying and many times we're not even asking the child what they want and what they say. I recently sat in a SCAN meeting and we had a child that was old enough to have a say [about] what the child wanted to do and it was argued by the Families Department that — the total opposite and it was the policeman who just came back time and time again to: is this in the child's best interests. (CMC 2003, p. 587)

Supporting parents

The *Child Protection Act 1999* recognises that families have the primary responsibility for the upbringing, protection and development of their children and that the preferred way of ensuring a child's wellbeing is through the support of the child's family. The Act provides that a child's parents have the opportunity to take part in making decisions affecting their children's lives and that if a child is removed from his/her family the aim should be to safely return the child to the family if possible.

Funding increases for the Department of Families in 2002–03 have seen an increasing amount of money used to fund support services for families with problems. A significant amount of the $42 million funding increase was directed at delivering programs through non-government organisations aimed at supporting children and families to prevent children being taken into long-term care.

The Inquiry heard from biological parents that departmental staff were too busy or inexperienced to provide necessary support to families. For example:

- Whilst I believe that the department had every intention to support us as

> parents, unfortunately they do not appear to have the resources to do so. At a Family Meeting on 25 April 2003 it was arranged for a departmental worker to visit twice weekly (more if required). That worker has only been able to visit twice in the past four weeks, due to her exceptionally heavy workload. Furthermore I have not been provided with any details in regard to the children's health, wellbeing, or progress at school over the past nine weeks. (confidential submission)

- … the departmental officer concerned was very new to the department when being involved with us and jumped too far by her decision to remove our kids, which could have been prevented if being more involved with us from the start when we asked, or looking into what else could be done. (confidential submission)

Dr Lonne told the Inquiry:

> You need to make an initial assessment and certainly more recently you need to make an initial assessment so that it doesn't blow up, right, and so that we can get in there quickly ... you investigate but you've still got cases that are ... called child protection follow-up cases, that then drop off the radar because it's more important to respond immediately to the new incoming. And, in a sense, you've already partly assessed that case so you're fairly sure that that won't be too bad. But that, of course, then means that you don't have the time to assist the family that you've actually taken on as a case. From their perspective — from the family's perspective that's the child protection follow-up, they feel abandoned. They feel like — quite often they feel like the department descends like a ton of bricks. There's a lot of heat generated and then they're abandoned. … (CMC 2003, p. 658)

Ms Gwenn Murray (engaged by the department to conduct an independent external audit of notifications of harm in respect of current foster carers) said:

> With the lack of intensive support services to assist and strengthen families to keep children safely supported at home, an over-reliance on alternative care, and particularly foster care, has therefore been created. (CMC 2003, p. 303)

In 2001–02 a natural parent was believed to be responsible in 84 per cent of all substantiated notifications of harm to children in Queensland (AIHW 2003b) Given this, the government's increased emphasis on assisting families to prevent harm to children would appear to be a cost-effective strategy to lessen the burden on the alternative care system. Professor Matthew Sanders from the University of Queensland advised the Inquiry:

> The point that I'd make generally about prevention is that for every $1 we spend in prevention we probably recoup $6 within a couple of years of having spent that $1 in the youngster not having extra services and additional problems that have been created. (CMC 2003, p. 636)

The Inquiry received 29 submissions from the biological parents of children who had been the subject of protective action by the Department of Families. While some parents appreciated the need for the department's intervention in their families, many did not welcome its involvement in their lives and most believed they had been treated unfairly. The lack of a coordinated body designed to advocate on behalf of biological parents in departmental matters may compound their dissatisfaction with the department and increase the sense of helplessness in the face of the bureaucracy that is the child protection system. As the Esther Centre told the Inquiry:

> A high percentage of people are reporting invisibility in the system. The focus is entirely on the child and often the foster carer gets much more recognition of their status and rights and responsibilities. Parents feel far more — that the foster carers are far more heard in the system than they are and that they are sidelined and become more and more incompetent and unconfident as a result of the minimal role and people making decisions all around them without them understanding process, understanding their rights, understanding anything about what is happening other than, you know, trying to deal with the emotional issues of having a child removed and someone who is doing better than you doing what everyone considers a wonderful role. (CMC 2003, p. 246)

Valuing carers

There was general agreement from all those who gave evidence to the Inquiry that the majority of carers did an extraordinary job in often very difficult circumstances. Most interested parties also shared similar views on the benefit to carers, and the children in their care, of comprehensive and ongoing training for carers. However, submissions to the Inquiry from or on behalf of carers were largely critical of the department.

> Foster carers are not paid a wage and the allowance they receive barely covers the expenditure needed to maintain children. Foster carers are pressured by Families to accept placements of young people whose behaviours they are not equipped to manage and for whom they do not have adequate physical and emotional resources. (Integrated Family and Youth Service submission)
>
> Foster carers are frequently treated almost as a necessary evil rather then specialist volunteers who contribute much emotionally, personally and financially to the care of children. (confidential submission)

The Queensland Government submitted that it increased the foster care allowance by 1.5 per cent in 1999–2000 and by 4 per cent in 2000–01. In 2001–02 it increased the total allowances paid to foster carers by 10 per cent, which enabled the creation of the Outfitting and Incidentals Allowance ($17.50 a week), the Entry Into Care Payment ($200 when a child enters into a long-term order), and the Start Up Outfitting Allowance ($50 for placements greater than five days). The government also submitted that the foster care allowance was increased a further 6 per cent in 2002–03 for those carers looking after children aged 11 years and above.

The Queensland Government cited other initiatives it had undertaken to support foster carers, including trials of respite services and the employment of additional foster and relative carer support workers. The employment of support workers may go some way to addressing a concern raised by Foster Care Queensland (FCQ) concerning the level of support offered to carers by the department. FCQ submitted that foster carers engaged by non-government agencies enjoyed a greater level of support than those foster carers attached directly to a departmental area office, due to non-government organisations having dedicated staff to work with foster carers in the non-government sector. FCQ stated in its submission that:

> The appointment of a dedicated position of alternative care worker is crucial within area offices. (p. 11)

With regard to the allowance paid to carers, FCQ submitted that the current allowance was inadequate and should be subject to increases in line with the consumer price index (CMC 2003). Other agencies such as PeakCare believed that foster care should be professionalised, with foster carers receiving 'a level of remuneration that reflects the level of responsibility that they agree to assume' (PeakCare submission).

In reviewing submissions received from and on behalf of foster carers, it appears that many foster carers feel that, once a child is placed with them, they gain a fairly significant right to influence decisions on the child's future. There is, however, no legislative basis for this assumption. The Child Protection Act provides that if an approved foster carer agrees to care for a child in the chief executive's custody and guardianship, the department and the foster carer must enter into a written agreement for the child's care. The Act also insists that if a child on a child protection order is removed from a foster carer, the carer must be told why, and the carer can have this decision reviewed by the Children Services Tribunal.

Foster carers inherit many responsibilities when they take a child into care, but apart from the abovementioned right to appeal against a decision to remove a child from their care, the only rights enjoyed by foster carers are those allowed them by the state. Mr Bruce Doyle, the Deputy President of the Children Services Tribunal, submitted that foster carers should have the right to apply to the tribunal for a review of the department's decisions about a child placed with the foster carer. Mr Doyle suggested this could be achieved by enabling foster carers to become 'aggrieved persons' in schedule 2 of the Child Protection Act for decisions made under sections 78, 86(2) and 86(4) of the Act. While this measure may make the department more accountable for decisions made regarding children in foster care, it would also have the potential to

significantly increase the workload of area office staff.

The manner in which the department dealt with standard-of-care issues for children in foster care was the subject of opposing views. On the one hand, the QPSU said:

> Staff are very, very vocal to at least me when I'm visiting that the reason why they don't deregister carers is because it's too hard. There are a number of cases that a number of officers have had in the past where they've attempted to deregister carers and they've been unsuccessful in doing so.
>
> The other concern is that — the requirement to have physical proof. Professional officers will be able to tell from a child's acting out that they are able — that there's something wrong in that environment and that perhaps the child should be removed. But there'll be no physical evidence and it seems that the onus to prove that a foster carer is not a good placement is far too high. That is something that members are very concerned about. (CMC 2003, p. 194)

Ms Gwenn Murray told the Inquiry:

> The auditors found that children are more likely to be believed — and I think this is fairly important to say — when they disclose harm from their natural parents than when they disclose harm with respect of foster carers. (CMC 2003, p. 301)

However, Foster Care Queensland stated:

> … we're the most alleged-against group in society because the parents of the children don't like it that their children have been taken away; the children very often don't like it because they've been taken away. There are a host of other people in the community who would also want to make allegations against us.
>
> A carer can produce evidence, can have witnesses, and in many cases they aren't listened to or that isn't taken into account. (CMC 2003, p. 322)

Some foster carers submitted the following views:

- Natural parents are often given many chances by the department to get their act together and yet when a foster carer goes a little bit wrong — they are not given a second chance. (confidential submission)
- Often the carers are first aware of allegations when the Family Services officer comes out and removes the child, or the child is removed from school and does not return to the foster home. Often the foster family is left up in the air as to what has happened. In some instances the foster carers are not given any chance to respond to allegations. During this time of indecision by the department, the foster family is feeling isolated, they feel like a criminal and they are very upset by what has happened or not happened. They too often are not even given a chance to say goodbye to the foster child. Very few allegations are handled sensitively by the department. (confidential submission)

Many submissions to the Inquiry from or on behalf of carers included complaints that carers were given little or no information on a child's background when the child was placed in care. In some cases, this can lead to carers being ill prepared to deal with a child's behavioural, physical or intellectual problem when that problem manifests itself. As noted earlier in the chapter, at a practical level this may lead to difficulties in obtaining informed and relevant medical intervention for a foster child. Mismatching children and carers is seen as a widespread problem, largely due to the inadequacy of placement options.

Non-government organisations

Non-government organisations play a significant role in the delivery of foster care services in Queensland, including the recruitment and training of foster carers, as well as the provision of early intervention and therapeutic services.

> … there has been about a 30 per cent increase in the provision of grants and subsidies paid to non-government organisations, as a direct reflection of government policy to enhance the capacity of the non-government welfare sector, for the provision of preventative and supportive services of many kinds.

(Department of Children's Services, *Annual report 1984–85*, p. 1)

> Building on its record of increasing funding to non-government bodies to keep pace with external impacts such as changes in the taxation system, industrial awards, and superannuation, the government has committed an additional $33 million over four years to offset increases in the cost of service delivery. The Department of Families relies on close working relationships with the non-government sector — providing an estimated 37 per cent of its budget ($125.9m) in 2001–02 in funding to community organisations. (DPC 2002, p. 17)

> The level of new funding acquired in recent years has been insufficient to enable government and non-government sectors to effectively implement legislative and policy requirements. The level of new funding allocated to the non-government sector has been disproportionately low. (PeakCare submission, p. 16)

> Non-government fostering agencies began operating in Queensland in 1992. At that time agencies became the main recruitment training, assessment and support provider of generally approved foster carers. During the past decade there has been a gradual growth within these agencies, yet resourcing the agencies has also gradually been reduced in real terms. (Anglicare Fostering Network submission, p. 1)

The Department of Families (2003c) provided $35 247 387 to non-government organisations in 2002–03 for child protection and family support services. An additional $7 151 242 was provided to non-government organisations to trial the provision of services in the areas of prevention and early intervention, family support centres, responsive placement options for young people and short-term respite.

In considering the information received by the Inquiry, it is apparent that there are some marked advantages to having non-government organisations deliver certain services to children and families. Non-government organisations are able to provide specialist services that the department is not equipped to provide, such as intensive in-home support to families and therapeutic residential care. Because these organisations are funded to provide discrete services, other emerging demands within the child protection system cannot suck money away and divert the organisation from delivering its service. Non-government organisations may in many instances be much better placed than the department to engage with families, because they do not exercise a statutory function and therefore may not attract the same hostility that a family may direct toward a government department. Non-government organisations are also geographically diverse.

A primary concern raised by those non-government organisations that made submissions to the Inquiry was that there was a need for greater clarification of their role and the role of the department in delivering certain services. For example, Life Without Barriers told the Inquiry:

> There needs to be a robust case management system that defines very clearly the respective roles of the department and community agencies and that doesn't exist. (CMC 2003, p. 99)

Other organisations advised:

> There is a lack of clarity about the respective roles and responsibilities of government and non-government sectors and the nature of the relationship between them. This is a critically important issue given the interdependence between the sectors to provide a holistic response to children, young people and their families. (PeakCare submission, pp. 19–20)

> There is no framework for partnership between the department and the non-government sector. The department's focus on management is clashing with the sector's focus on practice. (Marsden Families Program submission, p. 10)

On the evidence available it seems that, once a child is removed from a suspected harmful environment, there is often only limited capacity for FSOs to undertake ongoing therapeutic intervention with a child or a child's family. If this work is to be done, it is more likely than not it will be done by a non-government organisation and in many cases an alternative care placement will be sourced through a non-government organisation. Action taken by a non-government organisation in relation

to a child in need of protection needs to comply with the department's statutory case management framework for that child. Accordingly, if there is insufficient understanding and cooperation between the department and a non-government organisation there is a greater likelihood that an alternative care placement will break down and that therapeutic work with a child will not reach any meaningful conclusion.

The Inquiry heard evidence that there is a power imbalance between the department and non-government organisations. As Life Without Barriers explained:

> On the one hand the government is the provider of services itself; it is also the purchaser of services from community agencies. It also sets standards and monitors the kind of service delivery that occurs. (CMC 2003, p. 103)

To some degree this is unavoidable, because the Department of Families administers the *Child Protection Act 1999* and funds carers and non-government organisations. It does, however, raise an issue concerning the role of non-government organisations in recruiting, training and supporting carers, providing therapeutic services to biological parents and at the same time helping children in need of protection. That is, if a non-government organisations has carers, parents and children as its clients, to whom does it owe its primary allegiance? In the same way, it follows that an FSO who has a professional relationship with both a carer and a child placed with the carer could be similarly compromised if concerns are raised about the standard of care being provided to the child.

The Inquiry was advised that children placed through non-government organisations received better care, and the foster carers attached to non-government organisations received greater support than children or carers who were directly affiliated with the department. The reasoning behind this was illustrated in the following submission:

> The non-government sector has undergone a process of licensing over the last two years as an external provider of out-of-home care to young people in the child protection system. This is a flow on from the Forde Inquiry that has not been extended to foster care provided directly by the department. Licensing is a quality control whereby non-government agencies are held accountable by an external evaluator as well as the department for the service they provide for children and young people. We must have clear policies that we can demonstrate we follow to indicate how we meet the standards of care as set out in the Queensland *Child Protection Act 1999*. Our licensing also requires us to have clear and accountable ways of dealing with matters of concern. When those of us in the sector have asked why these same standards do not apply to the government sector we are told that they do, but are implemented as an internal process and without external evaluation as, 'after all we are the department'. It has been our observation that the department's placements have more children and young people in them than do non-government placements and that the department's foster carers receive less support and supervision from departmental staff than do non-government foster carers from their agencies. We believe children are significantly safer in non-government placements and note that the severe incidences of abuse that happened to young people and led to this inquiry occurred in placements lacking non-government agency involvement. (Integrated Family and Youth Service submission, p. 2)

Several non-government organisations submitted that the recruitment, training and assessment of foster carers should be left entirely to the non-government sector, with the Department of Families having an overarching regulatory role. The question of whether outsourcing this function to non-government organisations is good value for money remains open. Some departmental managers consulted during the Inquiry were 'unsure' about whether the shared family care agencies in their region provided value for money. Others believed that the money given to non-government organisations now would be better spent on hiring additional departmental staff to recruit, train, assess and support foster carers, leaving non-government organisations to undertake prevention and early intervention work.

The Inquiry heard from several sources that many children in need of protection

would benefit from specialist medical, psychiatric, allied health and education services and that care and protection of children was not solely the responsibility of the department, but required the involvement of several government agencies. It did not become apparent to the Inquiry why specialist services were not routinely provided where available. In part, the explanation for less-than-optimal service provision may be that currently it is not routine practice for a child entering alternative care to be the subject of a multidisciplinary assessment. The Inquiry also heard that there was a lack of specialist therapeutic services outside the Brisbane and Townsville areas, and that providing multidisciplinary therapeutic services to children and families was expensive and therefore not standard procedure.

The Inquiry was advised that the simplest way to ensure more children in need of protection would receive a multidisciplinary assessment would be to enhance the role SCAN teams play, both in the number of cases SCAN teams assess and also in the level of influence a SCAN team can have on case management decisions (CMC 2003).

ENHANCING ACCOUNTABILITY

For any government agency exercising power over the rights of the population, robust accountability systems represented through open and transparent operating procedures and processes are essential components of good governance.

The removal of a child from parental care is undoubtedly a significant impost on the rights of both the child and the parents — even if the removal is in the child's best interests.

The Inquiry heard evidence and received a number of submissions that addressed the statutory powers of the department and the administration and oversight of those powers. There was evidence that the exercise of these powers is routinely delegated, on a daily basis, to FSOs who are often comparatively inexperienced officers in their first year out of university. According to information presented to the Inquiry, generally these officers are held internally accountable for the clinical aspects of their decisions to their team leaders, unless the child dies or suffers some other significant adverse consequence, which brings the matter to the attention of the director-general, the minister or the general public.

The evidence described already in Chapter 2 has highlighted some of the serious internal accountability and supervisory problems that exist in the department's current working practices. It is apparent to the Commission that one of the most problematic areas of accountability is the department's handling of reports by children in care of abuse, by carers, parents on contact visits, or others. While section 148 of the Child Protection Act makes the reporting of abuse of children in residential care mandatory, the reporting of allegations within foster care is not. The CMC was alerted to many cases where children and adolescents in care have made disclosures regarding abuse to which the departmental response has been to make no recording on the file or to take little or no action, even when the complaint has been substantiated.

The audit of files conducted by Ms Gwenn Murray found that when a notification is recorded the investigation of the complaint is often poorly done by the department and the response to substantiated complaints can be inadequate (CMC 2003). The Commissioner for Children and Young People told the Inquiry:

> I'm of the opinion that the state has the responsibility of not only doing no harm, but providing a better outcome for the person concerned when the state intervenes. At the moment we're not even meeting the lesser of these criteria.
>
> If it was mandated that allegations of harm to children in foster care were to be reported to a central recording section and recorded on the audit database then the information relating to harm and care is at least recorded in compliance with the legislation and the information would actually be able to

be found, unlike the current situation.

A database of this type would help identify trends in terms of where breaches and notifications are occurring, and this type of scrutiny makes it more difficult to victimise people.

We have actually had some carers tell us that if they speak out on some topics all of a sudden they have a breach of standards of care placed on them within a few days. (CMC 2003, p. 707)

The Inquiry was also told that there should be an ethical imperative to have an independent person investigate anything not considered appropriate for an FSO to be involved with (CMC 2003). There was concern expressed as to whether FSOs were the most appropriate officers to be conducting investigations (leaving aside issues about their investigative skills), due to the potential for conflicts of interest, given that the FSO will often be required to maintain an ongoing relationship with a foster carer against whom allegations have been made. It may obviously be difficult for a person in that position to assess and investigate allegations objectively (CMC 2003).

Turning to external review mechanisms applying to these everyday decisions, a review can occur at present through these means:

- a presiding magistrate's assessment of an application for a child protection order and the granting of such orders
- the SCAN teams
- the Commission for Children and Young People (CCYP)
- the Children Services Tribunal.

The evidence before the Inquiry suggested that there are some limitations regarding each of these avenues of review. The Inquiry was told the following:

- Magistrates are not clinically trained in child-welfare issues and, while they may have developed an appreciation of the issues involved in child protection orders and the behaviours of those involved in the process, the hearing process requires that they rely heavily on the advice provided by the FSOs regarding the circumstances in which the child is living and what actions will be in the child's best interests (CMC 2003). Further, only those decisions involving the placing of children on orders are reviewable through this avenue.
- With respect to demonstrating due process to the parties involved in the process, parents (LAQ submission) and relative carers (CMC 2003) are often not advised of court hearing dates, of their rights in respect of the matter or of the decision to place the child under an order.
- The present approach to the SCAN team process means that SCAN teams only consider those children who are referred to them. Further, regarding independence in assessment and decision-making processes, the Inquiry heard that the SCAN teams are often presented with case plans, accompanied by a decision prepared by the FSOs, as a 'fait accompli'. The Inquiry was also told that some SCAN recommendations are not followed through and some FSOs had a negative perception of SCAN teams, without appearing to realise the value they can add to the decision-making process:

  My recent experience in relation to the SCAN team was recommendations that were made that were simply not followed through. The SCAN team made minutes, had an agenda, but didn't read its previous recommendations and didn't call to account those workers who had undertaken to do tasks from the previous SCAN meeting. So in doing that they simply mirror what's happening in case planning in the Department of Families and no external check or balance or way of moderating practice. (CMC 2003, p. 280)

  [SCAN] is an educative process for the people who work in Families to be prepared to cope with, understand and accept critiquing and not regard it as criticism because it's not — I don't think it is — there's a fair bit, as we've seen in the press, a fair bit of scapegoating of junior staff and blame apportioning and not a culture of having healthy critique to learn how to change your management and to do different things. (CMC 2003, p. 597)

For a SCAN team to function properly, it needs good coordination, respect for the opinions of the various members and a team commitment to promoting the best interests of the children under consideration in an open and accountable manner. The Brisbane Mater Hospital SCAN team was put forward at the Inquiry as one that demonstrates those qualities and is operating effectively. (More about the role of the SCAN teams appears in Chapter 6.)

- The CCYP is subject to jurisdictional limits in the departmental decisions that it can investigate. The current Commissioner for Children and Young People told the Inquiry that the CCYP could only act in respect of complaints and was limited to asking only for an explanation from the department, rather than reviewing files and interviewing relevant parties. Further, under a protocol between the Department of Families and the CCYP, the department has 28 days to respond to any request for information, although the commissioner noted that at times all the commission received within those 28 days was an acknowledgment of the request (CMC 2003).
- Similarly, the Children Services Tribunal is subject to jurisdictional limits in its capacity to review departmental decisions. Legal Aid Queensland noted:

> The lack of adequate funding of the Children Services Tribunal coupled with the attitude of many family services officers whose cases are referred there is also a concern to Legal Aid Queensland. The family services officers often take the view that they are professionally under attack in some way and therefore they approach the process of the tribunal in a defensive and closed manner rather than engaging in an independent review of decision making in the interests of the child or young person. (CMC 2003, p. 543)

The deputy president of the tribunal noted:

> Voluntary Care Arrangements should be given statutory recognition under the *Child Protection Act 1999*. There should be mechanisms to scrutinise and review these arrangements. A decision about a child who is subject to a voluntary care arrangement should be reviewable by the Children Services Tribunal on the same basis as if the decision were made about a child under a child protection order. This would require legislative change. (Bruce Doyle submission, p. 5)

With respect to ensuring that children in particular know their rights in foster care and the avenues for complaint when those rights are breached, 'Max', a foster child, said to the Inquiry:

> Many children don't know what their rights are. There is not enough info available for children and young people for their rights. I was put in foster care at the early age of four. I am now 17 and only recently through CREATE I knew I had a charter of rights. A possible solution that could be taken up is that we could develop a special poster for children in care that states their rights and entitlements so they know where they stand. (CMC 2003, p. 254)

The idea of expanding the present Community Visitor Program to include foster homes was promoted at the Inquiry, with the Director-General of Families accepting that it was an accountability measure that should be considered further (CMC 2003). While there was some debate as to whether all foster homes should be included in the program (CMC 2003), there was general consensus that those with six children or more should be a priority. It was accepted that it would take some time for the Community Visitors to build a rapport with the children and young people they were visiting, but the Inquiry was advised that the present community visitors had already been very successful in this respect in the residential care setting (CMC 2003).

Finally, FCQ made the following comment to the Inquiry regarding the need for proper external accountability for the foster care system in Queensland:

> While it may be not welcomed by the minister, director-general and many officers across the state who have worked hard to correct and improve the system, it may be necessary to consider more external scrutiny and support for the short term to ensure that the necessary funding and changes are made to improve the system in the long term. This would include a child advocate, a

case review advocate and foster carer advocacy. All groups representing to this Inquiry will most probably include a bias to their own area of interest.

The children, workers and foster carers deserve to have their concerns addressed this time and not miss out again to the vision of a grand new approach. The system has recognised the need for change and has shown that a good system can be built on the current improvements if there is sufficient funding and an inclusive, open and accountable approach and that the focus, in all cases, is on the best interests of the child. (CMC 2003, p. 335)

PROTECTING INDIGENOUS CHILDREN

Indigenous children are grossly over-represented in the child protection system in Queensland. Despite making up only 5.2 per cent of Queensland's children, Indigenous children constitute 22.6 per cent of those children on care and protection orders living in out-of-home care and 25 per cent of the children on long-term guardianship orders (Department of Families 2003e).

The problems encountered by the department in providing services to Indigenous communities are confronted by all Australian governments. Numerous reviews have been conducted in the last ten years that focus on the child protection systems throughout Australia and significant discussion is consistently directed towards the particular problems faced by Indigenous communities. The situation in Queensland parallels that in other states, although the Cape York communities present some unique challenges for government. The CMC heard from a variety of organisations and individuals that the system is failing Indigenous children in important respects.

Cultural differences

The problems experienced by Indigenous communities regarding child protection issues are markedly compounded by a disparity between standard governmental protocols and certain key aspects of Indigenous culture. The degree of divergence between these two ways of understanding 'how the world works' is in large part a function of geographical location, with the experiences of Indigenous people in urban centres being quite different from those of Indigenous people in rural and remote areas. The following scenario, submitted to the Inquiry by Legal Aid Queensland, provides an example of the problems that arise in rural Aboriginal communities:

> A family services officer investigating a complaint visited an Indigenous couple. There were reports of the father drinking at a camp by a creek in town. The mother was at home with the children but because the father was sighted at the camp it was assumed the mother was with him. The father had hit the daughter as a disciplinary measure when he found out that she had been sniffing paint. The family services officer looked around their house and noted that there was hardly any food in the fridge and the children's clothes were not clean. The officer told the parents that the children were being removed from their care because the father had hit the young girl and the children were not being looked after properly because they had head lice and scabies. The boys were placed with a European family in a town nearly a hundred kilometres away. The parents did not know where the young girl was placed. It is submitted that this is a classic example of a young Caucasian woman, with hardly any life skills, only educational skill, assessing the situation from a middle-class European perspective. She assessed that this was not a clean and healthy home. By community standards, the family were giving their children the best possible environment they could. However, the environment fell short of the standards that the family services officer is used to, and she assessed it from that perspective. There was a court date for a court assessment order. The parents attended court without any legal representation. The magistrate informed the parents that she would adjourn the hearing so that they could obtain legal advice. They visited a legal aid office, saw a community liaison officer and a family law solicitor who arranged for an application for a grant of legal assistance to be made by the family so that they would be represented when the case returned to court. The Family Services officer had not informed the parents that they had a right to seek legal advice. (LAQ submission, pp. 13–14)

Legal Aid Queensland's submission also listed the following problems that confound the relationship between the department and Indigenous communities:

- failure [of department] to engage the client or Aboriginal and Torres Strait Islander representatives or agencies in an appropriate manner
- failure [of department] to adopt an appropriate method of information gathering
- a lack of sensitivity [of department] toward the specific needs and characteristics of Aboriginal and Torres Strait Islander clients
- a lack of understanding between the Department of Families, the Aboriginal and Torres Strait Islander Agency and families in the first step of the child protection proceedings

> Another major concern is that contact between families and their children, and family meetings to case plan, are held at the offices of the Department of Families, which is not culturally appropriate. This is often an intimidating environment for people, and they perceive it as being a hostile and threatening place. (LAQ submission, pp. 11–12)

The CMC received several submissions that discussed the unique disadvantages experienced by Indigenous people. In particular, the CMC was told that decisions too often appear to be based on individual interpretations of the guidelines and situations, resulting in a lack of consistency in child protection practices. It was suggested that too frequently FSOs are young females with little experience of parenting and almost no understanding of the cultural differences evident in some communities.

In addition to the issue of heavy workloads, the Inquiry was told of a reluctance at times by departmental staff to act — a reluctance stemming from a misguided sense of Indigenous cultural values:

> I believe that there is a mindset in the community government workers that abuse has always been a part of the Aboriginal way of life and are willing to accept it as the norm. (confidential submission)

In part, Aboriginal and Islander Child Care Agencies (see below) are intended to provide a means of bridging this cultural divide between Indigenous people and those government agencies that have the potential and responsibility to exercise some very intrusive powers.

The role of Aboriginal and Islander Child Care Agencies (AICCAs)

AICCAs were established in Australia in the 1970s to give extra support to families and children arising from the comparative socioeconomic disadvantage of Indigenous people. AICCAs embody the principle of self-determination and participation (Butler 1993). Their responsibilities vary across the state; however, their normal functions include shared family care work, early intervention and prevention, and family support.

Many comments made to the CMC suggest there are a number of problems with the operation of AICCAs in Queensland. An Indigenous foster carer who spoke at the hearings said:

> [A former AICCA worker] has told me that there are numerous children, Indigenous children, who are within the system, within the Department of Families in her area, she doesn't even know their names or who they are. She isn't told of meetings that she's supposed to go to the Department of Families and the Indigenous child's family. They're not informed. Half the time if they are informed they've got no resources, therefore they can't get there because they've got no car. They're given no case notes, no history. So there's just a whole sort of breakdown, basically, of sharing of information between the two areas. It isn't working as it is. They need to restructure the whole AICCA system.
>
> There should be one standard for a child, no matter what colour their skin is. No matter what their culture is. No matter what their heritage is. That child should be protected under the same guidelines as every other foster child within the system, regardless of who oversees them and their area. (CMC 2003, p. 423)

AICCA employees told us that (from their perspective at least) they had little real influence in decision making and that sometimes they were not consulted at all regarding Indigenous placements (confidential consultations). The CMC also heard that the level of consultation the department employed with Indigenous representatives was unequal in nature, and hence inconsistent with the spirit of the Child Protection Act.

> Authorities expect the communities to adhere to the bureaucratic manner of communication to which government officers are subject … Whilst this is difficult for the officers concerned the effects rebound negatively upon our communities and ultimately the children for whom we bear concern …The communities experience of communication by government is often one way, in as much as follow-up from government officers back to the community rarely occurs … the communities are left with the familiar experience of being under valued and used for an agenda that serves other than the interests of the Indigenous people involved. (Aboriginal and Torres Strait Islanders Corporation for Legal Services submission, p. 3)

There were other significant problems associated with AICAAs that were identified during the Inquiry. In the last two years a number of AICCAs have been de-funded by the government. In evidence provided at the hearings the Minister for Families stated that:

> … there are a range of problems with AICCAs involving lapses in quality of service delivery, an inability to respond to requests for service, an inability to comply with reasonable levels of administrative probity including evidence of mismanagement of funds. (CMC 2003, p. 34)

Obviously problems such as these should not be taken lightly, and the government should not be providing financial support to organisations that cannot demonstrate that they are fiscally responsible bodies. However, irrespective of the degree of financial transparency and accountability characterising individual AICCAs, it was suggested by a number of AICCA employees and non-Indigenous organisations that the funding provided to these agencies to fulfil their service agreements is insufficient. PeakCare submitted:

> As indicated in the Department of Families' response to the 'At What Cost' Report (CCSF 2001), the percentage of child protection and family support grants to Indigenous organisations provides an indication of whether Indigenous children and their families have equitable access to services. Good performance is when the level of spending is roughly equivalent to the proportion of Indigenous children on child protection orders (22.5% at 30 June 2001). In 2000–01, the portion of grants allocated to Indigenous organisations was 14.9 per cent. This is likely to be significantly lower with the closure of a number of Indigenous organisations since 2001. (PeakCare submission, p. 30)

The current level of resourcing for AICCAs was described by the Aboriginal and Islander Corporation for Legal Services in its submission as 'a token of what is seriously needed'. The corporation noted that the assessments of the effectiveness of AICCAs drastically underestimate the need for adequate provision for both the frontline staff of such organisations and the community-based corporations that provide them with community legitimacy. It added that, when attention is given to the plight of Indigenous children in care and the problems of effective service delivery, the department typically responds by alleging that the AICCAs have failed to meet departmental standards — the under-resourcing issue is ignored.

Other AICCA employees stated that Indigenous organisations have always been given a small amount of money with which they are expected to provide a disproportionate number of outcomes for that community.

> We don't [get support in administration areas] — we've got to employ people in the community. We only get a small budget. We can't attract people with an accounting degree or people with the skills to come and do book — you know, our financials. I mean, it's ad hoc … we've got no money to train … an Aboriginal community is made up of — of the grassroot people … half of them might not have finished Grade 10. The older ones, you know, they haven't. They never learned to manage their own budget, and sometimes — sometimes they can't do that, so how are they going to manage a bigger budget, you

know? (CMC 2003, p. 364)

Importantly, the Inquiry drew attention to the fact that most AICCAs are only funded for the number of children on child protection orders and most, if not all, early intervention/prevention work they do is not recognised. An AICCA employee gave the following example of the type of work undertaken by their agency:

> What we have been doing is assisting families who are living in cars. I had a mum with nine children living in two cars. All the children attended school, they were well-spoken, well-dressed, well-fed, but because mum was an Indigenous person she found it very difficult to get private housing … she had a Housing Commission debt so she couldn't get a house through the Housing Commission and as I say they were living in two cars, the children were well-fed, well-dressed, but the 13-year-old started to experience health problems.
>
> We then immediately started looking through the private housing to get her a house and it didn't work. So we went straight to the Housing Commission and asked and pleaded for her to be given a home, which they did, they came to the party and we were able to house her. There was no notification on that family. We worked very very quickly with that family. (CMC 2003, p. 682)

AICCA employees were at pains to stress the importance of being adequately funded to provide these types of early intervention/prevention services:

> We are not funded to do early intervention prevention work. We don't have a choice. We're a community-based organisation. Our community need us. They come to us. They want help from us. They historically have problems with the Department of Families that goes back generations. They want our community services to service them and meet their needs. They don't think the department wants to do that for them. (CMC 2003, p. 681)

The CMC was told that AICCAs experience considerable difficulties in recruiting Indigenous carers because of this historical mistrust that Indigenous people have towards the department as well as towards government paperwork and the general processes involved in being formally accepted as a foster carer.

> …[W]e've then got to recruit foster parents, try and recruit Murri foster parents and when we do we all sit there and do the paperwork with the FSO, but we can't sign off on it, it's got to go back to the department … when you're recruiting foster Murri ones sometimes they can't read or write, so you've got to go through everything and some of the questions are very hard … Most Murri people as we all know have got criminal histories somewhere so they're too frightened to — to become a foster parent … we try to explain to them, you know, if it's a crime that was done twenty years ago when they were young and if they can justify… that they've become good parents themselves because of their mistakes that they might have made, but they've still got that fear … that's why no one wants to … be an indigenous carer. They'd rather just … take that child from mum for a couple of months or whatever, look after it, then give it back when that mother — parent's — on track again without going through that process of all the paperwork … (CMC 2003, p. 394).

Extra support services offered to Indigenous communities

The consultations undertaken by the CMC with Indigenous communities highlighted the lack of early prevention and intervention activities currently being offered to Indigenous families as well as a perceived lack of support for community-based initiatives (confidential consultations). Indigenous people also told the CMC that the government does not have a very strong research base regarding Indigenous issues, and, as a result, the policies developed for implementing programs and services in remote and rural communities are at times of questionable relevance and practicality (confidential consultations).

Child placement principle

As noted in Chapter 1, the Aboriginal and Torres Strait Islander child placement principle is contained in section 83 of the Child Protection Act. The principle requires that, in making a decision about the person in whose care an Indigenous child should be placed, the director-general must give proper consideration to placing the child

with (in order of priority):

- a member of the child's family
- a member of the child's community or language group
- another Aboriginal or Torres Strait Islander who is compatible with the child's community or language group, or
- another Aboriginal or Torres Strait Islander.

To implement this, AICCAs in most jurisdictions assist in decisions as to the placement of Indigenous children.

> The removal of Indigenous children from their environment to a non-Indigenous environment can cause long-term damage. The department must place a high priority on providing Indigenous children with the opportunity to grow up with their natural parents, and not among strangers. If they stay in their own communities or families, they have frequent contact with members of their own families including grandparents, aunties, uncles and cousins from both sides of their families. (LAQ submission, p. 11)

However, the CMC was told that the placement principle is not always followed and AICCAs are sometimes not involved in placement decisions concerning Indigenous children. The CMC heard from many organisations that were critical of the department's implementation of this principle. This view was also reflected by some of the evidence in Operation Zellow (see Chapter 2).

The Queensland Aboriginal and Torres Strait Islander Legal Service Secretariat (QAILSS) in its written submission asserted that the department is not complying with sections 6 and 83 of the Child Protection Act. Section 6 requires the director-general to consult with a recognised Indigenous agency (such as an AICCA) prior to making decisions about an Indigenous child, and section 83 incorporates the above placement principle and a similar consultation obligation on the part of the director-general when making decisions about where and with whom an Indigenous child will live. Specifically, QAILSS submitted:

- departmental staff are failing to contact AICCAs in relation to child notifications
- decision-making by departmental staff is 'culturally inappropriate'
- case management by the department is 'appalling' in many child placements
- AICCAs should be allowed access to Indigenous children placed with non-Indigenous agencies and foster carers. (QAILSS submission)

As at 30 June 2003 there were 245 Indigenous children in the care of non-Indigenous foster carers. In grappling with the high proportion of Indigenous children in non-Indigenous placements, the Queensland Government said:

> For Aboriginal and Torres Strait Islander children, the principle of being placed within their extended family and community, wherever possible, is enshrined in the *Child Protection Act 1999*. Achieving this is not always easy. Currently, there is limited capacity in Queensland's alternative care system to provide sufficient placements for Aboriginal and Torres Strait Islander children in accordance with this child placement principle. (Queensland Government submission, p. 5)

During the public hearings, the current Minister for Families, Ms Spence, noted that only 69 per cent of Indigenous children in care are placed in accordance with the placement principle:

> Approximately 69 per cent of those in care have been placed in accordance with the Aboriginal and child placement principles. Essentially, the purpose of this was to preserve the sense of identity by maintaining their own family, community and culture. This was done in consultation with the recognised Aboriginal and Torres Strait Islander Child Care Agency or AICCA. This has become problematic. Firstly, there are a range of problems with the ACCIAs involving lapses in quality of service delivery, an inability to respond to requests for service, an inability to comply with reasonable levels of administrative probity including evidence of mismanagement of funds …

> Secondly, there has been an over-reliance on relative care. We recognise that this is an issue for both Indigenous and non-Indigenous communities with approximately 36 per cent of children and young people being placed with relative carers as of 30th of June this year. But the question here remains, will this placement achieve a goal of protecting this child from harm and keeping the child safe? As well, there is also a severe shortage of Indigenous foster carers with the end result that to comply with this principle too few Indigenous foster carers are looking after too many children. (CMC 2003, p. 35)

The Department of Families (2003b) noted the importance of providing adequate support to relatives, who appear to form the majority of out-of-home care for Indigenous children (42% of Indigenous placements). However, the department also pointed out that, where there is no family member who will be committed and responsible for the child, other care options must be considered.

One confidential submission put it this way:

> There are carers who may not be related to the children, but who will keep strong cultural links for children and who will provide high-quality care as well as be committed to them for life, and this should not be overlooked in favour of relatives who may not be suitable.

Finding appropriate placements for Indigenous children is clearly a challenging task. As Legal Aid Queensland noted:

> As Indigenous carers are in such short supply throughout Queensland, the Department of Families often over-utilises these carers, placing very large numbers of children with them. These children often have highly challenging and difficult behaviours. The department does not provide the appropriate supports to the children, nor suitable resources for the carers. The outcome is that often these placements break down and children go from one placement to the next, experiencing numerous placements in a matter of months. (LAQ submission, p. 11)

The Leader of the Opposition, in his submission to the Inquiry, observed that the department's failure to provide adequate care and protection services has in the past led to Indigenous children being housed in commercial facilities including three teenage children being accommodated at a resort for a week in 2002. The Opposition considered that, given the cost of providing this sort of accommodation and the demonstrated problems associated with appropriate supervision, assisting community groups to provide emergency support (including accommodation, counselling and ongoing social support) is a more effective strategy (Leader of the Opposition submission).

Mandatory reporting

Perhaps surprisingly, despite the issue of mandatory reporting being included as a specific subject within the CMC's terms of reference for the Inquiry, it did not emerge as a prominent issue in submissions or consultations with Indigenous people and organisations.

QAILSS noted in its submission that mandatory reporting of suspected incidents of child sexual abuse should not be automatically assumed to be desirable. They provided the following example to illustrate their point:

> Sexual abuse occurs between a brother aged 15 and his sister aged 13. Some two years elapse; the girl is aged 15 and the boy is aged 17. The girl is suffering severe emotional problems requiring immediate counselling. Her mother becomes aware of the abuse that occurred and is in a quandary as to what to do. The mother is aware that if a counsellor is involved Families Queensland will also become involved as well as the Queensland Police Service. The end result is that the brother will be charged with an offence and possibly imprisoned. There has to be another alternative to mandatory reporting, which, in Queensland, would involve legislative changes. (QAILSS submission)

Mandatory reporting was raised by organisations and individuals located in Cape York during the Inquiry. Opinions varied widely, with some communities advocating a change in the requirements, while others thought the legislation should be left as it is.

Still other community groups believed that if mandatory reporting were to be extended it should include nurses, teachers and all staff employed at community health centres. This was seen as important in some remote communities where access to doctors is limited as there may only be one in the community.

Another option that was raised by Indigenous people was an automatic reporting system where sexually transmitted infections found in children under a certain age are automatically reported by medical practitioners to the department and the police. This would ensure that such infections in young children are quickly brought to the attention of the department.

Summary of issues re Indigenous children

If there is a central message entailed in the submissions with respect to Indigenous issues it is the view that the needs of Indigenous children are significantly greater than those of non-Indigenous children but the level of resourcing to meet these needs is significantly lower.

In addition, whatever the aspirations of the department, it appears that in its dealings with many Indigenous people it is perceived as not demonstrating an appropriate level of understanding of culturally specific factors.

At the very least, the department is confronted with a substantial problem in terms of reconciling external perceptions of its activities with its own understandings and objectives. However, on the basis of the submissions made to the CMC, it appears unlikely that the problems highlighted during the Inquiry are simply matters of perception rather than substance.

This final point applies equally well to both non-Indigenous and Indigenous children. While it could be argued that the widespread criticisms of the department reported in this chapter derive from a lack of appreciation of the true nature of its endeavours, the weight of available evidence makes it difficult to accept that the department is merely misunderstood. The fact that some criticisms may be misguided or overstated does not outweigh the fact that the department is being found wanting by key stakeholders across a very wide range of its service-delivery obligations.

TRANSFORMATIONAL VERSUS INCREMENTAL CHANGE

Criticisms of the Department of Families by some parties during the Inquiry have been severe, even allowing for those critics who have failed to recognise the significant steps already taken by the government and the department to address some known shortcomings.

Both the government and the minister acknowledge that much more organisational change is needed and the director-general has stated that, while this is a staged process, the implementation of all of the necessary change could take 'five to seven years' (CMC 2003). The Commission is of the view, given all of the evidence before it, that such a timeframe is unacceptable in terms of the harm that children would undoubtedly continue to suffer over any such period. Urgent reform of key aspects of the child protection system is needed now, particularly in ensuring that notifications of harm to children are systematically responded to in a better and more timely manner.

The fact that the Department of Families acknowledges that such an extended timeframe for change is required suggests in itself that very significant modifications to the department are called for. It suggests that the degree of change needed is so great as to warrant consideration of transformational change, involving major structural reform.

The recommendations outlined later in this report derive from consideration of these four basic questions.

- Is the department too 'sick' to fix?
- Will incremental change over five to seven years produce the degree of reform needed?
- Could a tightly focused department committed to child protection alone achieve better outcomes?
- If a focused department is preferred, should it be within or separate from the current department?

FINAL COMMENT

In the Commission's view, transformational change is not just the preferable option, it is the only option. The evidence does not promote confidence that the current departmental infrastructure, culture and work practices constitute the type of environment into which incremental changes can successfully be introduced to redress all of the systemic failings that have been acknowledged to exist. Fundamental structural and organisational reform is needed. Such change is in itself symbolic, involving the opportunity to examine core structures, processes and values, and to set a new vision.

The following chapters of this report outline a new vision for a whole-of-government response to the needs of children generally and those in the care of the state specifically. A new Department of Child Safety is proposed, which focuses exclusively upon the provision of more integrated and more child-focused protective services.

4

THE FUTURE FOR QUEENSLAND CHILDREN: AN OVERVIEW

This chapter outlines a new approach for responding to the needs of children, and in particular those in the care of the state. It provides an overview of a new vision for children generally and children in care specifically, a vision based upon a more explicit and more sophisticated use of multi-agency approaches to meeting the needs of children. Central to this vision is the establishment of a new department — the Department of Child Safety (DCS).

In the chapters that follow, further recommendations flowing from this primary concept are explained in more detail.

INTRODUCTION

The *Child Protection Act 1999* states the fundamental principle that every child has a right to protection from harm. Children in foster care are particularly vulnerable, but their need for protection cannot be met unless inadequacies in the broader child protection system are addressed. In turn, child protection cannot be separated from the provision of wider support for families and carers.

Effective protection of children requires a system that supports the development of *all* children, and identifies vulnerable families for targeted intervention on behalf of children identified as being at risk. No single agency can be expected to achieve all of this; a coordinated multi-agency response is required.

The examples given earlier in this report demonstrate that the child protection system in Queensland has failed to provide adequate protection to all the children for whom it bears responsibility. The problems identified are significant and systemic. In part they reflect the lack of an effective preventive program that could reduce the need for many children to be placed in protective care. But there is also a lack of clarity and focus about the roles of the Department of Families and other key stakeholders in protecting children at risk. Additional resources alone will not provide a solution to this problem.

The immediate need is to engender confidence in the child protection system by sharpening the focus on the safety and security of children. As a result of this Inquiry, the Commission is persuaded that the Department of Families is at present so overburdened, and its stakeholders so lacking in trust, that a new approach is needed. Only by concentrating unambiguously on meeting the needs of children at risk will it be possible to make the necessary changes. This can most readily be achieved by way of a new department focused exclusively on the following core functions:

- intake, assessment and investigation of notifications
- targeted support for children identified as being at risk
- the provision of alternative care for children identified as being at risk.

In parallel with the activities of the new department, there will need to be primary and secondary prevention programs directed towards the wellbeing and safety of all children, as well as more general family support services. These prevention services should not, however, be the responsibility of the new department; instead they should be delivered by other government agencies. Important as preventive programs will ultimately prove to be in reducing the pressure of new notifications, at this time the priority must be to return certainty and confidence to the core child protection system.

A STRATEGIC FOCUS ON CHILDREN

This Inquiry was set up in response to concerns about the abuse of children in care, particularly those in foster care. On the basis of the evidence obtained during the Inquiry, the Commission now urges the implementation of a new strategic focus on children. Ideally this will involve governments at all levels incorporating a specific focus on children in the delivery of universal services in areas such as health and education. The obligation to address these universal needs of children falls upon federal, state and local government alike. Given this, even though the particular interest of this Inquiry is in the revitalisation of the Queensland child protection system, it is necessary to place that objective in the context of the broader responsibilities of government to children.

The recent British Green Paper, Every Child Matters (UK Government 2003) says that child protection cannot be separated from policies to improve children's lives as a whole. It goes on to identify the following five key outcomes for children and young people:

1 **being healthy** — enjoying good physical and mental health and living healthy lifestyles

2 **staying safe** — being protected from harm and neglect, and growing up able to look after themselves

3 **enjoying and achieving** — getting the most out of life and developing broad skills for adulthood

4 **making a positive contribution** to the community and to society and not engaging in antisocial or offending behaviour

5 **achieving economic wellbeing** — overcoming socioeconomic disadvantages to achieve their full potential in life.

These provide a highly appropriate framework for a new strategic focus for government on the needs of children generally, and children in the care of the state specifically. Because of the breadth of the five outcomes it is immediately clear that the wellbeing of children cannot be the responsibility of any single agency. It follows from this that a whole-of-government approach is necessary to tackle the causes of poor outcomes for children. These causes include poverty, inadequate access to health care and education, and inequalities across gender and ethnicity. Crucial in this regard will be a stronger focus on giving support to parents, especially those who are socially or economically disadvantaged.

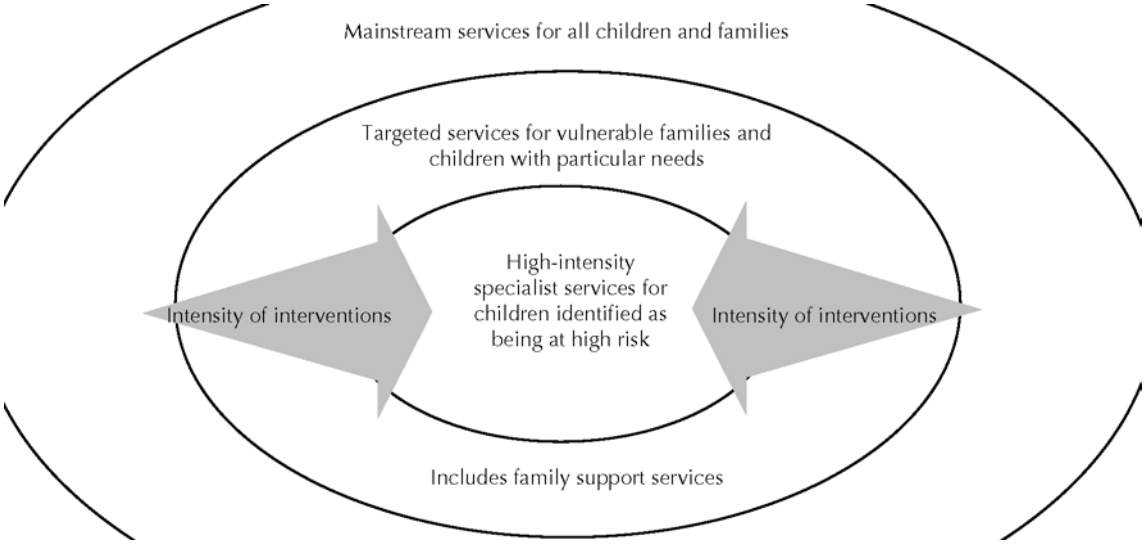
Central to such a new strategic focus by government would be the commitment to coordinated multi-agency service delivery directed to meeting the needs of children. This coordination of multi-agency services is especially necessary when the issue of child abuse is being confronted. The causes and consequences of child abuse are highly complex and this inevitably means that responses to such abuse need to be equally complex.

In order to deliver the five key outcomes identified above it is necessary to ensure that the mainstream services delivered by departments such as health, education and police collectively meet the specific needs of children and their families, and in so doing reduce the demands placed upon the lead agency for child protection.

A general overarching model for responding to the needs of children is presented diagrammatically in Figure 4.1. As can be seen in this diagram, the needs of children are categorised by their level of intensity and the degree to which they are targeted. At the outside margin are very standardised services such as those provided by Education Queensland, which (for most children) require relatively low-intensity interventions (indicated by the tapering arrows).

In contrast to the outer margin, however, the centre of the model represents children with high-intensity special needs that may depend almost entirely on the efficient delivery of targeted services. Between these two extremes are children for whom targeted services are required if undue or unnecessary adverse outcomes are to be prevented.

Figure 4.1. Government support for children



Source: Adapted from Department of Child, Youth and Family Services (NZ) (2003).

It will always be a challenging exercise for government to achieve a coordinated vision, when services important to achieving positive outcomes for children are spread across numerous agencies. For this reason the Commission urges governments at all levels to consider cooperating to formulate a comprehensive and well-specified strategic vision of how to put children first, in terms of both opportunity and security. Central to the success of this strategic vision, however, will be a lead agency responsible for coordinating the delivery of multi-agency child protection services. A commitment by government to improving children's lives is a high-return investment by the citizens of the present in the citizens of the future.

CHILD PROTECTION NEEDS

Mainstream programs that enhance the general wellbeing of all children may reduce factors associated with poor outcomes. However, some children are already at risk or live in vulnerable families. Through a combination of detrimental factors, many of these children have little opportunity of growing up in a safe and supportive environment. There must be an emphasis on ensuring that such children are identified earlier, and provided with targeted services to safeguard them from abuse and neglect.

An effective child protection system focused on safeguarding children from harm will involve a commitment to the prevention of future harm as well as a response to the needs of children already abused or at risk of abuse. Child protection programs will be distinguished from mainstream services by their emphasis on addressing specific risks of harm.

The next section of this chapter proposes a model for a coordinated child protection system in Queensland.

A DEPARTMENT OF CHILD SAFETY

The extent of systemic failings within the Department of Families identified in the earlier chapters of this report has persuaded the Commission that these cannot be remedied through a process of incremental reform. No doubt the present problems faced by the department are a product of the history of child protection in Queensland. Decades of low resourcing, combined with increasing notifications of abuse, have combined to reduce the department to one with a culture driven by crisis management. The immediate need is a restoration of community confidence in the department that is charged with the care of children at risk. Unless this is achieved, and the confidence of all stakeholders in the system restored, other praiseworthy programs for longer-term prevention of abuse and support for families will be undermined.

It is for this reason that the Commission proposes the creation of a new Department of Child Safety (DCS), directed towards meeting the needs of children at risk and undistracted by any other tasks or goals. This department must not be expected to bear responsibility for all aspects of child protection, in terms of either prevention or response. If too great a burden is placed upon the department it will be destined to fail. Child protection must be recognised by government as being the responsibility of a wide range of agencies collectively participating in a whole-of-government commitment to the wellbeing of children.

As already noted, no single agency can be expected to meet all the needs of children in care. To varying degrees and at times, children in care will have differing physical and psychological health needs, education needs, accommodation needs, family support needs and so on. In many instances the skill base will already exist within government to allow those needs to be met. In such cases it will be most efficient for the agency with the necessary skills to deliver the required service directly to children in care rather than require the DCS to either duplicate or outsource the service. This represents a fundamental change in the way in which responsibility for child protection matters is understood by government.

Central to this shift in thinking is the need for a lead agency defined *exclusively* by a strategic focus upon the wellbeing of children for whom the government has assumed a guardianship role. Importantly, however, if it is to achieve the objectives envisaged for it by the Commission, this new department will need to focus on a number of key areas in which the Department of Families has been found wanting. It needs to be an agency that is committed to:

- addressing the needs of children as its number one priority
- providing a broad range of options for case-managing children at risk of harm
- being the lead agency in a coordinated, whole-of-government response to child protection issues
- using effective and sophisticated intake, assessment and investigative procedures and, where appropriate, specialist staff, in responding to allegations of abuse and neglect
- adhering to best-practice standards in working with children in care, foster carers, biological parents, private care providers, and other agencies involved in the provision of child protection services
- supporting staff through appropriate induction, training and professional development opportunities
- being open and accountable at all levels, both in its internal processes and through external and public scrutiny.

The new department will need to coordinate the delivery of services for at-risk children whose needs cut across the service delivery obligations of multiple agencies. During the Inquiry, the Commission heard evidence about children whose medical and other needs were inadequately attended to by the Department of Families. It will be critical for the new Department of Child Safety to ensure that it responds to children with complex needs in terms of the full range of these needs. Only in this way can these most vulnerable of children be assisted to achieve the five key outcomes listed earlier.

RECOMMENDATION

4.1 That a new Department of Child Safety be created to focus exclusively upon core child protection functions and to be the lead agency in a whole-of-government response to child protection matters.

Reason: Only through an approach unambiguously directed towards meeting the needs of at-risk children will it be possible to make the changes necessary to deliver positive outcomes for vulnerable children, and restore public confidence in the child protection system.

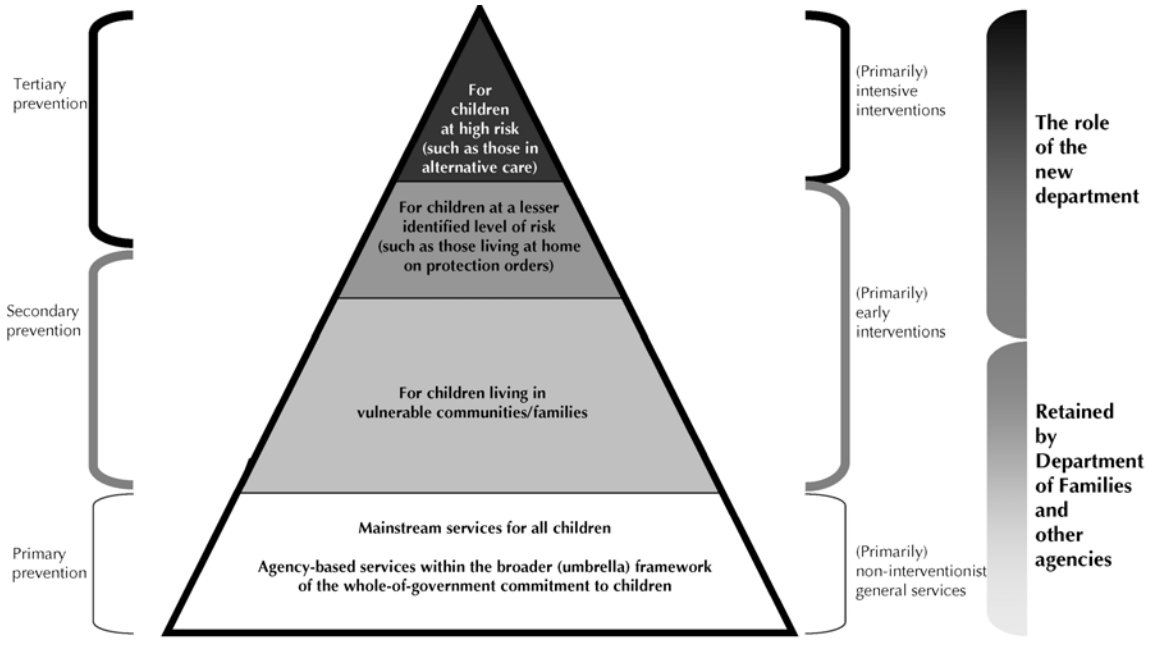
IMPLEMENTING THE CHANGES

The structural changes that will be necessary to create a new department characterised by a revitalised commitment to child protection will provide an opportunity for management to nurture and promote an entirely new culture of service to at-risk children. The Commission expects that the professional staff in the present Department of Families will provide the basis of the workforce within the new department. It also expects that, if the transition to the new department occurs in the context of the implementation of the recommendations of this report, staff will be empowered to escape from their present crisis-driven environment and adopt a more positive child-centred approach to their work. From the Inquiry there is every indication that the vast majority of Families frontline staff would welcome such an opportunity.

The scope of the new department is shown in Figure 4.2. Exactly how the new Department of Child Safety might operate can be made clear by very briefly considering the main features of its structure and functioning. (This is discussed in more detail in the three following chapters.) Moving from left to right, Figure 4.2 shows how the DCS will fit within the broader whole-of-government focus on children in Queensland, describing three key aspects of the new department and its relationship to other government agencies. The three aspects are:

- the DCS and primary, secondary, and tertiary prevention
- the DCS and early and intensive interventions
- the jurisdiction of the DCS with respect to other agencies.

Figure 4.2. Proposed scope of the Department of Child Safety



Key aspects of the new department

The DCS and primary, secondary and tertiary prevention

The nature and aims of child abuse prevention programs have been outlined in Chapter 1. Because the new Department of Child Safety should focus exclusively on the needs of children identified as being at risk, the department should have no direct service delivery obligations with respect to primary prevention programs. The major focus of the DCS should be tertiary prevention directed towards children on protective orders. The DCS should, however, assume responsibility for some prevention programs where individual children or specific families have been identified as being in need because of the risk of abuse.

For example, the new department might usefully be involved in prevention activity by working with families where children who have been the subject of low-level notifications continue to reside at home. Productivity Commission statistics reveal that Queensland has a high proportion of children where a further notification of abuse is substantiated within 12 months of an earlier substantiation. In 2000–01, 24.8 per cent of children in Queensland were the subject of a resubstantiation within 12 months, and a further 8 per cent of children were the subject of substantiation within 12 months of an earlier unsubstantiated notification. A commitment to working with parents to prevent further notifications of abuse is in the interests of the individual children, is in the interest of supporting the family unit, and has the potential to reduce the overall level of notification and the need for increased intervention in the future.

The DCS and early and intensive interventions

The DCS should focus primarily on intensive rather than early interventions. However, to the extent that early interventions are instances of secondary prevention programs targeting *identified* at-risk children, there is a role for the DCS.

The DCS jurisdiction and other agencies

The jurisdiction of the DCS should be very simple — any at-risk child formally brought to the attention of the department by way of notification or any other means should fall within its jurisdiction. It is proposed that the Department of Families or other agencies would retain functions relating to youth justice, child care, seniors, community support, and primary and secondary prevention. The Inquiry makes no recommendation as to whether those functions should remain with the Department of Families or be incorporated into other agencies. The recommendations of this report concentrate solely upon issues relevant to child protection.

A COORDINATED APPROACH TO CHILD PROTECTION

The need for a coordinated approach to policy and service development across state government agencies with respect to child protection has already been identified in the Queensland Government's Strategic Framework for Child Protection 2003–2006 (Department of Families 2003f). The Strategic Framework is given effect through the implementation of an action plan released in August 2003. The action plan (Department of Families 2003g) identifies government-wide initiatives to increase the focus on prevention and early intervention, to meet the safety and other needs of children and young people who have been significantly harmed, and to achieve a seamless and client-focused service system. This approach is consistent with the new model for child protection being proposed by the Commission. The action plan recognises that diverse agencies can contribute significantly to a common goal.

Consistent with the strategic framework action plan, it is the view of the Commission that some services required by children may best be delivered by agencies other than the new DCS. For example, some highly troubled children or young people will require significant therapeutic intervention. In some parts of the state this might be most cost-effectively provided through services currently available from Queensland Health. A whole-of-government response to such issues has the best prospect of providing cost-effective ongoing services to the greatest number of children in need.

Directors-General Coordinating Committee

To ensure that government is held accountable at the highest level for coordinating and delivering child protection services it is proposed that a Directors-General Coordinating Committee be set up, comprising the directors-general of all relevant departments including the Department of the Premier and Cabinet. It is proposed that the coordinating committee be chaired by the Director-General of the Department of the Premier and Cabinet.

Child Safety Directors

For such an approach to be effective it is necessary, however, that departments other than the DCS recognise that they too bear child protection responsibility, and ensure that programs and expertise within their existing departments are made available to provide appropriate child protection services. To this end, it is proposed that those departments with child protection responsibilities, including Education Queensland and Queensland Health, each create a position of Child Safety Director reporting directly to the director-general of the relevant department. These directors should have specific responsibility for operational delivery of their agency's child safety services and the coordination of those responsibilities with other agencies. They should also be responsible for ensuring that the agency fulfils its reporting obligations on its performance in this area.

Recommendations

4.2 That a Directors-General Coordinating Committee, chaired by the Director-General of the Department of the Premier and Cabinet, be established to coordinate the delivery of multi-agency child protection services.

4.3 That a position of Child Safety Director (CSD) be established within each department identified as having a role in the promotion of child protection.

Reason (4.2 and 4.3): Dedicated directors within departments, and a high-level coordinating committee, are essential for multi-agency cooperation, coordination and service delivery in a holistic and integrated child protection model.

MAINTAINING THE FOCUS ON PREVENTION

A crucial issue that needs to be recognised here is that, by pointing to the urgent need for a new department exclusively focused upon the interests of children in care, the Commission does not suggest that the government's commitment to prevention should be in any way diminished.

New funding for the Department of Families was announced in the 2002–03 budget under the government's Queensland Families: Future Directions policy (DPC 2002), and $42 million was applied during 2002–03. A major thrust of the Future Directions policy was increased investment in prevention. Before that, the Department of Families had made only limited commitment to prevention programs, the bulk of its activity being the response to notifications of abuse and provision of alternative care. In 2002–03 a total of $10.6 million of the new funding was allocated to non-government organisations for a program of prevention early intervention trials. It is intended that, with the completion of those trials in the current financial year, pilots chosen from the successful trials will be implemented into the future as part of a significant increase in investment in prevention.

It is clear that, with increasing levels of reported child abuse, a commitment to primary and secondary abuse prevention is necessary. Prior to the 2002–03 budget, governments had failed to meet that need adequately. The steps that have now been taken to do so are substantial and should be acknowledged.

The extent of the present departmental commitment to prevention can be seen from a perusal of the Department of Families *Ministerial portfolio statement 2003–04*

(Queensland Government 2003a). The output summary discloses that, in a total budget of some $400 million, prevention services and early intervention services are funded to the amount of $135 million. Of course, this investment is across all aspects of the department's business including community support and youth justice.

The four outputs of the Department of Families, as described in the MPS, are shown below.

Prevention services include:

- supporting and promoting individual, family and community safety and wellbeing in partnership with other government and non-government service providers
- building the capacity of communities, families and individuals to support and assist people to deal better with circumstances of difficulty
- supporting self-reliance
- minimising factors that are known to indicate that a family or individual is at risk of falling into crisis
- reducing the social and economic cost of intervention.

Early intervention services include:

- responding to an identified risk with the aim of reducing risk or resolving a problem before it escalates
- reducing risk, minimising the intervention required and strengthening the resilience of those at risk
- improving service outcomes and reducing the social and economic costs of further intervention.

Immediate response services include:

- short-term interventions that require immediate attention
- intensive work with communities, families or individuals facing particular identified risks or needs requiring immediate response
- responses which focus on safety, stability and minimising further risks, and meet immediate prioritised needs.

Continuing support services include:

- longer-term, planned services for communities and for families and individuals, many of whom are subject to statutory intervention
- building strengths
- more holistic responses with a focus on growth in self-reliance and reduced dependency.

The Future Directions program and the funding that supports it represent a significant and welcome commitment to primary and secondary prevention on the part of the Department of Families. Implementing effective primary and secondary preventive programs can be a lengthy process, and it is therefore important that programs are chosen and funding allocated on the basis of rigorous and objective evaluation processes. Clearly, however, it is likely to be quite some time before the benefits of such expenditure become apparent. The Inquiry supports the continuation of the existing commitment to primary and secondary prevention by the government. It is beyond the scope of this report to determine whether the present level of funding for prevention programs is adequate. However, it is not suggested there should be any reduction in the present level of commitment.

RECOMMENDATION

4.4 That the government maintain its commitment to developing primary and secondary child abuse prevention services.

Reason: If the increasing levels of reported child abuse are to be controlled, a commitment to primary and secondary prevention is necessary.

External accountability

In addition to significant reform within the department responsible for the protection of children, it is proposed that strengthened external accountability be established through a number of means, including by the creation of a new statutory position of Child Guardian within the office of the Commissioner for Children and Young People. The evidence before the Commission emphasises that there must be proactive and effective oversight of the new DCS and how it exercises its child protection functions.

Recommended external accountability measures are addressed in the next chapter.

5

THE DEPARTMENT OF CHILD SAFETY

This chapter describes some of the key features of the new Department of Child Safety (DCS). As discussed in Chapter 4, one of the defining aspects of a new approach to meeting the needs of children must be a greater commitment to coordination between government agencies. This chapter describes the key structural features of the new department, focusing on what the DCS should 'look like'. These structural components provide the basis for discussing, in the next three chapters, how the DCS will interact with external agencies as part of a whole-of-government approach to protecting children.

KEY FEATURES OF THE NEW DEPARTMENT

- focus and ethos
- funding
- workforce numbers
- management structure
- training and professional development of staff
- core functions
- administration
- accountability.

FOCUS AND ETHOS

Repeatedly throughout the Inquiry, the CMC was told of the negative organisational culture in the Department of Families. Reasons given included poor communication and information sharing, crisis-driven decision making, a lack of transparency in decision making, poor information technology systems and record-keeping practices, a high proportion of relatively inexperienced staff, demanding workloads, and a perceived tendency for management to blame frontline staff rather than share accountability.

Because the new department will have the principal responsibility for ensuring that child-protection services are delivered effectively and efficiently, it will need to be committed to an organisational culture that:

- is open and supportive in character
- reconciles the endeavours of workers and management
- adheres to best-practice standards in therapeutic interventions
- accepts clinical accountability at every level of the organisation
- strives for effective working relationships with external agencies
- acknowledges the necessity to document all clinical decisions
- values drawing attention to practice failures
- encourages the pursuit of excellence.

An open and supportive culture cultivates open, respectful, professional and responsive communication and decision-making processes. It ensures timely and comprehensive access to information, thereby allowing decision making to be a cooperative and consultative process, both within the DCS itself and with external agencies. An open and supportive culture promotes transparency and accountability, rather than avoidance of blame and responsibility. Such a culture is unifying and encourages shared understanding of job demands in the interests of a productive and harmonious work environment.

Reconciling the endeavours of workers and management refers to the differentiation of job demands and responsibilities so that not all aspects of child protection are vested with frontline staff. This means that officers do not undertake roles that clearly cause conflicts of interest (child/carer support versus investigations) or go beyond their expertise and experience. Clear delegation and appropriate assignment of officers to perform specified roles will ensure that individuals work within their area of expertise, thereby reducing anxiety and error. Separating the sometimes competing aspects of the family services officer (FSO) role, and more appropriately reassigning these responsibilities, will consolidate expertise and certainty in service delivery. If managed properly, this differentiation of roles and responsibilities will encourage recognition throughout the workforce that the organisation as a whole depends on a very wide range of staff functions, each making unique and important contributions to the goals of the organisation as a whole. Irrespective of individual roles, all DCS staff need to recognise that they are jointly striving for a common objective — child safety.

Adherence to best-practice standards of therapeutic interventions involves a genuine commitment to research, monitoring, evaluation, evidence-based and transparently accountable decision making.

Acceptance of clinical accountability at every level of the organisation requires a fundamental change in organisational policies and workplace practices. It requires a commitment at senior levels of the organisation, not just among frontline staff. It is also essential that the consequences of not complying with clinical accountability practices are understood at every level of the organisation.

In **striving for effective working relationships with external agencies** the DCS should ensure that 'its door is always open'. It is crucial that the DCS develop trusting relationships with external stakeholders, and it should hold regular consultative meetings and workshops to promote goodwill. In striving for the most effective working relationships with external agencies, the DCS should, where possible, facilitate shared training and professional development opportunities.

The DCS must actively acknowledge the **necessity to document all clinical decisions**. This documentation is absolutely essential for a reformed child-protection service. Documentation of all clinical decisions will also ensure that any problems that may occur are quickly identified, isolated and successfully remedied, without becoming systemically entrenched.

Drawing attention to practice failures is healthy for an organisation, and will assist the DCS in providing quality child-protection services. Valuing this process requires a preparedness to acknowledge when something is not working and, at times, make the difficult decision to discontinue the practice. The value of rigorous internal scrutiny cannot be overestimated. The process should occur in an objective and systematic manner, with decisions based on evidence derived from proper evaluation methodologies and clinical studies. The organisational culture needs to promote the recognition that, as lead agency for child protection, the DCS has an ongoing responsibility to 'weed out' practice failures and implement best-practice standards.

Encouraging the pursuit of excellence will be consistent with the role of the DCS as lead agency for child protection in Queensland. This ethos needs to be fundamental to every level in the organisation, and should be promoted continuously and rewarded wherever possible.

FUNDING BASE

Between 1998–99 and 2002–03 expenditure on child protection and out-of-home care services by the Department of Families increased from $76.8 million to $171.5 million — an increase of almost $100 million (Queensland Government submission 2003). Nevertheless, a consistent theme among those making submissions to the Inquiry was that the department was seriously under-resourced despite these increases.

Each year the Productivity Commission collects data on expenditure on child protection and out-of-home care services from each state and territory. Table 5.1 (below) presents data prepared by the Productivity Commission. The table compares child-protection funding in Queensland with that of the other states.

It can be seen from these data that between 1998–99 and 2001–02 Queensland's child-protection expenditure increased proportionately more than that of any other state in Australia (at 48.2%), although it should be noted that the baseline funding for 1998–99 appears to have been proportionately lower than in most other states, with the exception of Tasmania.

In 2001–02 the Australian average for expenditure on child-protection and out-of-home care services per child aged between 0 and 17 years was $165.35. Queensland spent $138.28 per child, which was less than the amounts spent by New South Wales, the Northern Territory, the Australian Capital Territory and Victoria, and more than was spent by Western Australia, Tasmania and South Australia.

Table 5.1. Recurrent expenditure by state and territory governments on child-protection and out-of-home care services 1998–99 to 2001–02

	Real expenditure per child				Increase 1998–99 to 2001–02 (%)
	1998–99 ($)	1999–2000 ($)	2000–01 ($)	2001–02 ($)	
Queensland	93.31	111.86	126.30	138.28	48.2
Tasmania	85.21	69.64	82.99	125.59	47.4
ACT	163.12	161.73	172.77	185.83	13.9
WA	101.77	102.18	112.06	134.86	32.5
Victoria	134.25	177.36	163.72	173.74	29.4
NSW	152.54	159.43	180.06	195.83	28.4
NT	153.20	168.29	180.70	191.44	25.0
SA	111.25	115.80	115.41	116.27	4.5
Australia	126.96	143.37	151.45	165.35	30.2
Queensland as a percentage of Australia	73.5	78.0	83.4	83.6	

Source: Comment and data provided by the Department of Families, November 2003. Data extracted from Productivity Commission (2003a, Table 15A.1).

Notes:

1. Data are in 2001–02 dollar terms.
2. Expenditure per child is calculated on the basis of children aged 17 years and under in the residential population.
3. Tasmanian expenditure increased in 2001–02, partly because some costs were not included in previous years' data.
4. The Australia figure for real expenditure per child represents the sum of expenditure for those jurisdictions able to provide data divided by the sum of the residential population for the target group (0–17 years) for those jurisdictions able to provide expenditure data.

The 2002–03 Productivity Commission report, to be released in early 2004, will reflect a significant increase in the Queensland Department of Families 2002–03 budget allocation. The department received a $42 million increase in recurrent funding in the 2002–03 budget as part of the Queensland Families Future Directions initiative.

Whether this increase in the department's budget will result in further movement of Queensland real expenditure per child towards the national average is uncertain, given there have been significant expenditure increases in other states. For example, in December 2002 the New South Wales Government announced an increase in total recurrent expenditure of $390 million over six years, commencing with an increase of $64 million in recurrent expenditure in the 2002–03 budget. Furthermore, the Victorian Government announced an additional $60 million for child protection in the 2002–03 budget.

While it is tempting to use the Australian average of recurrent expenditure per child as the basis for future funding decisions, the differences between jurisdictions in legislation, administration and the reporting of costs make it impractical to use that measure to place a precise figure on how much more should be spent on child protection in Queensland.

Queensland funding per child for child protection and alternative care falls below the national average and well below expenditure per child by New South Wales and Victoria. The funding comparisons are best viewed in relation to the rates for children on care and protection orders and children in out-of-home care (see Table 5.2).

Table 5.2. Proportions of children in care (per 1000 aged 0–17 years)

	NSW	Vic.	Qld
Children on care and protection orders in 2001–02	5.1	4.3	4.0
Children in out-of-home care as at 30 June 2002	5.0	3.4	3.5

Source: Data extracted from Productivity Commission (2003a, Tables 15A.8 and 15A.11).

It can be seen from the table that measures of children in care were similar for Queensland and Victoria. Expenditure per child, however, was significantly lower in Queensland in 2001–02 ($138.28) compared with Victoria ($173.74).

Although this report does not seek to specify the precise amount that the government of the day should dedicate to child protection and foster care, it can be confidently concluded that expenditure on those services in Queensland remains inadequate. A substantial increase in increased recurrent financial commitment is required.

In the following section and in other parts of this report recommendations are made for substantial increases in the number of child-protection workers.

While acknowledging that many of the problems identified cannot be solved merely through additional funding, the Commission is convinced that the historical level of under-resourcing of child protection in Queensland must be remedied. A government commitment to improved resourcing levels allowing for a substantial increase in child-protection staff is essential.

Nevertheless, in order to make broader recommendations about how the new DCS should be staffed, it is necessary to comment on the adequacy of the existing workforce in the Department of Families.

WORKFORCE NUMBERS

On the basis of the evidence obtained during the Inquiry, the CMC has no doubt that the current size of the department's workforce that is dedicated to direct delivery of child-protection services is insufficient to provide the level of service required. The absence of any child-protection workload measures in the department is unfortunate. This makes it difficult to provide informed comment on how staff numbers should be increased so that staff have reasonable workloads and children receive the services they deserve.

According to Department of Families data, budgeted positions in direct service delivery for the 2003–04 financial year included a total of 455 team leader and family services officer (FSO) positions (see Table 1.1, Chapter 1). That figure does not take into account area office managers, administrative officers and support positions in area offices such as family and community workers, family resource workers and community resource officers. It also does not include some additional service delivery staff provided under the Future Directions initiative.

The area of greatest need is for professional FSOs and their team leaders who bear responsibility for intake, assessment and casework, and the Commission has therefore concentrated its analysis on those positions. As at March 2003, intake, assessment and casework tasks were being dealt with by 455 staff consisting of 71 team leader and 384 FSO positions (as advised by the department in November 2003). On the evidence submitted to the Inquiry, staffing in this area is inadequate to meet the real level of need in Queensland. Table 5.3 (next page) outlines the CMC's view of the intake, assessment and casework staff numbers that would be required by the new DCS. As can be seen from this table, data from the Department of Families itself are relied upon in order to estimate what the appropriate organisational profile should be.

Based in the evidence outlined previously in Chapter 3 about workloads, it would appear that a ratio of 15 children to 1 worker is reasonable. Accordingly, the CMC has used that ratio in its calculations of the number of additional frontline staff required. It can be noted that Ms Gwenn Murray also adopted this ratio in formulating the recommendations arising from her audit.

On these figures, it can be seen that about 160 extra FSO and team leader positions are needed, as soon as possible, to allow the DCS to respond adequately to intake, assessment and casework requirements.

This report also specifies other specialist positions the Inquiry has identified as being necessary to meet the various needs of children. Those positions are additional to the 160 positions recommended here.

The Inquiry heard that difficulty may be experienced in recruiting large numbers of suitably qualified officers, particularly in view of the heavy recruiting currently occurring in New South Wales and Victoria. For this reason it is recommended that the new positions be created and filled progressively over the next two financial years.

The available data show that the rate of notifications is currently rising by about 13 per cent a year. Accordingly, calculations of future DCS staff numbers need to take the rate of increase in workload into account and increase recruitment accordingly.

It is important to note that the rate of increase in notifications does not factor in any specific recognition of the complex relationship between intake numbers and consequent assessment and caseload burden. It may be that a larger or smaller rate of increase in frontline staff will be required to address the child-protection workload in future years. This will require close monitoring and review by the new department. Given the difficulties experienced during the Inquiry in attempting to calculate workloads, the DCS will need to explore empirically rigorous means of calculating workloads and projecting forward staffing numbers.

Table 5.3. DCS service delivery staff

Function	FTE current needs	Basis of calculation
Intake	23	Department of Families received 31 068 notifications in 2002–03. It is assumed that each notification takes, on average, one hour to process, with an intake officer spending approximately six hours directly on work tasks.
Assessment	167	In 2002–03 there were 27 218 notifications that required assessment (CMC 2003). Department of Families data (monthly finalisation of initial assessments: area office by initial assessment details and monthly finalisation rate, Queensland, May to July 2003) indicate that its best-performing area completed initial assessments (IAs) of notifications at the rate of 13.6 per month per FTE during the period 1.5.03 to 31.7.03. Assuming a child safety officer (CSO) can complete 13.6 IAs per month, and assuming it is desirable to complete all assessments within 30 days, the DCS would need 167 CSOs to deal with the current number of notifications across the state (27 218 notifications/12 months/13.6 IAs).
Casework	292	As at 30 June 2003 there were 4380 children in alternative care. Based on a caseload of 15 children in alternative care per CSO, 292 CSOs would be needed to service existing children in alternative care.
CSO relieving staff	38	These staff would provide relief for CSOs doing intake, assessment and casework, when CSOs take leave entitlements. This measure takes into account 20 days recreation leave per officer per year, and assumes that a figure of 8% of the workforce reflects relief needs.
Team leaders	95	Using the current departmental measure of one team leader supervising five CSOs, 95 team leaders would be needed to supervise the 25 intake staff, 167 CSOs performing assessments and the 292 CSOs performing casework. In addition team leaders are, and will continue to be, drawn upon for special projects that are a routine aspect of a functioning child protection system.
Total current needs	**615**	**Existing frontline staff 455; extra frontline positions required 160.**

Recommendations

5.1 That there be a baseline increase of approximately 160 family services officers and team leaders to deal with intake, assessment and casework requirements.

5.2 That this increase be made progressively over the next two financial years and be in addition to other specific recommendations made in this report for the creation of specialist positions.

Reason (5.1 and 5.2): The size of the current Department of Families frontline child-protection workforce is inadequate.

5.3 That the DCS adopt an empirically rigorous means of calculating workloads and projecting future staffing numbers.

5.4 That frontline child-protection service staff numbers be increased annually in line with workload increases.

Reason (5.3 and 5.4): The available data indicate that an increased workforce will be required to address expected increases in the child-protection workload in the foreseeable future.

MANAGEMENT STRUCTURE

The fact that only 52 per cent of the current Department of Families child-protection workforce appears to be engaged in direct service delivery is a matter of serious concern. Given that the department's child-protection function currently has 113 people engaged in corporate and executive support, 54 in the policy directorate, and 339 in management and administration at regional and area levels, there appears to be considerable scope for change to the organisational structure and overall staffing profile of the new DCS. Such a change in the profile is not simply desirable but essential.

Despite the fact that Department of Families management and administration staff are almost equivalent in number to service delivery staff, there are critical management functions that, as at March 2003 (the most recent data the department was able to provide), appear to be understaffed. These include:

- management of non-government service delivery (7 staff)
- review and evaluation (12 staff)
- quality assurance (9 staff)
- operations (7 staff).

This is a total of only 35 head office staff dedicated to these four critically important functions. In addition, in October 2003, the minister announced allocation of new funding of $2.1 million to employ an additional five quality assurance staff and nine additional senior practitioners to ensure that quality deficiencies identified in the regions are rectified.

It is not possible at this point to determine the necessary staff levels for these functions, but the observation can certainly be made that the monitoring, evaluation and quality assurance functions need to be adequately resourced. The level of resourcing for these functions will need to be monitored as other recommendations in this report are implemented.

It is not the aim of this report to specify precisely which management and administration staffing will need to be reduced if an acceptable ratio of management/administration to service delivery staff is to be achieved. However, the immediate question that needs to be addressed in any examination of the organisational profile is that of the regional structure employed by the Department of Families.

The department currently has 220 management and specialist child-protection staff engaged in management and administrative functions at the regional level, spread across regional offices. It will be necessary to reassess the size and extent of the regional and area office structure in light of the smaller, more focused department recommended in this report. The CMC is not in a position to draw any definite conclusions about the appropriateness or otherwise of the current structure of regional and area offices but, in the interests of improving the currently unsatisfactory ratio of management/administration to service delivery staff, this issue should be the subject of critical scrutiny when the organisational profile of the new DCS is determined.

Recommendation

5.5 That the current regional structure used by the Department of Families be critically reviewed, with a view to improving the ratio of direct service delivery staff to management and administration staff.

Reason: The ratio of management and administrative staff to direct service delivery staff is unsatisfactory. The current regional structure appears unwieldy and may be contributing to an imbalance between frontline staff and management/administrative positions.

TRAINING AND PROFESSIONAL DEVELOPMENT OF STAFF

A commitment to enhanced training and professional development for all service delivery staff will be essential for the success of the new department. The DCS will have to ensure that all caseworkers are able to participate in comprehensive induction training before commencing any actual casework, and this induction training should then be consolidated by regular participation in ongoing professional development programs. The training program must emphasise knowledge of child development, parenting skills and record-keeping requirements. Frontline staff should not be permitted to obtain promotion to more senior permanent positions (e.g. team leader) without having successfully undertaken further training specifically related to those more senior field positions. This may require the DCS to negotiate partnership arrangements with providers of education services, such as universities or other teaching bodies.

In the same way, it may also be advantageous for the DCS to liaise with such education providers about the content of relevant undergraduate programs, in order to ensure that recent graduates, such as social workers, coming into the DCS workforce are undertaking appropriate study.

Ensuring that all field staff are appropriately and uniformly trained will not only increase the quality of service provided by individual staff, but will also foster a collective understanding of the DCS and the ways in which it performs its child-protection role.

Such training should include appropriate and ongoing Indigenous cross-cultural training sessions for all DCS staff. Given the evidence before the Inquiry about some of the communication problems perceived to exist between Indigenous communities and Department of Families staff, such training should be viewed as important for all DCS officers. In some communities, the possibility of local Indigenous people becoming involved in providing cross-cultural training should be explored by DCS management. The CMC's consultations also identified a perceived need for FSOs who will be working with some Indigenous communities to receive community-specific cross-cultural training before going to those communities. Similarly, it was suggested that other staff may benefit from area-specific training before going to new offices where much of their work will involve Indigenous communities.

RECOMMENDATIONS

5.6 That the DCS establish enhanced training and professional development processes for field staff as a matter of high priority.

5.7 That successful completion of induction training before assuming casework responsibilities be mandatory for DCS caseworkers.

5.8 That the DCS critically examine the possibility of forming partnerships with external agencies such as universities in developing and implementing an enhanced training and professional development program.

5.9 That DCS training incorporate appropriate and ongoing Indigenous cross-cultural training for all staff.

Reason (5.6–5.9): The issue of enhanced training and professional development needs to be recognised by the DCS as an ongoing obligation of fundamental importance. The current situation, whereby staff can assume significant casework responsibilities before undertaking any induction training, is clearly unsatisfactory.

Intake and assessment

The evidence from the CMC's investigations indicates that information about possible child abuse and neglect was not dealt with appropriately in many instances. There may be some benefits in the DCS managing intake and assessment work as a specialist function, with dedicated officers undertaking this work, separate from service delivery caseworkers. The deployment of dedicated officers may result in more satisfactory and consistent initial decisions about information received. The Commission understands that different ways of allocating intake and assessment work are employed across different area offices. There would be various possible models for consideration in this context, given the current area office structure. For example, one possibility would be to make intake and assessment work a completely centralised function.

The Ombudsman identified in the Baby Kate report the importance of training in risk assessment for officers conducting child protection assessments. There is some evidence that less experienced officers tend to be allocated to assessment work; yet poor decision making at this point can have devastating consequences.

The DCS should evaluate organisational models with a view to determining the most effective and efficient way of processing intake and assessment matters. Consideration should be given to the use of dedicated, appropriately trained officers to perform this function. Particular attention should be given to achieving consistency in the quality of assessments across the state.

RECOMMENDATION

5.10 That the DCS evaluate organisational models, including the use of dedicated officers, with a view to determining the most effective and efficient way of processing intake and assessment matters.

Reason: Intake and assessment are specialist functions that may be best performed by dedicated workers, independent of those who carry out the clinical intervention process.

Court matters

As noted in Chapter 3, Legal Aid Queensland highlighted some existing difficulties in the preparation of material by departmental officers in support of applications for court orders. The department advised during the public hearings that throughout the state there are 13 court officers in area offices who are dedicated to preparing and appearing in court matters. This facility is only available in a limited number of areas.

RECOMMENDATION

5.11 That the DCS consider whether there may be advantages in having all court preparation work undertaken by specialist staff.

Reason: This work is of a highly important and specialised nature. It may best be performed by staff with specialist skills and experience.

Investigations

Investigations of suspected abuse of children need to be conducted by trained staff who are not responsible for delivering services to the group to be investigated. For example, if an allegation of child abuse arose while the child was in foster care, the DCS cannot have a caseworker responsible for the group (the child, the foster parents or any other children residing in that family unit) also investigate the group in response to the allegation. Similarly, it is problematic for the investigator to be also faced with resolving difficult and time-consuming casework issues that could arise (such as finding an alternative placement for the child), depending on the outcome of the investigation.

The use of investigators independent of the casework process should also limit the damage that may flow to the DCS's relationships with group members as a consequence of the allegation being investigated. And there is less risk of a person who is independent of the casework processes prejudging — either consciously or unconsciously — an allegation or the outcome of the investigation, on the basis of past relationships and experiences with the family members.

Investigations of abuse and neglect allegations also need to be carried out efficiently and professionally, with due regard for the interests of all affected parties. Proper investigative records need to be kept, outlining what inquiry occurred, what decisions were reached and the basis upon which decisions were made. It may be appropriate for a specially trained caseworker to investigate more simple and straightforward matters, but for complex matters involving serious allegations a degree of specialised investigative skill would be useful.

RECOMMENDATION

5.12 That the casework and investigative functions of the DCS be vested, as far as is possible, in different staff members.

5.13 That the DCS employ staff with specialist investigative skills and an understanding of child neglect and abuse issues to investigate complex notifications about abuse of children in care.

Reason: Investigations are a specialist function usually best performed by trained investigators. There are clear advantages in having the investigative process undertaken by staff not involved in day-to-day casework. Operation Zellow (see Chapter 2) starkly highlights the importance of thoroughly investigating reported child abuse.

Prevention and early intervention

The function of prevention and early intervention is one that the DCS would share with the Department of Families (or whatever agency is accorded responsibility for providing primary prevention services). The new model described in Chapter 4 gives the new department a role with regard to early intervention that is specifically directed towards children in in-home care (on protection orders) who are identified as being at risk, and/or children on temporary parental consent placements (i.e. voluntary orders), and/or individual children suspected to be in need of protection.

Other prevention and intervention work would be performed by another agency, which would be responsible for providing primary and secondary prevention services. These would include non-interventionist mainstream services for all children, and specific programs targeting children residing at home but in particular communities or family groups that have been identified as vulnerable, in the sense of being at a higher risk of harm than is the norm. Examples of such higher-risk groups include families with drug or alcohol problems or mental illness.

RECOMMENDATION

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.

Reason: One of the central aims of the new model is to return a clarity of focus and purpose to child protection in Queensland. The DCS will be an agency focusing exclusively on meeting the needs of children identified as being at risk, and will concentrate on early and intensive intervention in that context.

Assisting biological parents

The Commission recognises that biological parents are also important stakeholders in the child-protection system. Parents are responsible for the majority (84%) of substantiated notifications of harm to Queensland children (AIHW 2003b). The first contact between most parents and departmental officers, therefore, often occurs when parents are the subject of an investigation of allegations that they are abusing or neglecting their child. Under the current system, if these allegations are considered to be substantiated (that is, in the professional opinion of the officers involved there is reasonable cause to consider that the child has been harmed), and the circumstances require the removal of the child from their family, the same FSO is often then expected to work with the parents to reunify the family.

The Inquiry heard that the current processes of investigation and removal of the child only serve to increase the parents' sense of failure. According to Ms Beverley Fitzgerald, the President of the Children Services Tribunal, this process gives parents the following message:

> You have failed as a parent. They know that already. They don't need an external voice to tell them that … (CMC 2003, p. 122)

Rather, what they need to be told is:

> At this point, for lots of reasons, this child may not be safe with you, but we can look now at services or help … that will maybe help address that. (CMC 2003, p. 122)

The Esther Centre pointed out that not only are parents dealing with the emotional issues of losing custody of their child, but they are often then confronted with a process they do not understand. This report has already noted the views held by many parents, to the effect that they are not given sufficient information about their rights or the processes involved. This alienation may cause parents to feel judged and then abandoned by the department, and to feel increasingly incompetent and lacking in confidence in their abilities to parent their child, in circumstances where their existing parenting problems might be remedied if they could obtain help (CMC 2003).

Given this sense of powerlessness in dealing with the Department of Families, it is not surprising that the majority of parents who contacted the Inquiry believed they had been treated unfairly by the department and had not received the services and assistance they required to regain custody of their children (confidential submissions and consultations with biological parents). For example, several parents spoke of a lack of resources, as a result of which they were denied necessary intervention and support services. One parent submitted to the Inquiry:

> Whilst I believe that the department had every intention to support us as parents, unfortunately they do not appear to have the resources to do so. At a family meeting on ... it was arranged for a departmental worker to visit twice weekly (more if required). That worker has only been able to visit twice in the past four weeks, due to her exceptionally heavy workload. Furthermore I have not been provided with any details in regard to the children's health, wellbeing, or progress at school over the past nine weeks. (confidential submission)

Given the emotion-charged nature of investigations into allegations made against parents, there is an obvious conflict of roles if the officers undertaking the support work are the same as those involved in removing a child from their family, or associated casework decisions. It would be extremely difficult for the same departmental officer to work with the parents towards reunification. It would be far preferable for one FSO to assume responsibility for establishing the trusting relationship with the parent that is necessary to facilitate change, and another FSO to undertake the child-centred casework. In this way it should be possible to avoid the ongoing conflict that arises from the one worker having responsibilities to both child and parent.

The Inquiry heard from child-protection professionals such as Dr Robert Lonne and Ms Gwenn Murray, who stated that parents often did not receive the services and interventions they required and efforts were not always made to maintain relationships between the child and their family (CMC 2003). There was also evidence that, even in

situations where parents initiated contact with the department when they recognised that they needed respite or assistance in parenting their children, appropriate support was sometimes not provided. According to the Esther Centre, their requests were often treated as notifications of maltreatment that required investigation (CMC 2003), when what the parents were seeking was help in addressing their difficulties.

The DCS will continue to recognise that it is in the best interests of the majority of children at risk if their families can be supported to provide the safe and caring environment necessary for the children's long-term wellbeing (*Child Protection Act 1999*, s. 5[d]). The DCS will therefore need to provide parents with the necessary respite and intervention services to maintain a safe environment for their children, and to work with parents towards family reunification in appropriate cases.

Professor Matthew Sanders told the Inquiry that the provision of early intervention services is a cost-effective method of child protection (CMC 2003), which is expected to reduce the renotification rate for abuse and neglect. For example, the US states of Florida and Missouri have recently trialled early intervention services designed to respond to the majority of child-protection notifications where there is no immediate or serious risk to children's welfare. Rather than responding with the normal investigative process, they provide parents with the services and support they require to maintain their children at home. Preliminary evaluations of these methods are showing promising results, with better outcomes for children and their families (Paxson & Waldfogel 1999, cited in Cahn 2002).

Further compelling evidence for this approach arises from the Productivity Commission (2003, p. 15.16):

> In Queensland, the proportion of children who were the subject of a resubstantiation [i.e. another report of substantiated abuse or neglect] within three months after an initial substantiation in 2000–01 was 10.4 per cent … the proportion who were the subject of a resubstantiation within 12 months was 24.8 per cent.

Obviously, the aim of the DCS and any child-protection agency is to reduce the recurrence of child abuse and neglect. A reduction in such further incidents to some extent reflects success in the initial intervention. As noted above, there are clearly also cost benefits in reducing the rate of renotifications of abuse. Accordingly, the Commission recognises the importance of parents having appropriate intervention and support services and sees the DCS as having an important role in working with families against whom an allegation has been made.

The DCS might usefully be involved in working with parents where children who have been the subject of low-level notifications continue to reside at home.

The Commission notes the work currently being done by the Department of Families in this area. Under policy no. 343-1, Intensive Family Support with the Consent of the Family, a family support response can be provided where a decision has been made that departmental intervention is required to protect a child, and the family has consented to the intervention. However, intensive family support can only be provided, under this policy, when a child protection notification has been investigated and assessed and a 'substantiated' outcome recorded. Also, intensive family support cases can only remain open for three months. If, after this time, it is assessed that the family cannot meet the child's protective needs without ongoing departmental intervention, the policy provides that a decision is to be made about what type of protective order is necessary to secure the child's protection.

It is thought that there may be advantages in pursuing preventive responses with families (such as those that have been the subject of several low-level notifications) in circumstances going beyond the restrictions imposed by the above policy. For instance, the imposition of a three-month time limit seems somewhat arbitrary. Also, at present the caseload pressures on FSOs are so great that attention is likely to be exclusively given to high-priority cases. Working with parents to prevent low-level notifications escalating into higher-priority cases is a cost-effective and direct preventive response. For it to be successful, dedicated staff unburdened by other casework responsibilities need to be allocated. Over time, this initiative has the potential to reduce the level of increase in notifications of abuse.

The Commission recommends that a number of dedicated FSO positions be set aside to work with biological parents of children residing at home who have been the subject of a low-level notification, and that these officers effectively be segregated from other casework responsibilities. This approach has recently been adopted in New South Wales, where funding has been provided for a number of dedicated positions to provide this type of service. In the circumstances it is difficult to determine the exact number of such positions that may be required in Queensland. However, the Commission envisages that approximately one FSO per area office would be required, on average, leading to a total of 40 such positions to be filled progressively over the next two financial years.

Recommendations

5.15 That child-centred casework and the provision of parental support be vested, as far as is possible, in different staff members.

Reason: There is a potential conflict between a function that involves decision making in the best interests of the child and the provision of support to vulnerable parents.

5.16 That, as a preventive response, 40 specialist FSO positions be created to work exclusively with parents whose children have already been the subject of a low-level notification and continue to reside at home. These positions should be filled progressively over the next two financial years.

Reason: Under the current system, biological parents are not always receiving the support and services they require to provide appropriate environments for their children. A commitment to working with parents is in the interest of the individual children, supports the family unit, and has the potential to reduce the overall level of notification and the need for intervention in the future.

Alternative care

The CMC is of the view that the new DCS should be responsible for all alternative care responses for children who have been formally identified as being at risk. As this would obviously be a core function of the DCS, it is discussed in Chapter 7, which details how the DCS should manage alternative care.

ADMINISTRATION

Information systems and record-keeping

A consistent theme, acknowledged by the Director-General of the Department of Families to the Inquiry, was the inadequate state of the department's current information technology systems. As discussed in other chapters, the current standard of completeness of case files, either in hard copy or electronic form, is alarming. However, the director-general informed the Inquiry of a program to address these issues as a matter of urgency. A sum of $12 million has been allocated to the development of a new integrated client management system for recording and retrieving data. The Commission acknowledges here that the information systems upgrade currently in its planning stage by the department is ambitious, comprehensive, and if implemented will dramatically improve a wide range of workplace practices.

Recommendation

5.17 That the DCS continue and complete the upgrade of information systems begun by the Department of Families, as a matter of the highest priority.

Reason: In the absence of adequate information and record-keeping systems, the DCS may fall victim to many of the current department's practice failures as outlined in the evidence before the CMC.

Responding to ministerial correspondence

In view of the evidence arising from Operation Zellow (see Chapter 2), the Commission considers that there should be some clear procedures laid down by the DCS in relation to responding to ministerial correspondence, preparing briefing notes for ministers and directors-general, and developing set information requirements for such documents. The procedures need to be properly incorporated into DCS policy to ensure a consistent approach by all staff and, as far as possible, the provision of full and accurate information.

The Commission recommends that the DCS establish a policy specifically outlining the requirements for handling such correspondence and briefing material. That policy should provide for the retention of briefing notes in electronic form, and of signed and dated hard copies on all of the relevant files. Officers who need to have input into the creation or approval of such briefing notes and draft ministerial responses should be identified by position in the policy, so that clear lines of accountability are known.

RECOMMENDATION

5.18 That the DCS prepare and promulgate a specific policy outlining the requirements for producing and approving ministerial correspondence and briefing material.

Reason: The evidence from Operation Zellow underlines the clear need for the DCS to institute a policy to enhance the provision of full and accurate information to the minister and senior staff.

ACCOUNTABILITY

Internal accountability

An issue that has recurred throughout this Inquiry is the fact that the current structure of the Department of Families vests clinical accountability almost exclusively with frontline workers. This is clearly unsatisfactory. Given the acknowledgment by the director-general that the department has a very substantial proportion of relatively inexperienced staff, it needs to draw upon the expertise of more senior officers in the department to routinely oversee and validate clinical decisions made by junior frontline staff.

The Commission is persuaded that the DCS will have a continuing need to draw upon the expertise of senior practitioners, who can provide frontline staff with the necessary degree of access to high-level expertise and experience. The role of senior practitioners will be to provide specialist advice in complex cases, and to monitor and review more routine case-management clinical decisions. There would therefore be two levels of 'sign-off' for all clinical decisions made by frontline staff: team leaders in the first instance and then senior practitioners. For this to be possible, officers at the senior practitioner level would need to be available to make decisions in all areas. In October 2003 the minister announced that a further nine senior practitioners would be appointed by early 2004. However, full implementation of the Commission's proposal is likely to require some further positions at the senior practitioner level.

In addition, and effectively constituting a further sign-off mechanism, there should be an enhanced SCAN process. Precisely how SCAN would work with respect to the DCS is discussed in more detail in the next chapter.

RECOMMENDATION

5.19 That, in addition to direct service delivery by frontline workers, the expertise of senior practitioners be drawn upon for providing specialist advice in complex cases and for routine reviewing of the clinical decisions made by frontline workers. Senior practitioners should embrace line management responsibility for these decisions.

Reason: It is unreasonable to expect junior staff to accept total accountability for clinical decisions, which are all too often highly complex matters that warrant the attention of staff with high levels of expertise and experience. Extensively drawing upon the expertise of senior practitioners will be essential if the DCS is to provide a markedly improved quality of service.

Complaints handling

The emotionally charged child-protection jurisdiction of the Department of Families has always meant that decisions made by the department are prime targets for complaint by interested parties. In any given decision-making scenario there is the capacity for at least one party to feel aggrieved and to act upon the grievance by making a complaint, either directly to the department or to another agency such as the Ombudsman, the CMC or the QPS.

Complaints made to the CMC during the Inquiry

In the course of the Inquiry the CMC received many complaints from individuals relating to the Department of Families and spanning a wide range of concerns, including service delivery issues. Dedicated officers from the Complaints Services arm of the CMC were allocated to deal with these complaints, which have been assessed in accordance with the CMC's usual procedures. The volume of complaints is such that many matters are still being assessed.

Information that gives rise to an allegation of criminal conduct against any person not within the jurisdiction of the CMC (as outlined in the Introduction) is referred to the QPS in accordance with section 62 of the *Crime and Misconduct Act 2001*. Any matters that warrant further investigation by the CMC for possible official misconduct are being investigated.[1] Information that raises a suspicion of maladministration is referred to the Ombudsman.[2] If the information raises a concern that there might have been disciplinary breaches by an officer of the department, that information is referred back to the department for further investigation, disciplinary action or a managerial response. Complaints involving service delivery issues are also referred back to the department for a managerial response.

It should be noted that a dedicated misconduct prevention unit (MPU) already exists within the Department of Families. The MPU liaises with the CMC, referring matters to the CMC as appropriate and undertaking investigations into appropriate matters. The MPU also performs a coordinating role, as well as undertaking educative work about corruption prevention within the Department of Families.

Complaints and the DCS

As outlined in Chapter 4, it is envisaged that the new department will take primary responsibility for the delivery of child-protection services. This will mean direct involvement with a demanding client base. In conjunction with other relevant agencies, difficult decisions about issues such as the provision of services and placement will need to be made on behalf of children who come within the jurisdiction of the DCS. For these reasons, it is only to be expected that the types of service delivery complaints that have formerly been made against the Department of Families will continue to be made against the DCS.

It is important for the proper functioning of the DCS that there be a sophisticated mechanism for receiving, addressing and tracking all complaints. The Commission recommends that an appropriate complaints assessment and handling unit be established within the DCS for this purpose. This unit would receive, assess and resolve any complaints against the department. In some cases it might also be appropriate for the unit, or other areas of the department, to conduct inquiries. The unit should have a strong capacity to liaise with other relevant complaint-handling agencies, such as the Ombudsman and the CMC, and with the other agencies that have child-protection responsibilities.

However, the complaints-handling unit must not merely act as a referral agency. The DCS should have clear and adequate processes for handling most complaints

internally. Many will relate to service delivery or other administrative issues, which should receive a quick response from the DCS. There need to be established assessment, review and response procedures so that clients and other stakeholders can have confidence that their concerns are being addressed in a timely and responsible fashion.

By monitoring and analysing the subject matter of complaints, it would be possible for the DCS to identify any trends indicating an area where service delivery is problematic, and allow strategies to be swiftly implemented to fix the problem. The unit should have some capacity to monitor the strategies implemented.

The unit should also have some investigative capacity, as well as the will and resources to undertake expeditious, fair and transparent investigations, and to make robust recommendations where required.

Given the sensitive nature of the core business of the DCS, it is acknowledged that in many circumstances complaints could be generated by a breakdown in communications. Accordingly, the Commission is of the view that it may be appropriate to consider the development of a mediation capacity as an option for resolving complaints against the DCS.

The Ombudsman has recently undertaken a project — Effective Complaints Management — designed to assist Queensland public sector agencies in undertaking and dealing more effectively with their complaints-handling processes. The Department of Families has participated in this project. The Commission considers that the materials published by the Ombudsman in furtherance of this project would undoubtedly assist the DCS in developing an effective capacity for handling, and responding to, complaints.

RECOMMENDATION

5.20 **That the DCS establish a unit and clear procedures for receiving, assessing and responding to complaints.**

Reason: The DCS needs to have the capacity to respond quickly and adequately to complaints made to it, in a manner that earns the confidence of clients and other stakeholders.

External accountability

The evidence obtained during the CMC's Inquiry revealed significant failings within the accountability regime governing the Department of Families. The Inquiry has drawn attention to widespread and longstanding practice failures within the department, particularly in relation to children in alternative care, which were not identified or addressed by the existing internal or external accountability mechanisms.

Consistent with the view that responsibility for child protection needs to be the exclusive focus of a dedicated agency, the Commission considers that there should be a dedicated body responsible for proactively overseeing the DCS and its child-protection role.

The idea of an agency dedicated to representing the interests of children in care is not new. The predecessor of the Commission for Children and Young People (CCYP) — the Children's Commission — was originally established with a jurisdiction limited to children in the care of the Department of Families.[3] However, the conclusion of a review conducted in April 1999 was that the jurisdiction was too limited, as it did not extend to services provided in relation to juvenile justice legislation; neither did it extend to a range of services directly comparable to the children's services provided by the Department of Families but provided or funded by others. The review team considered that the commission had 'no role with the vast majority of children and young people who never came into contact with departmental services, and no role even with those that do when things that go wrong in their lives go wrong somewhere else' (DFYCC 1999b, p. 12).

The review team recommended that the commission's jurisdiction be extended to include all children and young people, not just those in care. This recommendation was accepted and implemented in the *Commission for Children and Young People Act 2000*. This Act also established the CCYP as an independent statutory body, expanded the community visitor scheme, and increased the CCYP's powers and functions in relation to handling complaints.

The Inquiry heard that the CCYP is still experiencing difficulties in effectively overseeing the interests of children with the powers available to it, despite the enhanced complaints-handling provisions and associated powers granted in 2000. The enhanced powers to access departmental documents and records are available only when the CCYP is investigating a 'complaint', and do not assist it in being proactive. The Commissioner for Children and Young People expressed concern, at the Inquiry, that the powers currently available do not extend to the systemic monitoring of the Department of Families' performance, including such things as reviewing case plans and ensuring that files are adequately maintained. The powers to oversee available to the external body need to be clearly stated in the legislation and need to be broad enough to enable not only investigation of complaints but also effective monitoring and auditing of the DCS.

In evidence to the Inquiry, the Commissioner for Children and Young People identified other impediments to the ability of the CCYP to monitor the foster care system, arguing that the CCYP has very little authority to monitor most aspects of foster care. The CCYP has limited contact with children in foster care, and has not had access to a list of children in foster care to make it possible to provide information to those children and promote the CCYP's services.

The Community Visitor Program administered by the CCYP does not extend to children in foster care households but is limited to children in residential facilities (both government and non-government funded), juvenile detention centres and mental health services. The Commission for Children and Young People Act expanded the program considerably in line with the recommendations of both the Forde (1999) and Briton reports (DFYCC 1999b), but the recommendation made in the Briton report to extend the program to large foster homes (say, six or more non-sibling children) was never implemented. Events since that time have demonstrated the need for children in foster care to have access to the advocacy services of community visitors, and be subject to monitoring by them.

The CCYP's resources have been spread across a very wide range of functions and responsibilities.[4] This means there is always the risk that overseeing child-protection services may not be accorded sufficient primacy, despite the requirement in the Act (s. 18) that the CCYP's functions must give priority to the needs and interests of children in care and other vulnerable children. To address this concern, the Commission proposes that the position of Child Guardian be established within the CCYP. The Child Guardian's sole responsibility would be to oversee the provision of services provided to children within the jurisdiction of the DCS, and decisions made in respect of them. The proposed structure and functions of the Child Guardian are described below.

Child Guardian

The Child Guardian would be responsible for monitoring and investigating complaints against the DCS or other service providers; conducting proactive audits, monitoring and reviewing those agencies; and coordinating an extended Community Visitor Program.

The Child Guardian's jurisdiction would include overseeing issues affecting any children who have formally come to the attention of the DCS and had services provided to them.

The Child Guardian should not have the power to overrule decisions of the DCS but should be authorised to make recommendations to the Director-General of the DCS. Where there is real concern regarding the decisions made by the DCS concerning children, and no agreement can be reached with the department, the Child Guardian

could then refer matters to the Children Services Tribunal in order to have the matter independently determined.

Functions of the Office of Child Guardian

To operate effectively, the Child Guardian will need to have a range of functions including the following:

- Respond to complaints by or in relation to a child or class of children within the jurisdiction of the DCS.
- Investigate matters relating to a child or a class of children within the jurisdiction of the DCS, either in response to a complaint or on his or her own initiative (for example, arising out of issues identified from research or its monitoring function).
- Monitor, audit and/or review the handling, by the DCS, non-government organisations or other agencies, of cases concerning a child or a class of children within the jurisdiction of the DCS.
- Monitor, audit and/or review systems, policies and practices of the DCS, non-government organisations or other agencies that affect children within the jurisdiction of the DCS.
- Monitor adherence to the child placement principle for Indigenous children, as set out in section 83 of the Child Protection Act (see Chapter 8).

In particular, the Child Guardian should be able to conduct regular audits (similar to Ms Gwenn Murray's audit) on his or her own initiative, and be vested with adequate powers to facilitate these functions.

The powers conferred will need to be sufficient to allow access to the files and records of the DCS, non-government organisations or other agencies, and to require these agencies to provide information regarding a child or class of children or a system, policy or practice for monitoring, review or audit. The powers necessary for the Child Guardian to undertake these functions will need to be specifically outlined within the legislation to reduce the uncertainty that presently exists in relation to the CCYP's complaints-investigation and monitoring function.

On receiving a complaint regarding a child within the jurisdiction of the DCS, the Child Guardian would have a range of options for dealing with the matter:

- Determine that this is a matter better dealt with by another overseeing body or organisation and refer the complainant to that body or organisation.
- Provide advice to the complainant that will enable them to resolve the matter themselves with the DCS or another agency.
- Require the DCS or another agency to provide information regarding their handling of the complaint or the case.
- Carry out an investigation of the complaint, including a full file review, interviews with other relevant parties, and any other investigative action deemed necessary.

The Child Guardian should also administer the Community Visitor Program, as this would constitute an important part of the monitoring function. The program should be extended to cover all children in active care, including all active foster homes. It is appreciated that this would substantially increase the scope of the program and that practically it might not be possible for every child in care to be visited. To this end, it would be up to the Child Guardian to make a decision based on resource availability about which places were to be visited on a regular basis. However, it is expected that priority would be given to places where there were numerous children, and where notifications had been made regarding foster carers. Other visits would probably be conducted either on a random basis or in a targeted manner derived from research or complaint trends generated by the CCYP.

Staffing the Office of Child Guardian

The Child Guardian should be a statutory officeholder with legislative responsibility for overseeing child-protection services. As the Child Guardian would be responsible for

safeguarding the interests of children on an individual basis, he or she would need the skills to interpret legislation, exercise coercive powers, conduct investigations, and determine which matters should be sent to the Children Services Tribunal for adjudication. Although it is not essential that the Child Guardian be a qualified lawyer, it is recommended that the person appointed should possess these necessary skills and have a demonstrated interest in promoting or safeguarding the interests of children.

As the external overseer of child protection within the state, the Child Guardian would have substantial responsibility, and so the level of the position should be sufficiently senior to reflect this responsibility. This seniority would also need to reflect the fact that the Child Guardian was vested with significant powers to facilitate the investigation, monitoring and audit functions of the office.

As the Child Guardian would be located with the CCYP, the relationship between the Commissioner for Children and Young People and the Child Guardian and their respective responsibilities and powers would need to be explicitly defined. The offices could be held by separate people within the CCYP, each with the appropriate qualifications and experience. If this option were to be employed, the Child Guardian would in effect be answerable to the Commissioner for Children and Young People but have specific statutory obligations attaching to the position of Child Guardian. Care would need to be taken in defining the terms on which the Child Guardian would be answerable to the Commissioner for Children and Young People, especially if the Child Guardian is responsible under the Act for the exercise of statutory powers..

Alternatively, the offices could be held by the one appropriately qualified person, just as the Queensland Ombudsman is also the Information Commissioner. The Commission has no preferred position about this.

The Child Guardian would need to be provided with a multidisciplinary support team to assist with:

- reviewing the case decisions relating to children in care or being assisted by the DCS
- reviewing compliance with policies and legislation
- conducting investigations
- determining whether a matter should be sent to the Children Services Tribunal for adjudication.

All of these activities must be carried out with the best interests of the child as the paramount consideration. The Child Guardian's support team would need to include staff with high-level expertise in a range of areas including, but not limited to, investigations, child protection, child development and child health. It would also be necessary to include Indigenous staff members to assist in monitoring compliance with the Indigenous Child Placement Principle.

Recommendations

5.21 That a position of Child Guardian, to be situated within the Commission for Children and Young People, be established, whose sole responsibility would be to oversee the provision of services provided to, and decisions made in respect of, children within the jurisdiction of the DCS.

Reason: In conformity with the view that child-protection needs to be the exclusive focus of a dedicated body, the CMC believes there should also be a dedicated body to oversee the DCS.

5.22 That the powers granted to the Child Guardian be clearly set out in the legislation, and include the powers necessary to investigate complaints and enable proactive monitoring and auditing of the DCS.

Reason: The current overseeing role of the Commission for Children and Young People is hindered by a lack of clarity in the specification and ambit of the powers of that office.

5.23 That the Community Visitor Program of the Commission for Children and Young People be extended to cover all children in the alternative care system, including those in foster care. This program should be administered by the Child Guardian.

Reason: The jurisdiction of the current Community Visitor Program is insufficient to meet the needs of children in the alternative care system. In particular, the current regime does not extend to children in foster care.

The Commission for Children and Young People

The CCYP would continue to perform its current role in respect of children and young people who are not within the jurisdiction of the Child Guardian. Similarly, the CCYP's role in employment screening and the issuing of blue cards should remain unchanged. Its research arm would need to ensure that adequate focus was given to research in support of the Child Guardian, and would need to be modified to reflect the recommendations concerning the Child Death Review Committee (see 'Child death reviews' section of this chapter).

The CCYP would also be responsible for maintaining a register of child deaths and conducting research regarding causes and patterns of child deaths in Queensland.

The CCYP would provide administrative and research support to the newly created Child Death Review Committee, and include information on child deaths in Queensland in its annual report.

The Children Services Tribunal

The Children Services Tribunal should remain a merits review body and retain its present jurisdiction, with one exception.

The tribunal should be given jurisdiction to review any decision made by the DCS that is referred for its consideration by the Child Guardian. This would allow a broader range of matters to be subject to merits review by an external body, with the Child Guardian acting as a filter to assist in ensuring that the tribunal was not unnecessarily burdened with extra cases. This avenue for bringing matters before the Children Services Tribunal would be additional to the existing right of applicants to make an application directly to the tribunal.

Some submissions to the Inquiry called for the expansion of the tribunal's jurisdiction to allow for the review of placement decisions relating to children in voluntary care. The Commission appreciates the need for an external body to oversee decisions relating to such children, to ensure that voluntary placements are not used as a way of circumventing the accountability mechanisms. However, the Commission considers that the recommendation that voluntary care placements should not exceed three months will overcome some of the problems identified. In addition, the Child Guardian would have the power to monitor the use and duration of voluntary placements and other short-term orders, and refer decisions to the Children Services Tribunal for review if warranted.

The Indigenous membership of the Children Services Tribunal may need to be increased in order to assist with monitoring the application of the Indigenous child placement principle. The tribunal, in its most recent annual report, acknowledged the need for increased Indigenous membership to reflect the growing number of matters involving Indigenous children brought before it (Children Services Tribunal 2003).

Recommendation

5.24 That the jurisdiction of the Children Services Tribunal be expanded to allow the Child Guardian to refer decisions of the DCS or non-government organisations to the Children Services Tribunal for merit review, where the Child Guardian thinks it is warranted.

Reason: This would allow decisions about which the Child Guardian may have some concern to be reviewed on their merits by a suitably qualified review panel constituting the Children Services Tribunal.

The Ombudsman's role

The Ombudsman's role regarding children in care should be maintained. The jurisdiction would remain complaints-driven, with particular focus on allegations of maladministration within organisations such as the DCS, the Commission for Children and Young People, and Queensland Health. It is expected that the Ombudsman would investigate non-urgent matters that require greater consideration of systemic issues and conduct of DCS officers, as is the present protocol for the Commission for Children and Young People.

The Crime and Misconduct Commission's role

There should be no change to the role of the CMC with regard to complaints involving the treatment of children in care. The CMC's jurisdiction relates to possible official misconduct, as discussed in Chapter 1.

Coordination between external bodies

While each of the abovementioned organisations would have a fairly distinct role, there would at times be some overlap between their jurisdictions. At present, the overseeing bodies have developed protocols to ensure that resources are used efficiently, and that the most appropriate entity takes the lead role in respect of any particular matter. It is expected that this cooperation will continue, with new protocols developed to take into account the jurisdictional and power changes outlined above.

CHILD DEATH REVIEWS

In addition to the routine monitoring of the DCS to be undertaken by the Commission for Children and Young People and the Child Guardian, there is one further mechanism that needs to be established. Where a child known to the DCS dies, it is important that the circumstances of the death be considered, in order to determine whether or not any failing by the DCS was implicated in that death. The death of a child will always be a tragedy. In the context of child protection and children in care, it could also represent the ultimate example of the system or its agents failing that child.

The two recent investigation reports of the Ombudsman's office into the deaths of Brooke Brennan and Baby Kate underline the clear need for independent mechanisms to scrutinise the circumstances surrounding the death of any child who is in care, or who has otherwise come to the attention of the department, particularly where there is any suggestion that death has resulted from abuse or neglect. Departmental decisions and actions relating to such children need to be independently examined to promote internal accountability and enhance future decision making, so that the lives of other children may in future be improved or even saved. This part of the report outlines the Commission's recommended mechanisms for responding to and undertaking reviews of such child deaths.

The CMC affirms that initial investigations regarding such child deaths should remain the responsibility of the Queensland Police Service. The DCS should be responsible for undertaking an initial case review of the quality and appropriateness of the department's involvement with the child. If there is evidence of maladministration or official misconduct, the Ombudsman and the CMC would investigate, in accordance with their current legislative responsibilities. In some circumstances, the coroner might also decide to hold an inquest.

To further enhance the proper examination of these deaths, the Commission recommends that the CCYP maintain a register of all child deaths in Queensland. It is also recommended that the CCYP conduct specific research regarding trends in the causes and patterns of death of Queensland children. For any child death, the CCYP should receive investigative reports from the relevant investigating authority (the QPS, the CMC or the Ombudsman) to assist in maintaining the register and in undertaking such research. The CCYP should also receive from the State Coroner any relevant inquest findings, for the same purpose.

Finally, the Commission recommends that a new body — the Child Death Review Committee (CDRC) — should be established to review all initial case reviews conducted by or on behalf of the DCS, from which recommendations for improved procedures and practice can be provided to the DCS.

The CDRC should be attached to the Commission for Children and Young People and provide feedback to it regarding findings. The Commission for Children and Young People will provide administrative support to the CDRC and undertake a broader research function in this area. The structure of the CDRC is discussed below.

Investigations by the police

Police will usually be among the first to attend the scene of a child's death. The QPS investigates child deaths from the perspective of whether criminal charges should be instituted against any person. Given that any child death suspected to have been caused by abuse or neglect will involve the possibility of criminal acts or omissions, it is entirely appropriate that the QPS remain the first point of investigative response.

Coroners Act 2003

Where the death is a 'reportable death' under the *Coroners Act 2003* (Qld), the police will report the death to the coroner and may assist with an investigation under that Act. What constitutes a 'reportable death' is defined in that Act and includes deaths in 'care' and 'custody'. Those terms are further defined. A 'death in care' includes circumstances where the deceased person 'was a child placed in the care of a licensed care service, approved foster carer or other person under the *Child Protection Act 1999,* section 82'.[5] A coroner may investigate reportable deaths.

The Commission notes that one of the objects of the Coroners Act (s. 3[d]) is to:

> help to prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with deaths, including matters related to —
>
> (i) public health or safety; or
>
> (ii) the administration of justice.

The Commission acknowledges the coroner's role in relation to deaths of children in care, and sees the recommendations at the end of this section as complementing that role.

Review by the DCS

The Commission considers that there should still be a form of departmental case review for all deaths of children who were either in care or known to the DCS (or its predecessor, the Department of Families). Obviously, there should be some limit on the time elapsed since last contact with the department, and the Commission suggests a period of three years prior to the death.

Not all reviews would need to be lengthy investigations. For example, where a child died of a terminal illness or through an accident with no care issues arising, the review would generally involve a simple summary of the department's involvement. It should be open for the DCS to elect whether to conduct the review internally or by competent external means. If there had been lengthy and significant or contentious involvement of the department with the deceased child, there would be reason for the review to be conducted by a competent external consultant. Where the review was conducted internally, steps should be taken to ensure independence in the process.

In reviews involving deaths of Indigenous children, consideration should be given to having an Indigenous adviser involved. In appropriate cases a person with recognised experience in child health or paediatrics must be involved, to ensure full consideration of all evidence.

The present timeframe of completing such departmental reviews within three months of the child's death should continue.

Investigations by other bodies

If a child's death involves possible official misconduct, the matter will need to be referred to the CMC. Under the *Crime and Misconduct Act 2001*, the CMC can deal with such complaints or information in several ways, including conducting the investigation itself, or referring the matter to the department or to the Queensland Police Service, depending on which entity is assessed as the most appropriate investigative body.

Where the Ombudsman receives a complaint that the death of a child involves maladministration by a government official, the Ombudsman may also elect to investigate the matter.

In such circumstances, a coronial investigation or inquest might also occur.

There is clearly potential for some overlap in the investigative jurisdictions of the various bodies. At present there are some protocols between the Department of Families and other organisations that regulate which entity investigates particular aspects of a matter. Each case is discussed on an individual basis to ensure that there is an efficient application of resources, and that investigations (especially in relation to possible criminal acts or omissions) are not prejudiced because of contemporaneous inquiries by another agency.

To help the CCYP monitor causes and patterns of child deaths adequately and ensure that opportunities to enhance the performance of the DCS are identified, all relevant investigative bodies should be required to provide reports regarding their investigations into child deaths to the CCYP. Similarly, the CCYP should have access to coronial inquest findings. It is acknowledged that some level of de-identification may need to occur in some reports, and that reports will need to be subject to an appropriate regime of confidentiality. There are several reasons for this, which might vary from case to case, including the need to avoid prejudice to criminal prosecutions and have due regard to the interests of people connected with investigations.

Structure of the CDRC

The CDRC should be established by legislation, and it is desirable that it consist of people with expertise in fields such as paediatrics and child health, forensic pathology, mental health, child protection and investigation. These people should be appointed by the minister for a limited period, perhaps of three years initially. The Children's Commissioner and the Child Guardian should be members and the Children's Commissioner should be the chair of the CDRC.

As noted, the CDRC's role will be to conduct an evaluation of all reviews undertaken by the DCS regarding child deaths, whether conducted internally or with the assistance, partially or completely, of external consultants. The CDRC's review should include access not only to the DCS report but, where necessary, all material relied upon by the reviewer(s) and DCS files regarding the child. The CDRC review should consider the scope and adequacy of the DCS report, and the conduct of relevant officers of the department in respect of their interaction with the child. It should also consider the application and adequacy of DCS policies and procedures, with a view to determining whether the DCS review has been thorough and adequate, and whether the conclusions and any recommendations expressed therein are justified and appropriate, having regard to all of the circumstances.

The CDRC should be able to make recommendations to the DCS regarding improvements to policies and procedures and any disciplinary issues that may warrant consideration by the director-general regarding the conduct of DCS officers. There should also be recognition that the CDRC can ask for and receive from the DCS follow-up or status reports upon the implementation of procedural, policy or work practice issues and any disciplinary outcomes.

5.25 That the new Department of Child Safety continue the practice of undertaking a review of all deaths of children in care, or who have been known to the department within the last three years. Steps should be taken to ensure that an appropriate degree of independence exists in the review process, and external consultants, experts and Indigenous advisers should be engaged in relevant matters.

Reason: It is considered that completely divesting the DCS of any review responsibility for child deaths would not serve to promote the desired culture of transparency and accountability. It is also extremely important that the department with child-protection responsibilities becomes aware, as quickly as possible, of any systemic or procedural factors that might have contributed to the death of any child interacting with it, and that might expose other children to risk.

5.26 That, following the establishment of the Department of Child Safety, discussions be held between the State Coroner and the relevant investigative agencies, with a view to developing protocols and other working arrangements directed to determining who is to be the lead investigative agency in different cases and how information can be appropriately exchanged between agencies.

Reason: The development of such arrangements is necessary to avoid possible prejudice to investigations or coronial inquests, to reduce any duplication of effort, and to ensure that all relevant information is available to the agencies involved.

5.27 That a new review body — called the Child Death Review Committee (CDRC) — undertake the detailed reviews of the DCS's internal and external case reviews.

5.28 That the jurisdiction of the Commission for Children and Young People be expanded to include the following roles:

- to maintain a register of deaths of all children in Queensland
- to review the causes and patterns of death of children as advised by investigative agencies
- through a Child Death Review Committee, to review in detail all DCS case reviews, whether conducted internally or externally, regarding the deaths of children in care and those who had been notified to DCS, within three years of their deaths
- to conduct broader research focusing on strategies to reduce or remove risk factors associated with child deaths that were preventable
- to prepare an annual report to the parliament and the public regarding child deaths.

Reason (5.27–5 and 5.28): Through a fuller understanding of the reasons why children in Queensland die, government action directed towards the prevention of child deaths should be better informed and more effective.

Endnotes

1 For example, Operation Ghost was commenced on the basis of information provided to the CMC by the Director-General of the Department of Families.

2 There has been regular liaison with the Ombudsman during the course of the Inquiry in relation to complaints received by both bodies. to ensure a cohesive response to such complaints.

3 The governing legislation for the Commission for Children and Young People limited 'children's service' to 'services provided in relation to … the *Adoption of Children Act 1964*, the *Child Care Act 1991*, the *Children's Services Act 1965* and the *Family Services Act 1987*'.

4 The functions of the Commission for Children and Young People are set out in section 15 of the *Commission for Children and Young People Act 2000*:

(a) to receive, seek to resolve, monitor and investigate complaints about services provided to certain children by service providers;

(b) to monitor and review the way in which service providers respond to complaints about services provided by them to certain children;

(c) to advocate for children and, in advocating for children, to seek help from advocacy entities, service providers and other entities;

(d) to promote the establishment by service providers of appropriate and accessible mechanisms for the participation of children in matters that may affect them;

(e) to monitor and review laws, policies and practices that —

(i) relate to the delivery of services to children; or

(ii) otherwise impact on children;

(f) to promote laws, policies and practices that uphold the principles underlying this Act;

(g) to encourage, facilitate and support the development and coordination of advocacy and other support services for children;

(h) to promote awareness among children about advocacy entities, complaints agencies and other relevant entities;

(i) to promote an understanding of, and informed public discussion about, the rights, interests and wellbeing of children;

(j) to conduct, coordinate, sponsor, participate in and promote research about the rights, interests and wellbeing of children;

(k) to conduct independent inspections of visitable sites;

(l) to screen persons employed, or proposed to be employed, in certain child-related employment;

(m) to screen persons carrying on, or proposing to carry on, certain child-related businesses;

(n) to report on, and make recommendations about, matters relating to the commissioner's functions;

(o) other functions conferred on the commissioner under this or another Act.

5 Section 82 of the Child Protection Act provides that 'the chief executive may place the child in the care of a licensed care service, approved foster carer or other person the chief executive considers appropriate'.

6

MULTI-AGENCY RELATIONSHIPS AND MANDATORY REPORTING

The importance of a whole-of-government approach to redressing the failings in the Queensland child protection system has been emphasised in earlier chapters. The aim of this chapter is to detail the specific challenges identified during the CMC Inquiry. As discussed in greater detail in Chapters 4 and 5, the Commission proposes that improved outcomes for vulnerable children can best be achieved by devolving the child protection functions of the Department of Families to a new agency — the Department of Child Safety (DCS) — which will serve as the lead agency for a whole-of-government approach to child protection.

This chapter describes how the DSC is to operate in a multi-agency setting. At the administrative level is the recommended Directors-General Coordinating Committee. At the operational levels are the SCAN teams and non-government service providers. This chapter will describe the multi-agency relationships in respect to these redefined roles. Finally, the chapter tackles the contentious issue of mandatory reporting of suspected child abuse.

THE WHOLE-OF-GOVERNMENT APPROACH

The necessity of a whole-of-government approach to child protection is graphically illustrated by the tragic and unnecessary death of a child, Victoria Climbie, in the United Kingdom. Victoria came to England from the Ivory Coast as a nine-year-old, in the company of her great-aunt. She died in February 2000, effectively from neglect and maltreatment, despite coming to the attention of no less than 11 government agencies. As Lord Laming, the author of the paper into Victoria's death (UK Government 2003), pointed out, what failed Victoria (apart from individual instances of poor casework) was not the law, but a systemic lack of inter-agency cooperation and coordination. Lord Laming found that, had there been a coordinated approach to Victoria's needs, these instances of poor casework would have been exposed, or the work of one agency would have been able to compensate for the deficiencies of another, in time to save Victoria.

As the lead agency for a whole-of-government approach, the DCS will have ultimate responsibility for the protective plan for each child in its care. It is therefore essential that the new department exhibit strong leadership and flexibility in the exercise of its functions. Generally, the DCS will take the lead in the day-to-day management of case plans; however, in some instances it may be considered more appropriate for an alternative agency to take on this role, with the DCS as the coordinating body.[1] This is the approach advocated in Every Child Matters, the Green Paper generated from the Inquiry into Victoria Climbie's death (UK Government 2003).

In developing a new Queensland child protection model, we have identified the following existing departments as having a role in the promotion of child welfare: Queensland Health, Education Queensland, Queensland Treasury, Disability Services Queensland, the Queensland Police Service, and the Department of Housing. Under the whole-of-government approach to child protection envisaged by the CMC, these departments will be required to provide services to meet the needs of children who are in the care of the state, or otherwise clients of the DCS. In the Commission's view, it will often be preferable, where possible, for these services (such as specific medical, disability and educational services and support) to be provided within the framework of government, rather than by private agencies outside the government system.

However, in giving effect to this model, it should not be ignored that these departments will each have their own core business and operational imperatives. A multi-agency approach to child protection will require a paradigm shift on the part of all agencies involved in child protection. It is hoped that the creation of the new department will substantially facilitate this shift in thinking.

The extent to which child protection issues are addressed within participating departments should become part of the overall measures of departmental performance. To this end, the Commission has recommended (*see recommendation 4.3*) that a new position — that of Child Safety Director (CSD) — be established within each participating department to meet these reporting and operational obligations. The CSD should be a senior officer, supported by appropriate staff, whose role will be to ensure that each department is meeting its child welfare responsibilities, and to coordinate the exercise of such responsibilities with other agencies. Each department with an identified role in the promotion of child protection should annually report on its performance of that role.

To promote the requisite inter-agency cooperation, a multi-agency steering committee consisting of the director-general of each department should be established (*see recommendation 4.2*). The general purpose of the DGCC was described in Chapter 4 and will not be reiterated here, other than to emphasise that the primary purpose of the committee would be to facilitate multi-agency service delivery. The committee could do this by ensuring that services provided by diverse agencies are coordinated, so that the full range of needs of identified at-risk children are met.

The committee must also ensure that partisan orientations towards the process are not permitted if a genuinely whole-of-government approach is to be achieved.

It is important to recognise that a whole-of-government approach will not fit solely within the jurisdiction of the Queensland State Government. In the interests of meeting the needs of children in the most holistic manner, input will also be necessary from federal and local governments, as well as from community groups.

It is crucial that child protection is 'owned' by the community rather than always seen as someone else's responsibility. Encouraging this sense of ownership will require an effective communication strategy on the part of the government generally and the DCS specifically.

At a practical, more operational level, however, the DCS will need to be able to take advantage of administrative mechanisms that can readily align the activities of sometimes very different agencies. A model for such a process already exists in Queensland in the form of the SCAN teams. When those teams work effectively, the sharing of information and the adoption of a true multi-agency approach facilitates outcomes in the best interests of children.

Recommendations

6.1 **That each department with an identified role in the promotion of child protection be required to publicly report each year on its delivery of child protection services.**

Reason: Mandatory annual public reporting of child protection activities is essential to improving accountability and service delivery in Queensland.

6.2 **That the Directors-General Coordinating Committee consider appropriate ways for the DCS and state government departments to interact with federal and local governments and relevant community groups.**

Reason: Such a range of participants is necessary to ensure that the Queensland child protection system is exposed to a variety of perspectives and expert opinions, and that it provides stakeholders with 'ownership' of strategies designed to improve service delivery to client children and their families.

SUSPECTED CHILD ABUSE AND NEGLECT (SCAN) TEAMS

SCAN teams operate as part of the broader child protection system. They have been operating in Queensland for over twenty years, having been initiated in 1980 by the Coordinating Committee on Child Abuse (CCOCA). At present this committee is still responsible for overseeing the teams; however, this role would be assumed by the Directors-General Coordinating Committee with the establishment of the new child protection regime.

The function of SCAN teams

A SCAN team is a formal information-sharing and planning construct, consisting of core members from:

- the Department of Families
- the Queensland Police Service (QPS)
- Queensland Health (authorised health practitioners)

as well as members of other agencies (for example, Education Queensland, Queensland Health's Mental Health Services, and Aboriginal and Islander Child Care Agencies) who may be coopted to sit on the team depending on the circumstances of the case.

The aim of SCAN teams is to coordinate a multidisciplinary response to cases of child abuse and neglect referred for assessment. To do this, the teams meet as often as deemed necessary to formulate recommendations for action. Such recommendations are not mandatory: there is no obligation upon any agency (such as the Department of Families) to follow through the decisions made by a SCAN team.

The guidelines for referral of matters to SCAN teams vary within agencies. For example, the police are directed to refer all suspected child abuse and neglect matters to a SCAN team, while Queensland Health is directed to refer all notifications made in accordance with the mandatory reporting requirements under the *Health Act 1937*. The circumstances where departmental staff are directed to refer matters are when:

- the initial assessment is conducted jointly with the QPS
- the use of health workers or services is required as part of initial assessment
- the alleged abuse or neglect has caused severe harm to a child
- sexual abuse is alleged
- the matter involves a notification relating to a child in alternative care[2]
- a child has been taken into custody
- an application for an order is being considered
- the child is under three years of age
- a number of agencies are involved (Queensland Ombudsman 2002).

Views on SCAN

The views expressed to the Inquiry regarding SCAN were generally favourable, at least in terms of the concept of SCAN and inter-agency cooperation. Dr Richard Roylance, a paediatrician and SCAN member, had this to say:

> One of the tests for me about whether something works or not is whether it's maintained with limited resources and those of you who are familiar with senior officers of Health … and senior officers of the police would be aware that regardless of any bureaucratic demand if they thought attending SCAN teams was a waste of their time or not useful for the protection of children, over a twenty-year period they would have stopped attending. I find it remarkable that when you look across the state there are isolated SCAN teams often in really remote areas where it's difficult to get police and Health to attend, but there is remarkable strong attendance and persistence in the majority of SCAN teams. (CMC 2003, p. 472)

Dr Ryolance's comments reflect the findings of a departmental review of the SCAN team system (Department of Families & CCOCA 2001), which found that:

> … all key stakeholders are supportive of the principles underlying the multidisciplinary approach to child protection embodied in the SCAN Team system.

Both the Minister and the Director-General of the Department of Families acknowledged during the public hearings that the SCAN system was a valuable one, and that the system could be built upon to improve the provision of services to vulnerable children. At the time of the CMC Inquiry, a departmental review of SCAN, designed to find out how the system could be improved, had been going on for 18 months.

It appears that the essential usefulness of the SCAN system has been recently recognised in departmental policy. As outlined by the Director-General of Families on 23 October 2003 during his evidence to the Inquiry, the department implemented policy no. 326–2, Responding to Matters of Concern Raised in Relation to the Standards of Care Provided to Children and Young People in Alternative Care, on 1 October 2003.[3] The policy states that if a matter of concern is raised in relation to the care provided to children or young people in alternative care, the response will be 'casework' or 'investigation and assessment', and no lesser response. It further provides that:

> All notifications in relation to harm to children and young people in alternative care will be referred to the relevant Suspected Child Abuse and Neglect (SCAN) team. Outcomes of SCAN discussions will be considered in planning actions arising from the matter of concern.

The implementation of this policy appears to confirm the widely held view that SCAN teams play a useful role in addressing the needs of vulnerable children. The policy does not, however, make mandatory the referring of concerns about those children in care who, while they may be under formal orders, have not been placed in alternative care (i.e. they may still be residing with their biological parent/s).

Concerns about the current SCAN system

While views about the SCAN system were largely favourable, some important concerns were expressed. It was generally acknowledged that a properly functioning SCAN team (such as the those at the Brisbane Mater Children's Hospital and the Royal Brisbane Hospital) assist with child protection by promoting coordination, planning and support. However, a SCAN team that is not functioning fully or properly is of little use to vulnerable children.

The Inquiry heard that the current quality of SCAN teams is extremely variable. The evidence from Operation Zellow in relation to the notifications of children contracting gonorrhoea (see flashpoint 7, Chapter 2) is an example where the SCAN process did not produce a good outcome for the children. Other information received during the public hearing indicated that the role of the coordinator of the SCAN team is pivotal.

The Department of Families has recognised the importance of the role of the coordinator in the SCAN team and, just prior to the start of the CMC Inquiry, had announced the creation of 15 full-time positions for SCAN coordinators within the department. The duties of these officers were to be exclusively centred upon SCAN activities.

Many of the concerns raised with the CMC about SCAN appear to be related to the tensions inherent in any multidisciplinary administrative mechanism. Concerns were expressed about the conduct of the department as 'lead agency', to the effect that appropriate referrals are not always made to SCAN or that, when they are, decisions about the direction of the case have already been made. It was also asserted that the department is dominant in the SCAN process and that it may fail to properly consider the views of other agencies (CMC 2003). Running counter to this view was the one expressed by some departmental staff that medical practitioners tended to dominate the SCAN meetings. Whatever the truth of the matter, the evidence was clear that there are at times noticeable tensions between the various disciplines contributing to SCAN teams.

Professional conflict between agencies is, of course, not unique to SCAN teams. For example, the Victoria Climbie Inquiry reported a high level of hostility by the area social services towards the local police child protection team, with a resultant lack of information sharing between the two key agencies. The failure of various agencies to intervene to save Victoria was attributed by Lord Laming to a failure to effectively communicate crucial information (UK Government 2003). It is clear from such evidence that if there is not an open exchange of information and a willingness to embrace a multidisciplinary framework then concepts such as SCAN will fail to deliver.

During the Inquiry, concerns were also raised regarding the level of SCAN funding and the level of training provided to team members. However, as noted above, one of the recent reforms announced by the Director-General of Families was funding for the creation of a number of full-time SCAN coordinators, who will address staff selection and training. The Commission supports that initiative.

SCAN and the DCS: the new model

Child protection can best be delivered by effective case planning and management in a multidisciplinary inter-agency configuration. An invigorated SCAN framework should be the foundation of this process. At the highest level, the Directors-General Coordinating Committee would reflect the strategic importance of the whole-of-government approach to child protection, with the SCAN teams reflecting this approach at a more micro level.

It is also expected that within the DCS all SCAN teams throughout the state would operate in accordance with the same standardised policies and procedures, although some degree of flexibility would be essential, particularly in light of regional characteristics.

Given the coordinated multidisciplinary approach recommended by the Commission, it is feasible that the core membership of some SCAN teams could be significantly expanded. The Commission is of the view that representatives of all government agencies recognised as having child protection responsibilities should be considered as possible core members of SCAN teams. In appropriate cases, all team members would be required to attend the initial planning meeting. Should a particular agency consider it cannot add value to the planning process, the specific issue should be addressed prior to, or at, the initial planning meeting.

The CMC's investigations and the Inquiry revealed evidence of inadequate case planning in respect of the children placed in care. Poor planning directly affects the quality of care the children receive, and ultimately the outcomes. Accordingly, the Commission is of the view that, consistent with the department's recently introduced policy, the SCAN teams should be advised of all cases of alleged abuse and neglect of children in alternative care, or under formal orders, as reported to the DCS. The first SCAN meeting should call for contributions from all agencies to develop or revise a case plan for the child. Additionally, in instances where applications for care orders are part of the child protection plan, legal advice should be available to the SCAN team at the appropriate time.

Further, as part of the initial case-planning phase, agencies are typically required to commit resources; therefore, it is expected that senior staff with the appropriate level of delegation would attend SCAN meetings on the basis that they have the capacity to commit resources to a case.

Attendance at a SCAN team meeting would not be limited to one person from each agency; for example, the health representative might wish to bring an occupational therapist if the case plan called for this particular expertise. Likewise, the DCS representative might request that the family services officer (FSO) assigned to the child or family be in attendance.

The SCAN case-planning framework should encompass the formulation of the case plan and agreement by all the members in a truly multidisciplinary manner. It is

important that the team allocates responsibility not only for aspects of the case but also for the coordination of the plan. It is likely that an officer from the DCS will take on the responsibility for coordination; however, this is not intended to prevent the plan being implemented in a multidisciplinary manner.

Under section 88 of the *Child Protection Act 1999*, six-monthly reviews of case plans are required. In certain cases, there may be benefits in involving SCAN teams in these reviews because, if a review found that aspects of the case plan had not been carried out, the team could seek an explanation and ensure the gaps were promptly attended to. There will obviously still be a need, as now, for SCAN teams to meet as often as necessary to consider new and ongoing cases.

To facilitate these revised levels of responsibility in the development and monitoring of care plans, SCAN teams must receive sufficient funding to ensure that they have the capacity for maintaining detailed records, both hard copy and electronic. The teams will be required to record detailed notes of:

- decisions made
- reasons for the decisions
- dissent from any decision
- responsibility for decisions
- the implementation process.

To help maintain accurate and complete electronic records, it will also be necessary to develop a database that can validate records and generate basic reports. Given the additional terms of reference for SCAN teams, it may prove necessary to allocate further funding to those agencies that are required to fund this coordinated SCAN approach, including the DCS.

At present, SCAN team recommendations are essentially advisory, with the Department of Families as the lead agency deciding to what extent any SCAN recommendations will be given effect. Given the expected level of multi-agency commitment to SCAN, the DCS will be under a strong obligation to comply with all SCAN recommendations. It is not being suggested that the DCS relinquish the lead agency role, but rather that any divergence in case management from the SCAN recommendations be recognised as a matter for detailed 'exception' reporting. As lead agency with ultimate responsibility for child wellbeing, the DSC must retain the capacity to act contrary to SCAN recommendations if it believes such recommendations are not in the child's best interests. However, any such departure needs to be comprehensively documented and reported to the Director-General of the DCS.

The Inquiry was told that the successful interlinking of officers from multidisciplinary backgrounds to form collaborative SCAN teams should not be taken as a 'given'. There was evidence that often the professional dynamics of the members result in a challenging working environment (CMC 2003). Therefore, to obtain the most benefit from the multidisciplinary qualities that SCAN teams offer, resources should be allocated for training and team building. SCAN team training should also aim to dispel any lingering cultural views that the SCAN approach is an encumbrance and to encourage team members and the wider child protection community to recognise and appreciate its value.

To provide further accountability, the Director-General of the DCS will have direct responsibility for the SCAN system — the effective functioning of the system being one of the new department's performance indicators. Further, as ownership for the SCAN process traverses many agencies, performance reporting should be included in the annual reports of each agency. The functioning of the SCAN teams should also be a standing agenda item on the Directors-General Coordinating Committee.

As well as regular monitoring and review of SCAN teams by the DGCC, it is important that a full review of the functioning of SCAN teams occurs regularly, at intervals to be determined, in due course, by the DCS and the DGCC. Such reviews could include internal audits by the DCS to measure compliance with policies and procedures, including official record-keeping systems.

6.3 That the existence of the SCAN teams be enshrined in statute to reflect their important contribution to the child protection system.

Reason: Under the new departmental model, the existence and operation of multi-agency SCAN teams are a core means of officially responding to cases of suspected child abuse in Queensland. The requisite commitment, response and service delivery required of agencies in this new model warrant the SCAN teams being recognised by statute.

6.4 That the operation of SCAN teams be based upon agreement to a standard set of interdepartmental policies and procedures.

Reason: It is critical that all departments are clear as to their role and responsibilities relating to participation in the SCAN process and that the roles and functions of SCAN teams across the state be standardised, as far as possible.

6.5 That SCAN teams receive appropriate levels of funding to discharge their responsibilities effectively, including appropriate funds for proper record-keeping systems and SCAN team training.

Reason: SCAN teams, as a core micro-level response to child abuse and neglect, need to be sufficiently funded to operate at high levels of effectiveness and accountability.

6.6 That SCAN team recommendations are accepted by the DCS, except in instances where the DCS believes the recommendations are contrary to the best interests of the child, and that any departure from a SCAN team recommendation is reported to the Director-General of the DCS and made the subject of detailed 'exception' reporting.

Reason: The SCAN teams constitute a panel of experts equipped to provide high-level advice on individual case-management issues. Non-acceptance of SCAN recommendations should therefore only occur where the DCS believes it can demonstrate that the advice is contrary to the best interests of the child. Exception reporting and supervision is needed to monitor and evaluate such views.

6.7 That SCAN be a standing agenda item on the Directors-General Coordinating Committee.

Reason: With child protection a priority for the Queensland Government, the progress of SCAN teams in Queensland should be subject to regular monitoring by the Directors-General Coordinating Committee.

6.8 That full reviews of the functioning of SCAN teams occur regularly and that audits be conducted to measure compliance with policies and procedures, including official record-keeping systems.

Reason: Reviews of SCAN functioning will provide benchmark data and a means for evaluating the teams' performance.

NON-GOVERNMENT SERVICE DELIVERY

Non-government organisations have always played a major role in providing services to children in need of protection. In 2002–03, the Department of Families provided $35.25 million by way of 237 separate grants to non-government organisations for the delivery of early intervention, prevention, family support and placement services. (Department of Families 2003c, Grants Report). This funding is in addition to the $7.15 million provided to non-government organisations for Future Directions projects.

On 1 July 2002 the Department of Families created a Non-Government Services Directorate to:

> provide strategic leadership and management in funding policy development, contract management and service monitoring in respect of non-government services funded by the department. (Department of Families 2003c, p. 63)

Grants are provided under the *Family Services Act 1987* and funding policies and practices must comply with the Guidelines for Grant Administration issued by Queensland Treasury in 1997 (Department of Families, policy no. 133-2).

Engaging the services of a non-government organisation involves the negotiation of a service agreement between the department and the organisation. The agreement specifies the funding standards and accountability requirements. At a minimum, the policy Standard Condition of Funding (Department of Families 2002b) specifies that funded organisations must maintain accounts that describe how grant money is spent and provide an annual return to the department that includes comment on how agreed performance measures were met. Funded organisations also agree to participate in the monitoring and evaluation of their funded services.

The department's policy regarding non-government services (no. 133–2) specifies that, if the department has concerns about the service being provided by a funded organisation, the organisation may be subject to additional reporting requirements, or grant advances can be made on a monthly basis to reduce departmental risk. In extreme cases, an organisation's funding may be ceased.

One of the functions of the Review and Evaluation Branch of the Department of Families, created on 1 July 2002, is to assess the effectiveness of non-government services funded by the department. To facilitate these evaluations, the branch developed and implemented the evaluation framework for the Future Directions initiatives (Department of Families 2003c).

Policy no. 133–2 also specifies that staff operating at an area office level are expected to bring any misgivings about the operation of a funded organisation to the attention of their regional director, who in turn will involve the Non-Government Services Directorate. A decision will then be taken regarding any action to review the organisation's performance.

The Future Directions policy continues the practice of the Department of Families to directly provide the same services it funds non-government organisations to provide. For example, the department has employed additional staff to provide prevention and early intervention services, as well as funding non-government organisations to provide these services. Similarly, the department has employed additional staff to undertake recruitment and training and provide support to foster carers while continuing to fund non-government organisations to provide these services.

Currently the non-government sector is an important contributor to the child protection system and under the DCS this dual system of service provision, whereby services are provided by both the government and non-government sectors, will be maintained. Therefore it is important that both the government and non-government sectors provide integrated quality services designed to meet the identified needs of children. Because of this dual system of service provision, it will also be important for the DCS to monitor and evaluate the services that are provided by both non-government and government agencies so that children and their families have access to the quality services that meet their individual needs.

The Inquiry heard that currently there is limited service integration across the sector with a 'stand alone' approach to service provision (PeakCare submission). The present system of funding non-government organisations through recurrent grants and individualised packages is not conducive to integrated service delivery and further promotes the use of isolated services (Life Without Barriers submission). Previously, the department has attempted to tailor services to clients' needs and to develop more integrated and responsive service models (e.g. Mapping of Alternative Care Services in Queensland, joint initiative of the Child Protection Service System Improvement Project, Families and PeakCare, June 2002). The Inquiry was told that these efforts have often either been 'piecemeal', and not taken an integrative approach to examining the alternative care system, or were never implemented (PeakCare submission). Similarly, while the government has instigated commendable initiatives to provide more integrated services for clients under the Future Directions package, the Inquiry was told that these initiatives were often under-resourced (Life Without Barriers submission)

and, according to the Abused Child Trust, were not always based on world's best practice or supported by sound evidence (CMC 2003).

Consequently there is no ongoing service policy, practice development or strategy for resource allocation. This has led to inefficient system duplication between government and non-government services, continued the 'ad hoc' development of the non-government service sector, and meant that non-government organisations have faced significant challenges in their attempts to respond effectively to their clients' needs (PeakCare submission). Not surprisingly, non-government organisations have reported being pressured to sacrifice quality for quantity of service and this has resulted in mounting tensions between government and non-government organisations (PeakCare submission).

Recommendation

6.9 That a strategic framework for child protection be developed, articulating the range, mix and full cost of services required to respond effectively to clients' needs, particularly complex needs; and that the implementation of this framework be adequately resourced.

Reason: There is a need for the development of an integrated service system that effectively responds to the identified needs of children.

Resourcing

The Inquiry was informed that non-government organisations have been consistently under-resourced for the services they are required to provide. This results in limited capacity to deliver the effective, flexible responses necessary to meet the individual needs of children and their families (Life Without Barriers submission; PeakCare submission). For example, Life Without Barriers informed the Inquiry that because of this chronic underfunding the department often needed to use funds from Child Related Costs to 'top up' the current service system. Although these funds were originally intended as a supplement to the funded service system for children with extraordinary needs to meet, this system has now become a service system in its own right and runs in parallel to the other service system (Life Without Barriers submission).

Currently funding for alternative care is normally based on payment for placement, rather than payment for services. This model is rather restrictive as it does not recognise the full range of services that may be required in individual cases. There is a need for a new service model that is less prescriptive and more responsive to the complexity of clients' needs.

For example, Mr Lindsay Wegener from Life Without Barriers informed the Inquiry of a more responsive funding model that recognises the complexities of service provision. The Industry Commission's review of Charitable Organisations in Australia (1995) recommended that non-government organisations be funded for:

(i) set-up component costs for the establishment of the service and its service user base,

(ii) fixed cost component for costs that remain fixed regardless of the level of service output (includes capital costs for maintaining and replenishing items such as motor vehicles and equipment and certain administrative costs and overheads for meeting government regulations and required service standards and undertaking service planning and development activities) and

(iii) a variable cost component in accordance with the number of service group users and the range, type, and intensity level of service components required by each service as determined by children's individualised care plans.

The set-up component is funded through a non-recurrent grant, while the fixed cost component is paid in advance on a monthly basis with variable costs paid monthly in arrears to cover the direct costs of delivering the program. Because of its existing financial reporting requirements, the department is unable to currently implement this resourcing model (Life Without Barriers submission).

In another attempt to address this discrepancy between identified needs and funding, other jurisdictions have proposed alternative resourcing models. For example, the Victorian Government (Department of Human Services [Vic.] 2003a) has suggested that, rather than buying a placement, funding should be on the basis of a 'care package' for each child, which may, or may not, include out-of-home care. This model recognises that most clients and their families require sustained support rather than brief interventions. Another model proposed in South Australia (SA Government 2003) suggests funding based on the principle of unit costing. There is an agreed benchmark of the costs for different categories of individual care and funding is provided according to the volume of children requiring care.

Both of these models aim to avoid the problem of resource-driven funding where there is a finite amount allowed for services; once this is exhausted children and their families cannot be provided with the services that they clearly need. For example, in Queensland foster carers reported that, even though they may be authorised to receive particular allowances (e.g. High Needs Allowance), limited funds are allocated for these payments for each region. If the allotted funds have been already exhausted in their region, carers are unable to obtain their entitlements (FCQ submission).

In Queensland, although a change from a resource-driven to a needs-driven funding model would result in increased service provision, some of these costs for the DCS would be covered by having other departments delivering some of these services in a whole-of-government approach to child protection. This would enable the department to create more responsive, individualised packages for clients, which could address longer-term outcomes for children and their families.

RECOMMENDATION

6.10 That alternative funding models that would more adequately meet the true needs of children, families and carers be investigated.

Reason: If the current resource-driven funding models continue to apply, children will not have access to necessary services.

Role of the DCS and non-government agencies

There are difficulties for the Department of Families in its current role as both a provider and a purchaser of services, which results in confusion for both the department and non-government organisations about their respective roles and functions in relation to each other. When governments have primary roles in purchasing services, it is easy for the relationships between government and agency to be only on a transactional basis (Department of Human Services [Vic.] 2003a). According to non-government organisations, the Department of Families recognises the importance of working in partnership with agencies and 'speaks the rhetoric of partnership', but does not always put this into practice in its everyday interactions with the agencies (PeakCare submission). Non-government organisations, such as the Esther Centre, report they are often not treated as a partner in service delivery (CMC 2003).

It will be important for the DCS to establish a strong partnership with the non-government agencies to provide an efficient system that meets the protection needs of children. Service models that focus more on joint capacity building are more likely to result in an integrated service model that focuses on the partnership between agencies and government (Department of Human Services [Vic.] 2003a). Because of their close links with the community, agencies have important contributions to make to developing, planning, implementing and monitoring services. A recent Victorian report on out-of-home services concluded that only a sophisticated partnership strategy involving government-funded community service organisations, peak and consumer groups can deliver a program required to meet the needs of vulnerable children (Department of Human Services [Vic.] 2003).

RECOMMENDATION

6.11 **That a more progressive and contemporary integrated service delivery model, which creates a partnership between government and non-government organisations to deliver better services for clients of the child protection system, be developed.**

Reason: An integrated service model is necessary for the provision of effective and efficient services for children, their families and their carers. This should build on the substantial amount of work that has already been undertaken by the Department of Families.

Service delivery

While it is necessary for the DCS to establish collaborative relationships with agencies, it will also have obligations to monitor and evaluate service delivery by the non-government agencies. In doing this, it will need to address the following issues:

1. The roles of the state and the agencies need to be more clearly defined, so that there are defined goals for service providers. The exact roles the agencies will play in relation to recruitment, training and support need standardisation and consistent application.

2. Currently there is variability in funding controls that are exercised over various agencies. While some are tightly controlled by performance indicators, others are not. All agencies should be subject to consistent controls. Similarly, decisions to maintain a service are not always made on the basis of quality. It is essential that future funding of agencies is determined on the basis of performance and the skills of agency workers. 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.

3. The DCS needs to have service agreements, incorporating clearly defined performance goals and service standards, with all agencies. The DCS should also be responsible for implementing an effective quality assurance system that monitors each agency's compliance with service standards and its outcomes, and evaluates the quality and efficiency of the service, taking corrective action where necessary. This evaluation should serve as the basis for decisions about continued funding.

   Currently the Department of Families does not use minimum service standards and performance measures for licensing services and has no quality assurance system that allows monitoring of children's safety in care, which could inform licensing decisions (Department of Families 2003a). In both Victoria and New South Wales a 'minimum standards' approach is used to regulate alternative care services. If services do not meet these minimum standards, licences are not granted. To improve efficiency and decrease the chance of service failure, it is important that these standards are introduced at the licensing stage, and not at a later date when agencies are expected to meet standards that they may have been unable to comply with when the service was originally set up.

   The importance of setting and monitoring standards is clearly shown in the audit of residential and shared care agencies that was conducted by the Department of Families in 2002–03. After auditing, approximately half of the agencies involved had additional conditions placed on their licence. Particular difficulties that were found included the following:

   - Statement of standards policies had either not been developed or had not been finalised.
   - Policies on reporting matters of concern and harm had not been developed.
   - There was inadequate record-keeping.

- Agencies had foster carers without current approval certificates who were awaiting reapproval.
- Personal history checks on carers were incomplete.

It is important that minimum standards are established whereby licensing standards are specifically detailed in the service agreements with agencies.

4. Similar standards of service delivery, monitoring and evaluation should apply to both the government and the non-government alternative care sectors. The Inquiry heard that many carers supported by the department did not receive the same quality of support services as non-government carers (FCQ submission; PeakCare submission).

RECOMMENDATION

6.12 That a quality assurance strategy is developed and implemented for all services (government and non-government) and a minimum standard be set for the licensing of non-government services.

Reason: The DCS has a responsibility to promote the wellbeing and safety of children in the alternative care system and to require accountability for the acquittal of expenditure on behalf of the community.

MANDATORY REPORTING

The abilities of the new department, the SCAN system, and non-government organisations to collectively respond to the needs of vulnerable children will largely depend on frontline professionals reporting child abuse. This means that the current child abuse reporting climate, including mandatory reporting regimes and the possible expansion of these, requires detailed consideration.

It is crucial that the DCS is able to respond to protect vulnerable children in its jurisdiction. The key components for the initiation of this response are: *knowledge* of abuse, and having children brought to its *attention*. To facilitate the notification process, a healthy reporting climate is a key requirement.

The current situation regarding the reporting of child abuse is that anyone may voluntarily notify the QPS or the Department of Families if they suspect that a child has been the subject of abuse. Section 22 of the Child Protection Act offers protection to people who report such abuse in good faith. Under the new regime it is not expected that this situation would change.

The Inquiry has examined whether introducing or expanding a statutory requirement, rendering it compulsory for certain classes of people or individuals to report suspected abuse of children, will improve the quality of the response to such abuse. Such a step should be contemplated only if it protects and promotes the interests of those children who are the focus of the department's integrated services. The danger is that the introduction of mandatory requirements for reporting may not increase the numbers of cases of serious and genuine suspected abuse being reported, but may merely induce reporting of cases better dealt with outside the child protection system.

The Queensland position

Reporting child abuse in Queensland is not compulsory, except for limited categories of people. Therefore, the issue becomes whether the mandatory requirement to report suspected child abuse should be extended to other categories. At present the only people or class of people required by legislation in Queensland to report child abuse are:

- medical practitioners, who are required under section 76K of the *Health Act 1937* to report reasonable suspicions of maltreatment or neglect of children within 24 hours of forming the suspicion
- staff of the Family Court, under the *Family Law Act 1975*

- employees of licensed residential care services and Department of Families staff who suspect harm has been suffered by children in licensed premises, under the *Child Protection Act 1999*.

Under Education Queensland's current Health and Safety Policy 17, teachers who suspect that a child has been abused are required to report this suspicion to their principal. If the principal reasonably suspects a child is at risk of harm they are required to report to the Department of Families, and where there is a possible criminal offence, to the QPS. This requirement has recently been amplified (in certain aspects) by legislation passed on 12 November 2003, which has amended section 146 of the *Education (General Provisions) Act 1989*.[4] The amendments have made it mandatory for employees of state and non-state schools who 'become aware, or reasonably suspect that a student under 18 years attending the school has been sexually abused by someone else who is an employee of the school', to immediately report this in writing to the principal (or principal's supervisor) of a state school, or the principal or director of the governing body of the non-state school. The state school principal is then required to report to the director-general's nominee, who is then required to report this abuse to the QPS. The non-state school principal/director is required to report to the QPS.

A person providing this information is not liable, civilly, criminally or under an administrative process, for giving the information contained in the report to someone else.

The Queensland rate of notifications of 21.9 per 1000 children aged 0–16 years in 2001–02 was marginally under the national average of 22.3 per 1000 (Productivity Commission 2003a, Table 14A.8). However, the rate of children in substantiated notifications was significantly higher in Queensland (8.3) than in any other state (national average 5.7). These statistics do not suggest any problem with under-reporting in Queensland and establish that reporting in Queenlsand is more likely to prove justified, as measured by reference to the level of substantiations.

The issue of whether the categories of people required to report should be extended was considered at some length during the deliberations leading to the enactment of the Child Protection Act. However, at this time the categories were not extended.

In 2000 the Queensland Crime Commission and the Queensland Police Service undertook Project Axis, a report into child sexual abuse in Queensland. As part of Project Axis the issue of legislative obligations to report suspicions or disclosures of child sexual abuse was considered. Project Axis did not make any recommendation for extending mandatory reporting.

Other Australian jurisdictions

Requirements for mandatory reporting of child abuse vary across Australia. The following overview briefly explains the legislative position of each state and of the Australian Capital Territory.

New South Wales

The categories of those mandated to report in NSW are broader than in Queensland. Under the *Children and Young Persons (Care and Protection) Act 1998* (NSW), the people mandated to report in relation to children under the age of 16 'at risk of harm' are those who in the course of their professional work or other paid employment deliver health care, welfare, education, children's services, residential services or law enforcement wholly or partly to children, and anyone holding a management position in any organisation that supplies such services. Anecdotal evidence indicates that mandatory reporting has general support in NSW.

Victoria

Under section 64(1A) of the *Children and Young Persons Act 1989* (Vic.) a wide range of professionals is required to report a belief that a child needs protection due to significant harm or a risk of such harm as a result of sexual or physical abuse.[5]

South Australia

Section 11 of the *Children's Protection Act 1993* (SA) states that when a member of a wide range of professionals forms a suspicion during the course of their professional duties (paid or voluntary) that a child is being abused or neglected, they must report this belief as soon as practicable to the Department of Human Services.[6]

The recent review of the child protection system in South Australia (the Layton report) considered the issue of mandatory reporting. Recommendation 50 stated that mandatory reporting had significant support within professional groups as well as the wider community. Recommendation 54 was that the *Children's Protection Act 1993* be extended to include as mandatory reporters:

- church personnel
- all individuals involved in providing care to or supervision of children
- all volunteers working with children
- all people who may supervise or be responsible for looking after children as part of a sporting, recreational, religious or voluntary organisation.

Western Australia

Western Australia's *Child Welfare Act 1947* (WA) does not make it mandatory for any individual or category of individuals to report child abuse or suspicions of child abuse. In 2002 the Minister for Community Development commissioned the Discipline of Social Work and Social Policy at the University of Western Australia to analyse '… the evidence that exists to support, or otherwise, mandatory reporting as an optional mechanism for addressing child abuse in Western Australia' (Harries & Clare 2002, p. 1). The resulting report declined to recommend that the legislation be amended to create any category of professionals or individuals for whom reporting should become mandatory.

Tasmania

Section 14(2) of the *Children, Young Persons and their Families Act 1997* (Tas.) substantially reflects the provisions of other jurisdiction in that it mandates a wide category of professionals to report to the Secretary of the Department of Health and Human Services if a child has been abused or neglected or if there is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides.[7]

The Tasmanian legislation also goes further as it contains a statutory responsibility under section 13 of the Act for any adult who suspects child abuse to take steps to prevent the occurrence or recurrence of the abuse. One step is to report the abuse to the Secretary.

Australian Capital Territory

Section 159(2) of the *Children and Young People Act 1999* (ACT) requires a large range of professionals to report any reasonable suspicion of sexual abuse or physical abuse, formed in the course of their professional duties, to the Chief Executive Officer of the Department of Education and Community Services.

Noncompliance penalties

Queensland does not impose a sanction upon medical practitioners for failing to notify. In most other jurisdictions, however, varying penalties apply for failure, by mandated persons, to comply with the legislature.

Submissions about mandatory reporting

The Inquiry received a number of submissions, both written and oral, as well as evidence during the public hearings, that dealt with the issue of mandatory reporting. A submission from the Queensland State Opposition specifically requested that the issue of mandatory reporting be considered. Other submissions outlined varying opinions regarding the extension of the current regime in Queensland.

Samples of the variation of opinion are:

- Bravehearts thought mandatory reporting should be extended:

  … widespread mandatory reporting … because if we can get to that child at that point (the first instance we know a child is in harm) and provide the right services and care then we've got a good future, quite possibly like anyone else, for that child. While there's difficulties attached to it and all the rest of it and there'll be a need for incredible injection of resources both to police, health and everywhere else to actually deal with it, we believe it should be a priority and it should be introduced. (CMC 2003, p. 408)

- PeakCare recommended mandatory reporting for all involved in out-of-home care and the community visitor program for families of six foster kids or more.
- Foster Care Queensland supported the broadening of mandatory reporting to include professionals such as teachers, child care workers and nurses.
- Ms Beverley Fitzgerald, President of the Children Services Tribunal, had an entirely different perspective on mandatory reporting, stating that it came from an 'investigative' construct and:

  I have yet to read any research that says mandatory reporting actually helped a child. (CMC 2003, p. 137)

- Likewise, the Esther Centre expressed reservations about the role of expanded mandatory reporting, stating during the public hearing that:

  If our only response to deal with concerns is mandatory reporting then I think the system is going to be so over-run that we're never going to get it better. (CMC 2003, p. 240)

- While expressing some reservations about universal mandatory reporting, Ms Annette Murphy, SCAN coordinator at the Brisbane Mater Children's Hospital, expressed the view that it would be useful to extend the mandatory reporting requirements in Queensland to the nursing profession. (CMC 2003)

Several other states already impose mandatory reporting obligations upon nurses.

General arguments for and against mandatory reporting

Research undertaken during the course of the Inquiry has indicated that there is considerable debate within child protection circles as to whether mandatory reporting is actually effective in protecting children. It appears that, generally, mandatory reporting is favoured by non-professionals but is viewed more sceptically by professionals.

Arguments in favour

The essential argument in favour of extended mandatory reporting was recently encapsulated in the South Australian Review report (SA Government 2003). It stated that mandatory reporting creates a climate that allows the community to make confidential notifications on the basis of which the state can intervene to protect children. The report claims that mandatory reporting provides detailed and accurate information, and that there is a higher substantiation rate. It also claims that mandatory reporting sends a very clear message to the community that child abuse will not be tolerated. Further, mandatory reporting can resolve ethical conflict experienced by some professionals regarding breaking the confidentiality of their clients/patients.

Arguments against

The arguments against mandatory reporting, or its extension, include that there is no advantage gained by reporting if there is no capacity within the system to respond effectively, and that a flood of notifications may have the effect of disguising those reports that require an immediate and strong response. In Victoria the view has been expressed that the system is buckling under the effect of the current regime of mandatory reporting[8] and that mandatory reporting can lead to a legalistic cycle of investigation and intervention, which arguably may not benefit the child or the family. Similarly, mandatory reporting is said to promote over-reporting for fear of being held accountable for not reporting.

The case against mandatory reporting is backed by research that compared two contrasting Australian regimes: New South Wales, which has mandatory reporting with financial penalties for failure to report, and Western Australia with no mandatory reporting (Ainsworth 2002). Ainsworth concluded that mandatory reporting did not create better outcomes. Essentially, Western Australia had higher substantiation rates for complaints received than did other jurisdictions. Further, he found no evidence of reduction in either child deaths or children's hospital admissions for non-accidental injuries as a result of mandatory reporting. Overall, Ainsworth asserted that mandatory reporting systems are overburdened with notifications, have many unsubstantiated reports (costly and time-consuming) and that mandatory reporting overwhelms services so that the most at-risk children and families may not receive the attention they need. As a result of all of these factors mandatory reporting systems have to be characterised as inefficient and ineffective.

Conclusions drawn by CMC about mandatory reporting

The Inquiry considered whether the extension of mandatory reporting in Queensland could confer a demonstrated benefit upon children subject to child abuse — not whether it would protect professionals or makes the public 'feel better' about child abuse.

Clearly, for the new department to function effectively it must receive notifications about children at risk from child abuse and provide a coordinated service to respond effectively. The evidence available indicates that a wholesale expansion of the categories of people mandated to report will not necessarily enhance the functioning of the DCS.

Having said this, however, currently Queensland doctors are required to report suspected child abuse under the Health Act, but registered nurses who tend to have more contact with children and families, particularly in rural and remote communities, are not so required. The Inquiry is persuaded that requiring registered nurses to report suspected child abuse will empower them to make complaints in appropriate circumstances, and provide statutory protection to them in this function, allowing them to meet the requirements within their code of conduct.

The evidence about the reports of the hospital staff in the second Operation Zellow flashpoint provides a good example of how nurses may be in a position to identify concerns about possible child abuse and neglect. It is also noted that mandatory reporting obligations extend to nurses in most other Australian jurisdictions.

Importantly, whatever the merits of the different views about mandatory reporting, there is little point to the extension of mandatory reporting in a system that cannot respond to the demands placed on it by such reporting. It is considered that nurses are well placed to make objective and reliable assessments of possible abuse. Any further extension of mandatory reporting can only be justified if it is clearly established that it would genuinely further the interests of children and not divert inappropriate cases to the child protection system. On the available evidence the Commission is not persuaded that further extension is justified.

As it is currently drafted, section 76K of the Health Act does not require a doctor to report a suspicion of child abuse or neglect to the Department of Families. All it requires a doctor to do is 'notify by the most expeditious means available to the medical practitioner a person authorised under' the Health Regulation 1996 to be so notified. Schedule 1 of the Regulation contains a list of senior Queensland Health, Department of Families and QPS officers. If a doctor chooses to notify a Queensland Health or QPS officer instead of a Families officer, the Department of Families will only find out about the doctor's suspicion if Queensland Health or the QPS forwards it on. Although section 76K(3) allows an authorised person who receives a notification 'to communicate the notification to other persons for the purpose of having investigations or inquiries made', the Commission believes that section 76K should still be amended so that it is mandatory for doctors (and — if the Commission's other recommendation is implemented — nurses) to notify the DCS about their suspicion.

6.13 That mandatory reporting of child abuse be extended to registered Queensland nurses by legislating under the Health Act.

6.14 That registered nurses receive appropriate training in their new responsibility.

Reason (6.13 and 6.14): The expansion of mandatory reporting to Queensland registered nurses provides another point of contact for children who are subject to abuse or neglect. In rural, remote and Indigenous communities it is arguably nurse practitioners who have substantially more contact with children than medical practitioners. It is crucial that cases of child abuse or neglect that come to the attention of the medical system, at all levels, are not overlooked.

6.15 That section 76K of the Health Act be amended to make it mandatory for doctors and nurses to notify the DCS about their suspicion of child abuse.

Reason: Given that the DCS will be the lead child protection agency in Queensland, it is important that reports about children in need of protection be made, in the first instance, directly to the DCS. A doctor or nurse should, of course, still be able to notify Queensland Health or the QPS (in addition to the DCS).

FINAL COMMENT

The realisation of both structural and operational elements of the new department and the multi-agency relationships that encompass these elements is crucial for the delivery of vastly improved child protection responses in Queensland. Together with the preceding two chapters, this chapter has sought to describe a new model of child protection in Queensland. The following chapter will provide a detailed description of a reconfigured alternative care system for children who come to the formal attention of the new Department of Child Safety.

Endnotes

1 An example of this might be a nurse in a remote area, who by the nature of her/his work will have more contact with the child and its family than a DCS officer.

2 This is the 'Matters of Concern' policy, which came into effect on 1 October 2003. This policy is further discussed in the body of this chapter and in note 3 below.

3 A 'matter of concern' is defined in the policy as 'any concern/s raised in relation to the standards of care provided to children and young people in alternative care'.

4 *Education and Other Legislation [Student Protection] Amendment Act 2003*, s. 14.

5 The categories include medical practitioners, nurses, psychologists, teachers, health education community and welfare services workers, youth and child welfare workers, police, probation officers and youth parole officers.

6 The professionals required to report in South Australia includes medical practitioners, pharmacists, nurses, dentists, psychologists, members of the police force, community corrections officers, social workers, all teachers, approved family day care providers, and any other persons employed by government and non-government agencies involved in providing services for children who are engaged in the actual provision of services to children or in a managerial position.

7 The categories of professionals required to report in Tasmania are similar to those mandated to report in Victoria and South Australia.

8 Introduced in Victoria in response to the death of a child, Daniel Valerio, at the hands of his stepfather.

7

THE FOSTER CARE SYSTEM

The purpose of this chapter is to describe the proposed new Queensland foster care framework. The chapter details the responses for children who require an out-of-home care placement. It also presents an important examination of the foster care system (including voluntary care) and recommends possible strategies to address the current crisis-driven method of practice. In addition to traditional foster care, it examines other placement options, including residential care and therapeutic care. Further, the chapter examines the best-practice literature regarding casework and long-term planning options in the context of the evidence presented to the Inquiry, and makes recommendations for the new system.

A NEW FRAMEWORK FOR ALTERNATIVE CARE

The alternative for those children who are no longer safe from abuse in their own home is, in the vast majority of cases, a foster care placement. A much smaller number of children receive other forms of alternative care such as residential placements.

The weight of the evidence before the Inquiry was that the current foster care system is not working effectively in Queensland in many important respects, as shown by:

- many children not being assigned a caseworker
- children not having any contact with an FSO
- non-existent or poor case planning
- high rates of placement breakdowns, resulting in multiple placements
- generally poor relationships between the Department of Families and foster carers
- inadequate training and support for foster carers
- a lack of confidence in the Department of Families on the part of stakeholders
- a shortage of appropriate placements for children.

While responsibility for the care and protection of children involves government, community and non-government agencies, the new department would serve as the lead agency for child protection in Queensland. Therefore, it must develop clear goals and objectives and identify the roles, rights and responsibilities of all stakeholders in the child protection system. It must also develop clear and focused policies and procedures to implement its goals and ensure the adequacy of services from all other departments, organisations and individuals involved in meeting the diverse needs of children in care. Although the current dual system (where alternative care services are provided by both government and non-government agencies) would remain with the recommended introduction of the DCS, it is important to note that the new department would be accountable for the provision of all appropriate services for children, even when the delivery of these services was outsourced to non-government agencies.

Some services would be provided by other agencies and departments, but core functions would be carried out by the new department (e.g. the receipt and investigation of notifications and the approval of carers).

To fulfil its statutory obligations, the DCS must maintain a core capacity to license carers. Currently, when carers are assessed by a non-government agency, regional

managers within the Department of Families are required to give the final approval for carers. The evidence suggests that, in practice, most managers simply 'sign off' on the decisions that have already been made by agencies (consultation with Finance & Asset Management, Department of Families 2003).

RECOMMENDATION

7.1 **That the Department of Child Safety be responsible for receiving and investigating notifications of child abuse and neglect, and take over responsibility for the final assessment and certification of *all* carers, and for assessing the appropriateness of carers' reapprovals.**

Reason: Receiving and investigating notifications requires the skills of a specialised, central department. The DCS should also assume responsibility for the final assessment of carers because it is the entity responsible for ensuring the welfare and protection of any children taken into its care.

Although the current dual system of providing services would be retained, it would be ideal to work towards a system that clearly differentiates between the primary client group served by each agency. In such a system, the DCS would work with the child, while other agencies would deal with foster carers and with biological parents. This would help to resolve conflicts of interest in situations where one worker is representing the interests of two different clients — for example, the child and the biological parent or the child and the carer.

When situations arise where the best interests of one party conflict with the best interests of the other, normally workers give precedence to the needs of one party. The Inquiry heard much evidence that this typically means that the interests of adults (parents or carers) takes precedence over the interests of the child (Australian Foster Care Association 2003). Having separate entities clearly representing the interests of their client group would result in:

1 the concerns of all parties being properly considered during any disputes

2 the interests of biological parents being represented for the first time (foster carers and children already have advocacy organisations: Foster Care Queensland for carers and CREATE for children). Importantly, agencies funded to work with biological parents could also fulfil an advocacy role for parents

3 easier reunifications — by having the child as the department's primary client it would be easier for the alternative agency to work with the parent to facilitate reunification. Currently there are difficulties for Families workers who remove a child from a parent and are then required to work with that parent towards reunification. Not surprisingly, many parents are hostile towards workers. This makes establishing the trusting relationship that is necessary to facilitate change very difficult. Another worker from a different agency who was not involved in the removal of the child would not have the same difficulties in establishing a supportive and trusting relationship with the parent.

FEATURES OF THE NEW DEPARTMENT

The remainder of this chapter sets out:

- how the new department would interact with non-government organisations (shared care agencies)
- what placement options there would be available — such as residential care, therapeutic care, foster care, respite care, and voluntary care
- the foster care protocols — such as recruitment, screening, training, support and remuneration
- the necessary casework, including the involvement of parents, children and carers

- long-term planning options — such as reunification versus permanency planning, relationships with biological parents and guardianship order options.

INTERACTION WITH THE NON-GOVERNMENT AGENCIES

Because the current dual system for providing foster and alternative care services would continue with the introduction of the new Department of Child Safety, the DCS would have an important role to play in identifying clients' needs and establishing sound working relationships with non-government agencies.

Identifying the need for new services

With sound record- and data-keeping procedures, the new department would be able to better identify areas where there are specific needs for particular services. Therefore, the DCS could take the initiative by inviting tenders for these identified services, rather than following the current reactive approach taken by the Department of Families. Currently, the Department of Families is working towards having non-government organisations propose new services; this would include proposing how, where and to what level the new services would be provided (consultation with Department of Families Acting Director, Finance and Asset Management, 2 October 2003). Having the DCS take the initiative for new services would accord with its lead agency status in relation to child protection.

Similarly, the DCS would need to consider the types of shared care agencies required to provide the diverse range of services necessary to meet the needs of children and their families. Staff from Families stated their view that many agencies were only interested in taking the 'easy' cases; they were unwilling to accept more challenging children, which left Families with an over-representation of the most difficult cases. These difficult cases are then typically assigned to departmental carers (confidential consultation 2003). Therefore, it is important to have either a selection of shared care agencies catering to different children (which includes sufficient agencies that 'specialise' in placing difficult children), or to have agencies that will accept both the easier and the more challenging cases. Decisions about funding for agencies should be related to the needs of the children requiring care.

Relationship between the DCS and non-government agencies

In the proposed new system, non-government agencies would continue to provide out-of-home child placement services; hence, the relationship between the DCS and these agencies will be of crucial importance in delivering effective services to children and their families.

According to some agencies, the Department of Families has not always cultivated good relationships with the non-government sector (CMC 2003). Staff from the agencies often complain that the department is defensive and has developed a 'siege mentality' where they view and treat workers from non-government agencies as the enemy (confidential consultation). Some agency staff spoke of their desire and efforts to work collaboratively with the department, and their impression that such efforts had often met with resistance.

There was also concern expressed by agency representatives that there was not always transparency in the department's decision making.

The department was seen by some as imposing standards of service on the agencies that it did not observe itself (confidential consultation 2003). It is important that the new DCS develop and maintain sound working relationships with the agencies and work in partnership to achieve better outcomes for children in need of alternative care.

Initiatives that would facilitate such relationships between DCS staff and agency workers should be given a high priority, as many agencies pointed out that their workers' training needs are not currently being met (confidential consultations 2003). In the interests of collaboration and the most efficient use of resources, DCS and agency workers should wherever possible attend joint training.

A likely additional difficulty for the DCS in establishing good relationships with the non-government agencies will be in negotiating the dual roles of partner and funder. This will be a difficult balance, given the inherent power held by the DCS as the provider of resources to agencies. The Inquiry was told by some agency representatives that this situation was often not handled well by the Department of Families, and that, during negotiations with non-government agencies about particular cases, some Families staff often made comments such as 'Don't forget where your funding is coming from' (CMC 2003, p. 369). These comments were perceived as threats designed to have them acquiesce to the department's wishes. Such comments do not help build the sorts of working relationships with non-government agencies that are essential for better outcomes for children. The issue of working effectively and appropriately in partnership with the agencies would need to be taken up in DCS staff training.

PLACEMENT OPTIONS

The Inquiry heard evidence from several sources that the range of placement options for children taken into care is inadequate in Queensland, with the result that currently there is a crisis in the provision of alternative care for children (FCQ submission). There are often few opportunities to match the child's needs with the appropriate service (PeakCare submission). Further, the Inquiry heard that there are insufficient foster care, or residential facility, places to accommodate the needs of all these children and young people.

Consequently, significant numbers of children are homeless, or seeking emergency or other temporary accommodation, or continuing in at-risk situations (PeakCare submission). 'Natasha', who is a former foster child, told the Inquiry that some children commit offences to be sentenced to juvenile facilities as a method of obtaining a reliable source of food and shelter (CMC 2003). For example, children as young as 12 or 13 are being placed in crisis shelters; the 2001 annual report of Youth Emergency Services (cited in Department of Families and PeakCare Qld 2002) states that 38 per cent of its service users were either under protective orders, or the subject of child protection follow-up by the department.

There has been a decline in residential placement options since the Forde Inquiry uncovered systemic child abuse in many large-scale institutions. Consequently, for those children and adolescents who are unable to tolerate typical foster care placements, there has been an increase in expensive, individually funded packages, or some are given temporary accommodation in motels or caravan parks. For example, in 2001–02, 63 children received funding under the Children with Disabilities in Care program at a cost of $4.3 million (PeakCare submission). These individual care packages and temporary arrangements often only provide children with either short-term services (PeakCare submission) or simply meet their immediate accommodation needs. They would seem to reflect a lack of adequate planning to meet the long-term care and support needs of these children.

While home-based foster care will remain the preferred placement option for many children, the Inquiry heard repeatedly that foster care is not suitable for all children and there is a need to increase the choice of possible placement options to meet the diverse needs of children coming into care. As Barber and Gilbertson (2001) have pointed out, the needs of children are variable and complex and best practice should always begin with an assessment of each child's suitability for a particular placement. Therefore, they find it worrying that the trend in all states has been to narrow the scope of possible placement options, relying more and more on conventional, family-based foster care. For example, in 2002–03, 2152 children were admitted to alternative care with 1596 placed with approved foster carers, 230 with relative carers, 174 with limited approval carers, five in residential facilities and 147 in other placement types (communication from Department of Families 2003).

However, traditional foster placements may not meet the needs of adolescents or children with severe behavioural or mental health problems. For example, more

independent living arrangements, such as supervised, small group homes, may suit adolescents who often have difficulties finding stable foster placements. To quote one adolescent who spoke to the Inquiry about why she did not want another foster placement, 'I don't do families' (confidential consultation). From her perspective, her previous negative experiences within family contexts had convinced her that this was neither a safe nor a desirable placement option for her. Without the provision of suitable placements that meet the needs of individual children and adolescents, they are more vulnerable to inappropriate placements and subsequent placement breakdown.

Recommendations

7.2 That the placement needs of children and adolescents in care be identified and a broad range of options — including foster care, residential services, family-group homes, therapeutic foster care, intensive support, and supported independent living — be provided to best meet the needs of individual children.

Reason: It is important that services match the specific, identified needs of children. Currently the placement needs of children and adolescents are not being adequately met, with some young people being forced to live in unsafe or unsuitable accommodation.

7.3 That the effectiveness of these placement options in meeting the needs of different groups of children and young people be evaluated.

Reason: Case planning should aim to match the child's characteristics with the type of placement option that evidence suggests is most likely to meet their individual needs. Acquiring information on the efficacy of particular placement options for children and young people would help to facilitate matching between children and placements, which would lead to less placement breakdown and better outcomes for children.

Residential care

Recently there has been a reappraisal of the role of residential care as a placement option for children in need of alternative care. Although there is a widely held belief that family-based care is the best option for children requiring out-of-home care, research has found that children in foster and residential care have comparable outcomes in relation to health and wellbeing. However, different types of children are more likely to thrive in particular types of placements. Regular foster care is more successful for younger children without clinically significant levels of disorder, whereas children and adolescents with major behavioural and emotional disorders may require specialist treatment foster care, family group homes, or, for those who cannot tolerate intimate contact with a foster carer, a residential placement in a more specialised facility. Residential care may also be the best placement option when there are sibling groups who will need to be separated if they are to be placed in traditional foster care (Department of Human Services [Vic.] 2003b).

Despite this unmet need for residential placement, there has been a continuing decline in the provision of residential facilities. According to PeakCare, in the 1970s there were 61 church-based residential care facilities in Queensland, while in 2003 this had been reduced to 20 residential care services, with 12 staffed by 'house parents', seven by youth workers, and one with both types of staff (PeakCare submission). Only about 1 per cent of children are currently accommodated in residential facilities, with only five children who entered care in 2002–03 placed in a residential care facility (data provided by Department of Families 2003). The CMC was advised that, consequently, funding for these services has been neglected, and no services receive sufficient funding to provide the intensive, specialist intervention that many young people require (PeakCare submission). When a recent independent external evaluation of residential care facilities was conducted as part of licensing Queensland care services, only 6 of 21 residential care services met, or substantially met, the 'standards of care' set out in the Child Protection Act. This ongoing neglect of residential care was further reflected in interviews with young people in residential

services and their parents. Forty-two per cent of the young people and 52 per cent of the parents reported that services needed improvement (PeakCare submission).

It is important, therefore, to:

- identify the numbers and types of children who require residential services, and the appropriate locations for new services
- ensure that standards of care are met and regularly monitored within residential placements
- employ professional staff who have been appropriately assessed for their suitability for employment
- ensure that children's welfare is regularly monitored by their caseworker, and any concerns or allegations are bought to the attention of relevant DCS staff for prompt and thorough investigation.

In relation to the type of residential placements required, smaller group homes are more likely to benefit most children than are larger-scale institutional care facilities, which have already been shown to create potentially dangerous situations for young people.

RECOMMENDATION

7.4 That the Department of Child Safety:

- identify the extent of the need for residential care services
- identify the type of children who would most benefit from these services
- develop service models that meet children's needs in this area
- identify the skills and training required by staff
- monitor and evaluate residential care services.

Reason: There are significant numbers of children who do not benefit from placement in traditional foster care and require placements in residential facilities.

Therapeutic care

Children who are entering care are more likely than other children to suffer from varying degrees of emotional and behavioural problems. Many submissions and consultations informed the Inquiry that children were often not receiving the treatment they required. While some of these children may still be appropriately placed in a traditional foster care home and receive outside treatment, for others the severity of their dysfunction necessitates therapeutic care.

In accordance with the whole-of-government focus on child protection outlined in this report, the Commission considers that it will be necessary for government to look at existing skill bases in the government sector that can provide therapeutic care. It should be an aim to draw such services primarily from that sector rather than from private providers. Queensland Health would be one obvious contributor.

One option for therapeutic care is treatment foster care, which has been found to be successful in the United States. The most thoroughly researched and evaluated model is the Multidimensional Treatment Foster Care (TFC) developed at the Oregon Social Learning Centre in the USA. This approach is a form of behavioural family intervention, described as family-centred, multi-component and multi-systemic (Chamberlain 1996). It focuses on the mediating role that parenting practices have on outcomes for children in foster care (Fisher & Chamberlain 2000) and involves training foster parents to provide daily treatment to high-risk adolescents placed in their care. Daily treatment is augmented by six other intervention components including: individual therapy, family therapy with the biological family, regular school consultations, psychiatric consultation as needed, and case-management coordination. TFC is an individualised, flexible service approach, which tailors the components and intensity of training to the individual needs of the child and foster family. In this way it is able to treat a wide range of clinical problems and needs.

TFC carers receive additional payments. Pre-service training is based on evidence-based parent training and requires 20 hours of training for foster parents prior to having an adolescent placed in their care. The training is both didactic and experiential. Ongoing consultation with a case manager, trained in both social learning parent training and developmental psychopathology, is an integral part of the TFC model. As foster parents provide the majority of direct treatment to the adolescent, the role of the case manager is to keep foster parents motivated and maintain treatment integrity. This is provided in the form of weekly group meetings with other foster parents and daily telephone contact.

The program content covers:

- reinforcing normal age-appropriate pro-social behaviours
- closely supervising children
- closely monitoring children's interactions with their peers
- using clear and specific limits and disciplinary consequences
- developing good work habits and academic skills
- supporting biological family members to improve their parenting skills
- decreasing family conflict between family members
- teaching the child or youth skills for forming satisfying relationships with peers and for bonding with adult mentors.

A review of TFC by Meadowcroft, Thomlison and Chamberlain (1994) showed that compared with control conditions TFC results in:

- longer placements, and fewer disruptions to placements
- better retention of foster parents
- 60–89 per cent of children discharged to less restrictive settings, such as their own homes, adoptive homes, or living on their own
- less involvement with the law, including fewer arrests
- less use of illicit drugs
- higher self-esteem and increased social competence
- increased sense of identity and personal worth
- reduced incidents of serious behaviour such as aggression, negative peer contact and truancy.

Although TFC was originally developed and evaluated for adolescents from the juvenile justice system, the program has been adapted to meet the needs of maltreated preschool children (Fisher et al. 2000). Consistent with the research with adolescents, it was found that carers adopted and maintained effective parenting strategies and there were consequent improvements in children's behaviour. When comparisons were made between TFC and children in typical foster care, the children in the typical foster care group demonstrated decrements in functioning in several areas. Also the stress levels of foster carers in the intervention group decreased during the intervention, whereas typical foster carers' stress increased.

Effective components of TFC have been investigated. Chamberlain (1996) compared its enhanced training and support and additional monetary compensation for the associated costs, with increased payment alone and with foster care as usual. The enhanced group showed significantly more stability in their placements and fewer problem behaviours in the children than in the other two conditions. Significantly fewer carers in the TFC group dropped out of providing foster care during the subsequent two years.

Providing enhanced support and training, in the form of weekly group training and brief telephone consultations three times a week, plus an increased payment to compensate families for the additional time and expense (e.g. transportation and child care) involved in participating in the enhanced services, resulted in significantly greater retention of foster carers over a two-year period, compared to just increasing

compensation for foster care (Chamberlain, Moreland & Reid 1992). The costs in implementing the program were offset by retaining more foster families in the system and increasing the skills of foster parents to deal with more complex problems.

Both interventions significantly increased the amount of time children stayed in their foster home, and the enhanced training and compensation resulted in a significantly larger number of children remaining in the foster home. Foster parents expressed high levels of satisfaction, accomplishment and appreciation for being acknowledged and valued as part of a professional team (Chamberlain, Moreland & Reid 1992).

Another trial of an early intervention program for children on entry into foster care was found to improve children's behaviour and improve foster carers' use of positive parenting strategies. Improvements were found in the intervention group, whereas children in regular foster care showed decrements in functioning in several areas.

Despite this evidence indicating the value of therapeutic placements, and the increasing needs of children for these types of services, currently there are limited services available to meet this need in Queensland. For example there is only one recurrently funded agency that provides intensive family-based services for 25–30 young people in South-East Queensland, and one Brisbane-based service, which is being piloted for one year (PeakCare submission).

RECOMMENDATION

7.5 **That more therapeutic treatment programs be made available for children with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated.**

Reason: There is a clear unmet need for therapeutic services for children in care. Research shows that placement breakdowns because of children's behaviour point to a need for therapeutic intervention. During case reviews, children who are experiencing difficulties in traditional foster care placements should be identified (e.g. more than two disruptions because of the child's behaviour) and, where appropriate, should be either provided with therapeutic interventions or transferred into therapeutic care.

Foster care

As already noted, foster care is currently the major source of placements for children who need to be removed from their families in Queensland. The low levels of non-family-based or residential care options causes immense pressure on the foster care system. Of the 4380 children in care at 30 June 2003, 3979 were in some form of foster or relative care (data provided by Department of Families).

If the state removes children from their biological family, it has an obligation to provide a better standard of care for the children than was available in their original home and to help the children achieve a better future than would have been possible had they remained in the care of their families. When children are removed from their families, it is widely accepted that a nurturing, supportive, family environment provides the most beneficial context for the care of the majority of children and adolescents. In Queensland, there are three types of foster carers: approved, limited approval and relative carers. Children placed in foster care families may either be on a child protection order or be placed with parental consent (voluntary placement).

Typical foster carers

As at September 2003, there were 1485 approved foster carers in Queensland. Of these 133 were male and 1372 were female; 107 carers identified as Indigenous (Queensland Government 2003).

Of the 1485 foster carers, 869 had children placed with them in September 2003, leaving 616 with no child placement. A total of 317 children were placed with 183 limited approval carers, and 1094 children were placed with 615 relative carers.

Table 7.1 shows that the number of children placed with approved foster carers has

more than doubled in the last ten years from 1071 in 1993 to 2568 in 2003. As the rate of children being placed with approved foster carers has increased at a greater rate than the number of approved carers entering the system, the average number of children placed with an approved foster carer is up from 2.05 children in 1993 to 2.96 children in 2003.

Table 7.1. Number of foster carers with placements and number of children with foster carers, Queensland, 1993–2003

Year	Total foster carers	Foster carers with placements	% of foster carers with children	No. of children with foster carers	Children per foster carer
1993	1571	522	33	1071	2.05
1994	1565	554	35	1200	2.17
1995	1612	565	35	1215	2.15
1996	1140	596	52	1344	2.26
1997	1278	613	48	1490	2.43
1998	1330	664	50	1529	2.30
1999	1365	678	50	1691	2.49
2000	1385	710	51	1791	2.52
2001	1427	776	54	2062	2.66
2002	1429	798	56	2226	2.79
2003	1485	869	59	2568	2.96

Source: Department of Families 2003 (unpublished data).

Current screening/selection monitoring processes for foster carers

Schedule 3, section 3 of the *Child Protection Act 1999* specifies that an approved foster carer is a person who holds a certificate of approval; this is issued by the Department of Families. The categories of relative carers and limited approval carers are created by departmental policy. The department defines a relative carer as a person related to a child, or a member of a child's community whom the child looks on as family or a close friend (policy no. 293-1, Assessment and Approval of Relative Carers). The department defines a limited approval carer as a person who has not been fully assessed or trained but is approved to care for a particular child or young person, for a specific purpose, for a defined period (policy no. 292-1, Assessment and Approval of Limited Approval Carers).

Approved foster carers

Before approving a person to be a foster carer, section 133 of the Child Protection Act provides that the chief executive must be satisfied that:

- the person is a suitable person to be an approved foster carer
- all members of the applicant's household are suitable persons to associate on a daily basis with children
- the applicant is able to meet the standards of care in the statement of standards
- the applicant is able to help in appropriate ways towards achieving plans for a child's protection.

The term 'suitable person' is defined in section 9 of the Child Protection Regulation 2000 as a person who:

- does not pose a risk to the child's safety
- understands, and is committed to, the principles for administering the Child Protection Act

- has completed any training reasonably required by the chief executive to ensure the person is able to properly provide the care
- understands the policies and procedures implemented by the chief executive to ensure the care meets the standards of care in the statement of standards.

The statement of standards is set out in section 122 of the Child Protection Act (see also Chapter 1 of this report). The statement of standards prohibits the use of corporal punishment, or any punishment that humiliates, frightens, or threatens the child in a way that is likely to cause emotional harm.

There are six steps in the process used by the Department of Families for assessing the suitability of a person to become a foster carer. These steps are specified in the department's policy no. 288-1, Initial Foster Carer Assessment and Approval:

- completion of an application form
- completion of a training course which may be provided by departmental staff, by the staff of funded agencies, or by contracted fee-for-service human services professionals
- suitability checks, which involve obtaining the applicant's criminal history, domestic violence history, traffic history, and child protection history with similar checks also completed on other adults living in the applicant's household
- referee checks
- medical information
- a written assessment containing a recommendation on whether applicants should be approved as a foster carer and including information on:
    1. the outcomes of history checks, and the responses/comments of the applicant in relation to them; participation in training, both from any written assessment materials and from the observations of trainers
    2. other reports and assessments which the applicant is able to provide, including information from other jurisdictions if the applicant has been previously approved to provide foster care
    3. observation of the applicant, family interactions, the physical home etc., both in interviews and in any other interaction with the assessing agency or departmental staff member
    4. any pro-formas or self-assessment tools used by the agency or departmental worker conducting the assessment.

Applicants are also given the opportunity to comment on information in the assessment report, which is then sent to the area manager who decides on the suitability of a person to become an approved foster carer. If a person is granted approval, the department issues the person with a certificate of approval to have effect in the first instance for one year. Section 135 of the Child Protection Act specifies that, after that, certificates of approval are to be renewed every two years.

While records of foster carers should be available from the central child protection database (CPIS), the database does not currently provide accurate up-to-date information, because not all data are entered promptly. There is no separate, easily accessible central registry of carers and their placements. Because of this limitation, it is difficult to quickly obtain accurate, up-to-date data on the exact number of carers, their status, and the children placed in their care. For example, although there are not enough carers to meet the placement needs of children requiring care, data provided by the department suggest that in September 2003 there were a large number of inactive carers, with 616 of the total 1485 approved carers without a foster placement. This is surprising, given the reported shortage of carers and the large numbers of children who are placed with other carers. Foster Care Queensland suggested that carers may choose, for personal reasons, to take some time out before accepting a further placement. Furthermore, the numbers may not be accurate, as there is evidence of poor record-keeping of the current status of carers and their placements by the department. Also, the Queensland Public Service Union (QPSU) told the Inquiry that some carers may not have placements because of concerns about the quality of care children have received in their homes (CMC 2003). Sometimes (as illustrated by the evidence in Operation Zellow — see Chapter 2), such concerns are

not formally noted by the officers, which creates a potentially dangerous situation where another worker may unknowingly place children with these same carers. However, given the large numbers of inactive carers involved, it is unlikely that more than a very small proportion of these carers are of questionable ability.

On the other hand, many carers suggested that they are often left without placements if they have been involved in disputes with the department. Several carers reported that carers who complain get denied placements or threatened with having their current children taken away from them: 'You are seen as a "trouble maker".' (Australian Foster Care Association 2003)

Recommendations

7.6 That a central registry be set up containing details of all carers, children currently in their care, and their availability for further placements. The registry should flag when carers are due for reapproval, whether they have been denied their initial approval or reapproval, and whether they have been, or applied to be, a carer in another state. Also, it should be possible for staff to search the registry by region, so that they can easily obtain an up-to-date list of carers and placements in their area.

7.7 That an audit of all current carers be conducted to obtain up-to-date data and determine their availability for placements.

Reason (7.6 and 7.7): The current data provided by the Department of Families demonstrate that up-to-date records of carers and placements are not easily accessible. Because children are in the care of the department, there is an obligation to keep these data and use the system to improve efforts to monitor the foster care system.

Respite care

In Queensland, respite care is available for children who are currently in foster care placements. During respite, children are temporarily placed in the care of other adults. Respite can be seen as meeting the needs of children for relationships with other appropriate adults, and also has the added benefit of providing carers with temporary relief from the stresses of caring.

Respite care has always been conceptualised as respite for the child, to remove any possible perception of rejection on the part of the children in care (PeakCare submission). However, the availability of regular respite services should be recognised as essential to give carers a break from the daily stresses of caring for children and thus to minimise the chances of dysfunctional parenting and placement breakdown. Currently, many carers have little or no access to formal respite (FCQ submission). A survey of non-government agencies found that only 15 per cent had received funding for providing respite services (Australian Foster Care Association 2003).

Access to appropriate respite for foster carers is essential to prevent carer burnout and placement breakdown. Currently foster carers do not receive any leave entitlements so there is no provision for regular holidays or any access to respite in times of illness or crisis (FCQ submission). Some pilot programs have been initiated in Queensland, but, according to Foster Care Queensland, these have been only moderately successful. Access to regular, planned respite is essential for the operation of a successful foster care system that retains carers and improves children's wellbeing. Currently the government is proposing to include a provision for respite in the initial placement planning process (Queensland Government submission). Alternatively, specific times during the following year could be identified for respite as part of the child's case plan.

The Commission considers that it is essential that the department identifies new and creative ways of recruiting respite carers. For example, Foster Care Queensland has suggested using the family and friends of current foster carers as sources of respite. They could be assessed as limited approval carers, which would have these advantages: (a) they would already have relationships with the children and (b) they could possibly care for the children in the foster carer's home so there would be no

need for the children to be displaced. This solution could be trialled and evaluated and, if successful, implemented on a larger scale.

Recommendations

7.8 That the DCS identify and implement new methods of recruiting respite carers.

7.9 That additional efforts be made to identify alternative respite options for children that could improve children's wellbeing, for example regular camps and school holiday programs.

7.10 That, to prevent carer burnout and limit placement breakdown, planned respite for carers be 'routine' and not have to be requested by carers. Plans for respite could be included in the child's case plan.

Reason 7.8–7.10: The provision of adequate respite services is essential to maintain a viable foster care system which retains carers within the system and is therefore able to provide children with the stable placements they require for their continued wellbeing. Respite can also be seen as an opportunity for increasing children's social support network and exposure to strong adult role models.

Voluntary care

Currently, when concerns about the abuse or neglect of a child are identified, the parent may consent to have their child placed in care (parental consent placements). Departmental policy (policy no. 345-2, The Placement of Children and Young People with Parental Consent) provides that these voluntary placements can occur if the following criteria are satisfied:

- The placement is necessary to meet the child's protective needs.
- The proposed placement does not introduce new child protection concerns.
- The parents are responsible for the harm to the child and acknowledge their culpability.
- The parents are assessed as able and willing to cooperate in protecting the child by consenting to the placement and agreeing to meet the terms of departmental intervention.
- There are no high-risk factors associated with the parents' ability to adhere to the planned intervention.
- The termination of the placement by a parent would not immediately endanger the child.

The preferred option is to place the child with a relative. This may be a family member or a person known to the child within their community network who is then classified by the department as a relative carer. The parent retains responsibility for the child and therefore makes private arrangements with the carer for the financial support of the child. If the proposed carer requires financial assistance from the department to care for the child (e.g. the parent is unable or unwilling to provide financial assistance, or the person cannot provide the placement without this additional support), the carer can apply to the area manager. In this situation the person is then required to be assessed as a relative or limited approval carer. Following a successful assessment, the carer is initially paid a fostering allowance for up to 28 days, even if the placement duration is longer. An extension of the payment beyond the 28-day payment period can only be granted by the Executive Director, Operations. Relative carers who are not assessed cannot be paid a fostering allowance (policy no. 345-2).

If there is no suitable relative or community member available to care for the child, they can be placed with an approved foster carer or licensed care service for up to 28 days. In this circumstance the carer or service is paid. Extensions to the child's placement beyond 28 days can only be granted by the Executive Director, Operations. In contrast, voluntary placements with relatives have no time limit.

In Queensland, unlike other states, voluntary care agreements are not regulated by the Child Protection Act. There are specific consequences of this lack of regulation:

- When children are placed with relatives or members of their family or community network, departmental policy states that assessments of the carer are needed only if the carer is applying for payment. There is no requirement to assess the suitability of a person acting as an unpaid carer.
- Certain safeguards in the Act do not apply (e.g. six-monthly review of placements, standards of care [s. 122] do not apply).
- The Children Services Tribunal and Commission for Children and Young People have no jurisdiction over voluntary placements.
- There is a lack of recording of relevant information by the Department of Families, which appears to have scant information on most voluntary arrangements.
- Area offices are not funded for the costs associated with voluntary placements, and any related casework is not 'counted' in head office figures.

The Commission considers that voluntary placements should be regulated under the Child Protection Act and that Queensland should look to legislation in other Australian states for guidance in setting the scope and conditions of such placements.

RECOMMENDATION

7.11 That the *Child Protection Act 1999* be amended to regulate voluntary placements.

Reason: Statutory protections available to children in foster care should be extended to voluntary placements.

FOSTER CARE PROTOCOLS

Within the DCS, foster care placements will remain the most important option for children coming into care. All of the evidence indicates that the current foster care system is operating inadequately, with not enough carers for the number of vulnerable children. There is a difficulty in recruiting and retaining carers within the system, and non-government agencies (PeakCare submission) and carers (Australian Foster Care Association 2003) report persistent difficulties in their relationships with the Department of Families. It is necessary to have regard to the current foster care system, and its problems, in order to devise possible solutions to the current crisis-driven method of practice and to produce an effective, efficient foster care system that facilitates sound, long-term outcomes for vulnerable children and recognises the valuable contributions made by the majority of foster carers in the lives of these children.

As noted in Chapters 2 and 3, during the CMC's consultations with former and current foster children we heard of experiences in foster care that covered a continuum from horrific cases of sustained abuse to accounts from young people who acknowledged the love and support of their foster carers and spoke of the major contribution they had made to their lives. These particular children saw their foster carer as someone who had provided them with a promising future. They particularly emphasised how important it had been to become a member of the family.

Certainly, although significant numbers of children have bad experiences in care, many foster children are satisfied with their foster placement. Indeed, a recent South Australian study found that the majority of foster children in that state (80%) were satisfied with both their placement and their individual case worker (Delfabbro, Barber & Cooper 2002).

Certainly, foster parents who are skilled and supported can have a powerful influence for good on the development of children in care. While the adverse physical, behavioural, emotional and developmental effects of abuse on children have been

well documented (Herrera & McCloskey 2003; Hodges et al. 2003), the adverse consequences of children experiencing abusive early parenting can be partially ameliorated through subsequent exposure to a stable, nurturing and responsive environment. Such an environment is essential for the normal development of children in foster care (Dozier et al. 2002).

Yet many children in foster care do have behavioural, social, emotional and learning difficulties. They often have problems in forming attachments with foster parents, siblings and peers. The high prevalence of behavioural and emotional problems including conduct disorders, oppositional defiant disorder, ADHD, post-traumatic stress disorder, depression and obsessive-compulsive disorder in foster children can result in extremely challenging, disruptive and sometimes violent behaviours that require special skills and patience on the part of foster carers. Foster care of abused and neglected children is a specialised and demanding role that requires knowledge of, and sensitivity to, the special needs of vulnerable children (Roberts 1993). The high expectations placed on foster families to meet the needs of children in care requires that particular attention is devoted to the selection, assessment, preparation, training and support of foster parents so that parents have the skills they need to undertake the task.

Recruitment

Currently, recruitment of carers is done by both the Department of Families and non-government shared care agencies. The current profile of Queensland carers is of an aging population with significant numbers of carers being in receipt of pensions or benefits, or on low incomes (Queensland Government submission). The lower socioeconomic status of many carers places them under additional financial stress, and children in their care are more vulnerable to maltreatment (McFadden & Ryan 1991). Like other states and countries, Queensland is facing continuous difficulties in the recruitment and retention of carers.

Consequently, while recruitment will remain a joint responsibility for the new department and non-government agencies, specific initiatives will be required to increase the number and diversity of foster carers, to devise more efficient screening procedures to identify carers who are likely to be retained by the system, and to avoid cumbersome and poor processes that lose potential recruits because of a failure to follow up initial inquiries (Barber & Gilbertson 2001). For example, there is a fostering group set up at Harvard University in the United States that recruits carers from the university community.

Foster carers themselves have been found to be an important source of potential recruitment in Kent, United Kingdom, with carers paid a bounty for introducing friends who go on to become foster carers (Barber & Gilbertson 2001). When the system becomes more effective (that is, when the majority of carers start reporting high levels of satisfaction with the new system), foster carers could serve as potential recruiters. At present, with the current high levels of carer dissatisfaction, it is unlikely that many carers would be willing to recruit friends.

Currently, screening takes so long that many potential carers lose interest before they are contacted by the department (FCQ submission), or screening is not particularly efficient, which results in an unnecessary expense to the system. For example, one agency reported that they do a brief screening process, then train applicants, and then typically accept only about 5 per cent of those they have already trained as foster carers.

Recommendations

7.12 **That initial screening mechanisms be more efficient and rely on identifying the characteristics that are associated with continuing in foster care and providing good outcomes for children.**

7.13 That efforts be made to recruit a more diverse group of carers, rather than continuing to concentrate recruitment efforts in lower socioeconomic areas.

7.14 That the DCS identify areas of high, unmet need and initiate recruitment drives to obtain more carers for specific types of children. Recruitment drives can be directed to areas of high need and focus on recruiting carers who can meet the needs of specific groups of children (e.g. teenagers, or children with special needs or challenging behaviours).

Reason (7.12–7.14): It is necessary to improve recruitment efforts to enlist foster carers as there are not enough carers in the current system to match the needs of Queensland children.

Selection

It is generally recognised that a thorough selection process for foster carers is fundamental to the provision of quality care to children. An assessment of prospective carers typically includes taking a family history (including criminal and child protection histories), and then assessing family interactions, parenting skills and motivation to provide care. A thorough assessment allows appropriate decisions to be made about the selection of suitable people to care for foster children, and may also result in more satisfactory matches between children and carers (Child Welfare League of America 2003).

Assessment of potential foster carers should include a comprehensive investigation of individuals, using information from multiple sources. These can include interviews, written statements, references and valid and reliable self-report measures of the potential of families to provide quality family foster care (e.g. the Foster Parent Potential Scale, Orme et al. 2003), as well as parenting style (e.g. the Parenting Scale: Arnold et al. 1993), relationship quality (e.g. the Relationship Quality Index: Norton 1983), and personal adjustment (e.g. DASS: Lovibond & Lovibond 1995). Selection of foster carers should include not only knowledge of key areas but also, in the case of parenting skills, case vignettes or hypothetical scenarios. These could be incorporated into the process to elucidate whether prospective carers can solve difficulties that may arise with a child placed in their care.

Decisions about approval

Under the current system, when agencies recruit carers, they typically conduct the assessments and then make recommendations to the Department of Families, which normally accepts these recommendations. The current process and the lack of evidence of further inquiry by the department suggests that it 'trusts' the agency has completed a thorough assessment.

As the proposed DCS will maintain a statutory responsibility for approving foster carers, it should have responsibility for the final assessment process for carers. It will, therefore, be important to consider the benefits of alternative approval models. For example, one submission to the CMC outlined a process in the United Kingdom where there is a clearly outlined assessment and reporting process (e.g. number of visits and interviews required with prospective carers; material discussed). Final approval decisions are made by a 'panel' of professionals and the carer is given a specific approval for a particular number of children of certain ages and genders (Watson-Hunt submission). While it is well known that to achieve placement stability it is better to match children with carers, this is often not possible because of the current limited carer population. This type of specific approval system would represent a beginning of efforts to match children and carers more satisfactorily, at a very basic level.

Recommendation

7.15 That the DCS be responsible for the final approval of foster carers. Special attention should be focused on processes that give carers specific approval for numbers and types of children.

Reason: There is a need to consider alternative approval processes that may provide a more thorough assessment of carers, which will increase the likelihood of successful placements for children and carer satisfaction. Processes that give specific approval could be used in initial efforts to match children with carers.

Retention of carers

Foster parenting involves a level of stress that is considerably greater than that typically experienced by other parents, which makes the recruitment and retention of carers a challenge to all child protection systems. Many prospective foster parents discontinue their involvement. One study found that 50 per cent of families who began pre-service training did not complete it, and a further 46 per cent who completed training either discontinued, or planned to discontinue fostering within six months of training (Rhodes et al. 2003). The proportion of families who voluntarily decide to discontinue with fostering prior to approval is much larger than those who are rejected (Kadushin & Martin 1988). Therefore, it is important that reliable measures are used to identify the qualities of carers associated with the provision of effective foster care.

For example, some evidence shows that the level of family resources predicts continuity in foster care. The greater the number of resources a family has (e.g. higher education, higher income, being married, having time for fostering, having parenting and fostering experience, belonging to a place of worship, having social support, working in a helping profession), the greater the probability of the family continuing fostering six months after training (Rhodes et al. 2003). Using emotional stability and parenting skills as key selection criteria in selecting foster carers also results in much higher retention rates of foster carers than normal selection processes (Chamberlain 1996). Foster families with fewer psychosocial problems experience fewer difficulties caring for children with behavioural and emotional problems and are therefore less likely to cease fostering (Rhodes et al. 2003). Homes that provide a wide range of stimulation and demonstrate interactive parenting styles result in more favourable developmental outcomes for children in foster care (Smith 1994).

Research into the personal characteristics of successful carers has shown that these characteristics are very similar to those that tend to predict good developmental outcomes in any child (Chamberlain 1996). They include wanting to be, and enjoying being, a parent; mothers in particular having realistic expectations — hardy, but sensitive and responsive to children's needs; being good disciplinarians; and adopting an authoritative rather than an authoritarian style of parenting. (An authoritative parent uses assertive discipline within the context of a warm and supportive relationship with the child.)

Other personal characteristics that predict success as a foster carer include motivations based on strong personal needs (e.g. the desire to parent but being unable to conceive, or identification with deprived children because of own past personal experiences); and the emotional maturity to be a supportive parent (Dando & Minty 1987); women wanting a caregiver vocational role as a mother (Sanderson & Crawley 1982); being a single parent or older couple (45–55 years of age); mothers who are able to be realistic, enthusiastic, and make decisions dispassionately (Ray & Horner 1990); and fathers who have 'realistic' vocational interests, who are sensitive, self-sufficient and less rigidly disciplined (Dando & Minty 1987). Carers who have effective social support from partners, friends and agencies are more likely to continue as carers.

Qualities identified by foster carers themselves as important in fostering include emotional stability, high self-esteem, parenting experience and skills, stress-coping skills, and the ability to tolerate children's faults (Redding, Fried & Britner 2000).

Families who drop out prior to, or shortly after, completing the application process are more likely to have income levels lower than the national median. Lack of financial resources has been linked to maltreatment in foster care (McFadden & Ryan 1991). Income support has been identified as the main source of income for one-quarter of foster carers in Australia, while two-thirds of foster carers are not employed (McHugh 2002). The associated costs of caring for a foster child that are non-reimbursed

increases the financial stress on lower income families (Brown & Calder 1999) and contributes to people deciding not to become carers, or to cease being carers (Falconer 1998). This is particularly relevant in Queensland where there is a disproportionate number of foster carers on low incomes or Centrelink payments (Pollock 1998).

Recommendations

7.16 That regard be had to relevant research findings in order to identify the factors that are most likely to result in successful placements, and to use this knowledge to develop practical processes for the recruitment of suitable carers.

Reason: Although it is important to increase the recruitment and retention of foster carers within the alternative care system, it is also important to make these processes more efficient than those that are currently used to enlist carers.

7.17 That structured exit interviews with carers be conducted. This information should be used along with regular surveys of carer attitudes, satisfaction and concerns, and other appropriate research initiatives to identify problems and devise systemic solutions.

Reason: Exit interviews would be a way of learning the particular problems that discourage Queensland carers from continuing to foster.

Relative and limited approval carers

People intending to act as limited approval or relative carers are currently not required to undergo the same assessment and approval process as approved foster carers. Under the Act, information about a limited approval and relative carer's criminal, domestic violence and traffic histories can be obtained and assessed, but only when the child to be placed with the carer is in the director-general's custody and guardianship (s. 95). There is no provision for criminal, domestic violence and traffic histories to be obtained and assessed in relation to a person with whom a child is placed with parental consent.

While approved carers currently undergo a detailed approval assessment, the process for relative and limited approval carers is often different. For example, the level of assessment for limited approval carers varies in accordance with the purpose and timeframes for the placement, and the child or young person's case plan. Many relative carers, because they are frequently acting voluntarily, do not have to undergo the same assessment, review, and monitoring processes. The current departmental system appears to operate on the assumption that children are likely to be 'safe' when they have been placed with relatives, even though those carers receive no training or support, and typically are not monitored. Certainly, from the children's point of view, relatives are likely to be less disruptive to their lives and relationships. In the case of Indigenous children, placement with relatives has the important benefit of maintaining their family and cultural connections.

Several disadvantages to relative care have been noted in the research literature, including:

1. The same dysfunctional patterns that result in the child's parent being unable to provide a safe and nurturing environment may also be present in other family members. Some children have reported being exposed to the same abuse while in the care of their relatives as necessitated their original removal from their parents. Typically there is a less rigorous assessment of placement suitability by caseworkers.
2. Children normally stay longer with a relative and are less likely to be either reunified with their parents or adopted.
3. There is less protection of the child from the abusive parents.
4. There is less caseworker supervision of the child or support to the kinship family.
5. Often relatives provide a lower standard of living than non-kin foster carers.

Several recent reviews have concluded that, while there are commonly held beliefs about the benefits of relative care, there is little evidence supporting this preference for child placements (Department of Human Services [Vic.] 2003b). On the other hand, the Inquiry heard of many cases where caring relatives such as grandparents were selflessly committed to the care of children at risk in their parental home.

Given the evidence before the Inquiry about the very real difficulties experienced in finding foster carers in some Indigenous communities, it is clear that maintaining and promoting relative care is necessary if children at risk in those communities are to find carers.

The Commission supports the view that children subject to child protection orders who are being cared for by relatives should have the benefit of the same safeguards as other children in care. To this end, improved screening, monitoring and training of relative carers is required. It is important that any such initiatives have regard to the special needs of Indigenous communities and not further exacerbate tensions between Indigenous communities and the department.

RECOMMENDATION

7.18 **That a framework be developed for supporting relative care that includes enhanced screening and monitoring of carers and the provision of training opportunities and other support for carers. There should be an extensive consultation process, especially with Indigenous communities, in the development of the framework.**

Reason: It is important that children under child protection orders who are in relative care have the benefit of the same safeguards as other children in care.

Training

Increasingly, foster carers are required to be highly skilled and able to offer specialist care to children placed in their care. However, many foster parents report being inadequately trained to foster effectively. Given the special role that foster parents play in taking care of the most vulnerable children in our community, it is essential that they receive adequate preparation for this job. To ensure children are protected from harm in care, the government and the community at large must be prepared to invest in improving the support available to foster families. This is an investment in the children's futures.

Furthermore many foster parents also feel inadequately supported by professionals in their role. This lack of training and ongoing support has been recognised in many studies as contributing to placement disruptions of children and to foster parents discontinuing (Denby, Rindfleisch & Bean 1999).

Foster carers are more restricted than biological parents when it comes to disciplining children. For example, foster carers are prohibited from using physical punishment on children in their care, in spite of the fact that the majority of biological parents use at least mild forms of physical punishment at times (Minty & Bray 2001). Some foster carers may have found such punishment to be effective with their own children. In the absence of a thorough grounding in alternative strategies, foster parents may find themselves without adequate strategies to use when faced with a difficult foster child.

Therefore, given the high risk of placement breakdown, the additional stresses experienced by foster parents, and the level of behavioural and emotional difficulties in foster children, the establishment of comprehensive, high-quality training programs is essential. A flexible, multi-level, evidence-based approach to training foster parents is required so that foster parents receive the training they need to look after children in their care. This will equip them with skills to cope with the challenges of foster parenting and help them remain active as foster carers. Sanders and Stallman (2003) list these specific parenting skills needed by foster carers:

Basic positive parenting and child-management skills

- Developing good relationships with children
- Increasing appropriate behaviour
- Helping children learn new skills and behaviours
- Dealing with difficult behaviour
- Dealing with high-risk or stressful parenting situations.

Other parenting skills

- Teamwork and partner support
- Stress management
- Attribution training
- Anger management

The more confident parents become, the less likely it is that they will use dysfunctional parenting practices. Foster families must be able not only to provide a safe, secure environment for children unable to live with their biological parents, but be able to deal with challenging behaviours.

The literature on parent training has identified specific aspects of effective training programs.

- Behavioural family interventions (BFI) based on social learning models have the strongest empirical support. There is clear evidence that BFIs can educate parents about ways to promote satisfying relationships with their children as well as in managing a range of problem behaviours including disruptive behaviour disorders (Forehand & Long 1988; McMahon & Wells 1998; Webster-Stratton & Herbert 1994), attention hyperactivity disorder (Barkley et al. 1992), anxiety disorders (Barrett, Dadds & Rapee 1996), and autism and developmental disabilities (Schreibman, Kaneko & Koegel 1991).
- Parenting and family-oriented interventions have also been increasingly used to help educate parents of adolescents at risk of drug abuse, conduct problems and delinquency, depression and chronic illness about ways to handle these problems (Dishion & Andrews 1995; Irvine et al. 1999).
- It is important to use a comprehensive, multi-level intervention model of parenting and family support to provide a level of intensity of parenting support tailored to a family's needs. Group parent training in parenting skills alone without additional support may be inadequate to meet the complex needs of those foster families caring for children who have challenging emotional and behavioural difficulties (Sanders & Markie-Dadds 1996).
- Evidence-based, parent training programs need to run for a minimum of nine hours (McMahon & Forehand 2003; Sanders et al. 2000; Webster-Stratton 1990).
- Trained caseworkers should provide regular ongoing supervision with foster carers to ensure positive parenting practices are maintained and implemented correctly. It is recommended that supervision initially be weekly as foster carers learn to implement strategies and adapt to having the child in their care, and gradually become less frequent as foster carers become more skilled. This is especially important during the first six months, as this is the time when placements are more likely to break down. Caseworkers should also use a self-regulatory approach to help foster carers learn to generalise the use of strategies to new challenging behaviours or problems as they arise, thereby increasing their competency and self-efficacy.
- Foster parents need competency-based training and a system of accreditation that provides appropriate acknowledgment of the time and effort they put in to acquire the necessary skills.
- Effective support for foster parents needs to promote greater confidence and competence. This can be accomplished by increasing foster parents' self-sufficiency to become independent problem-solvers, self-efficacy so they have

more optimistic expectations about the possibility of change, use of self-management skills, and encouraging them to attribute changes or improvements in their situation to their own or their child's efforts rather than to chance, age, maturational factors or other uncontrollable events, and problem-solving skills.

- Training and support of foster parents in how to cater for the specialised needs of children should be individualised to fit in with other competing demands on the foster parent (Burry 1999).
- Individual rather than group sessions may be more appropriate for some families.
- Foster parents need training in developing good communication and negotiation skills to reduce the strain that may result from contact with the child's biological parents.

There are also core areas required in foster care training that focus on meeting the psychological needs of children:

- understanding the effects of different types of abuse on children
- the role of grief, loss and change
- understanding the origins of common behavioural and emotional problems.

A training strategy that enhances foster parents' competence, reduces their use of coercive parenting practices, changes their attributions and promotes teamwork between partners is likely to reduce the family risk factors associated with maltreatment, and increase appropriate emotional care and positive guidance for foster children.

Recommendations

7.19 That all prospective foster carers undergo compulsory training in parenting. All training programs should be evidence-based and undergo ongoing evaluations of their effectiveness.

7.20 That foster carers be required to undergo ongoing training, identified and organised during yearly reviews of the foster carer by their agency support worker. Carers' reapproval should be contingent on the successful completion of this training.

7.21 That there be a tiered, multi-level approach to training and support of foster parents. The level of need of the foster carer and the children in their care should be assessed and the most appropriate level of training and support required should be provided. In this way, carers who deal with more difficult children, or those with special needs, would receive additional, more specialised training.

Reason (7.19–7.21): Currently foster carers are not receiving adequate training for dealing with the challenging behaviour of many children who are entering care. This results in high levels of parenting stress and difficulty in retaining carers within the foster care system, which in turn results in children having more unstable placements. There is a clearly identified need for foster carer training to (i) use evidence-based training programs (ii) specifically include parent training and (iii) include a tiered level of training to match carers' competencies with the needs of different children. Effective training courses will improve carers' skills and abilities to deal with children's negative behaviour and so facilitate satisfying long-term outcomes for foster children.

7.22 That caseworkers be well trained and supervised in evidence-based parenting practices so they can support foster parents with appropriate parenting advice. This training should occur within their pre-service university based courses and through in-service training.

Reason: One of the important roles for caseworkers is to support the foster carers in providing competent parenting to the children in their care. Therefore these workers need to have a thorough understanding of effective parenting practices.

Support

Support is an important issue for carers. When they are adequately supported, they are more likely to be retained in the system, which limits placement breakdown for children. Support for foster carers is multifaceted and includes adequate monetary compensation, parenting advice, access to resources and services, including medical and mental health services, and social support in the form of support groups or mentoring relationships for children.

In the current Queensland foster care system, support for carers varies, depending on both their status as either a government or an agency carer, and the practices of their particular departmental regional office. When compared with departmental carers, agency carers report greater satisfaction with the support they receive from their agencies. A survey of foster carers conducted by the Australian Foster Care Association at its annual conference in 2003 revealed significant problems in the relationship between Queensland carers and the Department of Families. While carers generally saw their family, friends, fellow carers, teachers and other professional, non-departmental staff (doctors, therapists, counsellors) as providing satisfactory support for their roles as carers, approximately 42 per cent were very dissatisfied with the support they received from the department, and only about 18 per cent thought they received a good level of support. In contrast, carers who were affiliated with shared care agencies were generally satisfied with their support from the agency, with only 13 per cent rating it as unsatisfactory. Many carers, and mainly government carers, believed they were not treated with dignity and respect by workers (40% government, 18% agency); were not listened to, involved or kept informed (52% government, 33% agency); not supported and had their calls ignored (48%, 41% agency). They felt that issues were not handled professionally (38% government, 23% agency); and decisions were not made in the child's best interests (38% government, 23% agency).

A clear contrast between government and non-government carers became apparent when carers were questioned specifically about their relationships with their support workers. Agency carers reported they were more likely to be listened to, kept informed and involved in the child's case, their calls and claims were more likely to receive prompt attention, issues were more likely to be handled sensitively and professionally, and decisions were more likely to be made in the best interests of the child (Australian Foster Care Association 2003).

This generally poor relationship between carers and departmental staff is also apparent from workers' ratings of their relationships with government carers. Forty per cent of workers reported that they were not treated with respect and dignity; some felt they were not listened to, or kept informed (52%); that issues were not handled sensitively or professionally by government carers (38%); and decisions were not made in the best interests of the child (38%) (Australian Foster Care Association 2003).

Given the overall poor relationship between many carers and departmental staff, it is not surprising that carers and staff tend to view each other as an obstructive force rather than as an ally in the battle to meet the best interests of children in care. This poor relationship is of particular concern, given that a study reviewing the needs of foster parents found the primary need expressed by foster parents was for good working relationships that involve open communication between parents, department and professionals (Brown & Calder 1999). Carers saw this as integral to their ability to access appropriate services for the children in their care.

The differences between the satisfaction of agency and departmental carers appear to reflect differences in the operation of the agencies and the department. Unlike the department, agencies are often able to offer better support to their carers because they have 'quarantined' resources that cannot be diverted to other tasks (PeakCare submission). They limit the cases they accept, often refusing difficult cases, and are able to limit the number of placements for their carers. In contrast, departmental carers often miss out on support because workers are likely to be overloaded with other more pressing tasks. Because agencies attempt to shield their carers, government carers are also more likely to have larger numbers of children and be given more difficult cases.

RECOMMENDATION

7.23 That conditions and support for departmental carers be enhanced to ensure that they are not disadvantaged in comparison with agency carers.

Reason: It has been suggested that under the current system, departmental carers receive less support in their role as carers and are often given more difficult placements or greater numbers of children.

Improving relationships

Efforts also need to be made to improve the relationships between carers and the department, in order to cultivate a sound working environment where carers and staff are viewed as fellow professionals who make an important contribution to the wellbeing of children in foster care. Foster carers frequently complained that, despite the department's rhetoric suggesting carers were in partnership with it, in practice the attitudes of particular departmental officers were often quite different (Australian Foster Care Association 2003). There are several current departmental policies and procedures of relevance. Such policy needs to be regularly implemented to help address these difficulties and begin to develop a truly collaborative relationship between departmental staff and carers.

Placement meetings and agreements

It is current departmental policy that placement meetings occur between departmental staff and a child's foster carers to set goals for the placement; agree on the differing responsibilities of the foster carer and the departmental caseworker as they relate to the needs of the child; provide information and support to the foster carer; and share information about the child's development and needs (Department of Families policy no. 263-1, Case Management Framework). These meetings are intended to generate an agreement that sets out goals for the placement, how those goals will be met, any arrangements specific to the placement, and what resources are to be provided by the department. Foster carers supported the importance of these agreements, which 'could and should be a useful tool' and are 'very important so everyone knows where they stand' (Australian Foster Care Association 2003).

According to foster carers, there is variability in the application of this policy. Some carers are satisfied that the meetings and agreements clearly fulfil their stated purpose, while others report that they are not always completed on time or not implemented, and still others found they happened only if initiated by the carers. Carers reported that they were simply 'told' what would happen, not consulted about plans or decisions for the child. Many carers saw their involvement as 'tokenistic at best' because decisions had already been made by the department (Australian Foster Care Association 2003). During her audit of departmental case files, Gwenn Murray (CMC 2003) found that placement meetings often did not occur.

Also, many carers complained that they were often given little, or no, information about the child. In some cases this lack of information could put carers and children at risk and had previously resulted in dangerous situations where other children in the home had been victimised by disturbed foster children. According to foster carers, current placement agreements usually give only superficial information that is not helpful in dealing with the child: 'Carers are seen as clients not as partners and therefore not provided with enough information' (Australian Foster Care Association 2003).

RECOMMENDATIONS

7.24 That tools and resources be developed by the DCS to ensure that placement meetings are initiated by departmental staff and completed in a timely manner, preferably before a child is placed with a carer. Carers should be consulted and agreements negotiated by the carers and the DCS, rather than dictated by the department.

Reason: Placement meetings and subsequent agreements are essential for establishing the groundwork for a successful placement. While current policies and procedures do attempt to involve carers in a partnership with the department, their implementation is variable. Involving carers as an active partner in decisions about children in their care will increase carer satisfaction and provide better outcomes for children.

7.25 That, during placement meetings, foster carers be provided with all relevant information about the child. When foster carers accept a child for placement they should be given copies of the child's medical and dental records and the child's Medicare details.

Reason: It is essential that foster carers are provided with all relevant information about the child about to be placed in their care — including information about all dangerous propensities, whether the child has accused other carers of abuse, details of any maltreatment the child has suffered and the child's medical history — so that they can make an informed decision about accepting the placement.

Disclosing confidential information

The CMC heard that the amount of information provided to foster carers and non-government agencies by departmental staff varied, depending on the personal beliefs of the particular departmental officer, so that some FSOs disclosed relevant information to carers and agencies while others refused to do so in the mistaken belief that this would breach confidentiality (confidential consultations).

The collection and handling of personal information by the Queensland Government is, as of September 2001, subject to Information Privacy Principles. However, it must be remembered that the Privacy Principles are government policy and are subject to legislation and the existing contractual responsibilities of agencies (Department of Justice and Attorney-General 2001)

The *Child Protection Act 1999* contains confidentiality provisions and penalties for breaching these; however there are important exceptions. Section 187(3) states that a person (departmental employee, employee of a licensed agency, a foster carer or an AICCA employee) who has acquired information in their employment capacity may disclose information or give access to documents about another person's affairs to someone else where:

- it is necessary to perform the person's functions under the Act;
- the disclosure is directly related to the child's protection or welfare; or
- the disclosure is related to the director-general's function of cooperating with government entities that have a function relating to the protection of children.

The Explanatory Notes to the Child Protection Bill (1998) stated that such disclosure may not be directly related to the protection of the child it concerns, but may also be authorised in relation to the protection or welfare of another child or children (Queensland Government 1998).

Further, section 188(3) provides that where the director-general, police or anyone else in the course of performing duties under the Act gives information to another person about another person's affairs, the receiver of this information must not disclose such information to anyone else. Once again the receiver is exempted from penalty where a disclosure is made and the disclosure was:

- for the purpose directly related to a child's protection and welfare; or
- required or permitted by law.

These provisions are quite clear. If employees are incorrectly citing confidentiality and the privacy provisions as a barrier to disclosure of relevant information, further training is required regarding the legislation.

Given the weight of evidence about apparent reluctance or omissions on the part of departmental employees to share information with carers, it may be beneficial for the Act to also contain specific disclosure provisions that would regulate the new department's obligations in this area.

Chapter 8, Part 2 of the New South Wales *Children and Young Persons (Care and Protection) Act 1998* contains various disclosure obligations that apply to out-of-home care. They include:

- Requiring the agency responsible for the placement of the child to inform the authorised carer of all information that may be reasonably necessary to assist the carer to make a decision whether to accept the placement. (The agency must pay due regard to any wishes expressed by the child or young person concerning the disclosure of information [s. 143])
- Requiring the agency responsible for the placement to provide all information (including medical reports) in its possession concerning a child or young person that may be necessary:
  (a) to enable the authorised carer to provide appropriate care for the child or young person, or
  (b) to ensure the safety of the authorised carer and other members of the authorised carer's household (s. 144).

Also included in that legislation (s. 145) is a provision that enables a child to be given information concerning the proposed authorised carer by the designated agency responsible for the placement, before being placed with the authorised carer.

RECOMMENDATIONS

7.26 **That the Child Protection Act be amended to incorporate specific obligations on the part of the DCS to disclose relevant information to carers.**

7.27 **That the Child Protection Act incorporate a general disclosure obligation on the DCS to inform other departments, government agencies and non-government agencies (including AICCAs) of all information reasonably necessary to ensure their cooperation, assistance and participation within the child protection system.**

7.28 **That the department ensure that it has clear policies and procedures on disclosure of information and that it incorporate them in the training provided to departmental and agency staff.**

Reason (7.26–7.28): It is necessary to remove any perceived impediments to the disclosure of information about children in alternative care by departmental staff. There is an identified need to ensure that all DCS staff understand the legislative provisions about confidentiality and that the department's child protection functions are administered in a way that lessens the possibility of there being adverse effects upon children's protection and welfare, because of misguided decisions to withhold relevant information.

Case planning and review

Just as placement meetings are a necessary step in facilitating good outcomes for children, carers should also be involved in children's case planning and case reviews. Carers are an important part of the child's treatment team, and they should be recognised as such by the practices of the DCS. Because of carers' day-to-day involvement with the child they can act as a potentially important advocate for the child, and are essential to the success of any case plan. As carers play an important role in the implementation of any decisions (e.g. parental reunification), they should be included in the development and revision of the case plan. If a carer does not support a case plan it will be more difficult for it to be successfully implemented. Currently, there is no consistency in including carers in case planning. While a few carers reported being satisfied with their level of involvement and the decisions made for the child, the majority of carers reported that they were not seen as 'team members'. They often felt excluded, or ignored, and that any consultations were only 'tokenistic'. Decisions were frequently seen as being dictated by the needs of the biological parents, and many carers believed the best interests of the child were often not considered (Australian Foster Care Association 2003).

RECOMMENDATION

7.29 That tools and resources be developed by the DCS to ensure that foster carers are included in children's case planning.

Reason: It is important to recognise the valuable contribution that carers can make to case planning. Many carers will have detailed knowledge about the child, particularly when children have been in their care for substantial periods of time.

Additional support mechanisms

Mentoring for foster carers

Many foster carers expressed a preference for receiving additional support from other foster carers (FCQ submission). Foster Care Queensland has suggested that a mentoring system could be set up, where more experienced carers support less experienced carers, and suggests this mentoring may be particularly important for new carers. This would provide a cost-effective method of providing additional, experienced support for carers.

Mentoring relationships for foster children

There has also been a suggestion that providing mentoring programs for children can indirectly provide support for foster carers. These programs typically involve assigning an adult mentor to a child. The mentor meets regularly with the child to develop an ongoing, supportive relationship. Mentoring relationships with children and adolescents have a beneficial effect for the young people, including reducing the likelihood of the initiation of drug and alcohol use, violence or truancy. Mentored children earn higher grades and report improved relationships with their friends and families including greater social skills and greater comfort and trust in interacting with others (Jekiekek et al. 2002; Rhodes, Haight & Briggs 1999). By instigating a mentoring program for children, carers have access to another adult who will support the child. Mentoring also increases the child's own support base, increases the likelihood of good outcomes for the child, and engages larger segments of the community in the care of foster children.

The Commission considers that foster carers could themselves, if willing, be valuable mentors for children in care who are placed with other families. Such a mentoring program, if adopted, could also incorporate elements of respite care, with children spending some periods of time with their mentor. Foster children may be able to be matched with a carer/mentor who is responsible for the fostering of other children of a similar age. The proposed new department's adherence to proper screening processes for foster parents would also help to alleviate concerns that will arise in this context, by ensuring that only appropriate people are approved as mentors.

RECOMMENDATION

7.30 That consideration be given to the DCS implementing mentoring programs for foster carers and children in foster care.

Reason: Mentoring programs have been shown to facilitate good outcomes for children. Potentially they could provide a stable, positive, adult influence in a vulnerable child's life and indirectly give additional support to foster carers in meeting the needs of children in their care. They would also have the benefit of giving the carer regular brief periods of respite from the demands of parenting the child. The program could operate regardless of any changes in the child's placement, including reunification with parents.

Advocacy for foster carers

Currently Foster Care Australia and its state branch, Foster Care Queensland, assist carers to raise and resolve issues affecting carers and children. As part of its support services, FCQ provides individual advocacy for foster carers (e.g. assisting carers in appearing before the Children Services Tribunal). It is not funded for this activity, which causes an ongoing drain on its limited resources (FCQ submission).

Dealing with allegations

According to the Australian Foster Care Association (2003), many foster carers believe allegations made against carers are often poorly handled by the Department of Families. Therefore, it is important that an appropriate framework for dealing with complaints about foster carers is established and promulgated. Such a framework should include procedures for investigating allegations, appeal mechanisms, independent or external review process, and debriefing for carers and children if allegations are unsubstantiated (FCQ submission).

RECOMMENDATION

7.31 That the DCS ensure that an appropriate procedural framework is established for responding to allegations made against foster carers.

Reason: It is important that foster parents have an understanding of departmental processes in dealing with such complaints.

Remuneration

Queensland currently operates on the premise that carers are volunteers, and sees allowances as payments to compensate for some of the costs involved in caring. The sustainability of government services for at-risk children will continue to depend on volunteer carers as opposed to salaried carers. However, unless payments to volunteer foster parents fully compensate them for the cost of caring for the child, it is unlikely the increasingly complex needs of many children will be adequately met; not will the retention of foster carers within the system be encouraged.

An investigation of the adequacy and effectiveness of foster care allowances in Australia (McHugh 2002) has confirmed that the level of standard subsidies paid to foster carers in Queensland is substantially below the costs of providing the everyday needs of foster children. The investigation recommended that payments to foster carers reflect the real costs of caring for children, including the need for additional payments for birthday and Christmas presents. It was further recommended that carers of preschool-aged children have access to good quality child care paid for by the department. Supporting families by adding to existing resources may prevent families withdrawing or discontinuing from fostering. Foster carer groups are requesting that they be properly reimbursed for their caring-related costs (CMC 2003; PeakCare submission). As one carer related: 'My pockets are only so deep. Children's needs are so great' (Australian Foster Care Association 2003).

In 2001–02 the Department of Families increased the basic foster care allowance by 10 per cent. Subsequently, the Future Directions policy included a further 6 per cent increase in fostering allowance for carers with children aged over 11 years. Also, a further $1.5 million was made available to provide support for children with high needs. These enhancements do not, however, fully compensate for the cost of having a child in care, as estimated by the McHugh study (2002). Additionally the availability of allowances for 'extras' or high-needs support payments are resource-driven, rather than needs-driven. For example, if the region's allowance for child-related expenses is depleted, no further payments can be made to carers regardless of children's needs (FCQ submission). There is also often a delay in processing payments, which can create financial hardship for some carers. Carers spoke of sometimes receiving no payments for children for several weeks. In the meantime, apart from basic living costs, children may also have to be outfitted for school with uniforms, books and stationery (Australian Foster Care Association 2003; confidential consultations). Payments for carers need to be processed promptly, and regional emergency funds could be set up to provide carers with immediate funding at the start of a child's placement.

The current level of payments can be a potential deterrent to prospective carers and create economic hardship for low-income carers. While there seems to be some consensus on the need to increase foster carer payments, some people are concerned that higher payments may encourage people who are primarily interested in financial gain to enter the foster care system (confidential consultations). As they rightly point

out, such people are unlikely to provide the best placement options for children in care. Although this risk is valid, it can be combated through the selection and assessment process.

Another option is to look at tiered funding methods. For example, the United Kingdom has a 1–4 competency level system, where carers at level 1 are paid the basic allowance for each child, dependent on their age, while level 4 consists of carers with at least three years' fostering experience who care for children with more complex needs. These carers receive higher payments for their services. All carers are required to complete several training courses during each year to maintain their current competence-level rating and associated payment during their annual review (Watson-Hunt submission).

Recommendations

7.32 That foster carers receive appropriate remuneration to cover the actual costs of caring for a child, as well as receiving additional payments to attend training as required and pay the associated costs of child care and transport for such training.

Reason: It will be easier to attract and retain carers in the foster care system if people are not expected to personally subsidise their caring. Also, the provision of adequate remuneration will reduce the financial burden and related stress on foster care families.

7.33 That the DCS investigate introducing a tiered system for payments to foster carers that recognises the skills necessary to care for children with more complex needs.

Reason: If a tiered payment system is introduced it could readily by linked to the tiered training system that has also been recommended. Additional payments would provide an appropriate recognition of the higher-level skills attained by specific carers and acknowledge their work with children who have special needs or more challenging behaviours.

7.34 That the allocation of any additional payments (e.g. child-related expenses, high-support needs allowance) be on a needs basis, rather than on regional resource allocations. Children's needs and entitlements should be clearly detailed in the child's case plan.

Reason: Under the current system there is considerable inconsistency in the availability of these additional payments. While the needs of some children are met, others appear to be denied funding because of resource limitations. There needs to be a consistent application of policies about entitlements, so that funding is based on the identified needs of the children.

CASEWORK

The current procedures for developing a case plan are:

1 a case management meeting held by departmental staff about any non-negotiable actions that need to be taken by the department, followed by:

2 a family meeting where formal planning for the child is conducted by departmental officers, parents, child (where appropriate), and relevant support people (where appropriate), followed by:

3 a placement meeting, which involves negotiating an agreement with the child's carer about the goals of the placement. Parties receive and sign written records of the outcomes of the family and placement meetings, involving a planning agreement and a placement agreement respectively (Department of Families policy no. 263-1, Case Management Framework). The case plans are supposed to be reviewed at least every six months.

While it is clearly recognised that it is impossible to achieve good long-term outcomes for children entering care without the completion of a detailed and thorough case plan that involves long-term planning, the overall standard of case planning in the Department of Families, from the evidence before the CMC, is generally inadequate (CMC 2003; CREATE submission; FCQ submission; Zellow investigation). For example, under section 96 of the Child Protection Act, a family meeting, which constitutes part of the development of the case plan, is supposed to occur if the child is in need of protection. Departmental policy is for a family meeting to occur only if the child is in need of protection *and an order is sought* (policy no. 263-1, Case Management Framework). The policy content indicates that this section of the Act is not being complied with in practice. Consequently, children on voluntary placements may not be having case plans developed.

The departmental caseworker is responsible for developing case plans, but the Inquiry was told of children who had no caseworkers for long periods of time, and the majority of children who have caseworkers are reported to have little, or no, contact with their caseworker (Australian Foster Care Association 2003; CMC 2003; confidential consultations 2003; CREATE submission). In such circumstances it would be impossible for children to establish the trusting relationship with their caseworker that is essential to facilitate good long-term outcomes for the children. Departmental records also show little evidence of case planning, as noted previously in relation to the matters investigated by the CMC and those audited by Ms Gwenn Murray.

When case planning does occur, there is often no consistency. Standards vary depending on the individual caseworker, so if a new worker is assigned to the case the whole case plan may be changed to fit in with the personal beliefs and values of this worker ((Australian Foster Care Association 2003). If planning is evidence-based and focuses on the best interests of the child, this large variability in planning should not be occurring. Certainly, research with FSOs suggests that their casework is typically not evidence-based, with research participants not demonstrating a coherent, comprehensive and elaborated theory and research base for their practice (Osmond 2003).

Recommendations

7.35 **That there be thorough, standardised, evidence-based case planning that is consistently applied and focuses on the best interests of the child. This issue needs to be addressed both in university training courses and in ongoing training provided to staff.**

Reason: The evidence indicates that the current standard of case planning is inadequate and lacks a coherent evidence base, which leads to poor outcomes for children.

7.36 **That all children have an identified and designated caseworker from the DCS who maintains regular contact with the child and is responsible for the development of a detailed case plan that focuses on both the short- and long-term needs of the child. The plan must be reviewed at least every six months.**

Reason: Children need regular access to a worker who represents their best interests and develops a comprehensive and evolving case plan for their long-term wellbeing.

7.37 **That the DCS adopt clear policy so that section 96 of the *Child Protection Act 1999*, which states that a family meeting should be organised for all children requiring protection, is followed.**

7.38 **That the Child Protection Act be amended to make it necessary for a case plan to be submitted to the court before an order is sought (as presently occurs in NSW and the ACT).**

Reason (7.37 and 7.38): All children in the care of the department should have a case plan. As a family meeting is essential in formulating this plan, this meeting must occur for all children including those on voluntary placements.

7.39 That processes be implemented to ensure initial case planning is carried out promptly and case plan reviews are carried out every six months, as required under the *Child Protection Act 1999*; and that all stakeholders, but particularly the child, their family, and the child's carer, are invited to participate in every planning meeting.

Reason: Under the current system, case planning is not being fully implemented. This recommendation, which comes from the Commission for Children and Young People, is designed to encourage the implementation of appropriate casework.

Children's involvement in casework

There are current provisions for children to be involved in decisions about their lives if they are old enough, or of sufficient understanding to enable their meaningful participation in the decision-making process. The importance of children's involvement is stipulated in the Charter of Rights for Children in Care, which specifies that the child has the right:

> to be consulted about, and to take part in making, decisions affecting the child's life (having regard to the child's age or ability to understand), particularly decisions about where the child is living, contact with the child's family and the child's health and schooling. (Child Protection Act, Schedule 1, s. 74)

In practice, the evidence is that foster children are rarely involved in making decisions about their life, with many children and young people being unaware about their rights (Australian Foster Care Association 2003; CMC 2003; CREATE submission). For example, as related in Chapter 3, the Inquiry heard that some children are either forced to have family contact when they have stated they do not want this, or denied contact with their family and siblings when they have repeatedly requested this contact.

While there may be good reasons to deny children family contact, they should be offered an explanation. Children understand that they cannot always have what they want, but they do want an explanation for particular decisions (CREATE submission). Particular difficulties arise for children who are not kept informed (FCQ submission). When children are not provided with explanations, and particularly ones for traumatic events such as removal, this will increase their sense of insecurity because their world will be seen as unpredictable and uncontrollable. To improve the likelihood of favourable long-term outcomes it is necessary for children to be informed of what will be happening and be involved in decisions about their lives whenever possible. The importance of including children in case planning has been acknowledged and addressed in New South Wales, which has developed resources to facilitate children's participation in decisions that affect their lives (Drennan & Griffin 2003).

Recommendations

7.40 That tools and resources for the participation of children and young people in case planning be developed and used to ensure their participation in planning processes that are in keeping with the principles of the *Child Protection Act 1999*.

Reason: While children's rights to be involved and informed about decision making are specified in current legislation and policy, in practice such involvement often does not occur. Therefore it is necessary for the development of specific resources to ensure children's participation.

7.41 That the DCS be required to implement procedures to ensure that all children are informed within 24 hours of entering care why they have been taken into care and what they can expect will happen to them.

7.42 That the DCS ensure that all children who are the subject of an assessment of risk of harm and/or enter into the care of the department are given the option of a support person whom they know and trust.

Reason (7.41 and 7.42): It is important that children are able to maintain ongoing family relationships if possible, because a lack of contact may increase the sense of grief and loss that many children experience on entering care. For example, children are often particularly concerned about the welfare of their siblings, and efforts should be made to maintain these relationships. Foster carers often reported that, when siblings were placed with different families, visits only occurred if they were organised by the carers. When siblings remain with the biological family it is still important to enable the child to maintain contact, even in the most extreme situations where the child must be protected from parental contact during visits with siblings.

Biological parents' involvement in casework

While biological parents are important stakeholders in the child protection system there has been a comparative lack of research, policy and practice focused on working in partnership with parents to achieve the best outcomes for their children (Thorpe & Thomson 2003). Although currently the aim of the department is to reunify children with their biological parents, and parents are to be informed of, and participate in decisions regarding their child, parents often feel excluded from departmental processes. For example, often parents do not understand what is happening when their child is being removed, they are not informed of their legal rights, what processes will be followed, and what appeal procedures are available. Legal Aid told the Inquiry that parents are sometimes encouraged to enter into agreements without ensuring that they can comply with all elements of the agreement or without understanding the implications of that failure (CMC 2003).

Although parents are invited to attend family meetings, they typically do not feel empowered by the process; they are more likely to be simply informed of decisions. Ms Jennifer Wiltshire and Ms Julie Clarke told the Inquiry that typically parents do not play an important role in deciding how problems will be addressed (CMC 2003). Even in the most extreme situations where it is unsafe for parents to have access to their children, they still have the right to be kept informed about their children.

Recommendation

7.43 That tools and resources be developed by the DCS to ensure that the procedures for involving parents in casework (e.g. family meetings, planning agreements) are followed, and that their support worker be included in these processes.

Reason: Despite policies and procedures to involve parents in their child's case planning, in practice parents have often been excluded from this process, and so it is important to implement mechanisms to facilitate their involvement. This is particularly important when the case plan involves reunification. If the parent is disengaged from the process, reunification is less likely to succeed.

Foster carers' involvement in casework

Under the current system of casework, although foster carers are involved in placement meetings, and receive and sign placement agreements, there is no provision for their automatic inclusion in family meetings where decisions are made about the child's case plan. In practice, foster carers can be included in a joint family and placement meeting when there are issues that involve both the parents and the child's carer, but these joint meetings are seen as inappropriate when:

- safety issues preclude this
- planning is at a stage where the question of the parents' ability/willingness to meet the child's protective needs is still being discussed, and/or
- the parents object to the presence of the child's carer (Department of Families policy no. 263-1, Case Management Framework).

Whenever possible, however, it is preferable to hold one meeting that involves both the parents and the carer.

Reunification versus permanency planning

There are both national and international differences in the emphasis that is given to the importance of reunifying children and adolescents with their biological families. Until recently all states and territories of Australia favoured reunification, whereas in both the United States and the United Kingdom there has been an emphasis on permanency planning (Department of Human Services [Vic.] 2003b). This usually involves working on the 'dual goals' of reunification and alternative placement (including adoption) at the same time, working first towards reunification with the alternative plan as a backup if reunification fails.

There is a hierarchy of preferred placement options for children, with reunification with the biological family the first preference and adoption by carers or others, longer-term foster care and then residential placement as a last resort. Permanency planning has been designed to avoid having children experiencing indeterminate periods in care or oscillating between reunification and placements in care. This instability is known to pose a serious risk to children's long-term wellbeing and specifically places children at risk of behavioural and emotional problems; it often results in children having ongoing difficulties forming stable, positive, relationships with others.

While reunification is still the goal, typically there is a time limit placed on attempts at restoration to the biological family. For example, in the United States, after the child has been in continuous care for 15 of the preceding 22 months, the state must (with some limited exceptions) petition for the termination of parental rights (Department of Human Services [Vic.] 2003b).

Not surprisingly, countries with permanency planning policies have higher adoption rates for children in care. For example, in the United States and the United Kingdom where permanency is prioritised in the case plan, 6.6 per cent (US) and 4 per cent (UK) of children in alternative care are adopted, whereas in Australia and other countries that do not place time limits on efforts at reunification (e.g. Sweden) adoption rates are much lower. Australia has an adoption rate of 0.8 per cent, while Sweden has an even lower rate of 0.2 per cent. Sweden has no provision for either a permanent care order or adoption without parental consent, and focuses considerable resources on either preventing children coming into care or providing intensive treatment services for families where children have been removed. Consequently, few children come into care, and reunification is the goal for the majority of these children (Department of Human Services [Vic.] 2003b).

Australian states have also previously focused on continuing efforts to reunify children with their parents, but there are growing concerns about the importance of providing stable, secure, loving homes for these vulnerable children. Certainly data from the UK suggest that, while the majority of children experience only short periods in the alternative care system, about 40 per cent of children who were in care at the end of March 1999 had been in alternative care for more than three years. Once children had entered care, and the longer they stayed in care, the less likely they were to be successfully reunited with their biological families, so that a child who had been in care for 12 months had an 80 per cent chance of remaining in care for at least four years (United Kingdom Government 2000, cited by Department of Human Services [Vic.] 2003b).

There are several arguments for increasing the number of children in care who can be adopted. First, the outcomes for children who have grown up in care are generally poor; these children have lower educational outcomes, higher rates of unemployment, greater involvement with the justice system, poorer mental health, and more unstable relationships. In contrast, children who are adopted have better outcomes, similar to those of children in the general population. Although some children are successfully reunified with their families, there is no consistent evidence that reunification itself *automatically* delivers better outcomes for children than adoption or foster care (Department of Human Services [Vic.] 2003b). Success or failure will depend on the conditions at home and the quality of care and family relationships. Secondly, efforts

to keep the biological family intact are expensive and resource-intensive. Thirdly, advocates of permanency planning argue that it seeks to make the system more focused on children's rights, rather than reunification, which they see as giving precedence to the rights of the parents (Cahn 2002).

In response to these concerns, New South Wales has implemented permanency planning legislation. This legislation requires case plans to include a plan for the long-term placement of the child when a final order is sought from the Children's Court (s. 78). While the Act does not specify a time limit on efforts for reunification, it does state that when preparing the plan the director-general must assess whether there is a realistic possibility of restoration, and, if not, the plan should focus on another suitable long-term placement, which may involve adoption (s. 83).

While Queensland has continued to focus on reunification, the Department of Families has raised the issue of permanency planning in its *Stopping the drift* consultation paper (2003e). When discussing the possible implementation of a time limit for attempting restoration to the biological family, the example given suggests considering that adoption could be a long-term placement option for a child up to four years of age who has been in continuous care for 12 months, or for a child five years and over who has been in continuous care for two years.

While few people would argue against the necessity of providing children with a stable, long-term placement, the adoption provisions in permanency planning are often more controversial, particularly when they contain a time limit for attempting restoration. Several concerns have been raised about this provision. While permanent placements are important for children's wellbeing, placing a time limit on reunification efforts is problematic; families are fluid, and change can take a longer time to achieve than typically allowed for in legislation (Anthony McMahon submission).

The United States has had permanency planning legislation for a significant time and several problems with the adoption provisions are now becoming apparent. First, while it is relatively easy to find adoptive homes for infants, because they are 'in high demand', older children, those from ethnic minorities or those with special needs are less favoured as prospective adoptees. Consequently, many children have their links with their biological families severed and are then left waiting indefinitely for a new family (Cahn 2002). Also, even when older or special-needs children are adopted, the adoption has a greater risk of failure (US Department of Health and Human Services 2003b). Secondly, once children reach adolescence their disconnection from their biological families can give rise to identity issues. Thirdly, this legislation has created specific problems for particular ethnic groups in the United States. For example, the Hispanic community has no cultural practice of adoption, so children are at greater risk of being lost to their communities (Bausch & Serpe 1997). Difficulties with adoption have also arisen for the African-American community. Because of the social disadvantage suffered by a large segment of this community, few people can meet the criteria to become adoptive parents. Consequently, there are large numbers of African-American children left awaiting adoption (Cahn 2002).

Similar difficulties may well arise for our own Indigenous community because of the severe social disadvantage suffered by many Aboriginal and Torres Strait Islander communities. For example, some Indigenous communities, and particularly those in remote areas, suffer deeply entrenched systemic social problems resulting in a dysfunctional community syndrome (Robertson 1999), where communities are plagued by high rates of alcoholism, drug abuse, domestic violence, poverty, unemployment and homelessness. To compound these difficulties there is often little, or no, access to treatment and support services. Because of the complexity of these social problems and the poor provision of services, it is unlikely that many parents could resolve their difficulties within the short timeframes of one or two years typically allowed for in permanency planning legislation.

Without the provision of appropriate treatment and support services to help parents regain custody of their children, any attempts at restoration will most likely fail. Children may then be left in 'limbo' waiting for an alternative long-term placement or adoption to be organised. Therefore, Indigenous children would again be vulnerable

to being lost to their families and communities. Because of the severe social and economic disadvantage suffered by the Indigenous community, along with adoption not being a cultural practice within the Aboriginal community, it is unlikely there would be enough Indigenous parents to provide adoptive homes for these children. Difficulties in placing Indigenous children with Indigenous parents are already apparent in the current foster care system, where there is a chronic shortage of Indigenous foster carers to meet the placement needs of Indigenous children, a significant number of whom are then left with non-Indigenous carers. Not surprisingly there is considerable concern within the Indigenous community about any changes to the current Act that would facilitate the permanent removal of Indigenous children from their parents, families and communities. There is a fear that this could create another 'stolen generation' (confidential consultations).

Critics have also argued that a fourth problem with permanency planning legislation is that not enough resources and efforts are being directed towards preventing family difficulties from escalating into child protection concerns, and too little is spent on early intervention and on helping parents regain custody of their children. Since permanency planning was introduced in the United States, there has been a yearly decline in the funds allocated to reunification services (Cahn 2002). In Australia, too, child protection systems still fail to implement adequate intervention services, either to stop children needing to enter the foster care system, or to enable their prompt return to their families (Tomison 2002). Therefore it is difficult to terminate parental rights within what critics view as 'short' timeframes when they have not been provided with adequate services to address their problems.

Similarly, little Australian research has been completed on the outcomes of reunification or evaluations of specific reunification programs. Existing evidence suggests that reunification is unsuccessful for a minority of children and that resourcing issues are implicated in the likelihood of successful reunification. For example, if there is comprehensive service planning for the whole family, adequate preparation of the family for the child's return, the formulation of a well-developed case plan that keeps the family involved, and a social worker who is committed to reunification for the child, reunification is more likely to be successful (Department of Human Services [Vic.] 2003b). Lastly, critics of permanency planning argue that, rather than giving precedence to the rights of children, permanency planning is designed as a punitive response to parents (Cahn 2002), and is favoured by governments as a cost-saving method of removing children from the system (CMC 2003).

Decisions about the best long-term placement option for children will depend on the specific case. Neither reunification nor permanency planning can provide an adequate option that would meet the needs of all children within the foster care system. As such, neither should be an end in itself. Policies that dictate strong preferences for one outcome over the other will necessarily work against the best interests of some children. What is needed is a continuum of placement options which are adequately resourced so that individual children can have the benefits of the option that is best for them.

Recommendation

7.44 That the DCS evaluate research into the effect of reunification or permanency planning on children.

Reason: Currently there is limited Australian research on the effects of reunification or permanency planning on children. Although there now appears to be growing interest in permanency planning in Queensland, the concerns about including an adoption option in permanency planning legislation suggests that any change need to be evidence-based and to consider the specific concerns of the Indigenous community.

Any decisions about a child should be based on the best interests of the child. For example, reunification should be pursued only when it is in the child's best interests. Yet currently, the department is perceived by some key stakeholders to be pursuing

reunification at any cost with little concern for the welfare of individual children (Australian Foster Care Association 2003; CMC 2003).

The report of the Queensland Ombudsman into the death of 'Baby Kate' has already been noted in Chapter 2. In his report, the Ombudsman said the following about the decision by departmental officers to release Baby Kate into the care of her biological parents, Lisa and John:

> The decisions of DoF officers to release Baby Kate into the care of Lisa and John and to leave baby Kate in Lisa's care when the relationship between Lisa and John ended did not give appropriate weight to the legal requirement that the welfare and best interests of the child are paramount and that a child should be placed in alternative care if it does not have a parent willing and able to protect it. In making these decisions, DoF officers gave undue weight to the principle that their approach should be the least intrusive or a minimal intervention approach in respect of the family unit. My investigation suggested that their approach may be indicative of the widespread application of this principle by DoF officers with potentially dangerous consequences for the safety of children. [emphasis added]

The Ombudsman recommended that the department refer his comments about the application of the principles in section 5 of the Child Protection Act and the 'minimal intervention' or 'least intrusive approach' principle to the Coordinating Committee on Child Abuse, with a view to that body, or an appropriately constituted subcommittee, providing guidance on the weight departmental officers should give to such principles when conducting child protection assessments.

In its response to the Ombudsman's recommendations, in October 2003 the State Government advised that it supported this recommendation and that it would 'ensure that responses are warranted to the circumstances of the case and that the principle of "minimal intervention or least intrusive approach" is not weighted inappropriately in child protection assessments'.

This was to be carried forward by the Department of Families working with the Coordinating Committee on Child Abuse to review its approach to child protection, and through ensuring that staff were made aware of the need to give an appropriate weight to the safety of the child when applying the principle of 'least intrusive approach' in dealing with child protection matters. The government also noted that work was under way within the department concerning the development of definitions for the meaning of key terms to guide the weighting of the concept of a 'least intrusive' approach in practice. This work includes:

- drafting a practice direction for all staff in relation to the application of the principles in Section 5 of the *Child Protection Act 1999*
- developing training for family services officers, team leaders and area managers throughout the state in 2004 about key terms used in legislation and practice
- informing a review of the *Child Protection Act 1999* (as proposed in the Queensland Government submission to the CMC) to ensure that inconsistencies in translating the intent of the legislation to practice are addressed.

The government also noted that work on implementing this recommendation may require legislative change to the Child Protection Act (Queensland Government, Response to the Queensland Ombudsman's report, October 2003b).

In that respect, the CMC notes that section 87(1) of the Act states that the director-general must provide the opportunity for contact between a child in care and their parents and other appropriate family members. Section 87(2) allows the director-general to refuse or restrict such contact if satisfied that it is not in the child's best interests, or contact is not reasonably practicable.

Also, while the Child Protection Act does specify that the 'welfare and best interests of a child are paramount' (s. 5[b]) and 'if a child does not have a parent able and willing to give the child ongoing protection, the child has a right to long-term alternative care' (s. 5[g][i]), there is nothing specific in the legislation to emphasise that in respect of all decisions made under the Act children's rights take precedence over parents' rights.

There is nothing in the Act that is similar to the overarching principle contained in section 9, paragraph (a) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). Section 9 of that Act sets out a number of principles intended to guide how that Act is administered. Two of the key principles are:

> the safety, welfare and wellbeing of a child or young person who has been removed from his or her parents are paramount over the rights of the parents [emphasis added]
>
> unless it is contrary to his or her best interests, and taking into account the wishes of the child or young person, out-of-home care is to include retention by the child or young person of significant relationships, including birth or adoptive parents, siblings, extended family, peers, family friends and community.[1]

The current lack of any clear statement in the Queensland legislation, according precedence to the rights of the child over those of the parents, could be resolved by inserting an additional principle into section 5 based on the one noted above, from the New South Wales model. That model clearly sets out how any conflicts that may arise between the interests of a child and the interests of the child's family should be resolved.

RECOMMENDATION

7.45 That an additional principle be inserted into section 5 of the *Child Protection Act 1999* clearly providing that any conflict that may arise between the interests of a child and the interests of the child's family must be resolved in favour of the interests of the child.

Reason: There is nothing in the current Queensland legislation that emphasises that children's rights take precedence over parents' rights.

Relationships with biological parents

The rights of children are sometimes seen to conflict with those of their parents, though in many cases relationship maintenance is in the child's best interest. Even in situations where children will never be able to be reunited with their families, it is still important to work with the family to encourage parents to maintain some form of contact with their children.

Dr Robert Lonne pointed out to the Inquiry that foster children need to understand the family situation that led them to being placed in care (CMC 2003). If children are denied a continuing relationship with their parents, 'they have no real way to work through these life issues, and so what you then end up with is young people who have major emotional issues, major identity problems, who quite often form relationships that are abusive or enter into abusive relationships, have children at young ages and the whole cycle repeats, and there's got to be a better way' (CMC 2003, p. 666).

It must be recognised, however, that relationship maintenance does not mean it is always in a child's best interest to be reunified with their family, or to have regular or unsupervised visits with their biological parents. Decisions about the nature of any contact should be made on a case-by-case basis. Children who are seriously distressed by parental visits, or do not wish to see their parents, should not be forced to have contact. Several foster children spoke of their distress at being forced to see their parents when they did not want any contact (CMC 2003; confidential consultations). Also foster carers reported cases of children having to be dragged into cars, or hiding when workers collected them for parental visits. Some children, on their return to carers, were sick or were found to have 'messed their clothes' during their visit to their parents (Australian Foster Care Association 2003).

Therefore, the amount and type of parental contact will vary for particular children. For many, reunification will be appropriate; for others regular visits will be important for their wellbeing; still others will require supervised access; while for another group, relationships may need to be maintained through phone calls and letters, which the child can decide whether to accept. Keeping parents informed about their child and

encouraging their continuing efforts to attempt contact is important. In this way, even if the child has decided that they want no contact with their parent, if they change their mind at a later date it is still possible for the child to choose to have a relationship with their parent. This is not an area that lends itself to specific recommendations. However, the level of contact between the parent and the child should always be determined by the child's best interest.

Guardianship orders

For completeness, it should be noted that there are currently two types of orders which terminate parental rights to make short- and long-term decisions about the care, welfare and development of their children. First, under section 61(e) of the Child Protection Act, the department may apply to the Children's Court for an order granting short-term guardianship of the child to the director-general. The maximum duration of a short-term guardianship order is two years (s. 62 [2][b]), though there are no limitations on the number of further extensions. While the order is in force, the parents lose their rights to both the custody and guardianship of their child, which are transferred to the director-general.

Secondly, parents can also lose custody and guardianship of their child if the Children's Court makes a long-term guardianship order that ends the day before the child turns 18 years of age (s. 62 [2][c]). In contrast to short-term guardianship orders, long-term orders can be granted to a member of the child's family (who is not a parent), a person nominated by the director-general who is not a member of the child's family, or the director-general.

In practice, long-term guardianship orders are almost always made in favour of the director-general. For example, during the year ended 30 June 2003, 95 per cent of all guardianship and custody orders were made in favour of the director-general (Department of Families 2003c). This practice appears to be inconsistent with section 59(4)(b) of the Child Protection Act, which says:

> the court must not grant long-term guardianship of a child to the director-general if the court can properly grant guardianship to another suitable person.

Although there have been cases where foster carers have asked the department to bring an application for an order granting long-term guardianship of the child to the carer, it is very rare for the department to bring such an application. There is evidence that, even in instances where a child's separate legal representative has recommended that a foster carer be made the child's guardian, the director-general has refused to nominate the carer (FCQ submission).

Application by an authorised carer for a sole parental responsibility order

Under section 149 of the New South Wales Act an authorised carer who, for a continuous period of not less than two years, has had the care of a child for whom the minister (either alone or with others) has parental responsibility, may apply to the Children's Court for an order awarding sole parental responsibility for the child or young person to the authorised carer.[2]

Before the authorised carer can bring the application, the carer needs to first obtain the consent of the person or persons who had parental responsibility for the child immediately before parental responsibility was allocated to the minister. An application that involves a child who is at least 12 years of age (and who is capable of giving consent) also requires the child's consent. A sole parental responsibility order can be varied or rescinded.

There is no equivalent of section 149 of the New South Wales Act in the Queensland Act.

RECOMMENDATION

7.46 That the DCS review the practices associated with granting long-term guardianship orders and short-term child protection orders (including custody orders).

Reason: Although it is possible for the Children's Court to make an order granting long-term guardianship of a child to a member of the child's family or support network, or to a long-term carer, in practice, long-term guardianship orders are nearly always made in favour of the director-general. Given the evidence that these types of orders are more likely to lead to children drifting in and out of care and experiencing multiple placements, the Commission considers that this practice could be the subject of review by the DCS.

FINAL COMMENT

The foster care framework currently operated by the Department of Families is *not* working for all children who require out-of-home placements in Queensland.

The vision discussed in this chapter proposes a clear framework with definite objectives firmly directed at ensuring the safety and protection of children. The framework presents a model for the new department regarding different placement options and improved systems of recruitment, training and support of foster carers. It defines the best-practice approach to long-term planning, which is based on the available evidence of practices that most effectively protect the best interests of children. The proposed framework is one for all Queensland children in need of care, with the recognition that the Department of Child Safety will have a range of responses available to it, and that flexibility in their application, particularly in rural, remote and Indigenous communities, is essential.

The following chapter examines in detail some issues specifically relevant to Indigenous children and the child protection system.

Endnotes

1 Under s. 86(1)(c), the Children's Court can make an order 'denying contact with a specified person if contact with that person is not in the best interests of the child or young person'.

2 The child protection legislation in Victoria (see s. 112 of the *Children and Young Persons Act 1989*) and the Australian Capital Territory (see s. 260 of the *Children and Young People Act 1999*) contains similar provisions.

8

INDIGENOUS CHILDREN

This chapter examines particular issues that Indigenous children and their families face when drawn into the child protection system in Queensland. The recommendations made here need to be read in conjunction with Chapters 5, 6, 7 and 9, as many apply as much to non-Indigenous children as to Indigenous.

The chapter begins with a brief demographic profile and a reminder of the historical treatment of Indigenous people in Queensland, which provides a useful context for many of the concerns raised by Indigenous people during the Inquiry. The chapter also outlines the provisions of the *Child Protection Act 1999* that specifically relate to Indigenous children, before addressing the specific concerns that came to the foreground during the Inquiry.

Central to this chapter is a discussion of the role of the Aboriginal and Islander Child Care Agencies (AICCAs) in providing child protection services for Indigenous children. The Commission acknowledges that the integration of AICCAs within the broader child protection system requires further attention, but is nevertheless persuaded that without the cooperation of AICCAs, or equivalent agencies, it will not be possible to provide the level of service Indigenous children are entitled to receive.

DEMOGRAPHIC PROFILE

According to the 2001 Census (OESR 2003):

- 112 772 people in Queensland identified as being of Aboriginal or Torres Strait Islander origin, representing 3.1 per cent of the state's overall population (27.5% of the nation's total Indigenous population)
- the majority of Queenslanders who identified as being Indigenous were of Aboriginal descent (77.4%), with 14.6 per cent identifying as Torres Strait Islander, and the remaining 8 per cent identifying as being of both Aboriginal and Torres Strait Islander origin
- 68.7 per cent of Indigenous people lived outside Brisbane (approximately two-thirds of the Indigenous population)
- nearly half (47.6%) of the Indigenous population were counted in five northern ATSIC regions (Cairns, Cooktown, Mount Isa, Torres Strait Islands and Townsville) compared with only 15.0 per cent of the non-Indigenous Queensland population.

As at 30 June 2001, approximately 19 032 people were usually resident in a Queensland Indigenous council area (the majority of these were of Indigenous origin). Of these, 13 676 usually resided in one of 15 Aboriginal community areas and 5356 in one of 17 island community areas (OESR 2003).

HISTORICAL OVERVIEW

The treatment of Indigenous people since the colonisation of Australia has been both dramatic and traumatic. As Justice Michael Kirby noted, in terms of Aboriginal people and the law:

> A charitable interpretation of the relationship between the Australian legal system, post-1788, and the Indigenous Aboriginal people of the continent is that it is a tale of indifference and neglect. A less charitable interpretation is that it represents a cruel assertion of power: sometimes deliberate, sometimes mindless, resulting in the destruction of Aboriginal culture, unparalleled rates of criminal conviction and imprisonment and massive deprivation of property and land. (Hazelhurst 1987, p. 15)

Since colonisation, laws have been passed by various Australian governments to monitor relations between Indigenous people and other Australians. State governments sanctioned the removal of Indigenous children from their families, particularly half-caste children. This forcible removal of children from their families became, in the experience of many Indigenous people, the dominating intervention practice characterising the child welfare system. (The children so removed are now referred to as the 'stolen generation'.)

In 1865 the Queensland Industrial and Reformatory Schools Act was passed, which defined 'any child born of an Aboriginal or half-caste mother' as a 'neglected child'. 'Aboriginality' therefore constituted neglect and provided a legal justification for the forcible removal of Indigenous children, who could then be placed in the 'dormitory system' on mission stations, industrial schools, homes and reformatories.

In 1897 the Queensland Aboriginal Protection and Restriction of the Sale of Opium Act was passed; this provided that any person of Aboriginal descent, except mixed-race males over 16 years and living as Europeans, could be declared wards of the state and exiled to a reserve, effectively abolishing their legal rights. This Act also established the position of 'Protector of Aborigines' and empowered the position with almost total control over Indigenous people. By the early 1930s about one-third of Indigenous people in Queensland were living on missions and settlements (HREOC 1997).

In 1939 the Queensland Aboriginal Preservation and Protection Act and the Torres Strait Islander Act were passed. These Acts established the Office of the Director of Native Affairs (who was the legal guardian of every Aboriginal child in the state), as well as the policies of preservation and protection. The director, who replaced the Protector of Aborigines, was made guardian of all Indigenous children under 21. At that time there were approximately 16 500 Indigenous people within the control of the government on settlements, missions and camps (Queensland Government 2001).

It was not until the 1960s that the policy of 'assimilation' was formally abandoned by the Commonwealth Government. In 1965 the Queensland Government passed the Aboriginal and Torres Strait Islander Affairs Act. This Act provided that each Queensland Aborigine would be born a 'free citizen' unless in need of 'assistance'. Community residents now needed official permits to live on a reserve, although these could be revoked by the director (who retained the power to transfer people arbitrarily between communities).

The Human Rights and Equal Opportunity Commission report on the stolen generation noted that:

> Nationally we can conclude with confidence that between one in three and one in ten Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970. In certain regions and in certain periods the figure was undoubtedly much greater than one in ten. In that time not one Indigenous family has escaped the effects of forcible removal. Most families have been affected, in one or more generations, by the forcible removal of one or more children. (HREOC 1997, p. 37)

It was not until 1971, with the passing of the Aborigines Act and the Torres Strait Islander Act, that the powers of removal were abolished.

Child protection today

Child protection within Indigenous communities continues to be affected by the legacy of the stolen generation. There is much evidence of the existence of ongoing

suspicion within the Indigenous community about the motives of government officials, who are still frequently viewed as coming to 'take the children away'. This suspicion, although understandable, complicates child protection matters within the Indigenous community where the long-term consequences of colonisation and socioeconomic disadvantage have contributed to a 'dysfunctional community syndrome'. Communities plagued by high rates of alcohol and substance abuse and disturbing levels of family violence are not surprisingly also characterised by having unacceptably high numbers of children who are vulnerable to neglect and abuse. The consequent over-representation of Indigenous people in the child protection system is evident in all Australian states.

According to recent figures provided to the CMC for the Inquiry (see Appendix C), in Queensland as at 30 June 2003 there were 3642 children on long- and short-term guardianship, short-term custody and temporary custody orders, 23 per cent of whom were identified as Aboriginal or Torres Strait Islander.

The Queensland Government submission to the Inquiry also states that 'Aboriginal and Torres Strait Islander children continue to represent a quarter of those in care, despite forming 5.7 per cent of their age range' (2003).

Further data from the department show that 145 notifications about children in care concerned Indigenous children in 2003 (24% of the total of 605 cases notified) and that these figures have increased steadily over time, as have the figures for non-Indigenous children (Appendix C, Part 1).

On 13 November 2003, the Productivity Commission released its report *Overcoming Indigenous disadvantage: key indicators 2003*. In Queensland there were 7348 cases of substantiated notifications for children (aged 0–16 years) in 2001–02; 795 of these were in relation to Indigenous children, which equates to over 10 per cent of the total number of substantiations.

The Productivity Commission's report further notes that 50 per cent of the substantiations in Queensland for Indigenous children (aged 0–16 years) were for neglect, compared with 37 per cent for non-Indigenous children. The remaining substantiations were 23 per cent for physical abuse (24% for non-Indigenous children), 21 per cent for emotional abuse (33% for non-Indigenous children) and 5 per cent for sexual abuse (6% for non-Indigenous children).

The Australian Institute of Health and Welfare (2000) noted the following factors as 'significant' in the over-representation of Indigenous children in substantiated cases of child abuse and neglect, and in alternative care:

- poverty
- poor socioeconomic status
- differences in child-rearing practices
- intergenerational effects of previous separations.

In relation to the last factor, it is said that the stolen generation has created a disruption to the normal process whereby children learn parenting skills from their own parents:

> Social justice measures taken by governments should have special regard to the inter-generational effects of past removals. Parenting skills and confidence, the capacity to convey Indigenous culture to children, parental mental health and the capacity to deal with institutions such as schools, police, health departments and welfare departments have all been damaged by earlier policies of removal. (HREOC 1997, p. 557)

Although Indigenous children are over-represented within the child protection system, the evidence indicates that there is a serious under-reporting of cases of harm to children. Many factors have been identified in research as to why individuals are reluctant to make notifications. They include:

- a fear of retribution from the perpetrator for the disclosure
- shame about the abuse

- fears that children will consequently be 'lost' to the community
- a conviction that no action will be taken about the notification
- a belief that effective protection for the child will not occur because of a lack of appropriate services
- inadequate therapeutic assistance or support offered to victims of abuse.

In 1999 the report of the Aboriginal and Torres Strait Islander Women's Task Force on Violence noted:

> Although sexual abuse against children was discussed when the Task Force raised the subject, the reluctance to discuss it is a serious concern. A number of the male and female Elders acknowledged that sexual abuse was occurring, but they said 'much of it is still not being discussed'.
>
> Of paramount concern was the fact that a number of people had reported the sexual abuse of children to the police and to the Department of Families, Youth and Community Care, to no effect … The primary concern, however, is the flaw in the current statistics regarding child abuse or child sexual abuse, due to the lack of response when cases are reported. Many Aboriginal woman believe that 'it's no use reporting sexual abuse because they don't believe you anyway'. (Queensland Government 1999, p. 99)

This perception that government is less than fully committed to addressing child abuse issues continues to be held in many quarters.

> The prioritisation system means that some cases which could benefit from early intervention are not responded to … some notifications are not followed up on, or left for up to three months — depends on budget — there is a price on child protection. The department says they don't have enough staff. (confidential consultation)

CHILD PROTECTION ACT 1999

There are a number of provisions in the *Child Protection Act 1999* that refer specifically to Aboriginal and Torres Strait Islander children and their families. Section 6 is entitled 'Provisions about Aboriginal and Torres Strait Islander Children'. Subsections (1) and (2) of that section apply to 'decisions' (the term is not defined in the Act) by the director-general or an authorised officer of the Department of Families, under the Act, about an Aboriginal or Torres Strait Islander child. Section 6(1) effectively provides that such decisions must be made only after consultation with the 'recognised Aboriginal or Torres Strait Islander agency for the child'.[1] If consultation is not possible before making the decision, then it must take place as soon as practicable after making the decision (see s. 6[2]). The Act further states (see s. 6 [3]) that, where the director-general or an officer of the Department of Families or the Children's Court exercises a power under the Act in relation to an Aboriginal or Torres Strait Islander child, the person exercising the power must have regard to:

(a) the views of the recognised Aboriginal or Torres Strait Islander agency for the child and Aboriginal traditions and Island custom relating to the child; and

(b) if it is not practicable to obtain the agency's views — the views of members of the community to whom the child belongs; and

(c) the general principle that an Aboriginal or Torres Strait Islander child should be cared for within an Aboriginal or Torres Strait Islander community.

Section 7 sets out the general functions of the director-general, which include helping Indigenous communities establish programs for preventing or reducing incidences of harm to children in the communities (s. 7[f]); and consulting with recognised Aboriginal and Torres Strait Islander agencies about the administration of this Act in relation to Indigenous children (s. 7[o]).

Additionally, and importantly, when placing an Indigenous child, the director-general *must* consult with the recognised Aboriginal and Torres Strait Islander agency for the

child before a decision is made about where or with whom the child will live (see s. 83). If this cannot be done prior to placement, it must be done as soon as practicable after the decision. Under section 83(4), when placing an Indigenous child the chief executive must:

> give proper consideration to placing the child, in order of priority, with:
>
> (a) a member of the child's family; or
>
> (b) a member of the child's community or language group; or
>
> (c) another Aboriginal person or Torres Strait Islander who is compatible with the child's community or language group; or
>
> (d) another Aboriginal person or Torres Strait Islander.

Additionally, the director-general must give consideration to (see s. 83 [5]):

> (a) the views of the recognised Aboriginal and Torres Strait Islander agency for the child; and
>
> (b) ensuring the decision provides for the optimal retention of the child's relationship with parents, siblings and other people of significance under Aboriginal tradition or Island custom.

KEY CONCERNS RAISED AT THE INQUIRY

The remainder of this chapter deals with the concerns that came to the foreground during the Inquiry. They are grouped under the following six headings:

- the role of Aboriginal and Islander Child Care Agencies (AICCAs)
- the Indigenous child placement principle
- placement options
- recruitment of specialised carers
- children and biological parents
- issues from Cape York, the Gulf and Torres Strait regions
- consultation.

Before turning to these issues, it is important to bear in mind the following points about how the new Department of Child Safety (DCS) could respond to concerns relating to Indigenous children in care. It is not the view of the Commission that there need be separate regimes for protective services applying to Indigenous and non-Indigenous children. While there are clearly issues specifically relating to Indigenous children that are not present (or not to the same degree) for most non-Indigenous children, this does not mean entirely separate services and/or delivery mechanisms need to be established.

Central to service delivery of the DCS will be an expanded range of response options for the needs of children in care. The 'mix' of the response options drawn upon will vary (sometimes markedly) in different communities, but the general suite of response options available to the DCS will, as far as practicable, be consistent and applied on the basis that all children are entitled to an equivalent quality of service provided by the DCS.

Having said this, however, there is one clearly important service delivery mechanism that will continue to apply only to Aboriginal and Torres Strait Islander children: the Aboriginal and Islander Child Care Agencies (AICCAs), the role of which is discussed in detail below.

The role of Aboriginal and Islander Child Care Agencies (AICCAs)

The Commission is convinced that the AICCAs, or equivalent community-based bodies, will need to play a pivotal role in the reformed system of child protection in Queensland.

Essential to the success of a new approach to protecting children is for that approach to be accepted by the affected communities. For this to occur, service delivery must be

genuinely sensitive to the complexities of the communities in the light of a long-standing (and entirely understandable) distrust of government agencies with extraordinarily intrusive powers.

The Commission believes that AICCA-type organisations currently provide the only logical mechanism for delivering key aspects of child protection services for Indigenous children. There are no other mechanisms available at present that satisfy the two vital criteria of sensitivity to cultural factors and acceptability to the communities concerned. Complicating this view, however, is the evidence that the Department of Families is currently dissatisfied with the capacity of some AICCAs to operate transparently and in accordance with their service delivery agreements.

The Commission is not in a position to reach conclusions on these issues and does not believe AICCAs should be in any way exempted from standard accountability requirements pertaining to the expenditure of public monies. However, the Commission is persuaded that AICCAs have the potential to be crucial to the success of child protection for Indigenous children, and, therefore, if these organisations need help in complying with accountability requirements, such help should be provided.

The concept of Aboriginal and Islander Child Care Agencies originated from the Aboriginal Legal Service in Victoria in the 1970s, following the successful implementation of similar agencies by Native Americans, which reduced the rate of child removal in their own communities. The first AICCA was established in Victoria, with other AICCAs set up soon after in the early 1980s in all other Australian states and territories (Briskman 2000). The basic principles behind the agencies are:

- self-determination
- the right to bring up children as Aboriginal and Torres Strait Islander children, and the right to rear children in a way that is uniquely Aboriginal and Torres Strait Islander in relation to their particular community, language, custom, culture and religion
- the need for additional assistance to families and children arising from the comparative socioeconomic disadvantage of Aboriginal people (Butler 1993).

The specific responsibilities of each AICCA in child protection vary from state to state, according to the capacity of the organisation, the level of demand, and the support the AICCAs receive from their respective funding bodies. Typically, they provide community and family input into decisions regarding the welfare of the children (Butler 1993). Within Queensland there is some regional variation, but the main objectives are to:

- support families
- keep families together
- reduce the need for children to be removed
- ensure that children are kept close to family and within their Indigenous community if they are removed
- provide advice to the department on placements.

It is not the role of the AICCAs to remove children from their families or to investigate reported cases of abuse or neglect.

Status of AICCAs today

In July 2003, the Queensland Government provided $3.8 million annually to fund 16 agencies, including the State Secretariat (Department of Families 2003h). The State Secretariat's functions were to advocate for the Queensland AICCAs, and to support, advise and represent them at a state and federal level while implementing reforms. AICCAs are funded to deliver early intervention and family support, and some also receive additional funding to provide licensed shared family care services.

In addition to state funding, the Commonwealth Department of Family and Community Services (FaCS) provides recurrent funding of $1.75 million to ten Aboriginal and Islander child care agency services in Queensland (Department of Families 2003h).

A concern raised during the Inquiry was the recent de-funding of a number of the AICCAs. In the last two years, six AICCAs as well as the State Secretariat have been de-funded. At the time of writing, there are only nine AICCAs operating in Queensland (Gold Coast, Brisbane City, Caboolture, Redcliffe, Townsville, Wide Bay and Burnett, Central Queensland, Mackay and Whitsunday, and Cairns).

In acknowledging the problems faced by AICCAs, the Department of Families noted (2003h) that many are small organisations that face difficulties in recruiting, training and retaining staff to deal with the complex challenges of responding to the needs of children in care and the volunteers who support those children. Government funding provided to these agencies does not necessarily include or take into account the holistic framework under which some AICCAs operate. The following comment was made during the public hearings by an AICCA worker:

> I've been involved in Aboriginal politics for the last 20 years. We've always been given a limited amount of money, but we're expected to provide more outcomes within our communities. (CMC 2003, p. 364)

A paper produced by the department, entitled *Aboriginal and Islander child care agencies: ensuring the best for Indigenous children in care* (2003h), states that:

> While many AICCAs provide a reasonable standard of service, the required level of service has not always been provided. Some of the problems experienced are:
>
> - difficulties in meeting licensing requirements
> - reports of lapses in service delivery quality
> - inability to respond to requests for service
> - inability to comply with reasonable levels of administrative probity, including evidence of mismanagement of funds resulting in financial loss, cases of fraud
> - inability to comply with accountability requirements of government funding.

While FaCS has announced that it will be undertaking a national review of its AICCA program, which it hopes to complete by early 2005, the review will not target any specific AICCAs, and the Australian Government has stated it is committed to supporting and maintaining the AICCAs (provided by FaCS 2003).

Throughout the Inquiry it was acknowledged that some of the AICCAs have had management and/or financial difficulties, leading to de-funding in some instances (CMC 2003). Others may have had difficulties in identifying and/or implementing services that are responsive to the holistic needs of Indigenous families. There is an obvious need to look at ways whereby Indigenous community agencies can be better supported to provide culturally appropriate services and at the same time be accountable to their funding bodies. The government needs to acknowledge the different capacities of the smaller organisations compared to the larger ones, and the need for each AICCA to continue to work in a way that is culturally appropriate for the needs of its specific region/community. It is also crucial to keep in mind that one of the most important issues identified throughout the consultations was the need to maintain the independence of the AICCAs.

Consultations with community groups around the state revealed that there is a genuine and widespread concern among community members that the Department of Families will be closing down all the remaining AICCAs and looking at other independent alternatives for delivering child protection services to the Indigenous communities.

> Who knows what the department has planned? There are rumours that they want to mainstream the AICCAs and to me that suggests they want our Aboriginal workers within the department to make sure they are adhering to the child placement principle. We are already committed to ensuring that the principle was upheld, and worked very closely with the department. At the moment, we are independent from the department. We'll go back to the old regime where the department calls the shots, our kids will be taken away from their families and if we're a part of the department and we don't agree, we'll be out of a job. We can't advocate and our people won't trust us. They don't trust Aboriginal people

> who work for the government as it is. That is why AICCAs were set up. (Burrows 2003, p. 32)
>
> It is only through these support organisations that the Aboriginal and Torres Strait Islander community feel confident in placing their children in care and only the AICCAs know the family and extended family structures. We are a growing population — why are we axing essential services? Do not introduce an Indigenous component in the department's structure because Aboriginal and Torres Strait Islander people won't respond in any way. (confidential consultation)

With respect to this issue, the department noted (2003h) that while the current functions of AICCAs have been traditionally performed by those agencies, they could be performed by any Indigenous agency recognised by the department. Community groups' response to this view has generally been that it is not appropriate for the department to consult with just any Indigenous agency on child protection matters:

> Queensland Aboriginal and Torres Strait Islander Legal Secretariat's response to this is that it's not appropriate to have any Indigenous service doing child protection work, just as it's not appropriate to have university students on work experience conducting unsupervised assessments of suspected child abuse victims. Indigenous child protection work must be carried out by persons trained and experienced in that field of work. Not any Indigenous person will do. (CMC 2003, p. 678)

It was apparent from consultations and submissions received by the CMC that the role of the AICCAs in child protection was widely recognised as vital (confidential consultation). It was also frequently asserted that those AICCAs that have been de-funded have not been replaced with an alternative culturally appropriate agency, with the situation in the Gulf, Torres Strait, and Cape York being particularly highlighted. Where services have been de-funded, the funding allocation has been directed to interim agencies, or transferred to departmental regional offices or a combination of both (information provided by Department of Families 2003). The department has implemented interim alternative service delivery model arrangements for two regions, Townsville and Cairns. CMC confidential consultations with community groups in far north Queensland regarding the interim arrangements of a transition team (within the department) in Cairns raised the assertion that there were inadequate staffing levels for administration of alternative care of Indigenous children. It was claimed there were only two Indigenous workers in alternative care:

> The staff are overworked, as they are expected to recruit, train and support carers — for non-Indigenous children there are nine workers in the same area. (confidential consultation)

Other issues highlighted during the CMC consultations regarding the transition team included:

- staff employed on constant short-term contracts
- extremely limited resources in comparison to other programs in the department
- a lack of meaningful leadership or direction from within the department
- unstable work environment for workers
- FSOs giving insufficient attention to recommendations of the Indigenous Alternative Care Workers in the department, regarding placements of Indigenous children in care.

Overall, the consultations conducted with Indigenous groups suggest that the new interim models being employed by the department are struggling to gain their support (confidential submission).

In other initiatives in the Indigenous area, the department has created several Indigenous Family and Community Worker (FACW) positions within the department and across the regions, as well as some positions funded by the department but employed by external agencies (e.g. Community and Family Support [CAFS] workers). However, from the evidence there is some confusion about the roles and responsibilities of these workers among the general community, given the department's

statutory obligations:

> The department said these have worked 'really well'. It would have been better to have these community-based, rather than departmental positions. If someone says they work for the department, they assume they are there to remove the children. (confidential consultation)

> They were treading a fine line with their roles for a while and there was some overlap with responsibilities of FSOs and the community support workers. The department was allowing the ... Community and Family Support worker to do statutory work. This was creating havoc in the community. (confidential consultation)

Indigenous people working within AICCAs also pointed out that difficulties can arise when cultural obligations conflict with service agreements with the funding body. The CMC was told that there was a conflict between the service provision of the AICCAs and the department's view (as perceived by the AICCA workers) as to how services should be provided to the Indigenous community. Specifically, the CMC was told that government funding provided to these agencies does not necessarily include or take into account the holistic framework under which some AICCAs operate, which often directly conflicts with their licensing and funding agreements with the department. The framework within which they deliver their service acknowledges a wide range of complex issues, such as the social problems, health, family, environment, education and culture in the relevant local community. These cultural obligations typically draw the AICCA into providing 'prevention' services that, although important, are not always part of the service delivery agreement the AICCA has entered into with the department.

This is an important issue that will need careful consideration. The implementation of the recommendations made in the earlier chapters of this report will result in the new DCS having no role in the provision of primary or more mainstream prevention services. In that case it may be that AICCAs would be better served if their funding came from two primary sources (apart from any Commonwealth funds received). Funding for direct child protection services could be provided through the DCS, and funding for prevention services could come from the reconfigured Families department (or whatever agency is responsible for the provision of primary prevention services). Primary prevention programs/services (as well as education programs) in Indigenous communities should be a function of AICCAs, or equivalent community-based bodies — but funding and monitoring this function would not be the responsibility of the new Department of Child Safety.

Recommendations

8.1 That the government recognise the ongoing need for independent community-based Indigenous organisations, and that these organisations be provided with the necessary support and resources to provide culturally appropriate child protection services to the Indigenous community. This support should include training and professional development, as well as assistance complying with service agreements and accountability requirements.

8.2 That, where AICCAs have been de-funded, they be replaced by appropriate independent Indigenous organisations that have the support of their local community and that, wherever possible, these organisations employ staff with backgrounds in child protection.

Reason (8.1 and 8.2): The new child protection system envisages a continuing role for independent Indigenous organisations, operating in an effective and culturally appropriate manner within local communities.

8.3 That, in acknowledgment of the extent to which cultural factors draw AICCAs into the delivery of prevention services, the nature of both the service agreements and the funding of individual AICCAs be carefully reviewed.

Reason: Clear links between funding and the performance of child protection services are necessary, in order to support the enhanced focus on child protection work in the new DCS. The evidence suggests that the lines between prevention initiatives and alternative care services are frequently blurred in Indigenous communities. AICCAs cannot realistically be expected to operate effectively in delivering child protection services unless expectations about their delivery of these different types of services are clearly delineated.

Indigenous child placement principle

As noted earlier, section 83 of the Child Protection Act states that, in deciding where to place an Aboriginal or Torres Strait Islander child, the director-general must give proper consideration to placing the child with (in order of priority):

- a member of the child's family
- a member of the child's community or language group
- another Aboriginal person or Torres Strait Islander who is compatible with the child's community or language group, or
- another Aboriginal person or Torres Strait Islander.

Submissions made to the Inquiry highlighted the fact that, despite the provisions of the Act, the number of Indigenous children placed with non-Indigenous carers is relatively high, as is the number of children placed outside the community to which they belong. As at June 2003 there were 723 Indigenous children in out-of-home placements; and 245 (or approximately 34 per cent) of these were placed with non-Indigenous carers (data provided by the Department of Families 2003). It is important that the DCS work to improve the proportion of Indigenous children placed with Indigenous carers.

A number of Indigenous and non-Indigenous organisations called for independent monitoring of the department's compliance with the child placement principle. The Commission is persuaded that independent auditing would be advantageous in informing the DCS's operations, and that the Child Guardian should be responsible for monitoring DCS compliance with the Indigenous child placement principle. This function would readily fit within the new functions of the Child Guardian. Where the Child Guardian considers there has been inadequate compliance with the principle, that information should be raised with the DCS for explanation.

If resolution cannot be achieved between the Child Guardian and the DCS over a particular case, the matter could be referred to the Children Services Tribunal, as noted in Chapter 5.

The 2002–03 annual report of the Children Services Tribunal noted that there is only one Indigenous member on the 16-member tribunal, despite the fact that 30.5 per cent of tribunal matters involve Indigenous children (CST 2003). The tribunal acknowledged the need for increased Indigenous membership to reflect the growing number of matters involving Indigenous children brought before it. The Commission supports that call.

Important as the child placement principle is, the paramount consideration, in making a placement decision, must always be the welfare and best interests of the child. While section 5 of the Act says that the whole of the Act is to be administered in accordance with this 'best interests' principle, the CMC believes that section 83 should be amended to state specifically that, in giving proper consideration to the range of placement decisions expressed in the section, the best interests of the child remain paramount.

Recommendations

8.4 That DCS compliance with the Indigenous child placement principle be periodically audited and reported on by the new Child Guardian.

Reason: The child placement principle constitutes a fundamental recognition of the important and unique aspects of Indigenous culture. Giving effect to this recognition is central to a viable child protection service.

8.5 **That the Indigenous child placement principle specifically state that a placement decision can only be made if it is in the best interests of the child.**

Reason: The best interests of the child should be paramount in any decision, regardless of whether the child is Indigenous or non-Indigenous.

Placements with non-Indigenous carers

On 19 September 2003 the United Nations' Committee on the Rights of the Child devoted its 2003 day of general discussion to the rights of Indigenous children. The recommendations of the committee included the following:

> The Committee reminds States parties, in cases where it is in the best interest of the child to be separated from his or her family environment, and no other placement is possible in the community at large, institutionalization should only be used as a last resort and be subject to a periodic review of placement. In accordance with art. 20.3 of the Convention, due regard shall be paid to ensuring continuity in the child's upbringing and to his or her religious, cultural, ethnic and linguistic background. (United Nations 2003)

Given that a third of Indigenous children placed in foster care are placed with non-Indigenous carers (data provided by the Department of Families 2003), consideration could be given to amending section 83 of the Act so that it specifically provides for the situation where an Indigenous child is placed with a non-Indigenous carer. One instructive model is section 13(6) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), which provides:

> The following principles are to determine the choice of a carer if an Aboriginal or Torres Strait Islander child or young person is placed with a carer who is not an Aboriginal or Torres Strait Islander:
>
> (a) Subject to the best interests of the child or young person, a fundamental objective is to be the reunion of the child or young person with his or her family or Aboriginal or Torres Strait Islander community.
>
> (b) Continuing contact must be ensured between the child or young person and his or her Aboriginal or Torres Strait Islander family, community and culture.

Currently, section 83(5)(b) of the Child Protection Act requires the director-general, when making a placement decision, to give proper consideration to (in addition to the views of the recognised Aboriginal or Torres Strait Islander agency for the child):

> ensuring the decision provides for the optimal retention of the child's relationships with parents, siblings and other people of significance under Aboriginal tradition or Island custom.

It needs to be emphasised here, however, that any ongoing contact between children in care and their families must only be retained where it is in the best interests of the child.

Recommendation

8.6 **That in situations where Indigenous children are placed with non-Indigenous carers, the child protection legislation should specifically provide that contact be maintained with their kinship group, where that is in the best interests of the child.**

Reason: Separating any child from their biological parents is a dramatic intervention in the life of a child. The magnitude of this intervention should not be unnecessarily increased for Indigenous children by simultaneously removing the child from their cultural community.

Placement options

Community groups consulted throughout Queensland consistently identified limited placement options as a particularly pressing concern, as noted in Chapter 7. The majority of Indigenous organisations also suggested that a much wider range of placement options needed to be made available in order to resolve the present problems. Some of the options identified were:

- safe houses
- emergency shelters for short-term placements
- group homes
- family-based care options
- children's residential shelter for longer-term placements
- recruitment of specialised carers for children with high or complex support needs.

Safe houses

Potential placement options identified here included individual family safe houses (which are already operating informally in some communities), where alternative placements were limited or non-existent. Groups consulted stated that the children knew where the 'safe houses' were located, if they ever needed to use them.

Emergency shelters for short-term placements

Community groups advised the CMC of the need for emergency shelters for the temporary care of children who had to be removed immediately from their homes. Indigenous people said that using a facility such as this would allow more time for proper consideration of suitable longer-term placement options.

Group homes

Another option arising during the consultations was for properly funded group homes with appropriate carers to accommodate six to eight children, which would be suitable for short-term placements and of particular value for keeping sibling groups together.

Family-based care options

Community groups identified the need for family-based care options, which would incorporate working with the whole family on a range of issues such as parenting, and drug and alcohol issues. This option would have families with children living together, but under supervision and/or accessing therapeutic services such as a substance-abuse management program. The option could also be used for transitional phases of family reunification programs.

This option would need to be resourced with support from appropriate professional specialist workers such as drug and alcohol counsellors, and psychologists. Professional staffing of the units was considered a very important issue:

> Need residential facilities for mums and dads for prevention/intervention, e.g. units connecting into one — where they have to stay and care for children — have staff help to teach — drug and alcohol counsellors on hand, psychologists — drugs are a big problem in the community — there have been quite a few hangings. (confidential consultation)

Children's residential shelter for longer-term placements

This option had widespread community support because appropriate long-term placements were non-existent in some communities. Like the family-based units/centres, these shelters would need to be professionally staffed. They would also need to define their functions carefully, to ensure that their usefulness did not suffer as a consequence of confusion about their actual purpose.

Recruitment of specialised carers

The CMC was told that the ability to find suitable carers (both general and relative) is difficult in the general community and very difficult in some Indigenous communities, for various and complex reasons. Those reasons include:

- inadequate training, support and respite for carers
- criminal history checks preventing approval of some carers.

The CMC consultations indicated that in some communities training for carers is non-existent or inappropriate. Again, in the Indigenous community context, there is a pressing need for more appropriate training and support for foster carers. In particular, carers need specific training to deal with especially challenging placements such as children with disabilities and special needs.

A further reason why it may be difficult to recruit Indigenous carers may be the lack of respite in some communities. Comments made to the CMC included the following:

> If carers ask for respite, the department will put it on their record as not being able to look after kids. The department offers no respite to carers.
>
> Relative carers are treated like victims — asking for respite — the department uses this against them. The department responds to carers who want respite with 'You obviously can't look after them.' It seems they are trying to cut carers altogether. (confidential consultation)

As recommended generally in Chapter 7, provision should be made for Indigenous carers to have enhanced access to respite care, and for adequate training and support (both financial and non-financial) to be made available to them.

It was also suggested to the CMC that the lack of Indigenous carers may in part be a consequence of the rigour of the criminal history checks conducted by the department. Departmental policies provide a framework for interpreting personal history information (Department of Families 2003e). While the policy states that information must be considered in a fair and consistent way, the CMC heard that this did not always appear to be the case to those concerned.

Other consultations, however, suggested that the department will make inappropriate allowances when carrying out criminal history checks on Indigenous relative carers. This was not always seen as being in the best interests of children. The CMC was told of instances where the department has allegedly placed children in high-risk placements where there is known violence occurring in that family.

Recommendations

8.7 That, subject to consultation, provision be made for Indigenous carers to have enhanced access to respite care, and adequate training and support be made available to Indigenous carers (as recommended generally in Chapter 7).

8.8 That urgent attention be given to identifying ways of encouraging more Indigenous people to become carers.

Reason (8.7 and 8.8): Fundamental to the success of child protection services for Indigenous children are the services of Indigenous carers equipped to draw upon various placement options to meet the full range of needs of children in care.

Children and biological parents

There was widespread agreement during consultations that Indigenous children and parents had little or no knowledge of their legal rights once they had come to the attention of the child protection system. Indigenous groups frequently put forward the view that the Department of Families was taking advantage of this situation and not informing clients of their legal rights, or in some cases providing them with incorrect information. It frequently appeared to be the case that Indigenous children were largely unaware of what was happening to them once the department had intervened

in their lives. It was also commonly reported that 'the jargon' or terminology regularly used by departmental representatives unnecessarily caused confusion and stress:

- The department's terminology TAO, CAO, CPO etc. needs to be in basic English. The court process to determine orders alienates families and this sometimes occurs without parents being present, leading to powerlessness and confusion.
- The department has complicated orders — people are signing orders they don't understand. People don't know their rights regarding appeals/ decisions. The department does not inform them.
- People are not informed of their legal rights before court proceedings [problems with Legal Aid forms]. This must be a priority. Because of the power imbalance with the department, clients don't feel 'they can put up a fight'.
- No-one tells the kids what's happening. They are in oblivion. Emotional harm — more kids are traumatised in care.
- They don't tell the parents their rights at the family meetings. Biological parents have no knowledge of their parental rights. (confidential submissions)

The new department will need to work in conjunction with biological parents, local community organisations and the recognised Indigenous child protection agencies to develop suitable case plans and communicate effectively with the children and other participants.

RECOMMENDATION

8.9 **That departmental policies and practices recognise the rights of children and biological parents and reflect this recognition in culturally appropriate ways that allow for all parties to be fully informed of, and involved in, case planning for children.**

Reason: It is undesirable to unnecessarily exclude biological parents from involvement in case planning because of a reluctance or inability to use culturally appropriate language and communication idioms.

Issues from Cape York, the Gulf and Torres Strait regions

The culture of Cape York, the Gulf of Carpenteria and Torres Strait regions is especially characterised by isolation and remoteness. Living in these remote areas presents very particular challenges in terms of access to services and facilities for children and families. Community groups consulted expressed frustration and anger about the lack of appropriate and equitable child protection services, associated community services and general infrastructure characterising these remote regions:

- There has been no real increase in child protection funding in the Cape and some communities get little or no funding (e.g. family support workers are given $12/hour) so it is difficult to attract workers within or outside the community.
- There is Shared Family Care in Cairns, yet nothing is set up for the communities or the Torres Strait. (confidential consultations)

Disproportionately high levels of alcohol consumption and violence in these communities markedly compounds child protection issues.

The issue of alcohol and violence is extremely prevalent in some of the communities, and the impact on the community and children is profound. Some stakeholders suggested that the introduction of individual alcohol management plans (in accordance with the recommendations of the Cape York Justice Study) had made a difference with regard to some of these issues. Reportedly, the level of violence and attendances at hospitals for trauma has been reduced where alcohol management plans (AMPs) have been introduced in communities. It was further stated that the level of crime had also been reduced in one community (*Courier-Mail*, 11 August 2003).

During consultations the CMC also heard that:

> Some of these communities have among the highest rates of foetal alcohol syndrome in the world.
>
> The tragedy is downstream effects in terms of damaging education opportunities for those kids who would otherwise have potential and implications for the whole community.
>
> We are getting a population of Aboriginal children who are never going to reach their full potential because of poor nutrition — poor brain growth. We have different standards for Aboriginal children, i.e. if we were to report all of these kids with failure to thrive[2] what would we do with them all? Currently just doing band-aid stuff and statistics show no improvement since 1997 with failure to thrive.
>
> The children who are affected by foetal alcohol syndrome are often 'disinhibited', have higher rates of alcohol and drug abuse — therefore they are more vulnerable to sexual abuse — 7–14 per cent are failure to thrive, 34 per cent children have chronic malnutrition. Alcohol abuse is an underlying issue. (confidential consultation)

Some community groups stated that the problems in the communities were not just alcohol-related; there were also concerns regarding nepotism within some of the local Indigenous community councils, which had direct implications on how resources were allocated within the local community, including housing.

> Overcrowding of the family house creates another plethora of problems. It is not uncommon to have 20 people living in a three bedroom house with one bathroom. (*Courier-Mail*, 6 August 2003)

Notwithstanding these difficulties, it is important to recognise that the Inquiry was also told of communities with high levels of resilience and significant numbers of people who currently work with children and families on a voluntary basis who are keen to continue contributing to protecting children and supporting families.

The CMC is of the view that there are substantial community resources that could be drawn upon by the new DCS in partnership with these communities.

Recommendation

8.10 That the DCS provide culturally appropriate child protection services that take account of the drug- and alcohol-related problems besetting some remote communities. This will require the provision of specific support services to address the special needs of children requiring DCS intervention in these communities.

Reason: Geographical isolation should not mean that children in remote communities have unnecessarily limited access to the range of protective services available to children in more populous regions. This is particularly important given that some of the very remote communities are faced with problems so serious that only major interventions by government can be expected to resolve their difficulties.

Consultation

The *Child Protection Act 1999* and associated departmental policies and procedures reflect the need to consult with the Indigenous community. Nevertheless, submissions made to the Inquiry consistently advanced the view that Indigenous organisations are not consulted in relation to Indigenous children, and that departmental officers fail to effectively and appropriately engage Indigenous community members (including biological parents) when an Indigenous child comes into the protection system.

The Act does contain confidentiality provisions and penalties for breaching them, but there are important exceptions to these, as noted in Chapter 7. The provisions in the Act are quite clear and allow the sharing of information that is directly related to a child's protection or welfare.

Given an apparent reluctance or inability on the part of some departmental employees to share information with other stakeholders, it is considered that the governing legislation should explicitly regulate the department's performance in relation to this issue.

RECOMMENDATION

8.11 **That the child protection legislation reflect the importance of Indigenous participation in decision making. So as to remove any ambiguity, the legislation should explicitly state the types of 'decisions' requiring consultation. The department, in consultation with Indigenous agency stakeholders, should develop an agreed protocol for sharing information about children and families involved in the child protection system.**

Reason: Indigenous people are entitled to informed participation in the decision-making process when Indigenous children come in contact with the child protection system.

Placement decisions

As stated in section 83 of the Act, the director-general must consult with the Indigenous agency for the child before a decision is made about placing an Indigenous child in care.

Once again, the CMC was told by many organisations that placement decisions were often made without reference to the Indigenous child care agency for that child. The Esther Centre, after consultation with Indigenous children and young people, noted:

> ... in some cases the appropriate Indigenous agency or community member was not consulted during decision-making processes. (CMC 2003, p. 252)

Placements should not take place until the Indigenous organisation/agency has been included in the decision-making process and has provided advice regarding that child to the DCS. The Indigenous agency consulted must have a background in child protection issues and be sufficiently familiar with the family. For example, the agency must establish links within the community in order to fulfil this requirement. Priority must be given to advising the DCS of possible placement options for a child.

Where placements are urgent, and the appropriate agency cannot be consulted, a genuine effort must be made to do so as soon as practicable. There should be additional options available for Indigenous children — for example a children's shelter within the community or a residential facility (as discussed earlier in this chapter), so that children do not have to be placed inappropriately.

There is a need to ensure that funding is provided to the Indigenous agency so that there will always be a person available to fulfil this consultation role. There may need to be a full-time or part-time position within the Indigenous agency dedicated exclusively to this function. The necessity for this will depend on the number of clients within the region, the geographical spread of clients and any other functions performed by the agency.

RECOMMENDATION

8.12 **That the DCS ensure its officers comply with the department's statutory obligation by consulting with an Indigenous agency before removing or placing an Indigenous child. A protocol (agreed between the department and the Indigenous organisation) must be developed to establish clearly how this consultation will occur.**

Reason: Indigenous people are entitled to informed participation in the placement of Indigenous children, to ensure that placements are not only in the best interests of the child but also, where possible, in accordance with the Indigenous child placement principle.

Case-management plans

It was evident from consultations with various Indigenous communities that case planning for Indigenous children in care was too often inadequate or absent. The evidence here reflected the problems inherent in the child protection system as a whole. Comprehensive and appropriate case planning is considered fundamental in ensuring that decisions are always made in the best interests of the child and in accordance with the child placement principle.

Legislation in other Australian jurisdictions ensures not only that case plans are developed but also that they prescribe involvement from the Indigenous community where the child is of Aboriginal or Torres Strait Islander descent. In Victoria, where the Children's Court makes a supervision, supervised custody, custody or guardianship order, a case-management plan is required (see s. 120 of the *Children and Young Persons Act 1989* [Vic.]). The Act goes on to state that any decisions made as part of the case-planning process must, as far as possible, be made according to specific principles (see s. 119 [1][m]):

> in the case of an Aboriginal child:
>
> (i) decision-making should involve relevant members of the Aboriginal community to which the child belongs; and
>
> (ii) in recognition of the principle of Aboriginal self-management and self-determination, arrangements concerning the child, and his or her care, supervision, custody or guardianship, or access to the child, must be made in accordance with the principles listed in sub-section (2).

The principles listed in subsection (2) of section 119 are:

> (a) persons involved in the arrangements mentioned in sub-section (1)(m)(ii) must be, or at least one of them must be, a member of the Aboriginal community to which the child belongs;
>
> (b) if a person or persons of the class mentioned in paragraph (a) is or are not reasonably available for that purpose, the persons involved in those arrangements must be members of, or at least one of them must be a member of, an Aboriginal community; or
>
> (c) if a person or persons of the classes mentioned in paragraphs (a) and (b) is or are not reasonably available for that purpose, the persons involved in those arrangements must be persons approved by the Secretary and by an Aboriginal agency as suitable persons for that purpose.

The CMC has not had the opportunity to engage in sufficient consultations to determine whether such provisions, if enacted in Queensland, would be of practical benefit to Indigenous children. However, the Victorian provisions do appear to have merit. The Commission recommends that the DCS consider these issues at further length and that DCS officers, wherever possible, consult with appropriate community members in the interim about relevant case-planning decisions.

Administrative measures would need to be established to allow this action to be properly implemented. For example, if case plans are to be regularly reviewed (say every six months, as recommended) DCS might determine to consult by notifying the AICCA, as well as other Indigenous people involved in the process, such as parents and carers.

Recommendation

8.13 That the DCS consult with appropriate community representatives in the case-planning processes for Indigenous children.

Reason: The involvement of Indigenous people in the case-planning process should ensure that the best decisions are made for the child.

Endnotes

1 Defined in the dictionary (Schedule 3) to mean an entity that, under an agreement between the state and the entity, is the appropriate entity to be consulted about the child's protection. Under s. 36 of the *Acts Interpretation Act 1954* (Qld), an 'entity' can be an individual, a corporation or an unincorporated body.

2 'Failure to thrive' is a term applied to children whose current weight or rate of weight gain is significantly below that of other children of similar age and sex.

9

LEGISLATIVE CHANGES

If the recommendations contained in this report are implemented, a significant number of amendments will need to be made to the *Child Protection Act 1999* and to the legislation that governs some of the bodies that currently have jurisdiction to review or hear complaints about child protection decisions made by the Department of Families.

The purpose of this final chapter is to highlight the key recommendations for legislative change that have been made in earlier chapters of this report. The chapter concludes with a recommendation that within two years the government review the implementation of the recommendations contained in this report.

CHANGES TO QUEENSLAND CHILD PROTECTION LEGISLATION

Additional principle

The underlying principles set out in section 5 of the Child Protection Act are intended to guide how the Act is administered. When the principles are read as a whole, it is arguable that the focus is on preserving and reunifying families, with a minimalist approach to intervention. The Commission has recommended, however, that an additional principle be inserted into the Act clearly spelling out that, if a conflict arises between the interests of a child and the interests of the child's family, it must be resolved in favour of the child (*see recommendation 7.45*).

Key players in the new child protection system

This report has recommended fundamental changes to the way in which responsibility for child protection is understood and delegated by government.

The first major recommendation (*see recommendation 4.1*) is the creation of a new department — the Department of Child Safety (DCS) — which will be responsible for the safety and wellbeing of all children who require some level of government care. New legislation could be passed to establish this new department and set out its structure, responsibilities and powers. Alternatively, amendments could be made to the Child Protection Act to reflect the fact that the DCS, and not the Department of Families, is to be the lead agency for child protection.

The second major recommendation (*see recommendation 4.2*) is the establishment of a Directors-General Coordinating Committee (DGCC), to be chaired by the Director-General of the Department of the Premier and Cabinet. The DGCC would coordinate the delivery of multi-agency child protection services.

The third major recommendation (*see recommendation 4.3*) is the establishment of a new position — entitled Child Safety Director — within each government department identified as having a role in the promotion of child protection.

These last two recommendations can be implemented on a purely administrative basis. However, the Commission's recommendation that every department with child protection responsibilities be required to publicly report its performance of these responsibilities should be inserted into legislation.

Recommendations 6.3 to 6.8 concern the use of Suspected Child Abuse and Neglect (SCAN) teams. SCAN teams currently operate under administrative arrangements and have no legislative powers to enforce their recommendations. The Commission has recommended that SCAN teams be given far greater responsibilities, and it is therefore important that their existence be enshrined in legislation. The legislation should also:

- stipulate the structure, role, functions and powers of SCAN teams, and
- identify who will be responsible for monitoring the performance of SCAN teams.

Notifications

The director-general's obligation under section 14 of the Child Protection Act to respond to a notification about a child who is in need of protection does not apply to an unborn child. The Queensland Ombudsman has recently recommended that the Act be amended to enable the Department of Families to intervene where it is suspected, before the birth of a child, that the child may be at risk of harm after birth (Queensland Ombudsman 2003, recommendation 6.4.3). The Commission agrees with this recommendation.

The only child protection legislation in Australia that applies to unborn children is the New South Wales Act. Section 25 of that Act provides that:

> A person who has reasonable grounds to suspect, before the birth of a child, that the child may be at risk of harm after his or her birth may make a report to the director-general.

The intention of this section is to provide assistance and support to the pregnant woman to reduce the likelihood that her child, when born, will need to be placed in out-of-home care. The principle is that of supportive intervention rather than interference with the rights of pregnant women.

The Queensland Government has recently indicated that it endorses the Ombudsman's recommendation and 'supports the need to ensure there are no impediments to agencies taking action to intervene in cases where they suspect an unborn child may be at risk of harm after birth' (Queensland Government 2003b, p. 7).

RECOMMENDATION

9.1 **That the *Child Protection Act 1999* be amended to enable the department to intervene where it is suspected than an unborn child may be at risk of harm after birth.**

Reason: Some pregnant women need assistance and support before the birth of their child to reduce the likelihood of the child needing to be placed in out-of-home care after birth. The principle is that of supportive intervention rather than interference with the rights of pregnant women.

Mandatory reporting

As noted in Chapter 6, the CMC does not believe that a wholesale expansion of the categories of people required to report will deliver a better child protection system. The evidence presented to the Inquiry clearly shows that the major problem with the system is not the failure of people (external to the department) to make reports, but rather the failure of the department to properly respond to the reports it does receive.

However, given the significant role that nurses play in Queensland, particularly in rural and remote communities, the CMC does believe that section 76K of the Health Act — which currently applies only to medical practitioners — should be amended so that it also imposes a reporting obligation on nurses and so that it requires medical practitioners and nurses to specifically report to the DCS (*see recommendations 6.13 to 6.15*).

Licensing of care services

It was pointed out in Chapter 1 that the scope of section 125 and the other licensing provisions in the Child Protection Act are not clear, essentially because the Act does not define a 'care service'. Some departmental officers have suggested that the licensing provisions apply only to agencies that directly care for children on a daily basis (e.g. residential facilities), or are responsible for placing children with a daily carer (e.g. shared family care agencies). This interpretation would exclude a number of agencies that are currently providing services to children who have been placed in out-of-home care — for example, those agencies that provide intervention services to children who have been placed with an approved foster carer, or some other carer.

The licensing provisions need to be amended so that there is no ambiguity about which agencies are required to be licensed. Before these amendments can be drafted, thought needs to be given to the real purpose of the licensing provisions and what it is they are meant to achieve.

Approval of individual carers

Under section 82 of the Child Protection Act, the director-general is entitled to place a child who is in the director-general's custody or guardianship under an assessment or child protection order with a licensed care service, an approved foster carer, or 'other person that the director-general considers appropriate'. In practice, this 'other person' is either a relative carer or a limited approval carer. Unlike foster carers, although assessment and approval processes for relative carers and limited approval carers are specified in policy, neither of these types of carers is required under the Act to be formally approved. In fact, the Act makes absolutely no reference to relative or limited approval carers. One consequence of this is that there are a number of provisions in the Act that apply to children who are placed with an approved foster carer but not to children who are placed with a relative or limited approval carer. For example, section 84 requires the director-general and an approved foster carer to enter into a written agreement for a child's care.

In the view of the Commission, the Act must regulate the assessment and approval of all carers, and consideration should be given to the extent to which provisions regulating the use of approved foster carers should also apply to both relative and limited approval carers.

RECOMMENDATION

9.2 That the Child Protection Act be amended to ensure that it regulates the assessment and approval of all carers.

Reason: Although assessment and approval processes for relative carers and limited approval carers are specified in policy, neither of these types of carers is required under the Act to be formally approved. In fact, the Act makes absolutely no reference to relative or limited approval carers.

Voluntary placements

Currently, when concerns about the abuse or neglect of a child are identified the parent may consent to the placement of their child in care. Unlike the previous child protection legislation[1] (and the legislation in all other states and territories in Australia), the Act does not regulate placements that take place with the consent of a child's parents ('voluntary placements'). This failure to regulate voluntary placements has serious consequences which reduce the protection provided to children in voluntary care in comparison with children in foster care.

There are a number of significant provisions in the Act that do not apply. For example:

- section 74 — which requires the director-general to ensure that the charter of rights for a child in care is being complied with — does not apply
- section 84 — which requires that the director-general and an approved foster carer must enter into a written agreement for the child's care — does not apply

- section 122 — which requires the director-general to ensure care meets the statement of standards — does not apply.

Children who are placed on a voluntary basis fall outside the jurisdiction of both the Commission for Children and Young People (CCYP) and the Children Services Tribunal, which means that the CCYP cannot investigate any complaints about the treatment of these children and the tribunal cannot review decisions made by the department about these children.

Departmental policies that apply to children who are placed on a voluntary basis do not impose strict limits on the period for which a child can be voluntarily placed in out-of-home care. The consent policy says that a placement with an approved foster carer or a licensed care service cannot exceed 28 days; however, it is possible for extensions to be granted, and the policy does not limit the number that can be granted. The payment of an allowance to a relative or friend is not meant to exceed 28 days, but again it is possible for extensions to be granted, and the policy does not limit the number that can be granted. According to the policy, placements with an unpaid relative or friend may continue 'for as long as negotiated between the parents and the person providing care'. Departmental officers explained that the consent policy is intended to be interpreted — and in practice, is interpreted — subject to the policy on intensive family support with the consent of family ('the intensive family support policy'), which places a three-month time limit on the use of such non-statutory interventions as voluntary placements.

Even if the two policies are meant to be read together, there is no clear statement (in either of the policies) to the effect that no child can be placed on a voluntary basis for more than three months. If a clear time limit was added to the policies, it would need to be worded in such a way that it was not possible to circumvent the intention of the time limit by simply terminating and then recommencing a placement. The CMC heard that this strategy is currently being used by some departmental officers as a way of avoiding the three-month time limit found in the intensive family support policy.

According to the consent policy, relatives and friends who care for children on a voluntary basis are not formally assessed and approved by the department, unless they are receiving an allowance from the department.

For all of these reasons, the Commission recommends (*see recommendation 7.11*) that voluntary placements be regulated by the Act. There will be placements made in circumstances where the department has assessed that a placement is necessary to meet the child's protective needs. The department has indicated that 'regulation of voluntary care placements will be considered as a part of the upcoming review of the Child Protection Act' (communication from the Director of the Review and Evaluation Branch, Department of Families, December 2003). The provisions on voluntary placement should be drafted so that protections such as the charter of rights and the statement of standards are extended to children in voluntary care. Those children should also be brought within the jurisdiction of the Commission for Children and Young People and the Children Services Tribunal. After reviewing similar provisions in other jurisdictions, the Commission believes that a three-month time limit (inclusive of any extensions) would be appropriate. This time limit would be consistent with the three-month time limit currently found in the intensive family support policy. The provisions on voluntary placements should also deal with the following matters:

- the criteria that must be satisfied before an agreement to place a child on a voluntary basis can be entered into — some of the criteria contained in the consent policy may be a useful guide (e.g. a voluntary placement can only be arranged if 'termination of the placement by a parent would not immediately endanger the child')
- the need for a voluntary placement agreement to be in writing and signed by both of the child's parents and the director-general
- the effect of the agreement — that is, the director-general gains custody of the child for the duration of the agreement

- the child's input into the making of the agreement — for example, a provision that says an agreement relating to a child who is 16 years or older cannot be entered into without the child's consent
- termination of the agreement, including termination by a child who is 16 years or older
- continuing contact with the child's family
- support for the child's family (because presumably the aim of a voluntary placement will always be to return the child to his or her family).

Indigenous children

This report makes 13 recommendations about the protection of Aboriginal and Torres Strait Islander children (*see recommendations 8.1 to 8.13*). Only some of these recommendations will require legislative amendments.

The first recommendation concerns the child placement principle, which is found in section 83 of the Child Protection Act. That section says that if the director-general intends to place a child in out-of-home care and the child is an Aboriginal or Torres Strait Islander, the director-general must:

> give proper consideration to placing the child, in order of priority, with:
> (a) a member of the child's family; or
> (b) a member of the child's community or language group; or
> (c) another Aboriginal person or Torres Strait Islander who is compatible with the child's community or language group; or
> (d) another Aboriginal person or Torres Strait Islander.

Evidence presented to the Inquiry shows that as many as a third of Indigenous children are not being placed with Indigenous carers. The Commission believes that the department should strive to place a higher proportion of Indigenous children with Indigenous carers. To that end, the Commission recommends that the new Child Guardian be given a statutory responsibility for auditing and publicly reporting on compliance with the principle. Important as the child placement principle is, the overriding consideration, in making a placement decision, must always be the welfare and best interests of the child. While section 5 of the Act says that the whole of the Act is to be administered in accordance with this 'best interests' principle, the CMC believes that section 83 should be amended so that it specifically states that a placement decision can only be made if it is consistent with the welfare and best interests of the child (*see recommendation 8.5*).

Section 83(5)(b) of the Child Protection Act requires the director-general, when making a placement decision, to give proper consideration to 'ensuring the decision provides for the optimal retention of the child's relationships with parents, siblings and other people of significance under Aboriginal tradition or Island custom'. However, unlike legislation in other jurisdictions, section 83 does not specifically provide for the situation where an indigenous child has to be placed with a non-Indigenous carer.

Given that a third of Indigenous children who are placed in out-of-home care in Queensland are placed with non-Indigenous carers, the CMC believes consideration should be given to amending section 83 so that it does provide some guidance on how placement decisions involving non-indigenous carers should be made (*see recommendation 8.6*). A useful model is found in section 13(6) of the New South Wales Act, which says:

> The following principles are to determine the choice of a carer if an Aboriginal or Torres Strait Islander child or young person is placed with a carer who is not an Aboriginal or Torres Strait Islander:
> (a) Subject to the best interests of the child or young person, a fundamental objective is to be the reunion of the child or young person with his or her family or Aboriginal or Torres Strait Islander community.
> (b) Continuing contact must be ensured between the child or young person and his or her Aboriginal or Torres Strait Islander family, community and culture.

Recommendation 8.13 concerns consultation with Indigenous agencies by departmental officers. Section 6(1) of the Child Protection Act says that 'a decision of the chief executive or an authorised officer under this Act' about an Indigenous child must be made only after consultation with the recognised Indigenous agency for the child. Because the Act does not define the phrase 'a decision of the chief executive or an authorised officer under this Act', it is not entirely clear when the department has a statutory obligation to consult with a child's Indigenous agency.

This ambiguity is not helped by the fact that section 6(3) contains a second obligation to consult — this time where the director-general, a departmental officer or the Children's Court 'exercises a power under this Act' in relation to an Indigenous child.

The department's obligation to consult with an Indigenous agency about the making of a placement decision is specifically covered in section 83. Clear guidance needs to be given to departmental officers in the implementation of those various provisions.

Case plans

The child protection legislation in New South Wales, Victoria and the Australian Capital Territory stipulates that a child's case plan must be reviewed by a court before the court can make a child protection order for the child. The Queensland Child Protection Act does not even require the department to develop a case plan — let alone stipulate that the plan has to be reviewed by the Children's Court before a child protection order can be made. The only provisions in the Act that say anything about the development and monitoring of case plans are sections 84, 88 and 96.

Section 84 requires the director-general and a foster carer who agrees to care for a child who is in the director-general's custody or guardianship, to enter into a written agreement for the child's care. The agreement must stipulate a number of terms, including the period of time that the foster carer will care for the child; information (from any case plan prepared by the director-general) about matters involving or affecting the foster carer; contact arrangements; the responsibilities of the director-general and foster carer to provide medical, therapeutic, schooling and other services to the child; and information about any special needs of the child, including any health or behavioural management needs (s. 7 of the Child Protection Regulation).

Section 88 applies where the director-general is granted custody or guardianship of a child under a child protection order. It imposes an obligation on the director-general to 'review the arrangements in place for the child's protection to ensure the arrangements are in the child's best interests'. The reviews must be conducted at least every six months.

Section 96 requires a family meeting to be held in all cases where the director-general 'is satisfied that a child is in need of protection and action should be taken to ensure the child's protection'. The purpose of the meeting is to 'provide an opportunity for decisions to be made to ensure, or contribute towards ensuring, the child's protection'.

The evidence presented to the Inquiry reflected that, generally speaking, the development and monitoring of case plans by departmental officers was of an inadequate standard. Given this evidence, the Commission believes that a specific provision on case planning should be inserted into the Act.

Recommendation

9.3 That legislation require the development of a case plan for the care of all children on child protection orders or in the custody of the director-general.

Reason: The insertion of a specific provision on case planning into the Act may result in higher standards in the development and monitoring of case plans.

Child protection orders

At this stage, the Commission does not recommend any specific changes to the provisions in the Act that deal with the making of child protection orders. However, there are some important issues that should be mentioned here. One concerns section 61(f) of the Act and the making of long-term guardianship orders by the Children's Court in favour of the director-general, and has already been covered in Chapter 7.

There are two other important issues that could be the subject of review by the DCS. Both are relevant to the department's current research into the problems associated with drift in care and multiple placements.

1 The first issue concerns the duration of custody and short-term guardianship orders. The maximum duration for both of these orders is two years (s. 62) but, in both cases, the order can be extended (s. 64). The Act does not place any limitations on the number of times that a custody or short-term guardianship order can be extended. This capacity to continually renew custody and short-term guardianship orders may be enabling departmental officers to avoid making long-term case plans for children who are in need of state protection.

2 The second issue concerns the range of child protection orders that are available under the Act. The child protection legislation in New South Wales, Victoria and the Australian Capital Territory all have provisions that enable a person who has cared for a child for a significant period of time to bring an application for an order giving the carer sole parental responsibility for the child.[2]

Disclosure of information

As noted in various earlier parts of the report, the Inquiry was informed by a number of sources that the amount, type and quality of information provided by departmental officers to licensed care services and carers appear at times to vary depending on the personal beliefs of the particular officer. Some FSOs are prepared to disclose all relevant information about a child's needs and circumstances to an agency or person who has been asked to place or care for the child (or is already doing so). Other FSOs, however, reportedly refuse to disclose any substantive information because they believe this will amount to a breach of the confidentiality provisions contained in the Act. These issues and the relevant provision of the Act (s. 187) have been addressed at length in Chapter 7.

Given the evident uncertainty about the ambit of the exceptions listed in section 187 as to when information can be disclosed, the Commission believes the Act should be amended to insert additional provisions that deal specifically with the disclosure (by the new DCS) of information to an agency or person who has been asked to place or care for a child (*see recommendations 7.26 to 7.28*). As noted in Chapter 7, sections 143 and 144 of the New South Wales Act could be used as a model.

Some consideration could also be given to whether provisions based on sections 145 and 248 of the New South Wales Act should be adopted. Section 145 enables the disclosure of information about a proposed carer to a child who needs to be placed in care and section 248 deals with the disclosure of information between the New South Wales Department of Community Services and other government agencies. While section 187(3)(c) of the Queensland Child Protection Act does provide for information to be disclosed by departmental officers to other government departments, there is no corresponding provision that empowers the director-general to require other government departments to disclose information to the department.

Section 248 of the New South Wales Act reads as follows:

> **248 Provision and exchange of information**
>
> (1) For the purposes of providing information to, or exchanging information with, a prescribed body, the director-general may do either or both of the following:
>
> (a) the director-general may, in accordance with the requirements (if any) prescribed by the regulations, furnish the prescribed body with information relating to the safety, welfare and well-being of a

particular child or young person or class of children or young persons,

(b) the director-general may, in accordance with the requirements (if any) prescribed by the regulations, direct the prescribed body to furnish the director-general with information relating to the safety, welfare and well-being of a particular child or young person or class of children or young persons.

(2) It is the duty of a prescribed body to whom a direction is given under subsection (1) (b) to comply promptly with the requirements of the direction.

(3) If information is furnished under subsection (1):

(a) the furnishing of the information is not, in any proceedings before a court, tribunal or committee, to be held to constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct, and

(b) no liability for defamation is incurred because of the furnishing of the information, and

(c) the furnishing of the information does not constitute a ground for civil proceedings for malicious prosecution or for conspiracy.

(4) A reference in subsection (3) to information furnished under subsection (1) extends to any information so furnished in good faith and with reasonable care.

(5) A provision of any Act or law that prohibits or restricts the disclosure of information does not operate to prevent the furnishing of information (or affect a duty to furnish information) under this section. Nothing in this subsection affects any obligation or power to provide information apart from this subsection.

(6) In this section:

prescribed body means:

(a) the Police Service, a government department or a public authority, or

(b) a government school or a registered non-government school within the meaning of the Education Act 1990, or

(c) a TAFE establishment within the meaning of the Technical and Further Education Commission Act 1990, or

(d) a public health organisation within the meaning of the Health Services Act 1997, or

(e) a private hospital within the meaning of the Private Hospitals and Day Procedure Centres Act 1988, or

(f) any other body or class of bodies (including an unincorporated body or bodies) prescribed by the regulations for the purposes of this section.

Request for services from other government departments

The Commission has recommended that the new DCS should work with other government departments to provide services (e.g. specialist medical attention) to children (and their families) who fall within the jurisdiction of the DCS. Every relevant government department in Queensland should directly contribute towards, and be responsible for, the protection of children.

One way to ensure that other departments are prepared to provide 'free' services to DCS clients would be to give the DCS a legislative power to make such requests. The following provisions from the New South Wales Act could be used as a model:

17 Director-general's request for services from other agencies

In deciding what action should be taken to promote and safeguard the safety, welfare and well-being of a child or young person, the director-general may request a government department or agency, or a non-government agency in receipt of government funding, to provide services to the child or young person or to his or her family.

18 Obligation to co-operate

The government department or agency must use its best endeavours to

comply with a request made to it under section 17 if it is consistent with its own responsibilities and does not unduly prejudice the discharge of its functions.

Record-keeping

Section 12 of the Child Protection Regulation imposes an obligation on the director-general to keep certain records about alleged mistreatment of children who have been placed with an approved foster carer or licensed care service. Section 13 of the Regulation requires the director-general to give the Commissioner for Children and Young People regular written reports about these records. Apart from these two provisions, the legislation says nothing about the department's obligation to keep records about actions taken or decisions made under the Child Protection Act or the Regulation. In contrast, the New South Wales Act contains a number of provisions specifically directed to the maintenance of records and access to them (ss. 14, 28, 159, 160 and 168–170).

There is no doubt that inadequate record-keeping by departmental officers and the department as a whole is one of the reasons the child protection system is currently failing to properly protect Queensland's children. It is also true that the department's record-keeping problems will not be solved by the mere insertion of more record-keeping provisions into the Child Protection Act (or its successor). However, if the legislation is made more prescriptive about the sorts of records that have to be created, preserved, publicly reported on and made available to children who are (or have been) subject to the jurisdiction of the new department, this may help to ensure that the Department of Child Safety does not repeat the record-keeping failures of the Department of Families.

CHANGES TO OTHER LEGISLATION

In Chapter 5 of this report, the Commission recommended that a position of Child Guardian be established within the CCYP with designated functions and specific powers designed to enable the position to oversee the DCS effectively.

It was also recommended that the Community Visitor Scheme be extended, that the Child Death Review Committee be established and that the CCYP assume some further responsibilities in relation to child deaths.

Additionally, the Commission recommended that the jurisdiction of the Children Services Tribunal be expanded to provide for the Child Guardian to refer a matter to the tribunal for merit review (*see recommendation 5.20*).

The implementation of these recommendations will require legislative amendments.

FINAL COMMENT

It cannot realistically be expected that any child protection system will be infallible. The problems revealed in this report are not unique; several other Australian states have recently undertaken wide-ranging reviews of their own child protection systems. Nevertheless, it must be accepted that the current system has failed. A new system must be embraced as quickly as possible.

It is the Commission's expectation that the adoption of the recommendations contained herein will be of clear and lasting benefit to, most importantly, the children of Queensland, particularly those in foster care, and also to all people and organisations associated with the provision of child protection services.

To assess this, the Commission intends to review the implementation of the report's recommendations in two years' time. Accordingly, it is recommended that the government reviews and reports to the CMC on the implementation of this report's recommendations within two years from the delivery of the report.

RECOMMENDATION

9.4 That the government review, and report to the CMC on, the implementation of this report's recommendations within two years from the delivery of the report.

Reason: Such a review and report will be necessary to enable the CMC to effectively review the level of implementation of the recommendations made in this report.

Endnotes

1 See ss. 47 and 48 of the *Children's Services Act 1965*.

2 See s. 149 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), s. 112 of the *Children and Young Persons Act 1989* (Vic.) and s. 260 of the *Children and Young People Act 1999* (ACT).

APPENDIXES

APPENDIX A: SUBMISSIONS

Letters inviting submissions to this Inquiry were sent to 330 individuals and organisations. Each letter also enclosed a copy of an information brochure which was produced specifically for the Inquiry.

At the time of writing this report, the CMC Inquiry into Abuse of Children in Foster Care had received information from well over 200 contributors. Most of this was in the form of formal submissions, either hard copy or electronic. Some information was received through telephone conversations and face-to-face consultations.

A large number of these contributions have been referred to the CMC's Complaints Section for consideration of possible misconduct.

Listed below are the names of academics, Queensland and interstate government agencies, and non-government organisations and other groups who provided submissions or information to the Inquiry and who were prepared to have their name or the name of their organisation published in this report.

For various reasons, many contributors requested their names not to be published.

Academics with expertise in child protection

Ms Anne Butcher

Dr Anne Coleman

Ms Elisabeth Drew

Dr Richard Roylance

Dr Robert Lonne

Dr Catherine McDonald

Mr Anthony McMahon

Dr Jennifer Smith

Dr Jane Thomson

Queensland and interstate government agencies

Aboriginal and Torres Strait Islanders Corporation (QEA) for Legal Services

Aboriginal and Torres Strait Islander Women's Legal and Advocacy Service

Australian Institute of Criminology

Children Services Tribunal, Queensland

Commission for Children and Young People

Department of Family and Community Services, ACT

Department of Health and Human Services, Tasmania

Legal Aid Queensland

Office of Director of Public Prosecutions, Queensland

Office of the Leader of the Queensland Opposition

Office of the Ombudsman (Queensland)

Queensland Aboriginal and Torres Strait Islander Legal Service Secretariat

Queensland Government

Queensland Police Service

Royal Flying Doctor Service of Australia (Queensland)

School of Social Work and Welfare Studies, Central Queensland University

Toowoomba and South West Regional Care System CAP Initiative, Department of Families

Non-government organisations and other groups

Abused Child Trust

Aboriginal Coordinating Council

Adoption Privacy Protection Group Incorporated

Anglicare Fostering Network

Australian Association of Social Workers (Queensland Branch)

Barnardos South East Sydney and the LAC Project

Bravehearts Inc.

Care

Cairns Shared Family Care

Central Queensland Aboriginal and Islander Child Care Agency

Centre for Social Justice

Child Wise

CREATE Foundation

The Esther Centre

Family Focus

Foster Care Queensland

Girringun Aboriginal Corporation

Grandparents and Grandchildren's Support Inc.

Historical Abuse Network

Integrated Family and Youth Service

KinKare

Kootana Women's Centre

Lifeline Ipswich and West Moreton

Life Without Barriers

Mackay Aboriginal and Islander Child Care Agency

Marsden Families Program

Mercy Family Services

Micah Projects Inc.

PeakCare Queensland Inc.

Queensland Council of Social Service

Queensland Parents for People with a Disability Inc.

Queensland Public Sector Union of Employees

SafeCare Inc.

Save the Children, Queensland

Survivors of Domestic Violence Inc.

South West Community Care Aboriginal Corporation

Women's Legal Service

Notes on some of the above agencies

The notes below have been taken from the websites of the various organisations.

Abused Child Trust

Established in Queensland in 1988, Abused Child Trust is an independent volunteer organisation comprising professionals who offer their services in the fight against all forms of child abuse and neglect.

Anglicare Fostering Network

The Anglicare Fostering Network consists of the Anglicare Fostering agencies in Queensland. These services operate in Rockhampton, Gladstone, Roma, Caboolture and Wynnum.

Barnardos South East Sydney
An agency of the international organisation Barnardos, which deals with the prevention of abuse and entry into care. It operates children's family centres, permanency programs for out-of-home care, adolescent services and advocacy work.

Bravehearts Inc.
Bravehearts, founded in 1996 by Ms Hetty Johnston, aims to 'break the silence' about child sexual abuse. Members comprise survivors, parents, friends, partners, professionals and all non-abusive members of the community who share in the belief that child sexual assault must stop. Its work in the community includes self-help groups and personal counselling; public awareness and child protection initiatives; a survivor/victim-focused means for the anonymous, yet official, disclosure of assault; media, government and general advocacy on behalf of parents and survivors.

Care
An agency of Churches of Christ in Queensland, Care employs over 1600 people who care for the needs of older people, children and young people, families and those who are disabled or disadvantaged.

Child Wise
Child Wise is an Australian organisation working in Australia and overseas to end child sexual exploitation and abuse. It is committed to ending the commercial sexual exploitation of children.

CREATE Foundation
The CREATE Foundation exists to improve opportunities for the 20 000 children and young people in care across Australia. CREATE runs programs and services to connect children to each other and their communities, build skills and resources for children in care, and change the care system from the inside out through the participation of children and young people themselves.

The Esther Centre
The Esther Centre (Centre for Addressing Abuse in Human Services and Faith Communities) provides support for people who have experienced physical, sexual, emotional and spiritual abuse in church institutions, faith communities and human services. The Esther Centre seeks to help people through the process of formally making complaints outside the criminal justice system.

Foster Care Queensland
FCQ is run by foster parents for foster parents. It has a broad range of functions including: the support of foster parents and children in their care; education and training of foster parents; providing comment and input into the ongoing development of policy and practice in the sector; being a channel for communication between government departments, the community, agencies and foster parents around the state; providing peak body functions for foster parents in the state; lobbying for the raising of standards of care; advocating on behalf of foster parents and children requiring care.

Historical Abuse Network
The Historical Abuse Network is for people who have experienced abuse in institutions, foster care and detention. Its aims are: to maintain a voice so as to continue dialogue regarding the recommendations from the Queensland Government's Forde Inquiry; to share and disseminate information; to support each other; to reconnect and create support groups for ex-residents of each institution and former children in care as required; to promote affirmative action; and to ensure recognition of the continued discrimination and disadvantage of ex-residents and former children in care.

Integrated Family and Youth Service
A Queensland-based group that aims to provide high-quality information and support to young people throughout Queensland.

KinKare
Represents and supports those who rear their grandchildren/relatives and those denied access to their grandchildren. Many members are rearing grandchildren through the Department of Families with the director-general having guardianship.

Life Without Barriers
A registered charity and not-for-profit organisation founded in 1995 by a group of business people in the Hunter Region of New South Wales, with a vision of improving the lives of people living with disabilities.

Micah Projects Inc.
Based in South Brisbane, Micah responds to people who experience exclusion, poverty, injustice and social isolation so that they may experience inclusion, economic wellbeing, justice and connection within their community of choice.

PeakCare Queensland Inc.
The peak body for the safety and wellbeing of children and young people and the support of their families. PeakCare works in partnership with key stakeholders including the Queensland Department of Families.

Queensland Parents for People with a Disability Inc.
QPPD, established in 1981, is an advocacy group that speaks out on behalf of people with a disability, especially on issues related to family support and respite, education, quality lifestyles for adults and guardianship.

SafeCare Inc.
Founded in Perth (WA) in 1989, SafeCare is an independent, community-based organisation that provides treatment, counselling and support services to families where child sexual abuse by a family member has occurred or where it is feared that it may occur.

Save the Children, Queensland
An agency of the worldwide organisation Save the Children, which was founded in 1919 and is the world's largest independent movement for children.

Women's Legal Service
A community-based legal service developed and operated by women for women. It seeks to improve women's access to justice and to promote change within the justice system.

APPENDIX B: HEARINGS

The following people appeared before the Inquiry during its eight days of sittings.

Day 1: 13 October 2003

- The Honourable Judy Spence MP, Minister for Families and Minister for Aboriginal and Torres Strait Islander Policy and Minister for Disability Services and Minister for Seniors
- Mr Frank Peach, Director-General, Department of Families
- Ms Sonia Godsave, Director, Human Resources, Department of Families
- Ms Cathy Taylor, Director, Office of Child Protection, Department of Families
- Mr Mark Healey, Principal Legal Officer, Department of Families

Day 2: 14 October 2003

- Mr Lindsay Wegener, State Manager, Life Without Barriers
- Ms Beverley Fitzgerald, President, Children Services Tribunal
- Ms Carole Marsden, Executive Officer, PeakCare
- Mr Russell Bricknell, Vice President, PeakCare
- Ms Penny Gordon, organisational psychologist

Day 3: 15 October 2003

- Mr Alex Scott, General Secretary, Queensland Public Sector Union of Employees
- Ms Alison Finley-Bissett, Queensland Public Sector Union of Employees
- Ms Karyn Walsh, Coordinator, Esther Centre
- Mr Mark Reimers, Advocate, Esther Centre
- Ms Diana Dawson, Queensland Centre Coordinator, CREATE Foundation
- 'Max', foster child
- 'Natasha', foster child
- Dr Jennifer Wiltshire, social worker
- Ms Julie Clark, social worker

Day 4: 16 October 2003

- Ms Gwenn Murray, Independent Auditor, Department of Families
- Mr Frank Young, Former President, Foster Care Queensland
- Mr Bryan Smith, President, Foster Care Queensland
- Ms Sheryl Lawton, South West Community Care Aboriginal Corporation (Charleville)
- Ms Donna Klein, Manager, Central Queensland Aboriginal and Islander Child Care Agency (Rockhampton)
- Mr Mal Walker, Mackay Aboriginal and Torres Strait Islander Corporation for Alternative Care and Foster Care Services

Day 5: 20 October 2003

- Ms Hetty Johnston, Founder and Spokesperson, Bravehearts
- Ms Rachaelle Bon, Administration Manager, Bravehearts and former foster carer
- Dr Jennifer Smith, Director of the Child Advocacy Service, Royal Children's Hospital
- Ms Elisabeth Drew, Social Worker, Part-time Senior Project Officer, Royal Children's Hospital

- Ms Annette Murphy, Suspected Child Abuse and Neglect (SCAN) Team Coordinator, Mater Children's Hospital
- Dr Richard Roylance, paediatrician
- Ms Hilary Lennon, Regional Resource Officer, Child Protection, Department of Families

Day 6: 21 October 2003

- Mr Bob Atkinson, Commissioner, Queensland Police Service
- Detective Senior Sergeant Maurice Carless, Officer-In-Charge, Juvenile Aid Bureau (Cairns)
- Acting Detective Inspector Peter Crawford, Sexual Crimes Investigation Unit
- Ms Nicky Davies, Senior Legal Consultant of Family Law, Legal Aid Queensland
- Mr Lawrence Springborg MP, Leader of the Opposition, Queensland
- Ms Jane Anderson, Chief Executive Officer, Abused Child Trust
- Dr David Wood, paediatrician, Abused Child Trust
- Three representatives of KinKare

Day 7: 22 October 2003

- Professor Matthew Sanders, Professor of Clinical Psychology, University of Queensland
- Director of Parenting and Family Support Centre
- Ms Bev Orr, President, Australian Foster Carers' Association
- Dr Robert Lonne, School of Humanities and Human Services, Queensland University of Technology
- Mr John Robinson, State Solicitor, Queensland Aboriginal and Islander Legal Service Secretariat
- Ms Rosemary Pratt, Coordinator, Kalwun Aboriginal and Islander Child Care Agency (Gold Coast)
- Ms Robin Sullivan, Commissioner for Children and Young People
- Mr Barry Salmon, Executive Director, Commission for Children and Young People

Day 8: 23 October 2003

- The Honourable Judy Spence MP, Minister for Families and Minister for Aboriginal and Torres Strait Islander Policy and Minister for Disability Services and Minister for Seniors
- Mr Frank Peach, Director-General, Department of Families
- Mr Mark Healey, Principal Legal Officer, Department of Families
- Mr Stephen Armitage, Deputy Director-General, Department of Families
- Ms Karen Copeland, Executive Director Policy, Department of Families
- Ms Cathy Taylor, Director, Office of Child Protection, Department of Families

APPENDIX C: THE DATA

INTRODUCTION

Sources of information

As well as conducting an extensive program of research, consultation and public hearings, the CMC:

- reviewed official published data for relevant information
- inspected the written submissions received for the Inquiry for relevant data
- requested a range of data from the Department of Families about children in 'out-of-home', carers, departmental staff and costs/resources
- conducted a survey of shared care agencies
- conducted a survey of departmental staff, which was facilitated by the Queensland Public Sector Union (QPSU)
- reviewed and documented the major issues arising from the submissions received by the Inquiry from carers affiliated with Foster Care Queensland (FCQ)
- spoke with current and former children in care.

This appendix provides an analysis of the data received from the department, the CMC surveys and the FCQ submissions. It is presented in three parts:

- Part 1: Children
- Part 2: Carers
- Part 3: Families staff

Each part also provides:

- a list of the data requested of the department by the CMC
- comments about availability of data and any concerns about the data provided
- key issues arising from the data
- the data, presented diagrammatically or in tables, where relevant.

Timeframes

Within each target group, data estimates are provided in several ways:

- point in time — refers to information about the population of children in care, carers or staff on 30 June of each year between 1993 and 2003
- entries — refers to information about children entering care, and new carers and staff beginning service, during each 12-month period between 1 July 1993 and 30 June
- exits — refers to information about children exiting or ceasing care, and carers and staff exiting or leaving the system, during each 12-month period between 1 July 1993 and 30 June 2003.

Limitations of the data

The public hearings and consultations for the CMC's Inquiry clearly indicated serious concerns about the quality of, and processes relating to, the collection, reporting and review of data by the Department of Families. Concerns about this issue were first noted by the CMC at the beginning of the Inquiry when requesting a range of data about children, carers, staff and costs from the department. Much of the information requested was unavailable — it was either not recorded or not reviewed by the department on a routine basis; and the data that were provided have some very important limitations that must be considered.

For example, the CMC sought information about all children in the care of the department and all carers and staff who report to it, to determine the full extent of the workload and throughput of the department on an annual basis. However, it was made clear to the CMC that the data routinely collected and reported for official purposes generally relate only to children on protective orders. That is, the official statistics do not illustrate the full day-to-day workload of staff or the actual large numbers of children and families who are assessed and supported by the department in a voluntary or on a temporary basis, in addition to those on protective orders.

According to the Department of Families, the concept of all children in care was 'not one that is currently used in any national or internal reports and has therefore proved difficult to extract and/or verify as there is no official data to compare it against'. Further, the department was unable to provide any information about the nature or number of system changes that may have occurred during the reference period (1992–93 to 2002–03), although it was thought that the data before 2000–01 are not comparable with current data. The department also noted:

> The only placement data that Information Services Branch can currently consider accurate are the data relating to paid placements. Voluntary placements are only entered into the data capture system when they are notified by an area office and there is currently no easily identifiable method for measuring the level of missing voluntary placements.

Other advice from the department was that 'the changes to data entry procedures and/or systems would also account for the very high number of children in the "other" placement and regional categories in the earlier years — although these records haven't been examined closely it is expected that many do not have a placement category (i.e. that it is blank or unknown)'.

In some instances, the data received were somewhat repetitive. Hence some of the data have not been reported in this appendix. The Commission acknowledges the considerable efforts made by the department in responding to its requests for data.

PART 1: CHILDREN

Data requested

At the start of the Inquiry, the CMC requested from the Department of Families a range of information about children in care. Those requests are listed in Table C1.1, along with relevant comments about the availability and quality of the data.

Key issues arising from the data

The number and location of children in care

- According to the data provided, the total number of children in care has increased by 52 per cent since 1993 (from 2891 to 4380), but the data must be interpreted with caution, given their limited comparability across time (see Table C1.2).
- The greatest increase in the number of children being admitted to care has occurred in the last three years; there has been a 57 per cent increase in the number of children admitted — up from 1375 in 1999–2000 to 2152 in 2002–03 (see Figure C1.1).
- The increase has been reflected in a sharp rise in the number of children placed with approved foster carers: between 1999–2000 and 2002–03. For example, the number of children placed with approved foster carers doubled from around 800 to 1600. There also seems to have been an increase in the number of children placed with relatives (see Figure C1.2).
- Between 1993 and 1999 there were considerably more male than female children in care (56% and 44% respectively), but in recent years the gap has closed and there are now only slightly more males than females (see Figure C1.3).
- Compared with other regions, Ipswich and Logan Region has the largest number of children in care. In the last three years this area has been responsible for an average of 680 children per year. Brisbane City Region follows, with an average of 538 children per year (see Figures C1.4 to C1.14).

Table C1.1. Data requested and comments

Data requested	Comments
As at 30 June for each year between 1993 and 2003, total number of children in care by type of care provided (approved family foster care, relative/kin care, residential care, respite/ emergency care, other, total).	Data provided, including children not on protective orders. The category 'carers with limited approval' was provided instead of the requested category of 'respite/ emergency carers'.
As at 30 June for each year between 1993 and 2003, total number of children in each category of care by: • geographical location (departmental region) • Indigenous status • gender • type of child protection notification that led to child being placed in care (e.g. physical, sexual, emotional, neglect, drug, domestic violence etc.).	Data provided, except the type of child protection notification that led to the child being placed in care. This information is not recorded and could not be accessed by the Information Services Branch of the department.
Number and type of notification received for children by type of care (e.g. foster care, residential care, other) and the outcomes of those notifications.	Regarding notifications, Families commented that there were some concerns about the reliability of the data provided. They reported: • In the department's current information system, notifications of the abuse of children who are at the time of notification in a foster care placement may not necessarily relate to the foster carers as potential abusers. The placement is recorded at the time of the notification — however, the notification may refer to an incident that happened during another placement or while the subject child(ren) was in the care of their parents, for example. This issue has been highlighted by the audit of notifications and initial assessments in relation to children who are currently in foster care (led by Gwenn Murray). As at 12 August (the date of Ms Murray's interim report), 45 per cent of notifications related to natural families. • Further, given the audit in process, and the corrections occurring on the system regarding notification data as a result of the audit, this data is constantly being updated at this point in time and will continue to be modified across the next few months as we aim to ensure data accuracy. • The data provided to the CMC, therefore, will clearly need to be interpreted with caution in terms of the picture that it paints regarding abuse of children in foster care. The caveats regarding data reliability, as detailed above, will need to be reported by the CMC Inquiry.
For each 12-month period from 1 July 1993 to 30 June 2003, the number of children leaving the system by amount of time spent in continuous out-of-home care.	Data provided.
For each 12-month period from 1 July 1993 to 30 June 2003, the number of children entering the system, by gender, age, Indigenous status.	Data not provided. Families commented that 'due to complexities in the method of recording placement these data cannot be easily derived for children in alternative care.'
For each 12-month period from 1 July 1993 to 30 June 2003, number of children leaving the system by gender, age, Indigenous status.	Data provided.
For each 12-month period from 1 July 1993 to 30 June 2003: • number of children who entered the child protection system by type of care provided (foster care, residential, respite, other) • number of children who left the child protection system by type of care provided (foster care, residential, respite, other).	Data provided. Families gave a note of warning about 'entry data', however: These data are not directly comparable with the 'entries' data. Due to complexities in the method of recording placement these data cannot be easily derived for children in alternative care. However all 'exit' data has been derived using this rule and is directly comparable with national child protection data published by the Australian Institute of Health and Welfare using this rule and is directly comparable with national child protection data published by the Australian Institute of Health and Welfare.
For each 12-month period from 1 July 1993 to 30 June 2003, destination of children leaving the system (e.g. adopted, returned to family of origin, re-entered system, turned 18).	This information is not collected by the department and so could not be provided.

- Ipswich and Logan Region has also shown a steady growth in the number of children in care over the last 10 years — up 170 per cent during that period. This has resulted in a more than 400 per cent increase in children placed with approved foster carers in that region. Again, however, the data must be interpreted with caution.
- The department told the CMC that it could not identify the region for approximately 20 per cent of children in out-of-home care, because this information was either unknown or not recorded by the department.

Indigenous children

- The overall number of Indigenous children in care has remained relatively stable since 1993, at just under 1000 children per year; while the number of non-Indigenous ('other') children has increased by 67 per cent since 1993 (see Figure C1.15). There appear to be a similar number of Indigenous children in the care of approved foster carers and relative carers (see Figures C1.16 to C1.21).

Notifications of abuse of children in care

- The number of notifications about children in care increased considerably between 1992–93 and 2002–03 (from 61 to 605). In 2002–03 about 75 per cent of the notifications about children in care that were investigated were substantiated (see Table C1.3).
- In 2002–03, most of the substantiated allegations were against non-carers (74%), although approximately one-quarter (26%) of the substantiated allegations were against shared family carers. In other words, about 14 per cent of notifications against carers that were assessed were substantiated, while 39 per cent of allegations against others that were assessed were substantiated (see Table C1.3, and Figures C1.22 and C1.23).
- Since 1998–99 there has been a significant increase in the number of cases substantiated against 'others' for children in approved foster care (see Figure C1.23) — up from 35 to 174 cases in four years.
- There appears to be a higher proportion of cases substantiated for children in approved foster care than for children in other types of care. On average, 62 per cent of initial assessments (IAs) for children in approved foster care resulted in a substantiation since 1992–93 (data not shown).
- Cases most likely to be 'unsubstantiated' since 1992–93 appear to be for children in paid relative care, where 35 per cent of IAs for these children were unsubstantiated (data not shown).
- Since 1992–93 the number of substantiated cases for all types of abuse of children in care has increased, although the largest increases have occurred in cases of neglect (up from just six cases in 1992–93 to 132 cases in 2002–03) and emotional abuse (up from 6 cases in 1992–93 to 83 cases in 2002–03). In the last three years, substantiated cases of neglect have increased by 65 per cent, while cases of emotional abuse have increased by just over 80 per cent. In contrast, cases of sexual abuse have remained relatively stable in recent years, with a slight drop in 2002–03 (see Figure C1.24).
- Male children are more likely to be victims of physical abuse and neglect, whereas female children are much more likely to be victims of sexual abuse (see Figures C1.25 – C1.28).
- Increases in all types of maltreatment of children in care have occurred among children in approved foster care (see Figures C1.29 to C1.32).

The assessment process

- There appears to have been a large increase in the number of assessments not finalised since 1992–93 — from 5 per cent in 1992–93 to 28 per cent in 2002–03 (see Table C1.4 and Figure C1.33).
- In 2003–03, there were 15 IAs not finalised for workload reasons — 2.5% of all notifications requiring an initial assessment (see Table C1.3).
- Investigations of notifications about children in care were not finalised in 33 per cent of cases of children in unpaid relative care and 29 per cent of those in

residential care. These proportions were twice as high as those for children in other types of care (data not presented).

Children ceasing care

- The number of children ceasing out-of-home care has increased sharply in the last three years, from just over 1000 children in 1999–2000 to more than 2600 in 2002–03 (see Figure C1.34). Most of those leaving the system do so from approved foster care (data not presented).
- In the last two years there has been a significantly higher proportion of children leaving the system after only one month in continuous out-of-home care. In 2000–01, fewer than 500 children spent under one month in care, whereas the number rose to more than 1300 in 2001–02; this was an increase of 170 per cent (see Figure C1.35).
- Most children leaving the system seem to be aged six years or older: in 2002–03, for example, 61 per cent of children fell into this category. In recent years 8–10 per cent of children have ceased care when less than one year old (see Figure C1.36).
- The number of Indigenous children leaving the system has increased steadily from around 120 in 1992–93 to almost 230 in 2002–03, whereas the number of non-Indigenous ('other') children remained relatively stable at between 450 and 550 during the years 1992–93 and 1999–2000 before increasing to almost 900 in 2002–03 (data not shown).
- It is important to note that the department does not record information about where children go when they leave care. Information about reunification, for example — a central goal of the department — is not recorded as an outcome in the department's current databases.

Placements

- Most children ceasing out-of-home care have had only one placement. For example, between 1992–93 and 2000–01 an average of 65 per cent of children in care had experienced only one placement; from 2001–02 to 2002–03 the average increased to 78 per cent of all children in care. On the other hand, the number of children leaving the system after five or more placements has remained relatively steady over the past 11 years at about 6 per cent of all children in care (see Figure C1.37).
- Around 40–50 per cent of children ceasing care each year have spent between one and six months in continuous out-of-home care. A smaller proportion (10–15%) had spent five years or more in care.

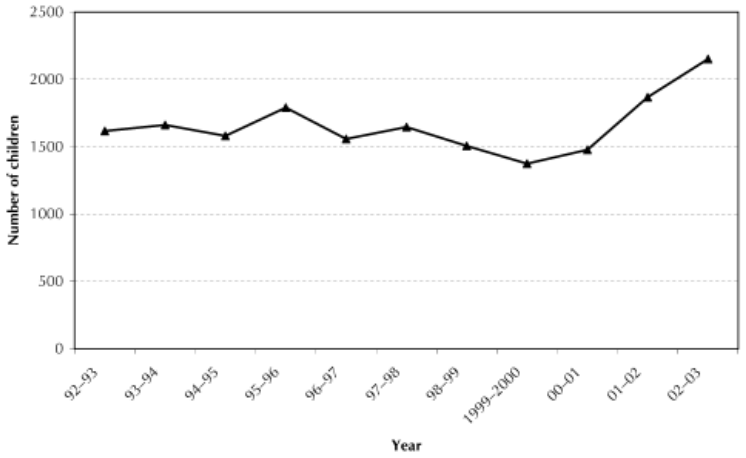
Table C1.2. Total number of children in alternative care by type of carer, as at 30 June, 1993 to 2003

Year as at 30 June	Approved foster carer	Relative carer		Carer with limited approval	Residential care	Other*	Totals
		Paid	Unpaid				
1993	1071	200	258	518	205	639	2891
1994	1200	244	231	508	181	638	3002
1995	1215	321	207	420	188	662	3013
1996	1344	434	229	334	160	655	3156
1997	1490	487	195	234	157	617	3180
1998	1529	542	174	196	104	604	3149
1999	1691	605	116	213	105	416	3146
2000	1791	698	113	243	97	288	3230
2001	2062	750	128	230	72	274	3516
2002	2226	862	122	255	57	301	3823
2003	2568	932	162	317	44	357	4380

Source: Performance Measurement Analysis and Reporting Unit, Department of Families, September 2003.

Note: * Other = placement classification unknown.

Figure C1.1. Total number of children* admitted to alternative care† by financial year (1992–93 to 2002–03)

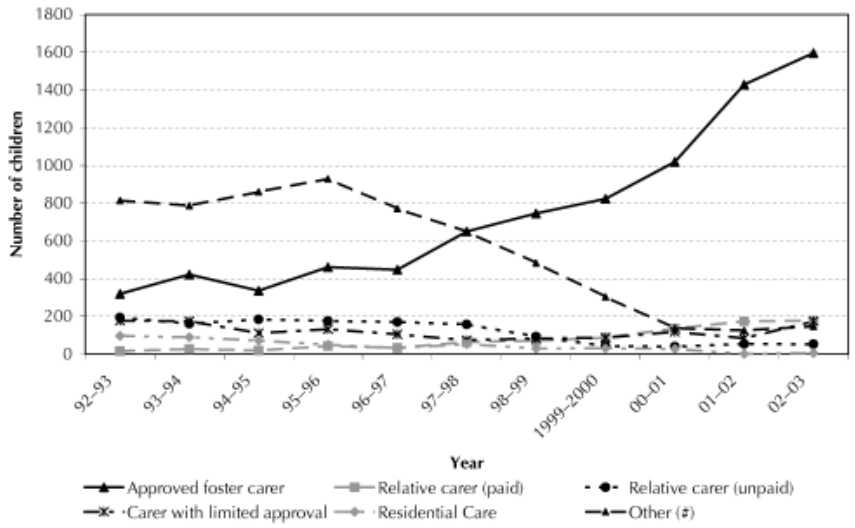


Source: Information Services Branch, Department of Families, September 2003.

Notes: * Includes children on protective orders only.

† Alternative care includes all placement types except 'home' placements.

Figure C1.2. Number of children* admitted to alternative care,† by placement type and financial year (1992–93 to 2002–03)



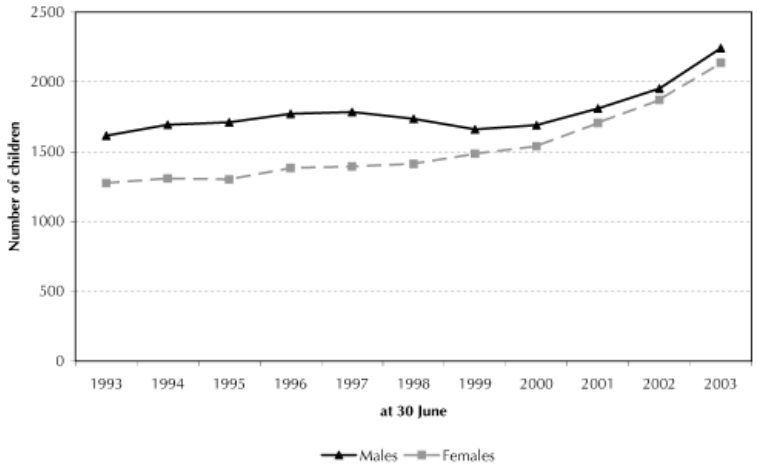
Source: Information Services Branch, Department of Families, September 2003.

Notes: * Includes children on protective orders only.

† Alternative care includes all placement types except 'home' placements.

(#) Other = placement classification unknown.

Figure C1.3. Total number of individual* children in alternative care by gender, as at 30 June, 1993 to 2003



Source: Performance Measurement Analysis and Reporting Unit, Department of Families, September 2003.

Note: * 'Individual' means that no child has been counted more than once.

Figures C1.4 to c1.14. Number of individual* children by type of care and region, as at 30 June, 1993 to 2003

Figures C1.4 Gold Coast

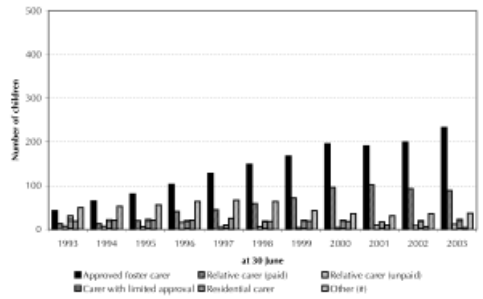
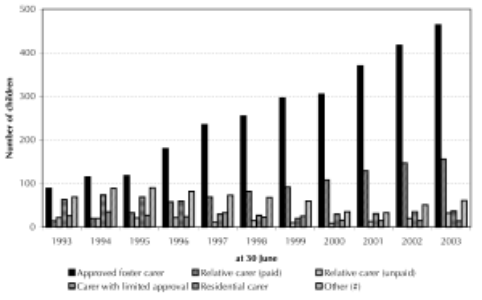


Figure C1.5. Ipswich and Logan



Figures C1.6 Brisbane City

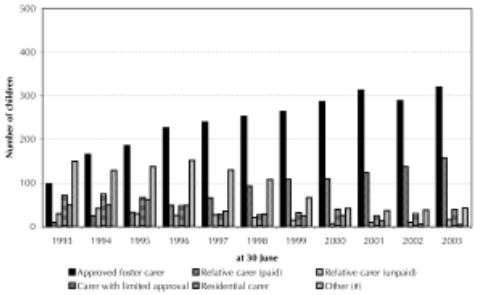
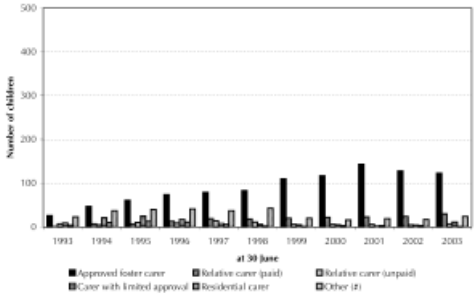


Figure C1.7. Caboolture and Redcliffe Peninsula



Figures C1.8 Sunshine Coast

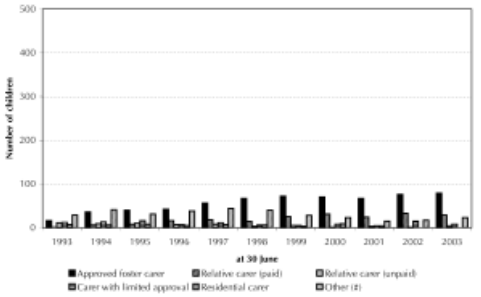
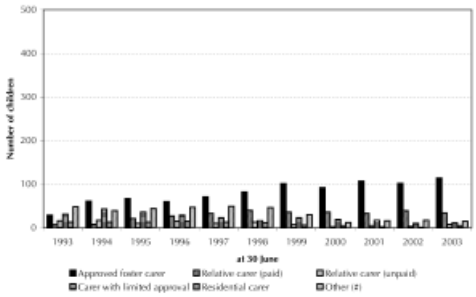


Figure C1.9. Toowoomba and South West



Figures C1.10 Wide Bay and Burnett

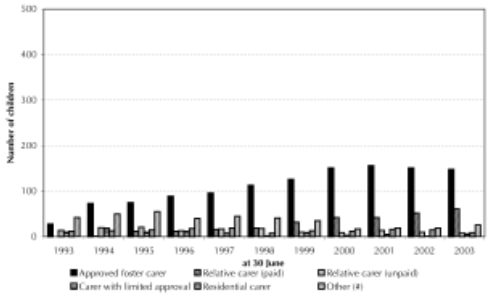


Figure C1.11. Central Queensland

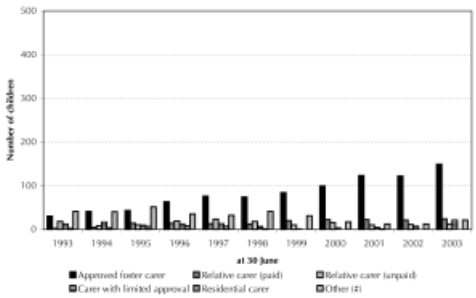


Figure C1.12. Mackay and Whitsunday

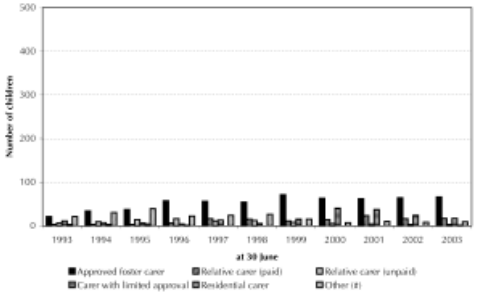


Figure C1.13. Northern Queensland

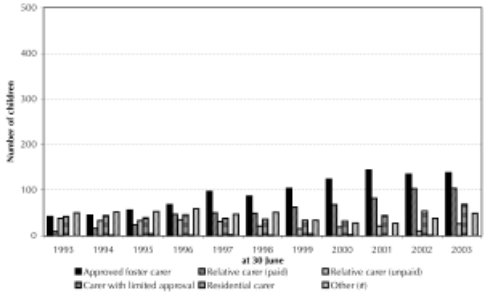
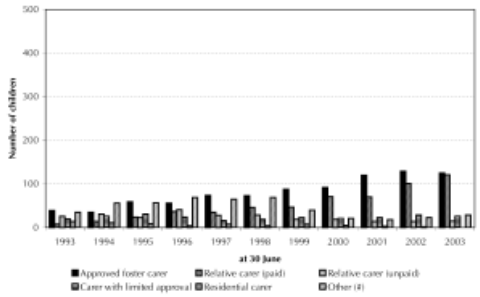


Figure C1.14. Far North Queensland



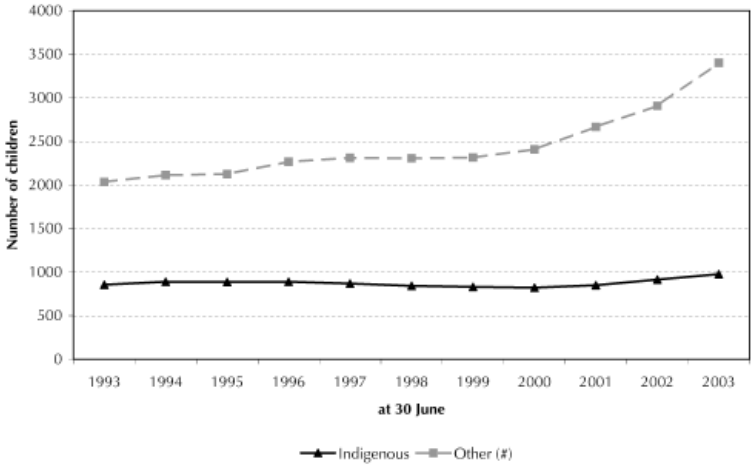
Source: Performance Measurement Analysis and Reporting Unit, Department of Families, September 2003.

Notes: 1. * 'Individual' means that no child has been counted more than once.

2. Data are not presented for approximately 20% of children where the region was unknown or not recorded by Families.

3. (#) Other = placement classification unknown.

Figure C1.15. Number of individual* children in alternative care by Indigenous status, as at 30 June, 1993 to 2003



Source: Performance Measurement Analysis and Reporting Unit, Department of Families, September 2003.

Notes: * 'Individual' means that no child has been counted more than once.

(#) Includes non-Indigenous and those whose Indigenous status is unknown or not stated.

Figures C1.16 to C1.21. Indigenous status of children by type of care, as at 30 June, 1993 to 2003

Figure C1.16. Approved foster carer

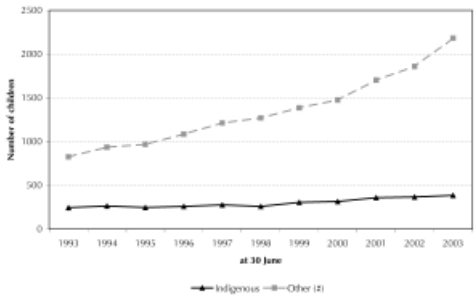


Figure C1.17. Relative carer (paid)

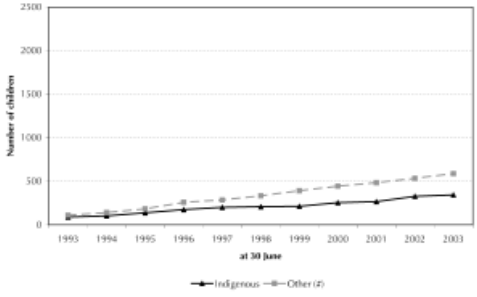


Figure C1.18. Relative carer (unpaid)

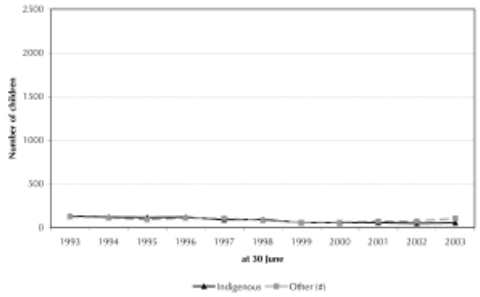


Figure C1.19. Care with limited approval

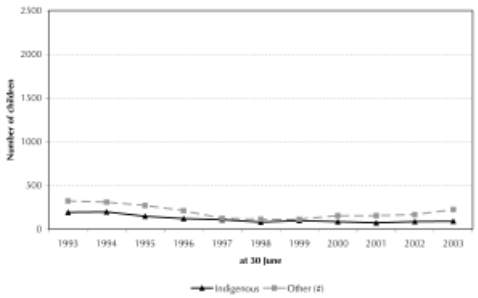


Figure C1.20. Residental carer

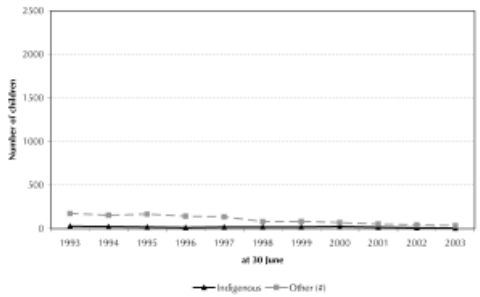
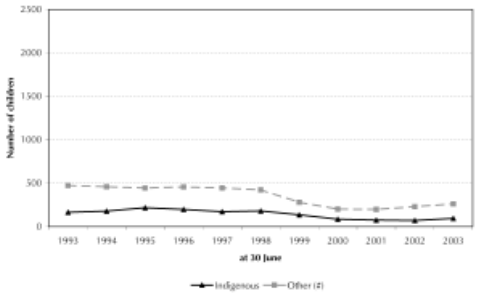


Figure C1.21. Other*



Source: Performance Measurement Analysis and Reporting Unit, Department of Families, September 2003.

Notes: (#) Includes non-Indigenous and those whose Indigenous status is unknown or not stated.

* Other = placement classification unknown.

Table C1.3. Children* in alternative care† by notifications, investigations, substantiations and year ending 30 June, 1992–93 to 2002–03

Year ending 30 June	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Child protection cases notified	61	108	85	137	116	127	154	365	459	499	605
Notifications requiring initial assessment	61	108	85	130	114	125	152	340	448	484	591
Children involved in initial assessments	32	47	41	56	49	55	48	205	258	273	364
Total number of assessments finalised	58	102	78	126	101	99	108	224	316	358	428
Substantiated harm or risk of harm	39	79	51	85	66	65	85	144	229	257	321
Notifications resulting in protective advice	–	–	–	7	2	2	2	25	11	14	14
Cases notified concerning Indigenous children	24	20	24	26	26	38	63	99	126	98	145
Cases substantiated against shared family carer	2	3	2	11	15	3	5	27	57	50	84
Cases substantiated against others	37	76	49	74	51	62	80	117	172	207	237
Initial assessments not begun or completed for workload reasons	–	–	–	–	3	–	–	7	9	12	15

Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. Counts in each row refer to 'incidents' that were reported while children were in placements.

2. A child can be the subject of one or more 'cases'.

3. * Includes children on protective orders only.

4. † Alternative care includes all placement types except 'home' placements.

Figures C1.22 and C1.23. Notifications about children in alternative care substantiated against shared family carers and others, by placement type and financial year (1992–93 to 2002–03)

Figure C1.22. Substantiations against shared family carers

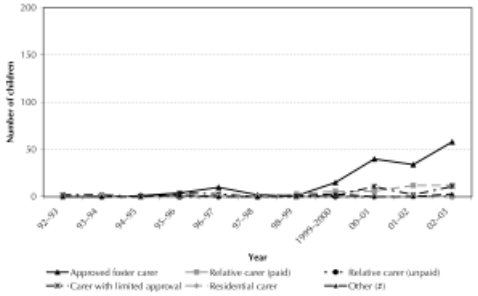
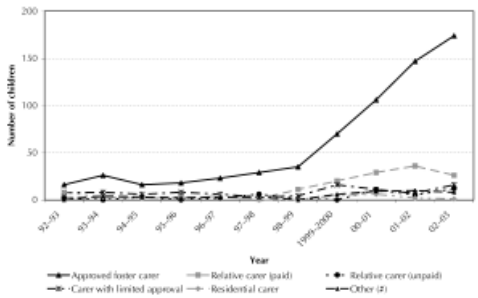


Figure C1.23. Substantiations against others*



Source: Information Services Branch, Department of Families, September 2003.

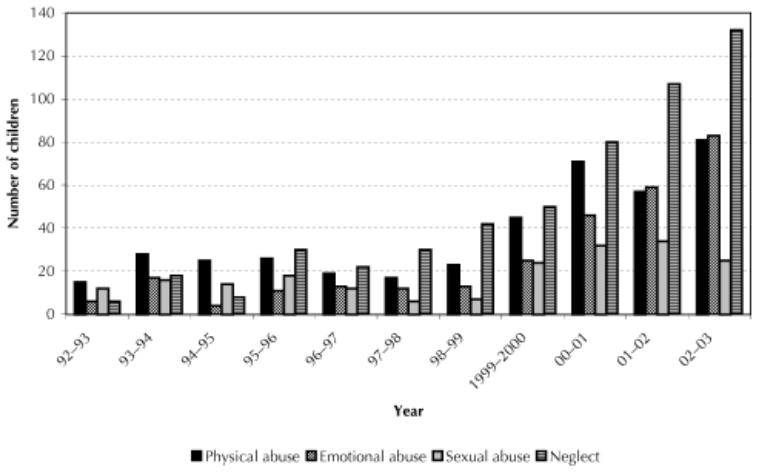
Notes: 1. Counts refer to 'incidents' that have occurred while children were in placements

2. A child can be the subject of one or more 'cases'.

3. (#) Other = placement classification unknown.

4. * Before 2000–01 the relationship of the maltreater was not available for all substantiations.

Figure C1.24. Children* in alternative care† — substantiations by most serious type of maltreatment and financial year (1992–93 to 2002–2003)



Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. A child can be the subject of one or more 'cases'.

2. * Includes children on protective orders only.

3. † Alternative care includes all placement types except 'home' placements.

Figures C1.25 to C1.28. Substantiated abuse of children in care by most serious type of maltreatment, gender and financial year (1992–93 to 2002–2003)

Figure C1.25. Physical abuse

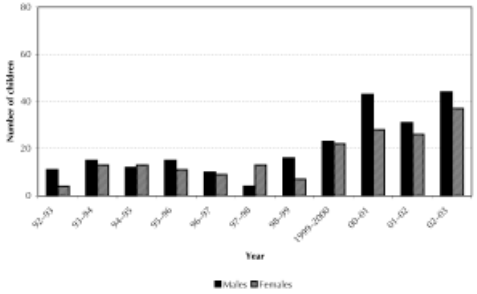


Figure C1.26. Emotional abuse

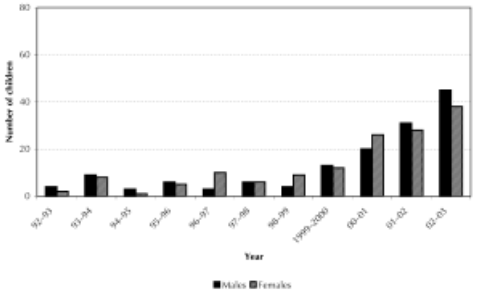


Figure C1.27. Sexual abuse

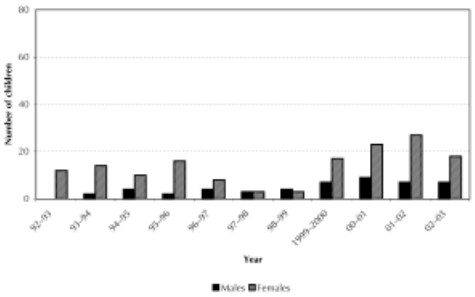
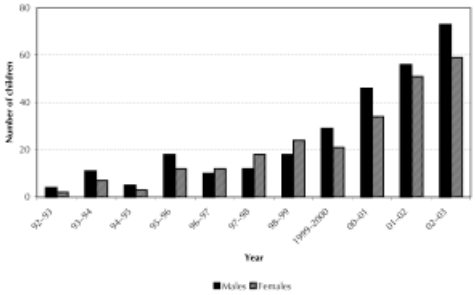


Figure C1.28. Neglect



Source: Information Services Branch, Department of Families, September 2003.

Note: A child can be the subject of one or more 'cases'.

Figures C1.29 to C1.32. Children* in alternative care† — substantiations by most serious type of maltreatment by type of placement and financial year (1992–93 to 2002–2003)

Figure C1.29. Physical abuse

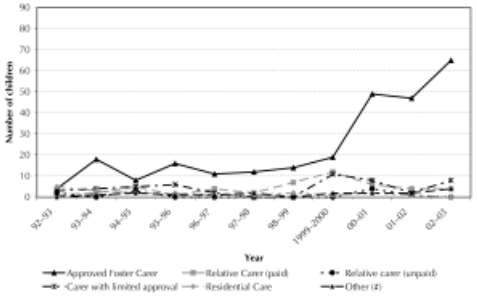


Figure C1.30. Emotional abuse

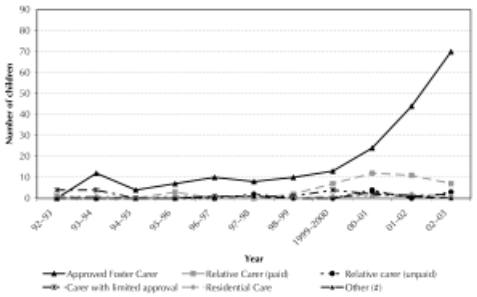


Figure C1.31. Sexual abuse

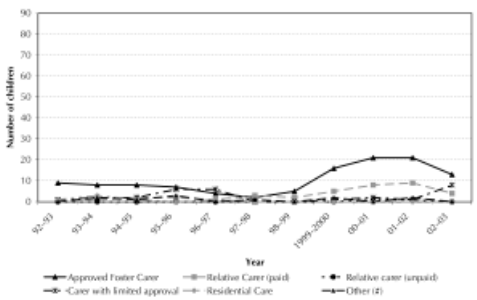
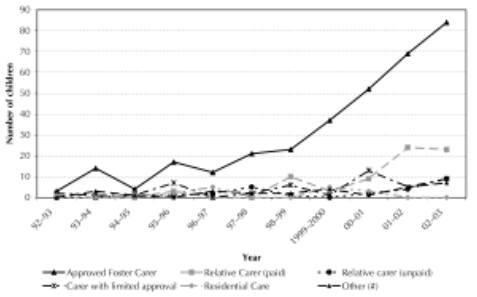


Figure C1.32. Neglect



Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. A child can be the subject of one or more 'cases'.

2. * Includes children on protective orders only.

3. † Alternative care includes all placement types except 'home' placements.

4. (#) Other = placement classification unknown.

Table C1.4. Children* in alternative care† by outcome of initial assessment and financial year (1992–93 to 2002–2003)

Year	Outcome of initial assessment							
	Cases with substantiated outcome		Unsubstantiated		Investigation not finalised		Total	
	No.	% of total	No.	% of total	No.	% of total	No.	% of total
1992–1993	39	63.9	19	31.1	3	4.9	61	100.0
1993–1994	79	73.1	23	21.3	6	5.6	108	100.0
1994–1995	51	60.0	27	31.8	7	8.2	85	100.0
1995–1996	85	65.4	41	31.5	4	3.1	130	100.0
1996–1997	66	57.9	35	30.7	13	11.4	114	100.0
1997–1998	65	52.0	34	27.2	26	20.8	125	100.0
1998–1999	85	55.9	23	15.1	44	28.9	152	100.0
1999–2000	144	42.4	80	23.5	116	34.1	340	100.0
2000–2001	229	51.1	87	19.4	132	29.5	448	100.0
2001–2002	257	53.1	101	20.9	126	26.0	484	100.0
2002–2003	321	54.3	107	18.1	163	27.6	591	100.0

Source: Information Services Branch, Department of Families, September 2003.

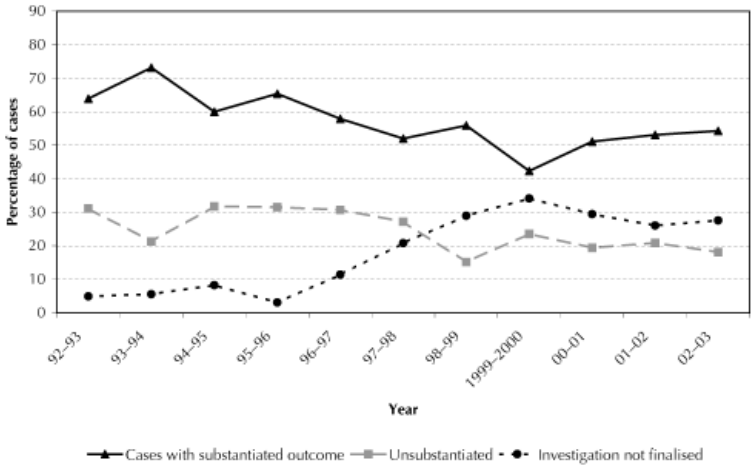
Notes: 1. A child can be the subject of one or more 'cases'.

2. Investigations not finalised include cases where no assessment was possible, part assessments, unable to commence complete, and still under investigation.

3. * Includes children on protective orders only.

4. † Alternative care includes all placement types except 'home' placements.

Figure C1.33. Children* in alternative care† — outcome of initial assessments, by financial year (1992–93 to 2002–03)



Source: Information Services Branch, Department of Families, September 2003.

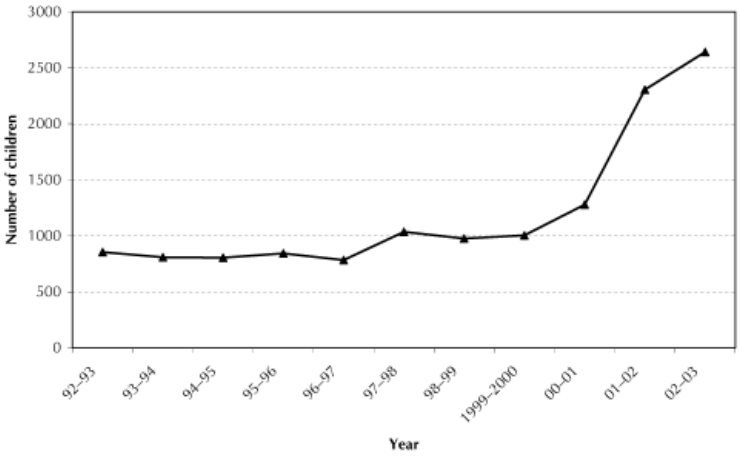
Notes: 1. A child can be the subject of one or more 'cases'.

2. Investigations not finalised include cases where no assessment was possible, part assessments, unable to commence complete, and still under investigation.

3. * Includes children on protective orders only.

4. † Alternative care includes all placement types except 'home' placements.

Figure C1.34. Children ceasing out-of-home care* by financial year (1992–1993 to 2002–2003)

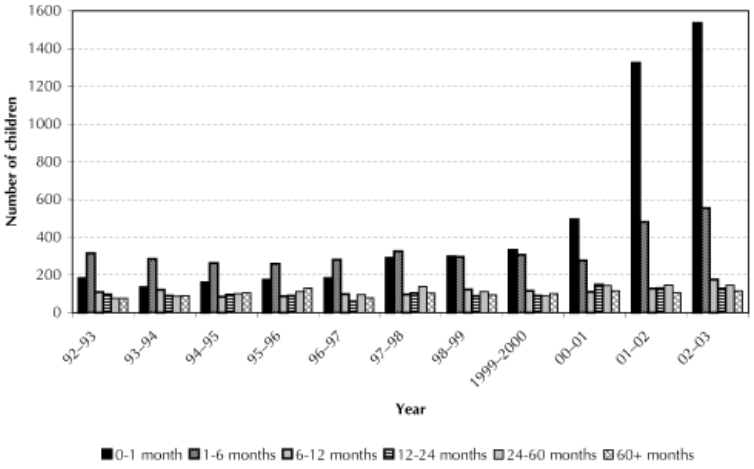


Source: Information Services Branch, Department Families, October 2003.

Notes: 1. * Out-of-home care includes all paid placements with approved foster carers, relative carers, carers with limited approval and residential care facilities and excludes home placements and unpaid carers.

2. These data are not directly comparable with the 'entries' data. Due to complexities in the method of recording placements these data cannot be easily derived for children in alternative care. However, all 'exit' data have been derived using this rule and are directly comparable with national child protection data published by the Australian Institute of Health and Welfare.

Figure C1.35. Children who ceased out-of-home care,* by length of time in continuous out-of-home care and financial year (1992–93 to 2002–03)

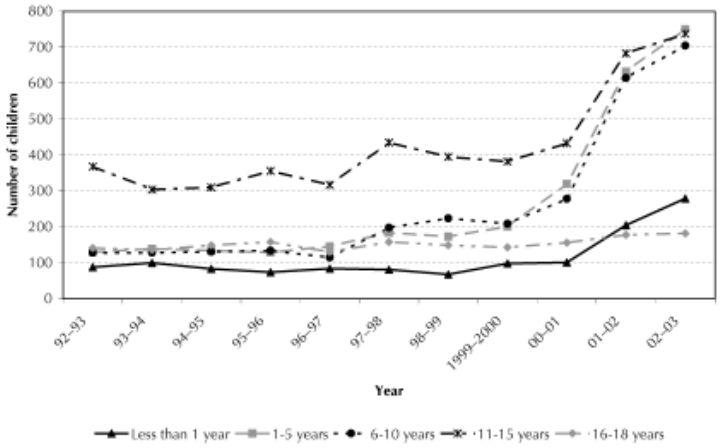


Source: Information Services Branch, Department of Families, October 2003.

Notes: 1. * Out-of-home care includes all paid placements with approved foster carers, relative carers, carers with limited approval and residential care facilities and excludes home placements and unpaid carers.

2. These data are not directly comparable with the 'entries' data. Due to complexities in the method of recording placements, these data cannot be easily derived for children in alternative care. However, all 'exit' data have been derived using this rule and are directly comparable with national child protection data published by the Australian Institute of Health and Welfare.

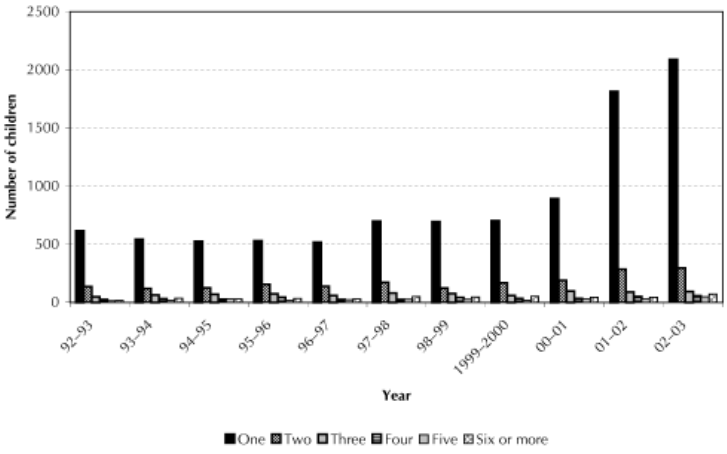
Figure C1.36. Number of children exiting out-of-home care* by age and financial year (1992–93 to 2002–03)



Source: Information Services Branch, Department of Families, October 2003

Note: * Out-of-home care includes paid placements only with approved foster carers, relative carers, carers with limited approval, and residential care facilities.

Figure C1.37. Children who exited out of home care* by number of placements and financial year (1992–93 to 2002–03)



Source: Information Services Branch, Department of Families, October 2003

Notes: 1. * Out-of-home care includes paid placements only with approved foster carers, relative carers, carers with limited approval and residential care facilities.

2. These data are not directly comparable with the 'entries' data. Due to complexities in the method of recording placement these data cannot be easily derived for children in alternative care. However all 'exit' data has been derived using this rule and is directly comparable with national child protection data published by the Australian Institute of Health and Welfare.

Consultations with children in care

During the preliminary phase of the Inquiry, the CMC consulted a number of children who were either currently or formerly in the care of the Department of Families. These children included members of Bravehearts Inc. (22 September 2003), representatives of CREATE in both Brisbane (25 September 2003) and Mackay (8 October 2003) and children attending the Southside Education Centre at Springwood (9 October 2003). As well, the CMC spoke to a number of counsellors and senior staff associated with these organisations: these individuals were able to provide us with insight into the nexus between the children directly in their care and, in many instances, the problematic relationship between the children and the department.

The CMC is grateful for the honesty and integrity of all who participated in the consultations and focus groups and extends its sincere appreciation for the time taken by each of the children and adults who spoke to us.

The issues raised by the children of greatest relevance to the terms of reference of the Inquiry are documented below and fall into the following categories:

- What is good about the system?
- Children's rights
- Resources
- Contact with FSOs
- Contact with the department
- Foster carers and their families
- Contact with others
- Contact with other relevant agencies
- Contact with natural family
- Children's files
- Accommodation
- Placements
- Abuse and notifications
- Cultural sensitivity
- How can the system be improved?

What is good about the system?

Those people consulted made the following comments:

- 'It may work for some who have been abused at home and move into a good foster home — it can provide a safe home … but we haven't seen it.'
- 'Some foster parents try to build relationships with the children. Some stay connected; others don't. Some help the kids stay in contact with their family.'
- 'Knowing that there are people there for you.'
- 'Youth camps can be good.'
- 'CREATE is good.'
- 'Transition can be good — [but it's] more a relief of finally being free of it all.'
- 'I have had a good loving foster family for seven years — just lucky — but it shouldn't have to be luck! It makes life different when you have that support.'
- 'It's the freedom — not being different. You're treated as a member of the family, not a token foster child … I've been with my family for two and a half years, and I've appeared like part of the family.'
- 'I've had half-and-half good experiences. My foster parents, they've been good. I shared a room with their daughter. When I was expelled from school my [foster] mum just accepted it … I was part of the family for two years and called them 'Mum and Dad'. They became foster carers to just take care of me, and have won awards in the region as foster carers.'
- 'I've been with my family for five years and they're now "my other family". I've never been left out. My foster sister got exactly the same presents as I did at Christmas. I get introduced by [foster] mum as "one of my girls". They're now my guardians. It's a very stable family.'

- 'My two mums get along well, and can talk to each other to arrange things about me. My foster mum is very supportive of my real mum.'
- 'In my current placement I'm treated as family. They trust me and that gives me a lot of freedom. If I want to go out, they trust me to do what's right and treat me with respect. They treat me as though they know I'm being good.'
- 'One placement was good, but I never really felt close to my carer. But I felt safe — that nothing bad would happen.'
- 'My foster mum calls me one of "my boys".'
- 'My [foster] mum is lenient. If I don't feel like going to school, she allows me not to go to school. There's not a lot of rules. There's plenty of freedom.'

Children's rights

- 'You feel vulnerable — you have to fight for your rights.'
- 'Nobody believes you or listens to you.'
- 'They don't inform you of your rights.'
- 'You constantly have to fight for what you want.'
- 'I always felt uncomfortable in homes with men — I felt more comfortable with a single woman. But nobody would listen to me.' [Note: this former child in care had been sexually abused.]
- 'You're told to be grateful for what you've got — even when you are sleeping on the floor and you have no food.'

Resources

- The clothing allowance is too limited.
  - 'We don't get it.'
  - 'It's not enough — it doesn't even pay for your uniforms.'
  - 'The department lost my clothes when they were in storage — they refused to replace them.'
- Resources are too limited.
  - 'The department say they need more resources — but what about the Goodwill Bridge? … why did they spend all that money on the bridge when there are lots of kids who are homeless and being abused … why can't they tell people just to walk a bit further?'
  - 'We see ads on TV asking for money for kids in Somalia, but it's happening in our own country. We know that [kids in care] shouldn't be sleeping on a park bench, but they are.'
- Foster carer money is not used appropriately.
  - 'Where is the foster care money going?'
  - 'The [carers] spend it on themselves.'
  - 'We have to eat home-brand food and they spend the money on good food for themselves.'
  - 'I never get breakfast.'
  - 'We feel that a lot of the carers are doing it to get the extra money for themselves and they are neglecting the needs of the children.'
  - 'There are too many families taking too many children to get the money … they can't control the kids and their only response is to hit the kids.'
  - 'One carer said to me she hated kids, and she was only doing it for the money.'
  - 'I only got $50 from $150 out of my Centrelink payment. I told the department, and they told my carers they couldn't do it. It's like I was being charged board, when my carer was already being paid to care for me.'

Contact with FSOs

- Good contact
  - 'I had a good FSO, but not many of them [children] have that.'
  - 'I will defend FSOs — they are on the ground and they have to defend us

against their senior officers. A lot think that they can make a difference but their hands are tied — it's more the managers that make the decisions and they [the managers] should be held accountable.'

- Bad contact
  - 'I've had 16 FSOs.'
  - 'My FSO is never available. They are not there for you — I have had to sleep on the streets.'
  - 'There is a lot of variability between FSOs.'
  - 'They are hard to contact, not responsive and they don't check on our needs.'
  - 'When I rang my FSO she would only talk to my carer — she refused to talk to me.'
  - 'They never send you a birthday card. You should be able to celebrate something. They only come when you are in crisis — and mostly not even then!'
  - 'I got my report card the other day and I wanted to tell someone about it — but I didn't feel that anyone cared.'
  - 'They change FSOs so regularly — and they change all of a sudden.'
  - 'I call up to talk to my FSO and they tell me that she has gone — they don't let us know.'
  - 'They aren't employing enough FSOs — lack of funding.'
  - 'FSOs are also taught not to have a close relationship with the child — there is no attachment — but you need someone to advocate for you!'
  - 'A lot of FSOs are young and a lot don't care — there is not one that I have come across that truly cares about kid's protection. They are inexperienced. We are told that they only take in people who have degrees, but a lot of us can't relate to them — we don't have clothes or food and they simply don't understand that.'
  - 'My FSO doesn't talk to me … I am supposed to go to a camp with her but she doesn't talk to me.'
  - 'You never see an FSO — they change and you don't even know it. It's like they are hiding. I tried to call but they didn't call me back — I needed some money and had to make a complaint.'
  - 'FSOs know they will lose their jobs if they buck the system.'
  - 'FSOs concentrate on the paperwork — they have no people skills. Each case is just a name on a piece of paper.'
  - 'I had one FSO in eight years, then I had four FSOs in one year.'
  - 'I've had five FSOs in a space of four to five months, and I never got to know them. I'd ask for a certain FSO, and a different one would deal with me.'
  - 'Yeah, you get two or three a month. The department don't know you or even who your FSO is. You have to start from scratch each time … it's not acceptable.'
  - They always cancel meetings … the good kids don't get attention … you have to play up to get attention … it's the good kids who don't get attention who end up worse.'
  - 'Contact? what contact ... ?'
  - 'I've tried ringing them, but only get recorded phone messages.'
  - 'Contact? Not much at all. They only contact you when *they* want something.'
  - 'They tell you that they're so overworked with lots of priorities. It means that you can only think: am I the last priority?'
  - 'I've sent mine an e-mail. That guarantees a response within a week.'
  - 'The FSOs just don't understand. It's nothing personal to them, but they act as if we don't have any say. You feel like saying: 'but why don't you ask me?'

Contact with the department

- Power
  - 'The Department of Families has too much power.'
  - 'I felt powerless … scared … I thought that they were going to gang up against me — they had another agenda … I felt ambushed.'
- Contact
  - 'The Department of Families expects the children to keep in contact with the department but in many instances they don't have the money to make the telephone call.'

- Services
  - 'Family Services will not pay for medical or dental expenses.'
  - 'I never went to the dentist during care — I got holes in my teeth — but the policy says that we have to be taken to the dentist every six months — it never happened … I went to Judy Spence's office and I got $2500 for teeth — why not before? It only happened after the [CMC] inquiry was announced'.
  - 'I had to fight for 12 months just to get a second pair of sheets.'
- Inaction
  - 'They don't like to hear about the bad stuff — they should be trying to fix the problem not just cover their butts.'
  - 'My sister ran away from the sexual abuse by our father — the department wouldn't take her away … she is now pregnant to my father — she's 15 — and the department [still] won't take her away.'
  - 'Kids shouldn't have to initiate the calls — it should be the other way around. They tell us to leave a message — but sometimes you can't ring to make a complaint because the foster parents won't let you use the phone and all of your mail is read — so you don't have any way of making a complaint — for example, the department has a 1800 number but some kids can't get to it.'
  - 'If you hound the department they make it difficult for you — hell for you — intimidation, phone calls not returned. The department has power which needs to be taken away from them. If you ring saying that there's an emergency, you get told that they'll get back to you in 48 hours. If it's an emergency, 48 hours isn't acceptable.'
- Crisis line
  - 'The crisis line numbers are hopeless — they're not clear on phone messages. On weekends and after hours, there should be manned phones, not recorded messages. You should always get a proper person to talk to.'
  - 'Don't you like the classic "please hold — we care about your call"?'

Foster carers and their families

- 'Going into a foster home is like being an intruder on Big Brother — you come with a label. It's really scary going into a new foster home — you don't know anything about them and they don't know anything about you (except some of the really bad things).'
- 'I was treated differently to their own kids — less than them. I didn't go to the toilet for three days. We foster kids stress over unfamiliar surroundings, toilets and showers … normal kids don't stress over these things, but we do, and they wonder why we become difficult and hard to handle as teenagers.'
- 'I think foster carers have too much power — they get warned about a week in advance that they are going to be visited.'
- 'Foster carers aren't provided with any information about us.'
- 'I've been in care for seven years. The second carers I had, they said to us — you can be treated as foster kids [e.g. be treated differently, go into respite minding] and have contact with the department, or you can be treated as normal kids and not have any contact with the department. I said I'd be treated as normal, and the department didn't check up at all. They were nice people and had their own kids too. But I went to the department about something and the carers went off something bad. It was real bad. I had to seek mediation for a while.'
- 'My carers didn't know me at all. They met me at a barbeque. My nanny — the person who my mum used to get to look after me — she took me to the barbeque with her own son. My carers wanted me because I was there. They had twins who had died. For a long time I thought I was the rebound person. But they've kept me, and so I feel a lot better. He's [foster father] so easy to talk to.'
- 'My carer called me "my foster daughter" when she introduced me to anyone, and told everyone about me and my story. It's not fair. It just creates a stereotype, and then you're judged against that stereotype.'
- 'In my current placement, I have a lot of boundaries set for me — like not being able to go out. I'm not really Harry Potter being locked in the cupboard under the stairs, though. I like them [foster carers] so much. But sometimes I feel like breaking the rules — but I don't, because I like them.'

- 'I'm very happy with my current carer. We had a chance to get to know one another a bit beforehand. We went to a local restaurant to meet and get to know each other first. I wasn't just dumped on the doorstep like some other times.'
- 'I was a rebel. I ran away at least once a week and stayed away for two weeks. I'd go back to my foster carer — I'd return for a shower and some fresh clothes, and then I'd run off again. They didn't worry too much.'
- 'My carers don't really know anything about me. They've got a girl, aged 10, and so I'm also treated like a small child. They don't think I can handle some things — like they won't let me enter a marathon. Like — I lived on the streets for three months — I can handle a marathon!'

Contact with others

- 'Teachers use your label as a "foster child" as an excuse for your behaviour.'
- 'There was this teacher at school who kept saying to me "we need to understand these things". But it's none of their business.'
- 'You always wonder, are they doing this because they're "sorry for me" or is it because of genuine concern?'
- 'Then there are the friends who spread information about you at school, so you get questions all day long. I've been in so many fights … !'
- 'Like they keep saying "How come you're in foster care?"'
- 'There was this woman from the church who was asking me, and I told her "it's none of your business", but she didn't let up.'
- 'The teachers are really bad. I've had a better day with my mum who's the biggest bitch.'
- 'You don't even know whether the marks the teachers give you are genuine or not — whether they're thinking "oh, what a sad little girl — I'll give her an extra couple of marks for this" … '

Contact with other relevant agencies

- 'The Children's Commission … I have been there and they don't help.'
- 'I was never counselled — it was only when I was 15 and went to the Children's Commission that the Department of Families arranged for counselling — the department said "oops —someone else is watching".'
- 'Information is not being passed on between regions and to central office — there are a lot of lost children up there — there's not much advocacy — they don't even know about the Children's Commission up there.'
- 'When official visitors attend accommodation centres they are viewed as people who are there to see the workers in the centre not the children — and the children do not feel comfortable talking to these people.'

Contact with natural family

- 'The family is not necessarily the best option because of the cycle of abuse.'
- 'My experience is that the perpetrator of the abuse in the natural family has to have unsupervised contact with the child — I hate it that the perpetrator has a right to visit and that the child doesn't get a choice … it shouldn't be forced … and yet there are others who aren't allowed to see there family when they want to.'
- 'Often siblings are split between carers and between FSOs — they don't get equal resources if the carers don't request more.'
- [comment by a carer] 'There is a lot of pressure on carers to supervise contact visits between biological parents and the child … [but] the parents hated me and yet I was the one who had to supervise their visits! When I refused to do it the department came but they went to the pub while the visit occurred.'
- 'My carers constantly denigrated my parents. They tried to "rescue me" — you know, to protect me, and break the cycle. But it caused a break up with my natural family.'

- 'I have 13 siblings, but I've lost contact with them. I'd like to get into contact with them again. I saw mum about five years ago. The early contact with my siblings was hard for them. They saw what I was getting, being in foster care, and what they were missing out on.'
- 'I ran away [from the foster home] at the start of this year — I was having a few communication problems with my carers. I went back home and spoke to my own mum, but she just threw stuff — bad stuff — in my face about me.'
- 'It's all crap. My mum just virtually told me to piss off. I felt the department wanted me to see my mum, so I did. You get this feeling of pressure from them to see your family, whether you want to or not.'
- 'You feel you're being "heavily encouraged" to see them.'
- 'I've always had contact — and we get along OK.'
- 'The FSO rang my dad without letting me know, to see what he thought about the application from my foster parents for guardianship. I was so annoyed. He's had no contact with me and doesn't know anything about me. The FSO said what a "nice guy on the phone" he was, and put pressure on me to see him, but I insisted on making my own decision. Dealing with him face to face is a lot different from "the nice guy on the phone". It was, like, "I'll make you talk to your dad!"'
- 'It's best for a child to stay away if the parents are really bad.'
- 'It would have been good for me to continue contact with my family — but it depends on the situation.'
- 'I didn't have contact. I was in care from age 12½ to 17, and had no contact then. The department encouraged me to have contact, but it was better not to. Some things she said — she really hurt me — we had the biggest bitch fight.'
- 'The FSO gives you such a dirty look if you say you don't want to have contact with your family.'
- 'They have no idea of what the family's like — full contact is a lot different from phone contact.'
- 'One placement I had for one month, I was living just around the corner from my mum. So it was a waste of time, because I was always around at mum's. It was cleaner there. That foster mum had eight foster kids as well as four of her own kids. Nothing was clean — it was really unsanitary. Nothing was washed, but we always had to have tea-tree oil in our hair to stop nits. I just wanted to stay at school. If I felt like having a hug, I had to explain to her why I needed a hug. When the FSO did arrive, she just stood at the front door and was shocked, it was so filthy. I'm a clean person. I couldn't stand it. I shared a room with this other girl who'd lock me out. So I'd be outside at 3 am, and play spotlight.'

Children's files

- 'The FSOs — they don't do handovers. Every new one you get asks you to tell them all about your background. It should be in your file.'
- 'I was diagnosed with a rare heart condition, which I later found out was hereditary. But it wasn't on the file that the FSOs have. I now have a pacemaker and defibrillator, and they had to go back to my parents to get all the information.'
- 'The files are too incomplete. None of the complaints I had made were even registered on my file.'
- 'I just found out that my dad is bipolar. But it wasn't on my file.'
- 'There are big holes in my life. I have conflicting stories from carers, parents and FSOs. There are invoices and tax receipts in my folder and why I'm in care. But I've been in care between 2½ and 18, and there's little else in my file.'
- 'I had a horse accident … a broken hip — none of these things were recorded in my departmental files.'

Accommodation

- 'Accommodation is in very short supply.'

- 'Many venues are unsuitable because they cater for both sexes … this is inappropriate as these children are teenagers, are starving for affection, have mental health issues [and] many girls are raped in these accommodation centres.' [One girl described the experience of being raped in a youth accommodation centre by a worker who is currently still at the establishment — the child was removed from the centre.]
- After 'cutting herself up' in a suicide attempt, one girl described being sent to another foster care family who had very young children. Although she had attempted to cover up her cuts on arms and legs, she left the foster care family, as she thought it inappropriate for the young children to witness her self-damaged physical state.
- When unable to access accommodation some of the girls reported that they had picked up men in the streets to secure accommodation. On one occasion a girl reported being imprisoned by a male and held as collateral for a bad debt. She was unable to leave the home until her friend paid the debt. She contacted the QPS as the man had threatened to attack her with an iron bar if the debt remained unpaid; however police advised they were unable to act unless actually attacked — she was attacked.
- In many cases these highly traumatised and disturbed children are all placed in care together. This experience serves to add to the trauma in that they further witness violence, drug taking and suicide attempts by other disturbed children. In a chilling disclosure one young girl described watching another girl slitting her own throat.
- There are wide gaps in the system. Some of these girls have reportedly begged on the streets for money, eaten out of garbage bins and slept in parks.
- Centrelink payments are unavailable for 15-year-olds.

Placements

- There are too many placements.
  - '[We] are moved around a lot.'
  - '[There are] no explanations when we are moved between placements — taken out of school etc. — and we are never ever told what is going on — at any age or stage.'
- There are too many children in one placement.
  - 'How can you have 13 abused kids and show love for all of them?'
  - 'These are extremely difficult children … they are this way because of the lives they have lived. They require intensive one-on-one situations which incorporate nurturing, caring, loving and understanding families … in many foster homes there are just too many children to adequately deliver quality of care.'

Abuse and notifications

- 'When I made a complaint about abuse in a foster family the department victimised me — they hate me … but I turned out to be right and some other kids had to be taken out of the home.'
- 'I made a complaint to the police about sexual abuse — they took my statement for 1½ hours — after that my FSO said "I don't believe you" and the file has now disappeared — is there a cover up by the department and the police?'
- 'When I was in care I was sent home when they didn't have a placement for me — my mother's partner who sexually abused me was still there. I had no say — and I had much resentment towards my mother that she didn't believe me.'
- 'To me everyone is a paedophile — that's wrong. I shouldn't have to think that way … the department didn't believe me — the only reason I was taken into care was because I was locked up — they didn't believe me about the sexual abuse. Why did it have to happen to me? I didn't get any support or counselling — I was never offered it.'
- 'My whole time in care was abuse … I can speak out now … no-one tells you that you can go to the police — you can't even get to a dentist.'

- 'There is no prevention or early intervention — I reported a cousin who was abusing a baby and the baby was being anally raped by her boyfriend. I had been notifying the department about the family for five years — they paid no attention. Eventually the doctor made a notification when the mother took her in for an HIV test — the poor child will grow up with severe issues ... that little girl … was [also] eating dog food. It was happening in my own family — it could have been prevented.'
- 'I had a baby at 16 — I was sexually abused for years and years but the department wouldn't give me 'depo' … and then I got pregnant …'
- 'I make notifications all the time but I am not listened to. I write it down now so that it goes on a file and I keep a copy … you have to learn the right way of going about it — but nothing has happened re any of my notifications.'
- 'I was sexually abused and I ended up running away.'
- 'Why don't they follow up the notifications?'
- 'Carers need to know that they are hurting the children.'
- 'I told my FSO about one place that I was abused but nothing happened. They are supposedly trained to pick up on that but they don't … they sacrifice the children for the foster carer.'
- 'When the abuse in foster care happened, all contact with my natural family (for example, my grandmother) stopped — the department was trying to cover it up … I was only 10 … nothing was ever explained to me … I was made to feel like I was guilty because I had spoken up. I was removed after my allegations but all of my siblings were left there … that's wrong!'
- 'Any abuse allegations are passed on to the next foster home. It's like a permanent stain — you are constantly criticised and asked "why did you do it?" … and it destroys your placements. There is no understanding that what you did was the right thing … only our school and CREATE have said that to us — there is no departmental or FSO support.'
- 'CREATE developed a form which could be used for children in care to report abuse — the department accepted it and it has been available for 12 months, but there was no roll-out or promotion of the form or a policy plan developed: FSOs and carers were not involved the process so these people are unaware of its availability.'
- 'I spoke out about abuse of kids in the family and was kicked out for it … the kids are still there … those kids are abused kids in the first place and their carer was hitting them — there was nothing I could do — I felt powerless.'
- 'I still feel scared to speak out because I think that I won't be believed — fear — past expectation that it will happen again.'
- 'The department won't remove kids from abusive environments because they have nowhere else to put them. It has to be a crisis.'
- 'The social worker changed all of the time. No-one actually came to speak to me — only to the foster parents — and they were the ones who were abusing her — no-one worked for me — they seemed like the model foster family.'
- 'My foster mother refused to take me to see a doctor — I burnt my leg — it was very serious and was bandaged for a full year — not once did the department's social worker ask me about it.'
- 'Nobody recognises what's going on inside … nothing has changed … there are no systems in place for protecting the children.'
- 'I thought it was worth taking them to court, but I have had to chase up the police and give them information. The foster brother has a daughter who is at risk of abuse by her father and her grandfather — I have asked people to look out for her but they don't. She is getting panic attacks which means that she could be being abused — I have called and asked if they have checked on her but they say no.'
- 'I was in foster care for six years — then in and out of homes in between being abducted by my mother … my mother prostituted me out … I went to 13 different primary schools … no-one wanted me …I was abused in one of the placements by their son — my mother knew that but the department did nothing … I was abused from home to home.'

- 'I used to cry to my departmental officer and beg to leave the foster home but they didn't ask why — they always took the side of the foster parents … mine was a model foster family — I never said that I was abused (I was very young) but I did beg to leave.'
- 'I had two children to a fellow who was 28 (when I was 13) … the department knew about it but did nothing. That fellow sexually and emotionally abused me for years — he still has access to my children.'
- 'My kids were abused in the foster homes and they came home to me because of that abuse … the department swept it under the carpet … police disregarded it … the Children's Court wouldn't look into it because my kids are in care.'
- 'No-one is there for the kids.'
- 'Kids are never taken to see a doctor — family services come once or twice — [there is] no proactive preventive work … what it comes to is keeping the foster parents happy — they have tea and biscuits — difficult when the kids are suffering abuse and they see the foster parents and departmental staff having tea and biscuits — they don't talk to the children and the children don't feel that they can speak up because of the power differential. The child sees the departmental staff in cahoots with the foster parents — the FSOs are not there for the children.'
- 'I have put in complaints about the abuse of my nephew/niece by the foster family, but the department claims that the kids are attached to the foster parents, which is wrong.'
- 'I was abused by my parents [and] abused by foster parents … the department walked in and saw foster carers abusing me and did nothing about it.'
- 'Re notifications — the department doesn't follow through — it's up to the carer to deal with it.'
- 'I lived in a foster home with 16 children … all children were eventually removed from the home [because of abuse] … the children did not report the abuse because they would prefer to have a home even if it was unsafe and traumatic. It was better than no home at all.'
- 'In my current placement my carer hit me once. I was having a real spak, screaming in her face and throwing things at her. We rang the FSO. She hit me another time for something I did, but it was only really gentle — and she self-reported to the department. I didn't want her to, but she did.'

Cultural sensitivity

- 'The department doesn't look after Asian and other cultural kids — the department can't speak Asian so they won't intervene when kids are abused.'
- 'I make notifications but they just say they can't progress them because what it happening has something to do with their culture … there aren't many other cultures in care because it's like a religion — the department is scared to take them out so they leave the kids to be abused … like on Mornington island — 13 Indigenous kids in one bedroom in foster care — how can the department accept that different level of care for Indigenous kids just because it is a different culture — it needs to be looked at … you can never compensate for the type of sexual abuse that would be going on in that kind of an environment.'
- 'They didn't have Murri staff members until recently … the department is scared about the stolen generation — we are white but we are also a stolen generation — we've been taken away and we've been abused — where is the sorry day for us?'

How can the system be improved?

- Accountability
  - 'A lot of initiatives come from the community, not the department, but it's not right — it is the department's responsibility.'
  - The Department of Families has too much power and absolutely no accountability — the department needs to be made accountable to the Act.'
  - 'Kids are let go early out of the system — the department is eager to shift cases on.'

- Files
  - 'There should be an up-front file with all your medical stuff in it. It's important to be able to access this. Then you can have a back file, with all the other information in it.'
  - 'They really need to keep a family life diary.'
- The provision of information
  - 'You need to look at the right time to give information to kids because when they are taken into care it is quite traumatic. So you need it to be done appropriately for all age groups — the information and the mode of delivery.'
- Child advocates
  - There should be an independent person for the kids — it just doesn't happen — there is nobody there for you. You are entitled to a support person — but you are not told that. Nobody tells you anything.'
  - 'There needs to be more of a one-on-one relationship between the child and the departmental officer.'
  - 'The child has no voice … kids are reluctant to speak.'
  - 'We need advocates for kids.'
  - 'We don't trust the system.'
  - 'You need early advocacy before everything goes wrong — it blows up and you are let down again … they build up your expectations and they let you down — for example, they promised that I could visit my sister but they didn't organise it. It's very cruel — you are constantly being let down.'
  - 'There is no evaluation. We need early support — it's not necessarily a financial issue — there are stereotypes — you are judged.'
- Kids' rights
  - 'They need to emphasise kids' rights … someone has to be accountable for kids' rights.'
  - 'They should take into consideration what you want when you're young. They don't listen to you when you're a kid.'
  - 'They need to find time/place for kids to talk to someone out of the home — there isn't a safe place to go if you have concerns.'
  - 'You need to build up self-esteem in the children.'
  - 'There is no package for kids so that they know their rights — it's not consistent across the state — very patchy — some great — others are not.'
  - 'Every foster home should have a poster of kids' rights, which has to stay in the foster home — it could have the rules of the home — for both the kids and the parents — and it needs to be monitored … you have to educate the children and the carers from [the beginning].'
- Children's belongings
  - 'Foster Care Queensland is making packs for kids — suitcases — most kids have nothing more than a black garbage bag to take their things with them … I have nothing of my life except my memories — and they are all bad.'
  - One idea out forward was the concept of a book of a foster child's life. Each family would add facts about the child (positive only) and take a photo of the child as the child arrives with the family, and when they leave. Likes and dislikes in areas such as school, food, preferences in music, television shows, achievements, school friends made etc., could all be contained and would belong to the child. The child would own their life in a book, specially and particularly theirs.
- Foster kids would make good FSOs
  - 'The department doesn't want foster kids to be FSOs — they are paranoid about access to the files — concerned that kids may come across information about themselves. But we would make the best FSOs because we know what it's like.'
- Improved access to files
  - 'You have to apply for your file — you aren't allowed to look at your own file — and when you do, everything is blacked out. They make the choice of what they let you see.'
- Organisational structure
  - 'They need an intake team, and then a care and protection team.'

- Official visitors
  - 'Official visitors need to go out and see foster kids.'
- Community involvement
  - 'It [foster care] needs more community involvement.'
- Activities
  - 'We suggest that there should be youth gatherings where someone from the department takes out a group of kids — Kyabra do it well — but you also need that one on one with the kids.'
- Resources
  - 'They should have a special appeal to get more money — pool taxpayers money — like for the new bridge — who uses it? Just tell people to go over the other bridge and get the kids off the streets … foster children should start protesting on that bridge!'
  - 'Departmental staff are entitled to go to conferences — they get $63 per day to eat — I could have fed my entire family on that for a week … that is where the money is being spent and kids are being sacrificed for it … they have a QANTAS account — instead of Virgin — they spend an extra $300 for a cardboard box of food for their staff — why not fly Virgin and spend the extra money on the kids?'
- Random/spot visits
  - 'Increase the number of workers, make one-on-one contact with kids a priority, have surprise/random home visits — see what's really happening.'
  - 'We need spot visits of carers … they need to ring more often and see how we are — they need to be concerned about us — show some interest.'
  - 'The department should see the kids outside the foster home or do spot checks on the foster carers.'
  - 'Random spot checks on family situations is highly recommended.'
- Accommodation options
  - 'Other options for accommodation are needed … I didn't want to go back to my foster care family … I moved out independently at the age of 15 — the department is not very supportive of meeting my needs now — I am struggling to get furniture — I have had meetings with the area manager — Mt Gravatt has $140000 for all kids — I can only get $2500 from my area. I have had to fight for everything … I could have lived with my grandma but the department didn't move quickly enough.'
- Counselling
  - 'In the States [United States] it is normal practice for each child to see a psychologist — it works brilliantly. It is the one chance for a young child to trust some one who is not in the system … it is the one chance for kids to say "is this normal?" to someone who is outside the centre of power.'
  - 'To get into the foster care system you have to have been abused — you need special care … you need an independent medical consultation for all children — not to be taken with the foster family.'
  - 'We need to look at the long-term gains — abuse — counselling — to prevent long-term effects/consequences.'
  - 'I think what could be done better is if they could understand better. My sister and I had to go to a child psychologist, who just didn't understand. The psychiatrist tried to "fix us" to "make us normal", instead of trying to help us to understand ourselves.'
- Improvements to the blue card
  - 'The blue card is inadequate — it only shows what people have been convicted of.'
  - The blue card is very superficial [and it] can take more than 12 months to get a blue card — in the mean time these people are still allowed to work with kids.'
- Whistleblower protection
  - 'Whistleblower protection doesn't protect people who speak up … need to look at the whistleblower policy.'
- Liaison with other departments/information sharing
  - 'The department doesn't send on files to other departments — [there is] very

poor record-keeping, inaccurate file notes — [it's] completely wrong … there should be someone doing a review of all of those files. It will cost — but the cost of litigation and the long-term consequences of abuse and ruining someone's life is greater.'
    - 'The department should go into the schools and ask about the foster kids — for example, do they have any behaviour problems? They should also see the kids doctors.'
    - 'There are problems with the privacy legislation.'
    - 'Reviews need to be done by an independent assessor not the regional manager … and [they] shouldn't just look at the files (because they are empty) ... They need to talk to people to get the full story.'
- Siblings
    - 'Separation of siblings is an important issue — kids can be broken up amongst different FSOs — it makes it difficult to arrange contact visits … need to make links with siblings mandatory.'
- Training
    - 'I think all FSOs should be made to spend two weeks in a group home to see what it's like.'
    - 'Carers need training in managing challenging behaviours.'
    - 'I've been to the training sessions, and they're too boring and vague. They need more hands on stuff, not hypotheticals.'
    - '[Foster carers aren't] told enough about the child they're getting.'
    - 'They need more tools and strategies to deal with the child, otherwise they can make it worse.'
    - 'They should invite young people along to the training sessions, to get their views … get us to talk about the things we've done, to prepare the carers. You know, like, "the bushfires I've lit"… let them know what they getting into. We did this at one session, and four carers dropped out on the first day. But some of them need to hear this stuff. Let them be self-selecting about being a carer.'
    - 'I think foster carers also need more insight and self-insight.'
- Adoption
    - One child had been in foster care since four months of age — her mother refused to put her up for adoption. She asked: "why can't we put ourselves up for adoption?'
- An apology
    - 'I want to see [a former minister] stand up there and acknowledge that it happened — and that would make us feel better. We are not believed by anyone. You begin to doubt your own perceptions, but the abuse really happened even though you are constantly told that you are an attention seeker — and they kept telling people that you are simply an attention seeker — labels get taken on board.'

Introduction

Three sources of data are provided in this section of Appendix C:

- data about carers provided by the Department of Families at the request of the CMC
- a summary of the major issues raised through submissions to the Inquiry by members of FCQ
- the results of a survey of shared care and residential agencies conducted by the CMC.

Foster carer data provided by the Department of Families

Data requested

At the start of the Inquiry, the CMC requested from the Department of Families a range of information about carers. Those requests are listed in Table C2.1, along with comments about the availability and quality of the data.

Key issues arising from the data

The key issues arising from the data provided to the CMC by the department are as follows:

- The number of approved carers with placements increased by 71 per cent (from 973 to 1667) between 1993 and 2003 (see Table C2.2).
- The number of approved foster carers with one child has remained stable since 1993, while the number with two or more children has increased (see Figure C2.1).
- There has been an overall drop in the number of children placed with carers with limited approval (see Figure C2.2).
- The number of relative carers with one child has increased from less than 70 families in 1992–93 to more than 400 in 2002–03 (see Figure C2.3).
- The majority of primary carers are female: the proportion of males as primary carer has declined from 27 per cent in 1992–93 to around 8 per cent in 2002–03 (see Figure C2.4).
- While the proportion of Indigenous carers remains low, there has been an increase from less than 5 per cent in 1992–93 to around 8 per cent in 2002–03 (see Figure C2.5).
- Since 1997–98 the number of approved foster care families entering the system has remained stable, while the number of carers with limited approval has doubled and the number of relative carers has increased by 124 per cent (please also note that the data from 1992–93 to 1996–97 show an increase in approved foster carers and relative carers and a decline in carers with limited approval — see Figure C2.6).
- Since 1997–98 the number of carer families exiting the system has remained relatively stable across each carer type (please also note that the data from 1995–96 and more notably 1992–93 are vastly different from other years: this may reflect data collection and reporting practices rather than actual changes — see Figure C2.7).
- The number of approved foster care families with no placements has remained relatively stable since 1996–97 at around 600 families per year — considerably lower than the 1000 families per year between 1992–93 and 1994–95 (see Figure C2.8).
- For those families with no placements, in 2003 approximately 30 per cent had a placement within the last three months. A large proportion (around 50%) were recorded as not having had a placement within the last financial year (see Figure C2.9).
- In recent years approximately 300 families per year were recorded as not having had a placement within each financial year (note that this is considerably lower than the number recorded between 1992–93 and 1994–95 — see Figure C2.10).

Table C2.1. Data requested and comments

Data requested	Comments
As at 30 June for each year from 1993 to 2003, the total number of carers by: • type (fully approved, relative/kin carers, respite/ emergency carers) • active/passive role (i.e. whether approved carer has children in care or not).	Data provided. Department defined carers' roles as active or passive according to whether they were with or without current placements.
As at 30 June for each year from 1993 to 2003, distribution of the number of children in care per foster carer and institution.	Data provided.
As at 30 June for each year from 1993 to 2003, a profile of foster carers, including: • gender and marital status of primary carer • Indigenous status • family structure, including number of biological children • sources of income (e.g. work, single parent income, unemployment benefits).	Information about the gender and Indigenous status of carers was provided. However, data on marital status, family structure and income were not provided. Department advised that they do not collect information about these variables, even though these factors are used as tools for assessing potential carers.
The number and type of training courses provided to each category of carer per year by: • agency/department providing training • number/category of carers attending each course (e.g. foster care, residential care, crisis care).	Department reported that these data are not collected, and advised the CMC to contact the shared care agencies to collect the relevant information.
For each 12-month period from 1 July 1993 to 30 June 2003, the number of carers entering the system by type: fully approved (foster care, residential care) relative/ kin, respite.	All data except those pertaining to residential and respite care were provided.
For each 12-month period from 1 July 1993 to 30 June 2003, the number of carers trained by type: fully approved [foster care, residential care], relative/kin, respite.	Department unable to provide this information; information sought through the CMC survey of shared care and residential agencies.
For each 12-month period from 1 July 1993 to 30 June 2003, the number of carers: • reapproved (by type) • rejected.	Department was unable to provide this information.
For each 12-month period from 1 July 1993 to 30 June 2003, the number of carers who entered and left the system by type: fully approved (foster care, residential care), relative/kin, respite.	Department was unable to provide information about residential or respite care, but all other information was provided.
For each 12-month period from 1 July 1993 to 30 June 2003, the number of carers who became passive (but were not removed from the books) by type: fully approved [foster care, residential care], relative/kin, respite.	Department advised the CMC that the data regarding 'passive' carers could only be obtained by counting carers without placements. It should also be noted that only approved foster carers are enumerated. This is due to the large number of relative and limited carers without placements and their considered assessment that data regarding such carers would not provide any useful information to the CMC as these carers are only used for specific children for a specific time.

Table C2.2. Number of carers* by approval type, placement and financial year (1992–93 to 2002–03)

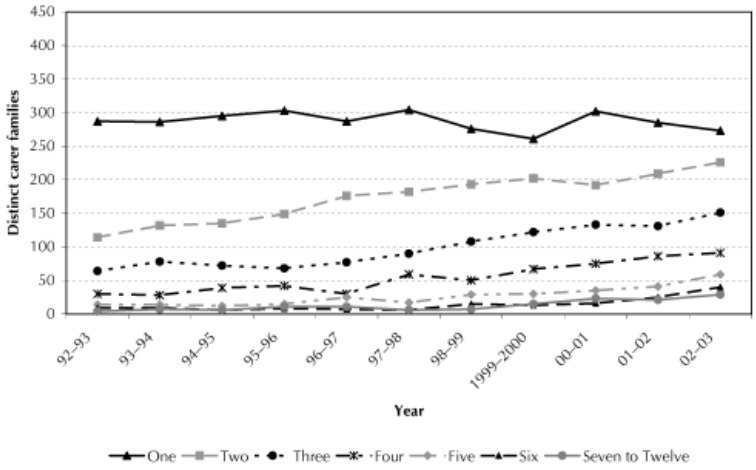
Year	Approved foster carer	Approved foster carer with placements			
		Foster carer	Carer with limited approval	Relative carer	Total
1992–1993	1571	522	347	104	973
1993–1994	1565	554	339	128	1021
1994–1995	1612	565	277	183	1025
1995–1996	1140	596	223	265	1084
1996–1997	1278	613	150	309	1072
1997–1998	1330	664	122	341	1127
1998–1999	1365	678	124	389	1191
1999–2000	1385	710	140	466	1316
2000–2001	1427	776	145	489	1410
2001–2002	1429	798	159	570	1527
2002–2003	1485	869	183	615	1667

Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. Carer counted once only based on approval hierarchy of ¯ foster, limited, relative

2. * Dual carers are counted as one-carer family.

Figure C2.1. Distinct carer families — number of children placed with approved foster carers by* financial year (1992–93 to 2002–03)

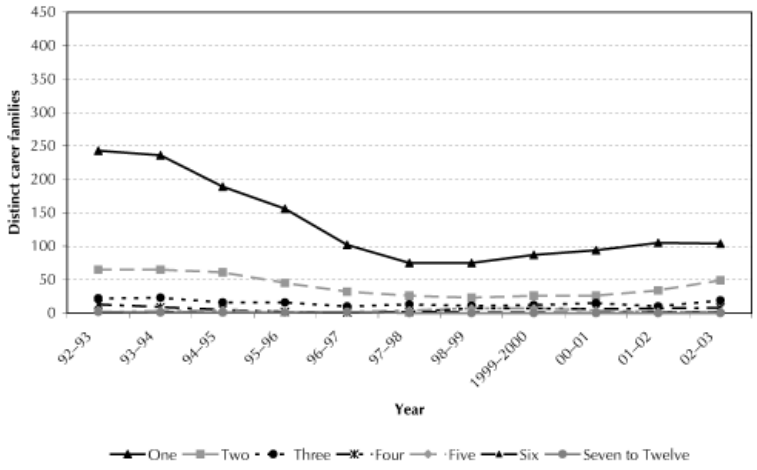


Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. Carer counted once only based on approval hierarchy of — foster, limited, relative.

2. * Dual carers are counted as one-carer family.

Figure C2.2. Distinct carer families — number of children placed with limited approval carers* by financial year (1992–93 to 2002–03)

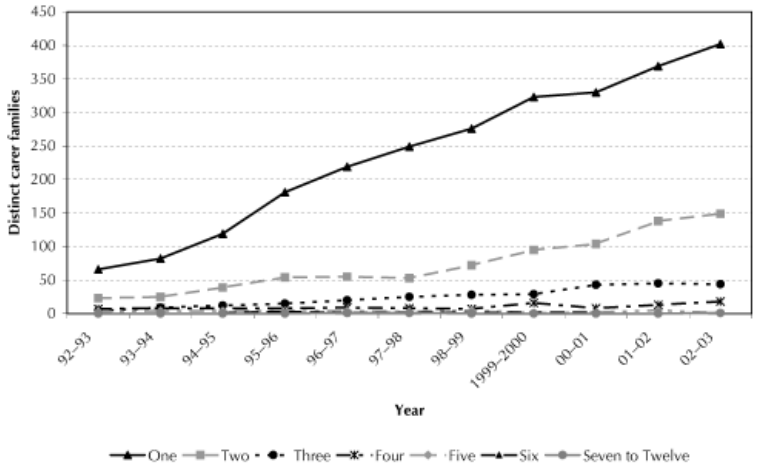


Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. Carer counted once only based on approval hierarchy of — foster, limited, relative.

2. * Dual carers are counted as one-carer family.

Figure C2.3. Distinct carer families — number of children placed with relative carers* by financial year (1992–93 to 2002–03)

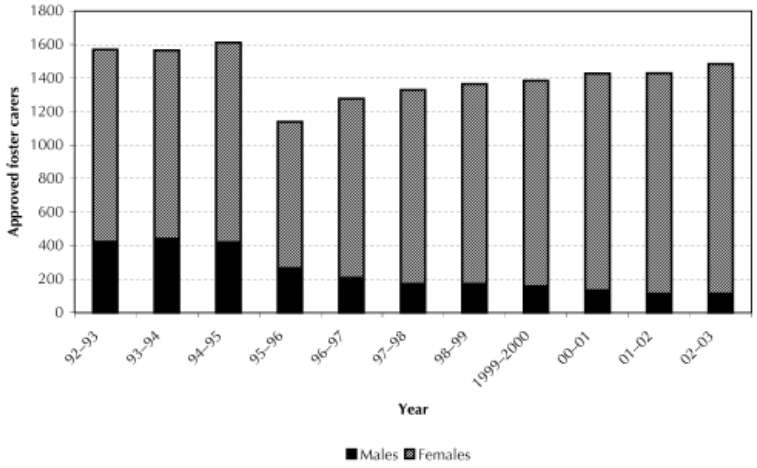


Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. Carer counted once only based on approval hierarchy of — foster, limited, relative.

2. * Dual carers are counted as one-carer family.

Figure C2.4. Gender* of approved carer families† by financial year (1992–93 to 2002–03)



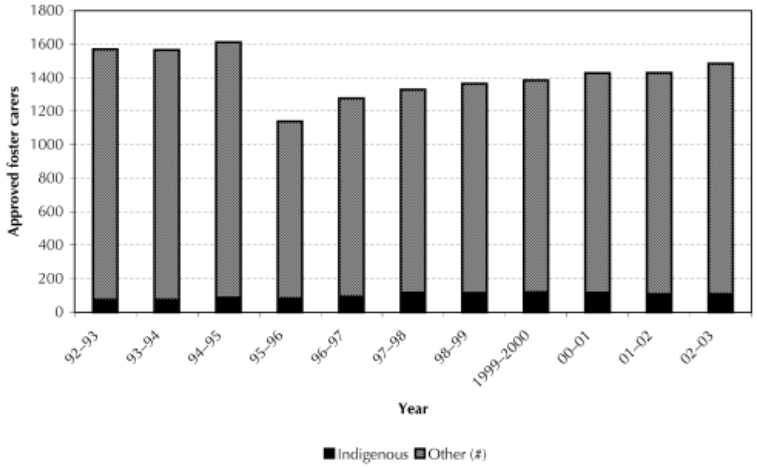
Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. Carer counted once only based on approval hierarchy of — foster, limited, relative.

2. * Based on the primary carer in the carer family.

3. † Dual carers are counted as one-carer family.

Figure C2.5. Indigenous status* of approved carer families† by financial year (1992–93 to 2002–03)



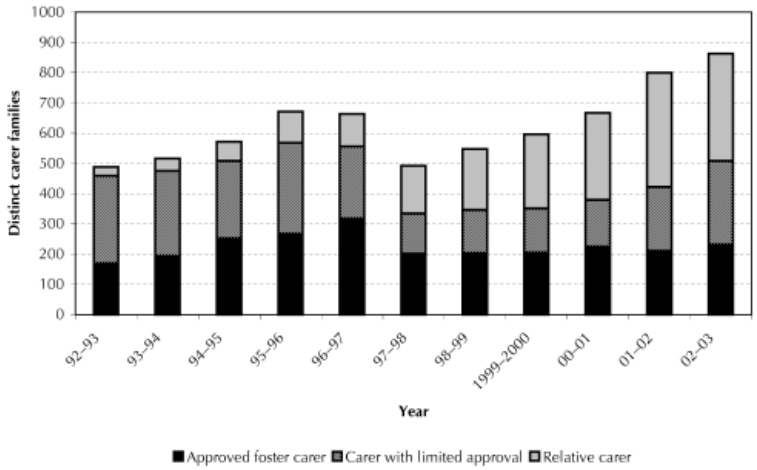
Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. * Based on the primary carer in the carer family.

2. † Dual carers are counted as one-carer family.

3. (#) Includes non-Indigenous and those whose Indigenous status is unknown or not stated.

Figure C2.6. Distinct carer families* entering the system by financial year (1992–1993 to 2002–2003)

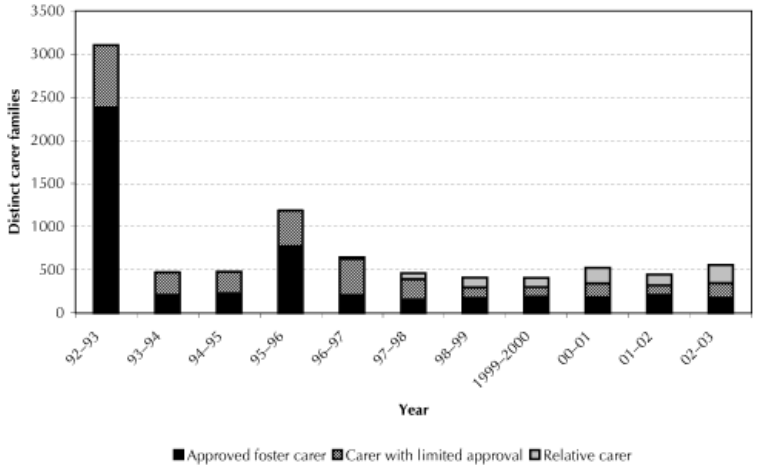


Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. * Dual carers are counted as one-carer family.

2. Carer counted once only based on approval hierarchy of — foster, limited, relative.

Figure C2.7. Distinct carer families* exiting the system by financial year (1992–1993 to 2002–2003)



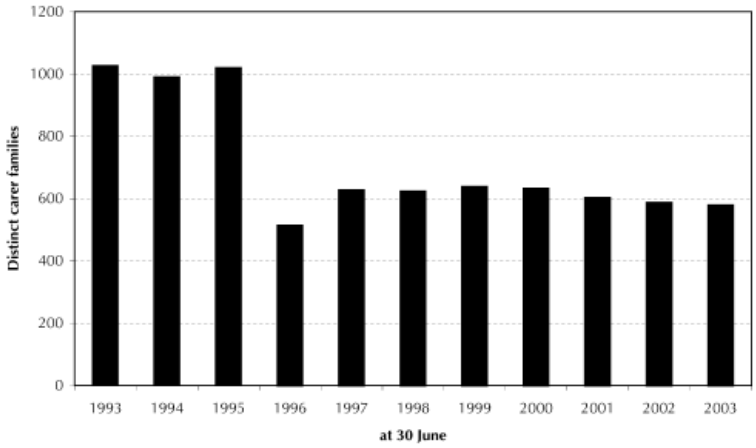
Source: Information Services Branch, Department of Families, September 2003.

Notes: 1. * Dual carers are counted as one carer family.

2. Carer counted once only based on approval hierarchy of — foster, limited, relative.

3. Exits from system don't include unpaid carers.

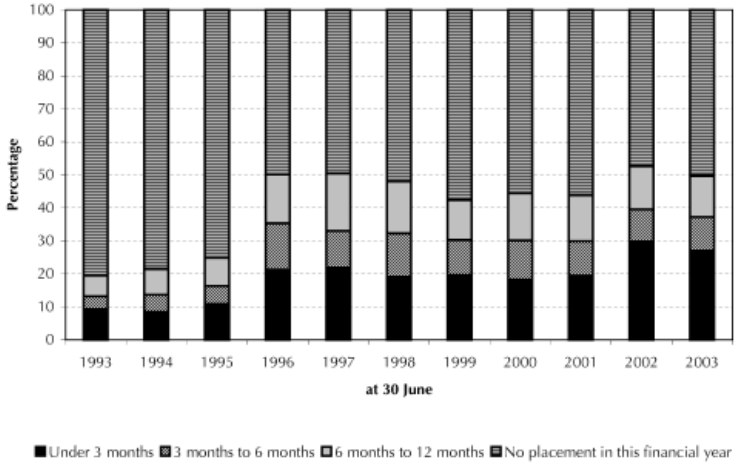
Figure C2.8. Approved foster care families* with no placement as at 30 June for each financial year (1993 to 2003)



Source: Information Services Branch, Department of Families, September 2003.

Note: * Dual carers are counted as one-carer family.

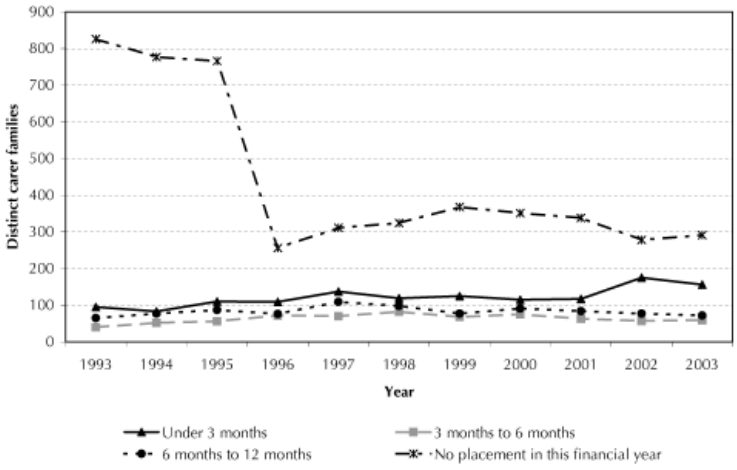
Figure C2.9. Proportion of carer families* with no placements by amount of time since last placement, as at 30 June (1993 to 2003)



Source: Information Services Branch, Department of Families, September 2003.

Note: * Dual carers are counted as one-carer family.

Figure C2.10. Approved foster care families* with no placement by amount of time since last placement, as at 30 June (1993 to 2003)



Source: Information Services Branch, Department of Families, September 2003

Note: * Dual carers are counted as one-carer family.

Foster Care Queensland submissions: The views of the carers

FCQ devised a form for members of their organisation to provide submissions to the Inquiry. Thirty-four submissions were received in this way. A CMC researcher methodically reviewed these submissions and summarised the key issues raised. The key issues addressed the following topics:

- carer issues
- notifications
- removal of child
- information sharing
- resourcing
- children's issues
- relationship between FSOs and children
- natural parents
- contact visits
- reunification
- decision making
- case plans and placement agreements
- training.

The carers made the following comments:

Carer issues

- Foster carers are treated poorly by the system.
  - 'We are rated as more of an enemy than the natural parents.'
- Carers are never able to challenge the decisions of the department.
- Carers who complain are denied placements or threatened to have children taken away from them — they are seen as trouble makers.
  - 'Foster carers need a voice without suffering the consequences.'
- The department does not listen to the views/concerns of the children or the carers: the general feeling is that they are ignored.
- The quality of the response by the department often 'depends which office you belong to.'
- Carers are not adequately supported.
  - 'Usually too little too late.'
- Regarding relative carers, family is not necessarily the best option but it can be 'a very good option for some children'.
- There needs to be a limit to the number of children placed with each carer.
- There is a need to conduct regular visits and checks on foster carers' homes by departmental staff.
  - 'Random spot checks on carers are necessary.'
- There is a need to conduct comprehensive background checks on foster and relative carers.
- There is a need to take notice of allegations made by other carers.
  - 'We sometimes know more than Families.'
- Allegations against foster carers are not adequately dealt with.
  - 'They are often assumed to be guilty until proven innocent.'
  - 'They need to be investigated properly and quickly.'

Notifications

- The department ignores carers' reports of abuse during contact visits.
  - 'Notifications have been used to keep carers in line.'
  - 'A child is believed when sexual abuse is an issue … why is it that a foster parent is not always believed when they make an accusation on behalf of a foster child who is too young … to complain for themself?'

Removal of child

- The removal of foster children is done without asking the child's opinion.
- Removal of the child should be done immediately if the child is in danger — if there are no problems it should be done gradually as the child will have formed a bond with the carer.

Information sharing

- Information given to the department (via an FSO) is not passed on to foster carers and not placed on file — this is often vital information which is not used. Carers are not given all the details about the child's family history, abuse history, behaviour problems, medical issues etc. and many carers are not given any information.
- The lack of information could put carers and children at risk.
  - 'Carers [are] seen as clients not as partners and therefore not being provided with enough information.'
  - 'Be honest and let us decide whether we can cope with the issues they give us.'
- Case notes are 'scratchy'/inaccurate/non-existent and placement agreements hold superficial information only that is not helpful.
- There seems to be some confusion regarding confidentiality regarding what information FSOs can and cannot share with carers.

Resourcing

- There are not enough staff to monitor placements etc. — FSOs do not visit/phone and some cases are not allocated a caseworker.
- There have been too many changes in staff.
- Staff are not replaced when on leave.
- Resources are consumed by the need to respond to crises.
- The department needs additional youth workers, family resource workers, FSOs and administrative staff.

Children's issues

- More information needs to be made available — some respondents said that children are well advised, some said not at all.
  - 'There is no funding for "extras" for kids — children's needs are so great — foster children shouldn't be excluded from opportunities for dance, music or swimming lessons, for example.'

Relationships between FSO and children

- Most FSOs do not have any/sufficient contact with children.
  - 'Some FSO would not know the kids in their care if they passed them on the street.'
  - 'FSOs should have regular contact with carers.'
  - 'Often the FSOs have to rely on what the foster carer says are the child's views and opinions as they're too busy to actually catch up with the child after school hours.'
- FSOs should have regular visits with children.
  - 'FSOs are not supporting the children … children do not have regular contact with FSOs.'
  - 'The FSO does not know what is in the best interest of the child — my children's FSO has not even met the children!'
- The support for the children comes from carers and their family and friends — there is very little support from the department or FSOs.

Natural parents

- 'Parental rights seem to outweigh the safety needs of children.'

- 'Natural parents' rights have sometimes come before the child's needs in case planning.'

- Parents who complain or 'make a lot of noise' get what they want — above the needs and wants of the child.
- There is the view that the department is wary/afraid of upsetting natural parents.
- Natural parents are given help and support while 'foster carers are treated as a nuisance.'
  - 'Parents are given too many chances.'

Contact visits

- There is the need to recognise that contact can be abusive — sexual/emotional/physical abuse can occur during weekend visits to natural parents.
  - 'Contact visits happen no matter how they affect the child or foster family.'
- Contact visits can cause trauma to the child and he or she can be uncontrollable when they return
  - '[It] takes days to settle down again.'
- Children are forced to go to [contact] visits when they don't want to — sometimes they can be emotionally upset and screaming at the knowledge that they have to visit.
  - 'Children are told that it is best for them to remain in contact [with natural parents].'
  - 'When foster families are harassed constantly by natural or step parents the department should do more to help stop the abuse.'
- Contact visits are not properly supervised.

Reunification

- Reunification is great when it works but it is important that the department 'listens to carers' concerns'.
- There is no monitoring of the family situation after reunification.
- There is a common view that the department's aim is to 'push for reunification'.
  - 'There is no consideration of the best interests of the child — the focus is on reunification at any price.'
- Reunification does not appear to be well planned and tends to be dictated by an order not by planning and review.
- Natural parents (particularly if affected by drugs etc.) need to stabilise and prove that they can be responsible for children
  - 'There should be minimum standards — one year of proof, for example.'
  - 'If the parent/s do not achieve [these minimum standards] within the time limit the children should be permanently removed and reunification permanently abandoned.'

Decision making

- Decision making needs to reflect the best interests/needs of the child.
- Decision making [currently] reflects the views of office managers and/or the budget/resources available.

Case plans and placement agreements

- Placement agreements are 'very important so [that] everyone knows where they stand.'
- Due to frequent FSO changes 'each FSO brings different interpretation to the case plan'.
- Carers are not involved in case planning — no attention is given to carer's views or their knowledge of the children in their care.
- Involvement by carers would allow the child's views to be passed on — children often discuss issues with their carer but are reluctant to speak with departmental workers

- Plans change without consultation
- Case planning appears to be dictated by the natural family only — the best interests of the child are not considered.
- carers are not seen as 'team members'.
- 'carers and the department should work together to meet all needs of the child'.
- FSOs need to take time with the first placement to ensure that there will be fewer changes required later.

Training

- The training for carers is minimal and not ongoing.
- Relative carers must be fully informed and trained … but there is currently a lack of support and standards and there is no formal reapproval process.
- Training should be compulsory for reapproval.
- Training should include expenses — travel and child care should be paid for.
- 'Carers should be graded and carers should be able to upgrade.'
  - 'Degree standard [should be required] for some cases of high needs children and [carers should] be paid accordingly.'
- Training for workers and carers should/could be done together.
  - '[It would be] nice to do the training on things together so we know exactly the same information and interpretation.'

Survey of shared care and residential services by the CMC

Why was a survey necessary?

At the announcement of the Inquiry, the CMC requested from the Department of Families a range of information about children in care, carers and departmental staff. Families was unable to provide some of the data requested, including information about the recruitment, assessment and training of foster carers by the shared care agencies, so it suggested that the CMC contact the agencies themselves to find out this information.

In response to this suggestion, the CMC designed a brief e-mail survey for the agencies and asked the department to provide the contact details of all agencies it currently funds. When that information was provided, many of the contact details were incorrect (e.g. telephone numbers were out of date; e-mail addresses were missing, inaccurate or incomplete). However, CMC staff contacted each agency to inform them of the forthcoming survey and to correct the contact details that were inaccurate. The corrected contact information was then given to the department.

Some of the agencies expressed concern and irritation at having to provide material to the CMC which, they said, had already been provided to the department — they were at a loss to explain why the department was unable to provide the material to the CMC. It is also important to note that the Department of Families has direct responsibility for a number of foster carers, but was unable to provide the material requested about the recruitment, training, assessment and monitoring of these carers.

Methods

On 17 September 2003 an e-mail survey was sent to 47 shared care and residential care agencies. By the due date, 29 September 2003, only seven responses had been received. A CMC research officer phoned each agency that had not responded to the survey. As a result, by 17 October 2003, 38 responses had been received, representing a final response rate of 81 per cent.

Domains of the survey

The questions in the survey contained the following domains:

- the nature of the service(s) provided for the department
- activities undertaken with the funding provided for the last financial year
- the strategies used to recruit, assess, train and monitor carers

- the numbers of children and carers associated with the agency
- some demographics about the carers
- methods of, and satisfaction with, reporting mechanisms to the department
- notifications of abuse.

Description of the sample

The 38 agencies that responded to the survey were as follows:

- Aboriginal & Islander Alternative Care & Child Protection Service
- Anglicare TRACC: Strengthening Families Program
- Beemar Yumba Hostel Aboriginal Corporation
- Cairns Shared Family Care
- CC Inc. Shared Care Queensland
- Connies Place: Father Riley's Youth Off the Streets
- Gold Coast Youth Service Inc. Supporting Adolescents Fostering Excellence Program
- Harrison House Residential Care Program
- Indigenous Family and Child Support Service — servicing the Brisbane City Region excluding Inala and the Gold Coast Region of Redlands area and including Stradbroke Island
- Integrated Family and Youth Service
- Karbul Indigenous Placement Agency
- Kingswood Lodge: Churches of Christ Care
- Kyabra Community Association
- Life Without Barriers — Regional Queensland
- Life Without Barriers — South East Queensland
- Mercy Family Services — Toowoomba
- Mercy Family Services — Zillmere — Accommodation Programme (Houses based in Virginia & Bracken Ridge)
- Pathways Bundamba Lodge: Churches of Christ Care
- Pathways Bundaberg Fostering Service
- Pathways Foster Service Beenleigh: Churches of Christ Care
- Pathways Fostering Service Gold Coast: Churches of Christ Care
- Pathways Fostering Service Mackay/Whitsunday: Churches of Christ Care
- Pathways Maryborough Fostering Service
- Pathways South West Fostering Service: Churches of Christ Care
- Rapt Brisbane Kingsbury Residential Service
- Rapt Shared Family Care
- Rapt Toowoomba Youth Program
- Save the Children Fund Queensland
- Silky Oaks Children's Haven
- The Station (Townsville Area Street Kids Association Inc.)
- TRACC Regent Park Residential
- TRACC South Foster Care
- TRACC South Intensive Family Based Care
- TRACC South West, Anglicare Western Region
- TRACC Springwood Residential
- Wee Care Family Incorporated
- Wee Care Shared Family Care
- Western Districts Shared Family Care.

Nine agencies did not respond:

- Barambah Aboriginal Community Care Agency Inc.
- Kidz Care Aboriginal and Islander Service
- Blackboy Outstation, Woorabinda Aboriginal Council
- Capricornia Alternative Care & Intervention Services Program, Central Queensland Aboriginal and Islander Child Care Agency Inc.
- Wide Bay Aboriginal Corporation for Child Protection Agency
- Kalwun Aboriginal and Islander Child Care Agency
- Kiah Hostel, Kummara Association Inc.
- Heytesbury Family Group Home, Peirson Services
- Anglicare — Central Queensland Ltd.

The CMC is most grateful to the agencies that responded to the survey. The following information provides a voice to the concerns that were raised.

Type of service provided

While all respondents provided either shared care and/or residential services for the Department of Families, most (63%) provided shared care services (24 respondents). A smaller proportion (42%) provided residential services (16 agencies). A few (3 or 8%) participated in the Child Protection Strategy (which requires an Indigenous worker to assist the department in casework), and about one-fifth (8 or 21%) provided other kinds of services (such as intensive/specialised care and support services).

To simplify the analyses, the type of service provided was categorised as either shared care or residential. There were two respondents that provided both of these services. Both were, therefore, included in both categories. Subsequently, for many of the open-ended questions described later in this section of the report, some of the information is provided twice.

Length of time services have been provided

Some of the agencies that responded to the survey had been providing services for the Department of Families for a considerable time (one agency, for example, had been providing services continually since 1940), while others had been in operation for only a relatively short period. The relevance of this divergence in time was explored for all of the analyses that follow.

Results

Services provided

The agencies were asked to provide information about the activities and/or services that they provided for the department with their 2002–03 funding allocation. The activities they described are listed in Table C2.3.

There appears to be some variation in the services provided by the agencies, but it is important to note that these analyses were based on the information provided. Not stating an activity did not necessarily mean that the agency did not receive funding for it.

Overall, however, it would appear that:

- the majority of agencies receive funding for staff salaries, although some agencies are not fully funded for this
- more than half of the agencies are funded for advertising/recruitment
- approximately two-thirds of the agencies are funded for training (although the amount of training funded for varies)
- more than half of the agencies are funded to provide support/counselling
- only a few agencies received funding for research
- about 15 per cent of the agencies are funded for respite services
- almost half of the agencies are funded for the assessment of carers.

Table C2.3. Types of services provided for Department of Families by 2002–03 funding

Shared care agencies	Residential facilities
• Staff salaries and training • Recruitment of foster care and relative families • Placement of children • Assessment of carers, intake and matching process • Support and training of foster families • Home visits, health and safety checks • Respite camps • In-home practical support and respite for foster families • Case planning • On-call services • Live-in family program for three-month block periods addressing issues such as budgeting, living skills • Transport of departmental clients/ children in care • Group activities for young people in care • Carer get-togethers and support groups • Regular phone contact with families • Administrative expenses • Data/statistics collection • Participation in Foster Agency Network meetings • Regional training and information strategies • Organisation of events (e.g. Christmas parties with gift for each child) • Standards of Care and Notification meetings • Provision of resource library • Fees for guest speakers • Crisis and transitional accommodation support • Counselling to children and families • Risk management assessment • Mentoring development and good practice frameworks • Development of partnerships • Support to children with high and complex needs • Therapeutic casework • Referral to specific needs agencies • School and community support for young people at risk of early school and home leaving • Re-approval of foster families • Relative carer assessments for the department due to workload pressures • Ongoing training and peer supervision of volunteers • Networking with other agencies in the community • Response to child protection concerns from the department and the community • Court support • Referral of cases to other agencies, e.g. housing, emergency care, food relief, legal aide, counselling, health, education, Centrelink etc.	• Staff salaries (youth workers and team leaders, residential care workers) • Administration expenses • Motor vehicle costs • Client-related costs • Staff training and travel • Staff recruitment • Counselling • Assistance of transition to other placement • Assistance with education • Carer recruitment training and ongoing support • Response to child protection concerns from the department and the community • Health and safety checks • Crisis and transitional accommodation support • Outreach support to children with high and complex needs • School and community support for young people at risk of early school and home leaving • Maintenance of links with other agencies • Monitoring and updating policies and procedures relating to licensing • Maintenance of local resource directory • Preparation of information booklets and sheets for client families • Preparation of renewal of approval documents • Matching and placement of foster children • Coordination of support groups for foster carers • Compilation of newsletter • Provision of 24-hour/7-day a week on-call service to carers and crisis care • Recreational and social activities/skills • Groceries/housekeeping • Pharmaceutical products • Advertising • Council rates • Memberships and subscriptions • Security • Fire-equipment maintenance • Live-in family program for three-month blocks • Referral of cases for specific attention of other agencies; e.g. housing, relief food and emergency care, legal aide, counselling, health, education, Centrelink.

Source: CMC survey of shared care and residential services, conducted September–October 2003

The recruitment, assessment, training and monitoring of carers

Recruitment

The survey sought information about the current strategies used by agencies to recruit carers. The information provided by respondents is listed in Table C2.4 below.

The agencies were also asked whether their recruitment methods had changed over time. While some explained that limited funding had been somewhat of a barrier, most agreed that their recruitment methods had changed (71% of shared care agencies and 75% of residential care agencies).

Not surprisingly, the agencies that started providing services prior to 2000 were more likely to state that their recruitment procedures had changed than those that had started their services during or since 2000. These changes are described in Table C2.5.

Assessment

Current assessment procedures for potential carers were described by each group. These are listed in Table C2.6.

Most agencies also agreed that their assessment procedures had changed over time (79% of shared care agencies and 58% of residential care agencies). The length of time that the service has been provided had a significant effect on whether assessment procedures were reportedly changed over time for shared care agencies (chi-sq = 18.1, d.f = 2, $p<.001$). These analyses suggest that the shared care agencies that started providing services after 1999 were more likely to say that their procedures had not changed than those that started services in or before 1999 (all of these respondents stated that these procedures had changed). The data suggest that this may also be the case for residential services (while the effect is not significant, the sample is small).

Training

The survey sought information about the training that the agencies provide to carers. These responses are listed in Table C2.7.

When asked whether training methods had changed over time, most agencies agreed that they had (78% of shared care agencies and 77% of residential care agencies). The length of time that the service has been provided had a significant effect on whether training procedures were reportedly changed over time for shared care agencies (chi-sq = 9.2, d.f. = 2, p =.010). The data suggest that shared care agencies that started providing services after 1999 were more likely to state that their procedures had not changed than those who started in or before 1999 (90% of these respondents stated that their procedures had changed). The changes described are listed in Table C2.8.

Table C2.4. Carer recruitment strategies used by agencies

Shared care agencies

- Articles and advertisements in local newspapers
- Selection of suitable carers from the existing general carer pool
- Department's future directions pilot project
- Shopping centre promotions, flyer distribution, television where possible promoting activities in the community
- Preparation of celebrity cookbook to promote foster care and raise funds for training
- Word of mouth from existing carers
- Public telephone calls
- School-awareness programs
- Local service clubs
- Childcare and church newsletters
- Radio advertising
- Information sessions
- Leaflets in letterbox drops, grocery stores and doctors surgeries
- Posters
- Integrated placement planning meetings where the needs of specific children and young people are identified
- Family day, RNA
- Contact with ASSPA committees within schools
- Local contact with Indigenous community corporations.

Residential facilities

- Advertise in print and other media
- Write selection criteria, interview and training, history checks, referee reports, probationary period
- Try to organise positive role models for both genders
- Word of mouth from existing carers/ PeakCare body and QCOSS
- Networking
- Volunteers
- Students on placement from university and TAFE
- Local radio

Source: CMC survey of shared care and residential services, conducted September–October 2003

Table C2.5. Changes to carer recruitment strategies over time

Shared care agencies

- More involvement with foster carers in the recruitment process as well as concentrating resources on particular areas rather than general community saturation.
- All recruitment and training is now done by the department through the Future Directions pilot program.
- Targeted specific high-need areas within the geographical area.
- Begun to use television advertising to ensure a greater reach over a wider area.
- In March 2003 all carers in this region became departmental carers so SFC no longer actively recruits.
- Limited approval carers to complete training after three months in an attempt to increase carer numbers for adolescent placements.
- Research-based strategic marketing and recruitment methodology developed by Griffith university masters students in order to secure new carers and establish program identity.

Residential facilities

- Much more comprehensive process than in the past.
- To fit into the change of licensing and lifeline community care restructure.
- More formal and thorough.
- Position description adapted, selection criteria more precise and more relevant to position description, interview questions reflect purpose.
- First-aid qualifications.
- All positions now advertised.

Source: CMC survey of shared care and residential services, conducted September–October 2003

Table C2.6. Carer assessment strategies

Shared care agencies

- Assess competency in pre-service training (sharing the care), interview process conducted (including discussion about life history, motivation to foster, family of origin, strengths and vulnerabilities, abilities to meet standard of care, understanding of statement of commitment and impact of fostering on the carer family)
- Assessment report written, summarising the information obtained from the interviews and submitted to the department with recommendations regarding carer approval
- From the beginning of 2003 the assessment procedures have been undertaken by the department in furtherance of Future Directions initiatives
- Initial enquiry form including questions/ assessment, send out initial information pack including questions for self-selection, initial risk assessment interviews prior to invitations to training, information nights to provide further opportunity for information/ sharing assessment, team meeting to assess each application out of which there is a decision to invite to training, seek further information, recommend persons attend counsellor for report if concerns identified, or invite to training if parties appear suitable, pre-service STC training, then further home visits/assessment
- Home visits
- Family assessment which looks at their family/household, personal history and situation, motivation to foster, understanding of standards of care and commitment to learning, parenting skills, support network, commitments (employment, social, financial) and health — then submitted to Families with recommendations
- Joint self-evaluation form
- Individual assessment forms
- Interviews with biological children and individual forms for children to complete with assistance
- Attitude to behaviours checklists
- Identification verification
- Locally developed foster carer assessment panels to facilitate joint discussion prior to final decision making with regard to approvals
- Foster carer agreements, contacts, procedures, managing complaints, confidentiality provisions, handbook
- Willingness to adhere to code of conduct
- The specific conditions of placement which have been approved (e.g. characteristics of children, number of children, type of placements, special needs)
- Foster carer's card.

Residential facilities

- Experience, qualifications, proven ability to work with young people in care and protection
- Police and department criminal history checks through the department
- Key selection criteria taken from the job description — includes skill, experience, knowledge and understanding, merit
- Home visits
- In-depth assessment report
- Lengthy interview process focusing on the safety of children and meeting their developmental needs
- Trainings, interviews, gathering information, writing the report and making recommendations about approval
- Continuing assessment
- Responsibility to ensure that people are 'suitable' under the Child Protection Act and able to meet the standards of care
- Advertise, assess applications and cull, based on certain criteria
- New checks introduced with the Child Protection Act in 1999 (to include DV, traffic and CPIS searches).

Source: CMC survey of shared care and residential services, conducted September–October 2003

Table C2.7. Carer training strategies

Shared care agencies

- Pre-service training 'sharing the care' by the department.
- Ongoing training: skills enhancement training, working with young people, eating disorders (ISIS), alcohol and other drugs, therapeutic crisis intervention, national foster carer conference, QAFS conference, various training events run by the department.
- One-on-one training in regard to specific issues that carers are dealing with as well as offering ongoing training and support sessions for carers around various issues.
- Financial assistance to carers to attend training events that are offered by other agencies.
- Camps for carers, children and natural families.
- Monthly training sessions.
- Long-term foster carers speak about the reality of caring for children/young people.
- Managing challenging behaviour.
- Suicide prevention
- Ask carers for ideas about the type of training they feel could support them in their role as carers
- Issues faced by children of parents with mental illness
- Future directions trials
- Standards of care advanced training as some carers had difficulty putting this into practice
- Risk assessment training
- ADD and ADHD
- Finance
- Domestic violence
- Life diaries
- Statement of commitment
- Sexual abuse
- Behaviour management
- Enhanced foster carer Triple P program
- Family contact workshop
- Resource library
- Post-training opportunities every three months
- One-on-one training within support visits
- Practice and procedures training
- Departmental processes
- Child-related costs workshop
- Skills enhancement training
- Safety skills development
- Queensland fire brigade and safety house
- Parenting in crisis 1 and 2
- Creative memories workshop.

Residential facilities

- Any relevant outside training is made available, e.g. suicide awareness, anger management, crisis intervention
- Internal training regularly carried out including model of practice, team building, mentor skills, communication skills, early intervention strategies
- Therapeutic crisis intervention training
- managing children with difficult behaviours
- Suicide prevention
- First aid
- Training in dealing with sexual abuse
- Strength based practice
- Managing people and practice
- Attachment theory
- Placement issues and skills
- Handling difficult client behaviour
- Working with young people who sexually offend
- Sharing the care training — basic information and statutory requirements involved in fostering
- Working with children with reactive attachment disorder
- Working with children with autism
- Oppositional defiant disorder
- Parenting training
- Grief and loss issues
- Any ongoing training our carers request
- Issues faced by children of parents with mental illness
- Reconnecting children with their families
- Drugs/alcohol
- Mental health
- Sexual abuse
- Child development
- Financial assistance to foster carers to attend training in the broader community (e.g. neighbourhood centres) to attend conferences
- Protective behaviours
- Children who have experienced domestic violence
- Triple P program
- Cultural awareness
- Childcare legislation
- Duty of care
- Whistleblowing
- Self-esteem development in children and young people/empowerment of children
- Communication and basic counselling skills
- The impact of physical, sexual and emotional abuse on children and young people
- Children's rights
- Complaints procedures
- Time and stress management.

Source: CMC survey of shared care and residential services, conducted September–October 2003.

Table C2.8. Changes in carer training strategies

Shared care agencies	Residential facilities
• The concept of training has changed and we now enter into support and supervision plans and a development process. This then is more individualised and carers have various options to access learning such as self-paced packages; group workshops, one-on-one with their support worker. • More emphasis now of standards of care. • Regular post-training emphasis. • More informal opportunities provided during home visits. • Joint training with local agencies. • Pre-service training increased from 18 hours to 30 hours, focusing on group processes. • Able to access internet to draw on larger pool of information. • Training methods have changed in accordance with the documentation and licensing procedures and as the department changes its training criteria. • As the foster care group changes — so do the training methods.	• More training available. • Developmental and attachment theory was not previously expected of residential care workers. • More extensive internal training has been developed over the last three years. • External training for residential carers has increased. • Greater emphasis to supervision and training.

Source: CMC survey of shared care and residential services, conducted September–October 2003.

A profile of carers

Given a number of concerns raised by submissions to the Inquiry, at the public hearings and by Ms Murray's audit regarding carers with either large numbers of placements at any one time and/or carers without any active placements, the survey sought further information about these issues. Respondents to the survey were able to account for 1055 carers. On average, most (87%) of the carers currently on the books of the agencies that responded to the survey are currently caring for at least one child in care (see Table C2.9). However, these data seem to be somewhat at odds with the data provided to the CMC by the department for the Inquiry, which indicate that only 58 per cent of approved foster carers currently have a placement.

Table C2.9. Carers affiliated with the responding agencies

Survey question	Shared care	Residential	Total*
At this point in time, how many carers affiliated with your agency/organisation are actively fostering or caring for children?	860	128	922
At this point in time, how many carers affiliated with your agency/organisation remain 'on your books' but are not actively fostering or caring for children?	132	8	133
Total number of carers	**992**	**136**	**1055**

Source: CMC survey of shared care and residential services, conducted September–October 2003.

Note: * Total does not equal shared care plus residential, because two respondents provided both services.

Number of children

Respondents were asked to describe how many children were in the care of the carers affiliated with their agencies at this point in time. While the agencies were asked to simply estimate these figures, the data presented in Table C2.10 indicate that approximately 1461 — or about 36 per cent of all children currently in the care of the department (which indicates that at 30 June 2003 there were 4380 in alternative care — see Table C1.2)[1] — were supported by these agencies.

However, it is important to note the discrepancy in the numbers provided: Table C2.10 refers to 637 carers, whereas Table C2.9 indicated that the agencies that responded to the survey were responsible for approximately 1055 carers. This discrepancy can be accounted for by missing responses. The information provided, therefore, only describes about 60 per cent of the children cared for by the carers described above.

Most of the children described were cared for by shared care agencies (90%). Few were cared for in residential settings (4%). As indicated previously, some (6%)[2] were cared for by agencies that described themselves as providing both shared and residential care.

Table C2.10. Number of carers and children in care by type of service

No. of children in foster home/ institution	Shared care		Residential		Total number of carers*	Total number of carers†
	Carers	Children	Carers	Children		
1	257	257	29	29	259	259
2	160	320	18	36	160	320
3	98	294	1	3	98	294
4	52	208	14	56	60	240
5	24	120	4	20	28	140
6	22	132	0	0	22	132
7	7	49	0	0	7	49
8	2	16	0	0	2	16
9	0	0	0	0	0	0
10	0	0	0	0	0	0
11	1	11	0	0	1	11
Total	**623**	**1407**	**66**	**144**	**637**	**1461**

Source: CMC survey of shared care and residential services, conducted September/October 2003

Notes: * Total number of carers does not equal shared care plus residential, because two respondents provided both services.

† Total number of children does not equal shared care plus residential, because two respondents provided both services

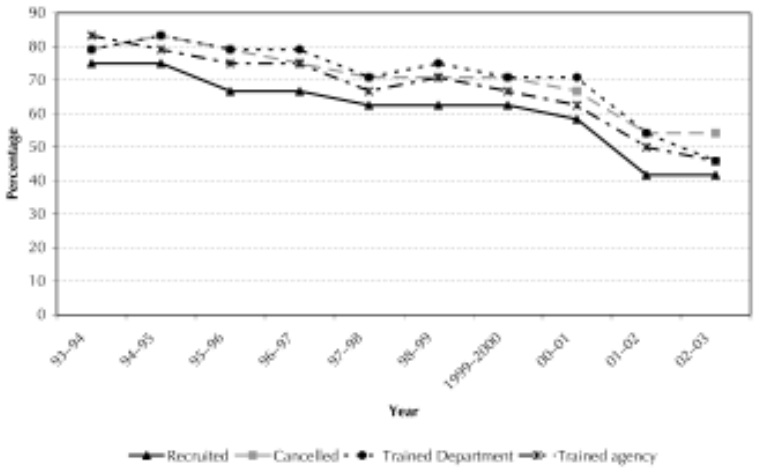
Number of carers recruited, cancelled and/or trained

Unfortunately, a large number of respondents did not answer the questions about carer recruitment, cancellation and training. For shared family care agencies, the amount of missing data ranged from 42 to 83 per cent and for residential care agencies from 75 to 94 per cent. Therefore, the analyses presented in this section of the report should be treated with extreme care. However, Figure C2.11 indicates that, over time, the amount of missing data decreases and that hence over time those data should become more credible. Agencies were informed that the CMC understood that providing this information might be difficult and asked them to explain why they were unable to provide the information if that was, indeed, the case. The reasons provided for the missing data are listed in Table C2.11 and include some that were relevant to the nature of the survey (i.e. the data request was not clear) and some that were relevant to the maintenance of, and access to, the relevant data.

1 Please note that the total number of children in care was identified by the department as 4380, but 357 of those children were probably in the juvenile justice system (classified as 'other'). For the purposes of these analyses, these children were removed from the calculations as the shared care and residential facilities responding to the survey would not have had any responsibility for this group of children.

2 Two respondents provide both shared and residential care and it is not known how many children are in each type of care.

Figure C2.11. Missing data



Source: CMC survey of shared care and residential services, conducted September–October 2003.

Notes: 1. Recruited: Number of 'generally approved' carers recruited by the agency

2. Cancelled: Number of carers recruited by the agency whose approval was cancelled or not renewed
3. Trained Department: Number of carers recruited by the agency that were trained by Families (in-service training)
4. Trained agency: Number of carers recruited by the agency that were trained by the agency

Table C2.11. Why some agencies were unable to provide information about the number of carers recruited, cancelled and/or trained

Shared care agencies	Residential facilities
• Due to the limited time available for this feedback, unable to access all of the necessary archives to retrieve this information. • The data requested is not clear. • No records exist. • Unable to locate previous years information. • The database that records this information is not functioning.	• No carers with this service. • No records exist. • Would need a lot more time to go back to comprehensively answer this question. • Unable to provide information as this is not a role of the residential agencies

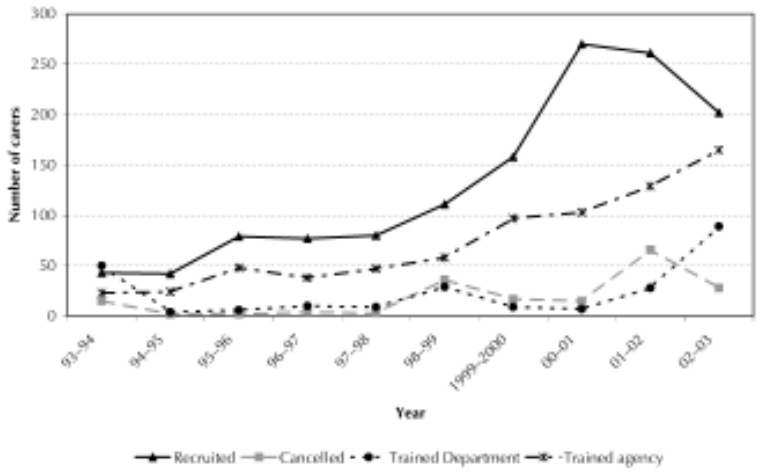
Source: CMC survey of shared care and residential services, conducted September–October 2003.

Shared care agencies

The following three figures provide information about the numbers of carers recruited and/or trained over the past decade by the shared care agencies. Figure C2.12 shows the total number of carers who were recruited, cancelled and trained per financial year by the agencies that responded to the survey. Figure C2.13, on the other hand, shows the mean number of carers who were recruited, cancelled and trained by the agencies that responded to the survey. The latter figure probably provides a better indication of change over time as it accounts for the changing amount of missing data. However, both figures show similar trends. It would appear that, over the 10-year period depicted, the mean recruitment per agency has doubled. However, there seemed to be sizeable increases in the financial years 1998–99, 1999–2000 and 2000–01, which preceded similarly sized decreases in 2001–02 and 2002–03.

The mean number of carers cancelled is generally low. However, the mean number over the last five years is higher than that of the previous five years. Between 1998–99 and 2001–02 the number of carers cancelled was at its highest, with one-third of the number recruited being cancelled during that period.

Figure C2.12. Total numbers of carers recruited, cancelled and trained by shared care agencies



Source: CMC survey of shared care and residential services, conducted September–October 2003.

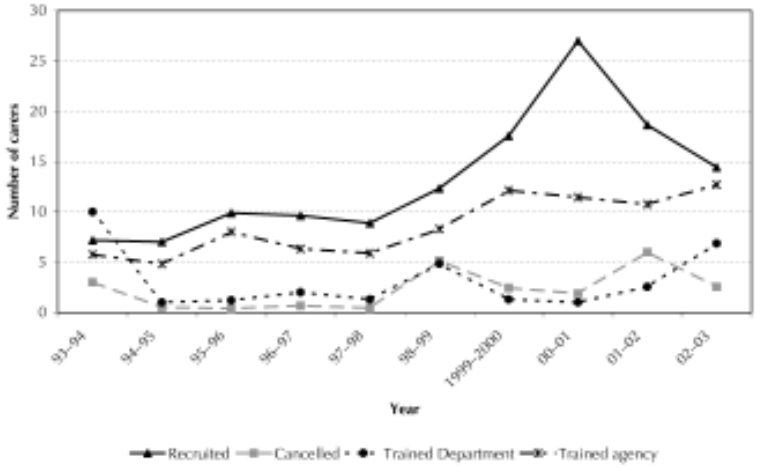
Notes: 1. Recruited: Number of 'generally approved' carers recruited by the agency.

2. Cancelled: Number of carers recruited by the agency whose approval was cancelled or not renewed.

3. Trained Department: Number of carers recruited by the agency that were trained by the department (in-service training).

4. Trained agency: Number of carers recruited by the agency that were trained by the agency.

Figure C2.13. Mean number of carers recruited, cancelled and trained by shared care agencies responding to the survey



Source: CMC survey of shared care and residential services, conducted September–October 2003.

Notes 1. Recruited: Number of 'generally approved' carers recruited by the agency.

2. Cancelled: Number of carers recruited by the agency whose approval was cancelled or not renewed.

3. Trained Department: Number of carers recruited by the agency that were trained by the department (in-service training).

4. Trained agency: Number of carers recruited by the agency that were trained by the agency.

The mean number of people trained by the agencies appears to have doubled during the 10 years of data provided. However this may be a reflection of the data collection and dissemination processes. Nevertheless, the mean number of carers trained by the department appears to be considerably less than those trained by the agencies.

Residential care agencies

With regard to the information provided by residential agencies, it is important to note that most of the data regarding recruitment and training were missing (missing data ranged between 75 and 94%). The data must, therefore, be treated with extreme caution.

Figures C2.14 and C2.15 provide some information about the total and mean numbers of carers recruited, cancelled and trained by respondents to the survey that provide residential care. Keeping in mind the note of caution, the data suggest that all of the training appears to be provided by the agencies (and that none is provided by the department) and that the number of residential carers cancelled has been zero up until the last three financial years.

Demographic profile of carers

The survey sought some information about the demographics of the carers affiliated with the agencies that responded to the survey. There were some concerns about the quality of the data, however, and the information provided must be interpreted with caution. For example, the number of carers reported by gender is clearly higher then the number of total carers reported in earlier sections of the survey. Owing to the inexact nature of the survey question, this may be due, in part, to some respondents reporting a foster care couple as one carer and others as two (some respondents reported a couple as one carer and then provided the gender of both, for example).[3] In recognition of the difficulty of providing some of the data requested, the CMC sought information from respondents about the potential causes of missing data. These responses are listed in Table C2.12.

Table C2.12. Why some agencies were unable to provide a demographic profile of carers affiliated with their agencies

Given the above limitations, however, the demographics of the carers can be summarised as follows:

- There are more female carers than male carers. There are more female cares who

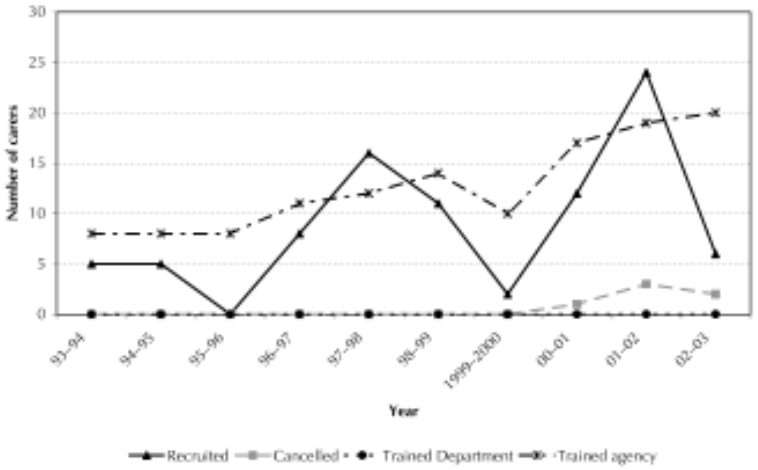
Shared care agencies	Residential facilities
• Two newly transferred carer families — assessment reports currently unavailable. • Some have adult children who are not living with them. • It should be noted that at initial assessment a number of these details are requested and are on file — the service is not necessarily aware of the types of benefits people are receiving . • To find out where each carer is born would require a total review of all files and as many carers were recruited before current staff this information may not have been collected (we have done a preliminary check and found this to be the case) — the agency does not believe it has the right to ask carers their current financial status. • Unable to locate this information on our database.	• No carers affiliated with agency. • Employees only — not sure of all exact details of their private life.

Source: CMC survey of shared care and residential services, conducted September–October 2003

3 This seems to be the case with some of the other demographics as well but not to the same extent. Other data problems include:

- missing responses for residential carers ranged from 25–56 per cent
- missing responses for shared carers ranged from 0–29 per cent.

Figure C2.14. Total numbers of carers recruited, cancelled and trained by those respondents to the survey that provide residential care



Source: CMC survey of shared care and residential services, conducted September–October 2003.

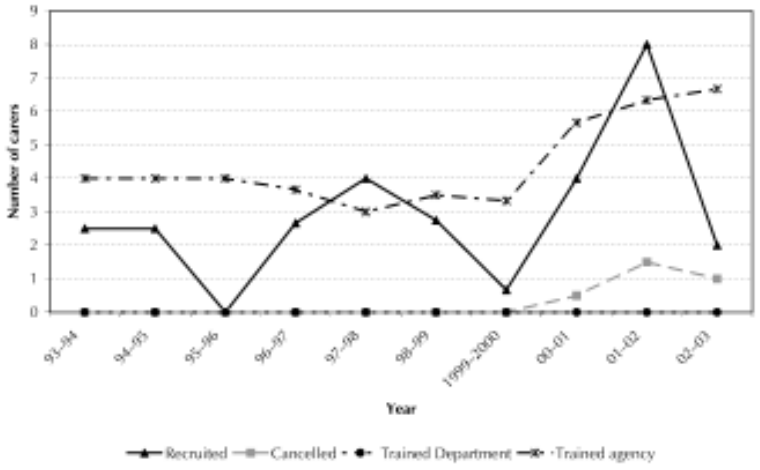
Notes: 1. Recruited: Number of 'generally approved' carers recruited by the agency.

2. Cancelled: Number of carers recruited by the agency whose approval was cancelled or not renewed.

3. Trained Department: Number of carers recruited by the agency that were trained by the department (in-service training).

4. Trained agency: Number of carers recruited by the agency that were trained by the agency.

Figure C2.15. Mean numbers of carers recruited, cancelled and trained by respondents to the survey that provide residential care



Source: CMC survey of shared care and residential services, conducted September–October 2003.

Notes: 1. Recruited: Number of 'generally approved' carers recruited by the agency.

2. Cancelled: Number of carers recruited by the agency whose approval was cancelled or not renewed.

3. Trained Department: Number of carers recruited by the agency that were trained by the department (in-service training).

4. Trained agency: Number of carers recruited by the agency that were trained by the agency.

provide residential services than those who provide shared care services (see Table C2.13).

- Being married is the most common marital status, with shared care agencies having a greater proportion of married carers (64%) than residential agencies (47%) — see Table C2.14.
- Approximately 50 per cent of carers are in full-time work for both shared and residential care. Less than 2 per cent of carers are on unemployment benefits for both shared and residential care. About one-fifth of shared care agency carers (19%) and about one-quarter of the residential carers (23%) are in receipt of another form of benefit or pension (see Table C2.15).
- Only 7 per cent of the shared care agency carers and 2 per cent of the residential carers were identified as Aboriginal or Torres Strait Islanders. The majority of carers were Australian born but not Indigenous, although the proportion was higher for residential carers (85%) than shared care agency carers (75%). Just over 10 per cent of carers were born overseas (see Table C2.16)
- Most carers appear to have their own natural and/or step children (76–77%), in addition to the children they foster (see Table C2.17).

The supervision, monitoring and auditing of carers

Current methods used to supervise, monitor and audit carers are described by each group of agencies in Table C2.18.

The agencies were also asked whether their supervision/monitoring and auditing methods had changed over time. Most agreed that this was the case (79% of shared care agencies and 82% of residential care agencies). Again, the length of time that the service had been provided was a significant factor in whether supervision methods were reported to have changed over time for shared care agencies (chi-sq = 9.7, d.f.=2, p=.008). The data suggested that shared care agencies that started providing services after 1999 were more likely to state that their procedures had not changed over time. Almost all (94%) of the agencies that began providing services in or before 1999 reported that their procedures had changed. While most changes reported were for the better, some were not (for example, concerns were raised about the viability of the Crisis Care Service and many reported increased paperwork). These changes are described in Table C2.19.

Regularity of review of carers

Agencies were asked to describe, on average, how often they met with approved carers recruited by their agency to review their progress. The majority of review times for the shared care agencies ranged from weekly to quarterly: approximately 4 per cent reported weekly reviews, 42 per cent reported fortnightly reviews and about one-third reported monthly reviews. For residential carers, the review times ranged from daily to six weekly, with the largest proportion (43%) reporting fortnightly reviews. Again, however, missing data was significant (56% of residential carer responses) and the summary data must be treated with caution.

Table C2.13. Gender of carers affiliated with the agencies

Gender	Shared care		Residential	
	No.	%	No.	%
Male	597	41	78	33
Female	858	59	157	67

Source: CMC survey of shared care and residential services, conducted September–October 2003.

Note: Numbers have been rounded and may not add up to 100%.

Table C2.14. Marital status of carers affiliated with the agencies

Marital status	Shared care		Residential	
	No.	%	No.	%
Never married	101	9	30	19
Married	695	64	75	47
De facto	84	8	20	12
Divorced/separated	155	14	33	21
Widowed	7	1	0	0
Not sure	43	4	3	2

Source: CMC survey of shared care and residential services, conducted September–October 2003.
Note: Numbers have been rounded and may not add up to 100%.

Table C2.15. Employment status of carers affiliated with the agencies

Employment status	Shared care		Residential	
	No.	%	No.	%
Full time	515	48	96	50
Part time	143	13	48	25
Unemployment benefits	16	2	3	2
Another pension/benefit	201	19	44	23
Not sure	189	18	0	0

Source: CMC survey of shared care and residential services, conducted September–October 2003.
Note: Numbers have been rounded and may not add up to 100%.

Table C2.16. Ethnicity of carers affiliated with the agencies

Etnicity	Shared care		Residential	
	No.	%	No.	%
Aboriginal	86	7	4	2
Torres Strait Islander	23	2	0	0
Australian born but not Indigenous	979	75	157	85
Born overseas	157	12	21	11
Not sure	54	4	2	1

Source: CMC survey of shared care and residential services, conducted September–October 2003.
Note: Numbers have been rounded and may not add up to 100%.

Table C2.17. Carers affiliated with agencies with natural/step children of their own

Biological children	Shared care		Residential	
	No.	%	No.	%
Any biological/step children of own	698	76	85	77
No biological/step children of own	197	22	26	23
Not sure	22	2	0	0

Source: CMC survey of shared care and residential services, conducted September–October 2003.
Note: Numbers have been rounded and may not add up to 100%.

Table 2.18 Supervision, monitoring and auditing of carers

Shared care agencies

- Carer re-approval process (one year after initial approval and then two-yearly).
- Ongoing monitoring through regular support provided to carers — fortnightly visits or as required, regular phone calls, monthly support group meetings.
- After-hours on-call system for carers.
- Monthly care plan meetings occur with the carer, the young person, TRACC and FSO to review the placement, especially regarding changes to key support needs.
- Records of carer training attendance are maintained and reviewed.
- At least weekly phone calls, some daily.
- Fortnightly playgroups on premises.
- Monthly gatherings on premises and monthly training.
- Social activities, e.g. picnic with carers.
- Star system which dictates the level of support provided to foster carers according to the carers experience, skill level, number of placements, length of placements, behaviours/needs of foster children
- Home visits fortnightly to once a month, depending on needs identified by the carer, agency or department; placement meetings occur three-monthly for most placements and six-monthly for children in long-term placements; placement agreements are completed 12-monthly unless significant changes warrant an earlier completion.
- Formal complaints system and procedures
- Liaison with departmental staff about the needs of children in placement of foster carers.
- Respite care.
- Carers are treated as part of the SAFE team.

Residential facilities

- Direct supervision and six-monthly staff appraisal.
- Regular contact when on shift.
- Staff meetings fortnightly.
- Supervision/debriefing whenever requested.
- Manager has one-on-one supervision with staff members every three weeks.
- Children's Commission representative visits monthly.
- Regular contact with carers and remind department when placement meetings are due.
- TRACC 24-hour on-call service.
- One worker is always on call (24 hours) so that carers can always access support.
- Home visits.
- Annual reviews.
- Provision of information (e.g. autism, treatment of head lice) to carers.
- Quarterly reviews.
- Incident reports.
- Communication book.
- Monthly visit by community visitor and visits by nominee.

Source: CMC survey of shared care and residential services, conducted September–October 2003

Table C2.19. Changes in supervision, monitoring and auditing of carers by the agencies that responded to the survey

Shared care agencies

- The process has become more structured whereby there are clear expectations of both the carer and the support worker.
- Adopted an integrated strengths-based model of service delivery
- Can now request any worker in the agency to do specific pieces of work.
- More holistic approach to working with our community members.
- Stringent staff appraisal process introduced.
- Supervision is now each day by team leader, plus extra supervision by manager.
- CCYP representative visits the house regularly.
- Changed with licensing requirements. We regularly update foster care agreements (every six months).
- Since July 2001, TRACC has been moving towards a strength-based supervision relationship between foster carers and their TRACC support worker.

Residential facilities

- Stringent staff appraisal process introduced.
- Supervision is now each day by team leader, plus extra supervision by manager.
- CCYP representative visits the house regularly.
- Because of licensing, Families conducts assessments on the program every three years. These assessments are compiled by departmental workers and evaluated externally.
- Since July 2001, TRACC has been moving towards a strength-based supervision relationship between foster carers and their TRACC support worker.
- With the LCC amalgamation, the human resource team developed a performance planning development paper that has since been adopted by all services.
- All supervision incorporates monitoring the impact of young people on their carers and how well carers are managing this impact.

continued next page

Table C2.19. Changes in supervision, monitoring and auditing of carers by the agencies that responded to the survey (continued)

Shared care agencies

- With the LCC amalgamation, the human resource team developed a performance planning development paper that has since been adopted by all services.
- All supervision incorporates monitoring the impact of young people on their carers and how well carers are managing this impact.
- Young people are also included in the monitoring. There are well-developed internal and external complaint mechanisms.
- Staff supervision and annual appraisal are part of best practice; emphasis on staff training; formal staff changeover between shifts.
- Carers are included in the team by including them in meetings, training and networking with each other in order to maximise their strengths and resources.
- Levels of support and monitoring have developed over time because of increasing pressure from the department to place more and more children with existing carers. The agency has taken steps to increase the number of carers to reduce the risk of overloading families.
- Regular training
- More child-focused in our practice; view our relationship with carers as a professional one.
- More emphasis on standard of care when moved from policy to legislation.
- Provide less supervision/monitoring of carers due to increase in number of carers.
- Home visits are more frequent.
- Case notes are more comprehensive.
- Home visit summaries are more prescriptive and based around the statement of standards and the child protection legislation
- Cessation of our unfunded after-hours support service — the transfer of this service to the department's crisis care service, which is already over-extended and poorly resourced, will reduce the support and monitoring provided to our carers after hours. The potential exists for inappropriately matched placements and fewer placement options.
- The department's crisis care service is Brisbane-based and unable to cover the entire state — agencies have specific knowledge of their foster carers.
- Home visit and placement meeting log
- Introduction of an incident-reporting register, which then requires follow up regarding the issue in the support visits
- Records kept of all incidents reported to the department and outcomes of these.
- Carer support group, called Cats, involves carers from a range of services. The group operates under a working agreement and meets every six weeks.
- Since Safe set up finance meetings with the department in relation to late payments, the problem has been fixed and carers feel more supported.
- Manual for carers
- Standards of care training
- Maintains a central register for any standards of care matters or allegations of harm
- Reporting of harm form: department initiates an investigation; officer approaches the service to obtain information and collect evidence; department then decide if the matter is a social issue, an allegation of harm, or a casework issue. If it decides allegation of harm, the reporting of harm form is completed and placed on the register, and any recommendations made are also placed on the register — copy on carer's file. The progress of the matter and any outcome is also recorded.
- More paperwork

Residential facilities

- Young people are also included in the monitoring. There are well-developed internal and external complaint mechanisms.
- Community visitor now visits residential nominee — weekly, staff supervision and annual appraisal are part of best practice. There is greater emphasis on staff training and formal staff changeover between shifts.
- Weekly team supervision (previously weekly supervision for the house parent).

Source: CMC survey of shared care and residential services, conducted September–October 2003.

Reporting

The survey sought information about the current methods of reporting activities of the agencies and their carers to the department. These are described in Table C2.20.

The agencies were also asked whether their reporting methods had changed over time. Most agreed that this was the case (71% of shared care agencies and 75% of residential care agencies). The length of time that the service has been provided did not have a significant effect on whether reporting procedures were reported to have changed over time. The changes described are documented in Table C2.21.

Satisfaction with reporting arrangements

Overall, most agencies reported being either satisfied or very satisfied with their reporting arrangements with the departments (73%), although residential care agencies appeared to be more satisfied (82%) than shared care agencies (67%). See Table C2.22.

Reasons for satisfaction/dissatisfactions with reporting arrangements

Despite the number of satisfied/very satisfied respondents identified above, when asked to explain their answers, the majority of respondents described concerns about reporting arrangements, rather than favourable attributes of the system (see Table C2.23).

Notifications of alleged abuse

The agencies were asked how many notifications of alleged abuse of children in 'out of home care' they had ever made to Families. Missing data accounted for 17 per cent of the shared care agency responses and 13 per cent of the residential care agency responses. Overall, however, the longer an agency had been established the more notifications they were likely to have made, especially for shared care agencies (although this difference was not statistically significant).

Taken as a whole, respondents to the survey reported that they had made 112 notifications of alleged harm to the department. The majority of these allegations were made by shared care agencies (70% or 78 notifications), while fewer were reported by residential agencies (20% or 22 notifications). The remaining notifications were reported by providers of both shared care and residential services (11% or 12 notifications).

Table C2.24 indicates that 30 per cent of the shared care agencies had made more than five notifications each (compared to 21% of residential agencies). It is also important to note that two shared care agencies had reported a high number of allegations: 18 and 26 notifications each.

Perpetrators of abuse

Regarding the notifications identified above, the agencies were asked to identify who the alleged perpetrators of the abuse were. The great majority of notifications by shared care agencies related to the carer (80%), while in the residential setting, allegations against carers (45%) and others (32%) were the highest. It is important to note that members of carers' families were also alleged to be the perpetrators of abuse in both settings (6% of shared care agencies and 8% of residential agencies) and that family members of the child in care have also had a number of notifications made against them (8% of the notifications made by shared care agencies and 16% of the notifications made by the residential carer agencies). See Table C2.25.

Satisfaction with the response by the Department of Families to notifications

The survey sought information about how satisfied the agencies were with the response by the department to the notifications they had made. Overall, greater than one-third (39 per cent) of respondents were generally satisfied or very satisfied with the department's response. A similar proportion of respondents (35%) reported being either dissatisfied or very dissatisfied. More than one-quarter of respondents reported their satisfaction level as neither satisfied nor dissatisfied for both agency types. However, the data also suggested that residential agencies were more likely to be satisfied/very satisfied (45%) than dissatisfied/very dissatisfied (27%). For shared care agencies, however, this profile was reversed, with higher levels of dissatisfaction (41% reported being either dissatisfied or very dissatisfied) than satisfaction (30% were satisfied/very satisfied). See Table C2.26.

Respondents were asked to explain why they were satisfied or dissatisfied with the department's response to the notifications made by their agency. These responses are listed in Table C2.27.

Table C2.20. Current reporting activities to the Department of Families

Shared care agencies	Residential facilities
• Quarterly reports • Functional review reports every six weeks • Statistics around placement provided monthly on a needs basis via email or case notes • Specific requirements around reporting matters of concern and standards of care • Monthly WRICSI meetings • Complex-case clinics • Care plan meetings • Case reports sent monthly to department • Email, telephone, incident reports, progress reports, case planning meetings and placement meetings • CEO meets with senior Families management on a regular and 'as needs' basis. • Annual service reports • Update FSO weekly on clients via email, case reviews (6–8 weeks). • Immediately notify department of any concerns we hold about the care of young people by staff, and the agency would take action. • Placement meetings • Foster carer re-approvals • Six-month capacity assessment of any foster carers who have more than five foster children. • Incident reports • Incident register • Monthly incident report summaries	• Email, telephone, incident reports, progress reports, case planning meetings and placement meetings • Written report • CEO meets with senior departmental management on a regular and 'as needs' basis. • Functional reviews (quarterly) • Provision of statistics • Liaison and finance meetings • Interagency forums with the area manager • Annual service reports • Update FSO weekly on clients via email, case reviews (6–8 weeks). • Immediately notify department of any concerns we hold about the care of young people by staff, and the agency would take action.

Source: CMC survey of shared care and residential services, conducted September–October 2003.

Table C2.21. Changes in reporting to the Department of Families

Shared care agencies	Residential facilities
• Formalisation of reporting process has been developed over the last three years in line with licensing requirements. • Mandatory reporting due to child protection legislation • Increased numbers of meetings • Standard of care • Statistical data collection/reporting tools have been developed that are more relevant and provide comprehensive information to the department. • New form for the functional review to incorporate qualitative and quantitative analysis of the services provided and surveying of foster carers and departmental staff. • Policy and procedure regarding formalised reporting of harm has occurred within last 18 months to two years: before this there was no formal method for reporting harm. • Capacity assessments • Project advisory group has been established to substitute the usual quarterly function reviews which were held with the department. • Liaison meetings	• CCYP representative reports to department. • A survey of Families staff and young people every three months, reported via the functional review. • Liaison meetings have been a recent development. • Emails to and from department • Formalisation of reporting process has been developed over the last three years in line with licensing requirements and technological changes which allow better communication (e.g. email). • Licensing requirements • More regular reporting to FSO.

Source: CMC survey of shared care and residential services, conducted September–October 2003.

Table C2.22. Satisfaction with current reporting arrangements

Satisfaction with reporting	Shared care		Residential	
	No.	%	No.	%
Very satisfied	3	13	6	38
Satisfied	13	54	7	44
Neither satisfied nor dissatisfied	0	0	1	6
Disatisfied	7	29	2	13
Very satisfied	1	4	0	0

Source: CMC survey of shared care and residential services, conducted September–October 2003.
Note: Numbers have been rounded and may not add up to 100 per cent.

Table C2.23. Reported reasons for satisfaction/dissatisfaction with current reporting arrangements

Shared care agencies

- Satisfied with reporting arrangements
- Satisfied with reporting to the department; however, alternative care appears not to consider information when placing children.
- Resourcing issues within the department make it difficult to access FSOs and other departmental staff.
- The information the department collects relates only to the quantity of children in placement and not the quality of care or issues affecting the family of the child in care.
- Database problems — hence difficult for all parts of the system to communicate and collate vital carer information.
- Data-reporting sheets do not accurately reflect the intake of children within the agency — they only acknowledge lack of ability to placement of children and not acknowledge children under guardianship orders.
- No contact with the funding arm of Families on a local level and functional reviews were not held in the last year; we feel the high-level service we provide is under-valued.
- No sense of partnership with department.
- Lack of commitment of all Families area managers.
- We have limited resources and don't appreciate criticism from the department about our service — unfair.
- No opportunity for partnership between department and agency.
- There is an emphasis on the shared family care area and minimal support given to family support — unbalanced.
- Frequency of contact is haphazard and always at our instigation.
- Reporting arrangements need to be improved to address fundamental issues regarding the formation of partnership approach. Currently little is done to collaborate and community agencies are bombarded by community members to address issues on their behalf. Department not seen as culturally sensitive.

Residential facilities

- Current reporting arrangements are satisfactory when both the department and the service commit to the process.
- There are a variety of mediums for communication with the department.
- Quarterly review process is open and enables regular contact with departmental representatives.
- Department frequently postpones meetings due to the worker's workload or a crisis.
- No contact with the funding arm of Families on a local level and functional reviews have not been held for last year; feel the high-level service we provide is under-valued.
- Department doesn't treat us as partners.
- We provide information on our carers but Families have no reciprocal information about departmental carers — this makes it difficult to gain an overall picture of the foster care needs of the region.
- There is an emphasis on the shared family care area and minimal support given to family support — unbalanced.
- When reporting matters to the department, the response time is very slow and depends on which FSO or team leader has case responsibility.
- Reporting to FSOs could be improved by passing on relevant information at point of referral and during child's stay.
- More departmental staff required.

Source: CMC survey of shared care and residential services, conducted September–October 2003.

Table C2.24. Number of notifications

Number of notifications	Shared care		Residential	
	No.	%	No.	%
None	4	20	3	21
One	6	30	4	29
Two to five	4	20	4	29
Greater than five	6	30	3	21

Source: CMC survey of shared care and residential services, conducted September–October 2003.
Note: Numbers have been rounded and may not add up to 100 per cent.

Table C2.25. Alleged perpetrators

Notifications against	Shared care		Residential	
	No.	%	No.	%
Carer	68	80	17	45
Member of carer's family	5	6	3	8
Family member of the child in care	7	8	6	16
Someone else	5	6	12	32

Source: CMC survey of shared care and residential services, conducted September–October 2003.
Note: Numbers have been rounded and may not add up to 100 per cent.

Table C2.26. Satisfaction with response by the department to notifications

Satisfaction with response	Shared care		Residential	
	No.	%	No.	%
Very satisfied	1	6	2	18
Satisfied	4	24	3	27
Neither satisfied or dissatisfied	5	29	3	27
Dissatisfied	5	29	1	9
Very dissatisfied	2	12	2	18

Source: CMC survey of shared care and residential services, conducted September–October 2003.
Note: Numbers have been rounded and may not add up to 100 per cent.

Table C2.27. Reported reasons for satisfaction/dissatisfaction with the response by the Department of Families to notifications

Shared care agencies

- No response to some notifications.
- Disclosure of notifier information poorly investigated or investigated with no process for meeting the child's rights.
- Confidentiality issues among departmental staff and other professionals (e.g. mental health).
- Variety of response times — no consistency.
- Agency worker needs to follow-up with department to ensure action is taken.
- Decisions take too long, and it is rarely clear whether a notification or standard of care or casework approach will be taken.
- Currently training in yet another notification process, despite last 'new' policy and procedure being released only a year ago.
- Investigative process by the department was more abusive than the actual allegations.
- Inconsistency in the way notifications are handled.
- Determinations reached in the investigation of notifications are generally satisfactory; however, the outcome is often unsatisfactory and distressing for carers and the children, as children have been removed and there are lengthy delays between initial investigation and final decision/report.
- Often we are only working on oral instructions; need more comprehensive information coming out of the assessment with specific recommendations and timelines for all persons involved.
- No feedback provided.
- Poor communication from the department.
- The best interests of the child cannot be served in a poor system.
- Matters have been downgraded to casework issues due to delays.
- Follow-up mechanisms poor.
- The department does not appear to be aware of the processes relating to the reporting of notifications.
- Children left with unsuitable carers as child extremely high need and shortage of carers in region, no residential facility — department frustrated by lack of resources and options.
- Children have notified on family matters and no action taken — department says not enough evidence.
- More resources for AICCA services would promote partnership with department.

Residential facilities

- No response to some notifications.
- Disclosure of notifier information poorly investigated or investigated with no process for meeting the child's rights.
- Confidentiality issues among departmental staff and other professionals (e.g. mental health).
- Variety of response times — no consistency.
- Agency worker needs to follow-up with department to ensure action is taken.
- Decisions take too long, and it is rarely clear whether a notification or standard of care or casework approach will be taken.
- Currently training in yet another notification process, despite last 'new' policy and procedure being released only a year ago.
- Investigative process by Families was more abusive than the actual allegations.
- Children will only talk to the house-parent; they won't speak to anyone else, so there is little that Families can do to follow-up.

Source: CMC survey of shared care and residential services, conducted September–October 2003

Suggestions for improvements to child protection in Queensland

The survey sought the opinions of respondents about how the child protection system in Queensland might be improved. A range of suggestions and opinions was provided (see Table C2.28).

Table C2.28. Suggestions for change made by respondents to the survey

Shared care agencies

- Need consistency across state; currently a dual system and no set standard.
- The role of SFC agencies needs to be reviewed and expanded.
- Relative and general carers need to receive the same level of support and opportunities.
- FSOs have too large a caseload.
- Early intervention for families — strength-based approach, in order to get help for the families across many services, in order to resolve issues requiring the children to require out of home placements.
- Provide stability and continuity for the child.
- Resources.
- One system — shared family care. Dual system has shown to be divisive among foster carers — they provide an avenue for foster carers who seek exclusion from the monitoring system thereby placing vulnerable children at risk.
- Children requiring placement have increasing levels of high/special needs.
- Increased acknowledgement of foster carer as valued members of casework team.
- Greater emphasis on children's and young people's rights rather than natural parents' rights.
- Provide more resources that support foster carers (e.g. child care so carer can attend training).
- Resources not used well – e.g. departmental trial program to train and assess foster carers could have been utilised by increasing resources in SFC agencies who have the experience and knowledge in this area.
- Preventive resources should be expanded without impacting on the tertiary response resources. crucial until such time as preventive services are effective enough to reduce the need at the tertiary end.
- The resourcing for carers should be linked to the level of need of the children.
- Regular respite for carers should be a standard practice.
- Closer monitoring of children in out of home placements.
- Make child protection a priority — less funding in admin and management and more on recruiting and retaining good quality FSOs.
- Funding for 24-hour emergency support.
- Incentive packages to rural and remote staff.
- Assessment of biological parents before children are returned.

Residential facilities

- Early intervention policies are not being followed.
- The cheaper the placement, the more readily accepted.
- Notifiers need to be taken seriously rather than being treated as a 'nuisance'.
- Responding to carers in proactive manner rather than ignoring them when requesting assistance until placement becomes harmful or has completely broken down.
- Abuse of the foster carer and the foster care system by placing too many children in the home (e.g. up to 10 children) — number should be limited to four or five children.
- Improve case-plan system.
- Children in foster care should be externally monitored by the Children's Commissioner, as happens with residential care children.
- Due to behavioural difficulties significantly increasing — for some children residential care is the only viable alternative: at present residential care is seen as the last option — many children prefer to live in residential care and need the benefits of therapeutic care to deal with behavioural difficulties, mental health and educational challenges.
- Overcrowding in foster families leads to emotionally damaged young people caring for younger children.
- Poor matching of child to care situation.
- We focus on what works financially, and not on what abused children need.
- Foster carers need better training and support.
- Children experiencing rejection time and time again via breakdown of placements.
- Foster caring should be seen as a profession and compensated as such.
- Adequate funding — currently have an operating budget of $3 per day per child — less than the fostering allowance — children in residential care have no access to the incidental allowance provided to foster carers for clothing and incidentals — young people have to access a clothing allowance via the child-related cost process
- The sector needs more residential care options — many young people are having their daily needs met via individualised packages due to lack of options other than family-based care. Less stability and costs more than a funded service.
- An overhaul of departmental hierarchy to ensure effective communication and unity in approach and purpose.
- Increased funding for appropriate numbers of Families workers, including youth workers.

continued next page

Table C2.28. Suggestions for change made by respondents to the survey (continued)

Shared care agencies	Residential facilities
	• Non-government sector need more funding. • Carers attend training that is relevant and ongoing. • Services in the local areas need to be able to complement one another. • More 'in home' support for families that are identified as having difficulties with their child at home, identified by kindergartens and schools. • The child protection system needs to be more proactive in areas of education, opportunities for children to express feelings, to be listened to, need to be addressed immediately, during and after the crisis. • There is evidence that health and education access are areas where children in care are suffering. • Case management services for children in care and in out-of-home placements be outsourced to accredited service provider agencies (standards to be regulated and monitored by commission for children and young people or a specially created children's guardian department like in NSW). • Holistic approach whereby residential facilities and carers work collaboratively. • More frontline workers in the child care and protection area. • Shift from focus on investigations to working with families. • South Australia's excellent child protection model could be adopted in Queensland.

Source: CMC survey of shared care and residential services, conducted September–October 2003

Several suggestions identified the need for consistency across Queensland, citing the current system as a dual system with no set standards. Some respondents identified a need to develop and implement early intervention policies and for the child protection system to become more proactive, rather than reactive. A need for more frontline workers in the child care and protection areas and the shift from the focus being on investigations to working with families in a collaborative and holistic manner was reported. It was also suggested that the case management component for children in care and in out-of-home placements be outsourced to accredited service provider agencies with the standards to be regulated and monitored either by the Commission for Children and Young People or a specially created Children's Guardian Department.

Other issues

Respondents were also given the opportunity to raise other issues that had not been addressed by the survey questions. They raised topics such as:

- the need to provide a therapeutic holistic environment which specifically addresses the problems associated with children and young people in care
- the instigation of a dedicated 1800 number for reports of abuse in care
- the provision of funds to fund after hours on-call services across the state
- the apparently financial rather than child focus of the Placement and Support (PASP) process
- regarding Indigenous services, the need for the State Secretariat to be reinstated, the need for culturally appropriate training to be provided to departmental staff, and that Indigenous relative carers receive no financial assistance
- the serious youth housing problem, as highlighted by the over-reliance on foster placements and private rental rather than public housing.

Table C2.29. Other issues

Shared care agencies

- After hours on-call services all over state are inconsistently funded.
- Therapeutic holistic approach for addressing the problems associated with being in care, emotional, sexual and physical abuse and grief separation from siblings and other family members, psychological (depression), how to cope with abuse within the foster/ relative placement — need ongoing support past 18 years of age to be able to succeed in life.
- State secretariat needs to be reinstated so it can support the AICCA agencies.
- The department needs to be providing culturally appropriate training to all staff on a regular basis (e.g. Indigenous).
- Constant staff changes in the department frustrate carers — many caseworkers have not even met children they make decisions about.
- Open forum or a 1800 number for reports of abuse in foster care.
- Relative care needs to be examined. Indigenous children are placed with extended family members with no financial contribution from the department. Indigenous health workers and AICCA staff step in to help those families who struggle financially to care for extra children.
- Lack of housing.

Residential facilities

- PASP process adopted by the department is placing FSOs under enormous pressure. Lengthy and slow turnaround. Financially focused and not child focused and directly opposes Families own early intervention 'focus'. PASP limits the choices of placement options by central control panel who have no direct knowledge of either the children or the regional needs. Also, PASP provides limited response opportunities due to meeting only monthly.
- Youth housing crisis — there is significant over-reliance on foster placements for young people. An over-reliance on private rental rather than public housing has resulted in families becoming more at risk.

Source: CMC survey of shared care and residential services, conducted September–October 2003

PART 3: DEPARTMENT OF FAMILIES STAFF

Introduction

Two sources of data for departmental staff are presented in this section of the appendix:

- data provided by the Department of Families at the request of the CMC
- information provided to the CMC by union delegates responding to an email survey.

Data requested and comments

Table C3.1. Data requested and comments

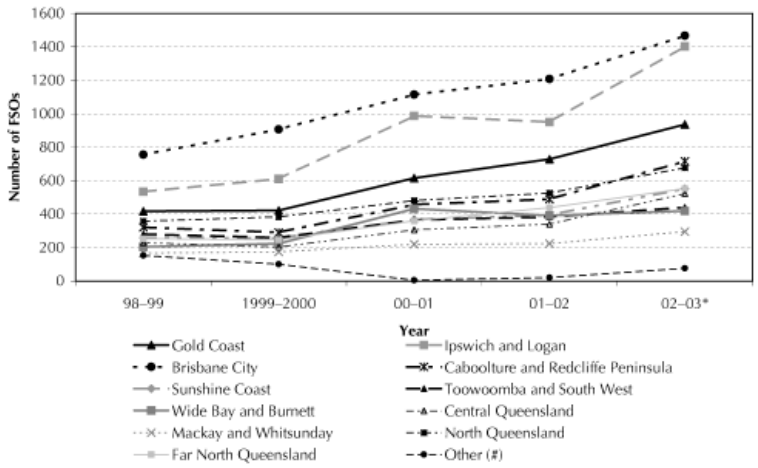
Data requested	Comments
As at 30 June for each year 1993–2003: • number of FSOs employed by geographical location • profile of caseload for FSOs (e.g. xx children in foster care, xx children in residential/ institutional care) by geographical location • number of area managers by geographical location • number of FSOs supervised by area managers by geographical location.	Comments provided by the department regarding the data provided: • for 1998 to 2003 only: data of this type are not available prior to this date • data on substantive and acting positions are only available after the period June 2000 to June 2003 • it is not possible to distinguish between FSO, team leader or area office manager staff working in child protection and youth justice areas • the data are head-count data only, not full-time equivalent data • these data also seek to respond to the request for 'First of the month snapshots over the past five years of HR data re FSOs, team leaders, and area managers (in the child protection area) indicating the numbers of staff working in their substantive positions and the numbers of staff in acting positions' • data relating to profile of caseload not provided.
Point in time data for the number of FSOs • compared to administration, team leaders and senior practitioners (1997–2003) • by EEO data (2001–03) • by age (2000–03) • by gender (2000–03) • by tenure (2001–03).	Data provided. Families commented that tenure data are from the date of commencement in the public service and not from date of commencement in the role they currently hold. However, HR Branch advise that it is reasonable to assume that for FSOs commencement in the public service is commensurate with their commencement as an FSO. These data are unable to identify whether there has been a break in an officer's period of service.
Entries and exits for each year 1 July to 30 June, 1993–2003: • number of FSOs recruited • number of FSOs trained by type of training provided • number of FSOs leaving service.	Data provided.

Key issues arising from the data

- Since 1997 the number of FSOs has increased by 57 per cent and the number of team leaders has increased by 168 per cent. However, the number of administrative staff has increased by only 2 per cent during the same period (see Figure C3.1, below, and Table C3.2, p. 326).
- Compared with all other regions, Brisbane City Region appears to have the largest number of FSOs overall. The number of FSOs in that region appears to have doubled between 1998–99 and 2002–03. Ipswich and Logan Region appears to have the second highest number of FSOs (see Figure C3.1, below).
- Currently, there appears to be one team leader for about five FSOs, one senior practitioner for about 64 FSOs and one administrative staff member per four FSOs (see Table C3.2 and Figure C3.2, p. 326).
- In the last three years there has been an increase in FSOs who fall into each of the three EEO target groups — Indigenous, people with a disability and NESB (see Table C3.3, p. 326).
- Most FSOs are female and most are aged between 26 and 35 years. This profile has remained relatively stable since July 2000 (see Figures C3.3 and C3.4, p. 327). However, there appears to have been an increase in the number of FSOs with less than one year of service in recent years (see Figure C3.6, p. 327, which shows retention, separation and movements for FSOs over the last six years).
- Figures C3.7 and C3.8 (p. 328) provide comparative child and staff data for the most recent financial year (2002–03) by region.[4] As is to be expected, the graphs illustrate similar profiles, although the amount of unknown regional data for children (classified as 'other') masks, to a certain degree, the true breakdown of these figures.

Data provided

Figure C3.1. Number of FSOs by departmental region and financial year (1998–99 to 2002–03)



Source: Information Services Branch, Department of Families, September 2003

Notes: 1. (#) Other = Region unknown

2. Regional boundaries changed during the period of data illustrated in this graph. The information shown was extracted and collated by CMC research staff by way of a detailed analysis of data provided by Families about area office staff. The data are, therefore, estimates only.

4 Data, which are estimates only, have been collated from a variety of departmental sources by CMC research staff.

Table C3.2. Staffing levels (1997–2003)

Status	FSO	Admin	Senior practitioner	Team leader	Ratio Admin: FSO	Ratio Practitioner: FSO	Ratio Leader: FSO
04.07.1997	365	132		44	1:2.8		1:8.3
03.07.1998	372	140		56	1:2.7		1:6.6
02.07.1999	403	120		61	1:3.4		1:6.6
02.07.2000	458	124	8	76	1:3.7	1:57.3	1:6.0
15.07.2001	465	124	7	96	1:3.8	1:66.4	1:4.8
30.06.2002	485	133	8	103	1:3.6	1:60.6	1:4.7
29.06.2003	574	135	9	118	1:4.3	1:63.8	1:4.9

Source: Information Services Branch, Department of Families, September 2003

Figure C3.2. Proportion of FSOs, administrative staff, team leaders and senior practitioners employed by the Department of Families at 29 June 2003

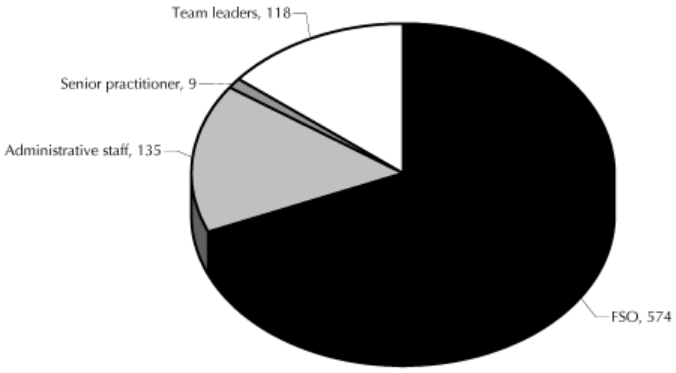


Table C3.3. FSOs by EEO categories (2001–03)

EEO category		Pay period end date		
		15.07.01	30.06.02	29.06.03
Indigenous	Indigenous	9	8	11
	Non Indigenous	246	225	369
	Data not captured	210	252	194
People with	disability	30	20	41
	No disability	218	211	342
	No response	7	2	1
	Data not captured	210	252	190
NESB	NESB	37	34	55
	ESB	218	199	327
	No response	0	0	2
	Data not captured	210	252	190

Source: Information Services Branch, Department of Families, September 2003

Note: Data are 'headcount' data. Administrative staff are AO2/AO3 working within area offices and Youth Justice Services. A significant number of FSOs have not identified as belonging to any target group.

Figure C3.3. FSOs by age (2002–2003)

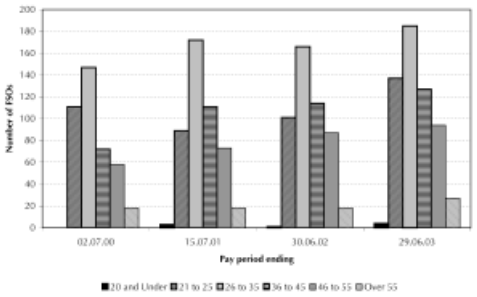


Figure C3.4. FSOs by gender

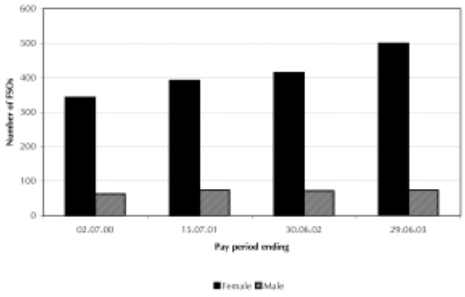
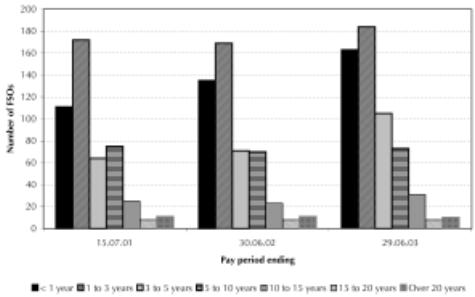


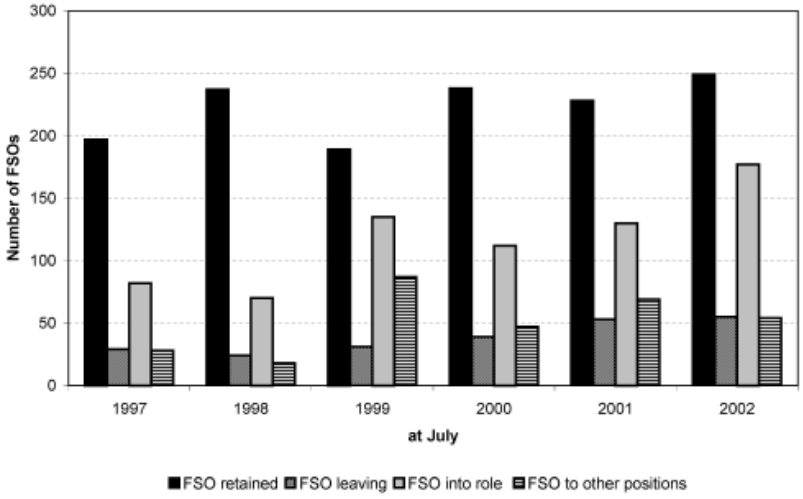
Figure C3.5. FSOs by tenure



Source: Information Services Branch, Department of Families, September 2003.

Note: Tenure data are from the date of commencement in the public service and not from date of commencement in the role they currently hold. However, HR Branch advise that it is reasonable to assume that, for FSOs, commencement in the public service is commensurate with their commencement as an FSO. These data are unable to identify whether there has been a break in an officer's period of service.

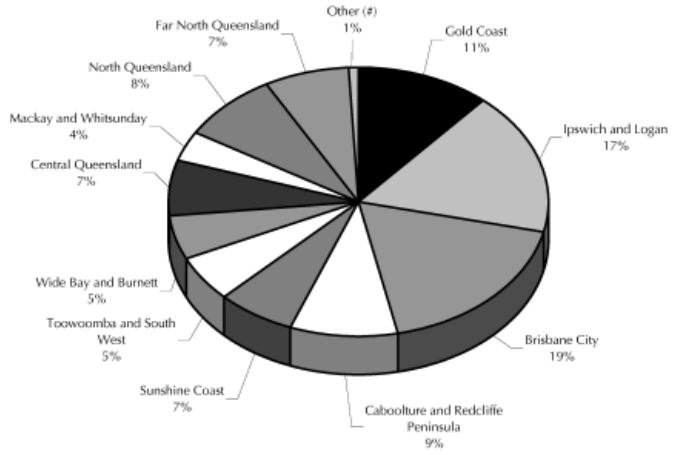
Figure C3.6. Permanent FSO retention/separation/movements from one year to the next



Source: Information Services Branch, Department of Families, September 2003.

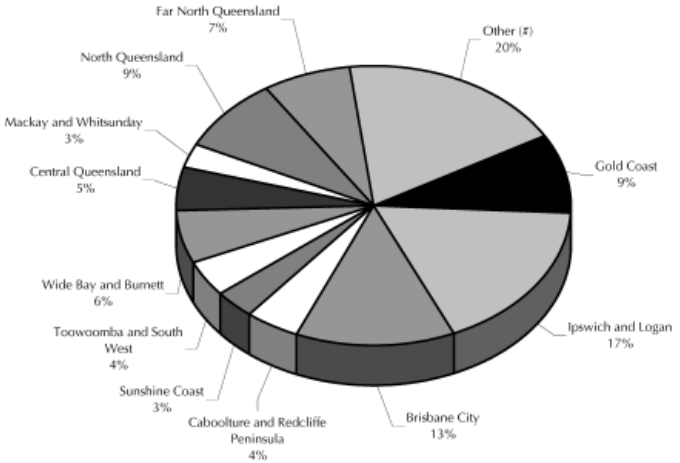
Notes:
1. Data are a point in time count at July of each year.
2. Counts are permanent staff only and do not include temporary staff.
3. Data are a 'headcount' not full-time equivalent.
4. 'FSO leaving' counts those staff leaving the department relative to the total of permanent FSOs identified in the previous year count — that is, it is not a turnover or separation rate.
5. 'FSO into the role' count can be deceptive as it is not a recruitment count and may include people coming back to the department from secondment elsewhere.
6. 'FSO to other positions' may also include secondments.

Figure C3.7. Number of FSOs by region (2002–2003)



Source: Information Services Branch, Department of Families, September 2003.
Note: (#) Other = Region unknown.

Figure C3.8. Number of distinct children in the care of an approved foster carer by region (2002–2003)



Source: Information Services Branch, Department of Families, September 2003.
Note: (#) Other = Region unknown.

Survey of union delegates

Methods

The QPSU facilitated a survey of area offices of Families for the CMC. The survey was sent out by e-mail on 20 October 2003 and returned within 48 hours by 20 of the 36 area offices targeted. This represents a response rate of 56 per cent.

Issues addressed in the survey included:

- staff turnover within each area office
- workload of each office, including the number of notifications, assessments and follow-ups conducted by each area office
- the number of Parent Consent Statements dealt with by each area office on a monthly basis
- student placements within area offices
- new initiatives implemented within the area offices.

Staff

As at 30 June 2003, the 20 area offices responding to the survey had a total 241.5 FSOs between them, an average of 12 per office. By the date of the survey, almost four months later (20 October 2003), 3.5 FSOs had left the department. The range of FSOs per office is shown in Table C3.4 below.

Table C3.4. Range of FSOs per office

Number of FSOs	Number of respondents	Percentage of respondents
Up to 5	5	25
6 to 10	4	20
11 to 15	5	25
16 or more	6	30

Source: CMC survey of area offices, conducted October 2003.

Note: Due to rounding, percentages may add up to more than 100 per cent.

Staff turnover

Between 30 June 2002 and 30 June 2003, the respondents indicated that 134 new FSOs had been employed at their offices, an average of seven new FSOs per office. The offices indicated that only about half (51%) of the new FSOs had been inducted and trained.

On the other hand, during the same 12-month period, the respondents indicated that 102 FSOs had left their offices, an average of five FSOs per office. While about half of the offices (50%) indicated that they had lost three to five FSOs, about one-third (30%) indicated that they had lost six or more FSOs in that period.

A number of reasons for FSOs leaving the office during that 12-month period were identified: half of the FSOs (50%) resigned, 26 per cent were transferred as FSOs to other area offices, 22 per cent of the FSOs transferred to other positions within the department (e.g. as a Team Leader), 22 per cent left for reasons such as long service leave or secondment and about 8 per cent took stress leave.[5]

Workload

Notifications: On average, respondents to the survey reported that they process about 38 notifications each month, although 40 per cent of the respondents indicated that they process more than 40 notifications each month. The total number of notifications during an average month for all 20 offices responding to the survey was 758.

Initial assessments: On average, the respondents to the survey reported that they undertake about 31 IAs in an average month (a total of 550 IAs per month were reported by all 20 offices responding to the survey), with 20 per cent indicating that they conduct more than 40 IAs per month.

Follow-ups: On average, the respondents to the survey reported that they undertake about 19 follow-ups in an average month (a total of 280 follow-ups were reported by all 20 offices responding to the survey), with 15 per cent indicating that they conduct more than 40 follow-ups per month.

Parent Consent Placements

Each office reported an average of 4.7 Parent Consent Placements at the time of the survey (the total number of such placements was 84 for all offices combined). The majority of offices had between one and five placements, but several reported more than 11 (see Table C3.5). About half of the respondents (56%) agreed that these arrangement were sometimes more informal than the 28-day monitored arrangements.

5 Figures add to more than 100% as multiple responses were given for this question.

Table C3.5. Number of Parent Consent Statements at time of survey

Number of Parent Consent Placements	Number of respondents	Percentage of respondents
0	4	20
Up to 5	8	40
6 to 10	3	15
11 to 15	2	10
More than 15	1	5
Missing	2	10

New initiatives

Most of the respondents (85%) reported that their office had trialled a new initiative and most (76% of those) reported that the initiative had been evaluated in some way. Table C3.6 presents a list of initiatives trialled in area offices responding to the survey.

Table C3.6. Types of initiatives trialled in area offices responding to survey

- Alternative Care Trial
- CEO Info Sharing Protocol Trial with Police, Education and Health
- Creation of a 'Short Term Team' to manage contested orders
- Departmental Induction Manual (trial)
- Differential Response Trial
- Early Intervention and Prevention Trial
- First year's trial
- Formalised team planning
- Future Directions Initiatives:
  - Family and Community Worker Trial
  - Indigenous Community Worker and Foster Care Worker
  - Reconnect Trial
  - Regional Placement Team
  - Respite Trial
  - Systems perspective
- Generic induction
- Group work for Youth Justice & young people of child protection orders
- Initial Assessment format
- Integrated Family Support
- Joint case management with DSQ, & YouthTrek
- Leadership and Management Program
- Lighthouse projects
- Managing for Outcomes in Child Protection
- Partnership work with Shared Family Care Agency
- Pre-Notification Checks
- QPA
- Quality Assurance Pilot (not a trial)
- Quality Performance Framework Trial
- Reconnect Worker Trial
- Referring clients and participation in Action Learning Teams in the external trials for Mercy Family Services, Brisbane Youth Service, Life Without Barriers Respite, Project Circuit Breaker, Red Cross Under 8s, Kinship Care through Lifeline
- Regional Intake Team
- Regional Relief Team
- Regional Relief Family Service Officer Pool
- Rotation of FSOs within Intake and Assessment team
- SCAN Team Coordinator (not statewide policy)
- Student Unit
- Team reflection
- Use of pre & post initial assessment forms clarify issues and focus the initial assessment (time-saving initiative)
- Video conferencing links
- Wynnum/Redlands Integrated Care and Support Initiative
- Youth Justice team to include child protection orders over age of 15.

APPENDIX D: RECOMMENDATIONS FROM INDEPENDENT AUDIT REPORT

Recommendations taken from Murray, G. *Final report on phase one of the audit of foster carers subject to child proection notifications*, External and Independent Reviewer, Foster Carer Audit Team, December 2003.

Foster care and the placement of children

1 Placement options

It is recommended that attention be given to providing intensive family support services to assist and strengthen families to safely keep children with their natural parents.

It is recommended that:

- small residential homes should be available for large sibling groups and young people who do not wish to have, or cannot cope with family based care or who are transitioning to independent living;
- the department consider the implementation of Family Group Conferencing as a means of diverting children from the child protection system, increasing diversity in alternative care options and relieving pressure on the foster care system;
- the department develop a clear policy framework which proactively seeks support options (eg placement, respite and social contact) within the child's family and community, eg the use of Family Group Conferencing. This policy framework should be developed in consultation with the departments Alternative Care Committee.

2. Assessment, approval, training and support for foster carers

It is recommended that the department:

- review and amend relevant policies with respect to determining foster carers' suitability, having regard to foster carers own children, non-household members likely to have ongoing or significant levels of contact with children;
- develop and implement clear standards and policy frameworks regarding the training and support to be provided to, and attended by, all foster carers. This should include the roles and responsibilities of persons or agencies responsible for the training and support of foster carers;
- develop and implement clear standards for the review of relative carer and limited approval carers including their compliance with legislative provisions;
- amend the 'Foster Carer Agreement' policy and procedures to include all foster carer approval types and monitor the 12 monthly review of the Agreements, to ensure that it is undertaken. A standardised Foster Carer Agreement proforma needs to be developed;
- amend the legislation to ensure that standards and monitoring requirements apply to all foster carer types;
- review the draft Sharing the Care training and include content that covers the issues identified by the Audit with clear information about listening to children and taking their disclosures of harm seriously;
- clearly articulate to foster carers the standards of care required for children and young people in foster care.

3. The number of children and young people placed with foster carers

It is recommended that the department:

- develop and implement policy that places restrictions on the number of children and young people or sibling groups that can be placed with all approved foster carers at any one time;

- the policy should take into consideration the findings of this Audit and have regard to best practice developed within child care as to restrictions on the number of children in foster care;
- the formula should state standards for the placement of children and young people with foster carers including specific requirements relating to:
  - The number of carers' own children,
  - Children and young people with high support needs,
  - Children and young people that have been sexually abused, or have sexually abused other children and the placement of more than one sibling group with a foster carer.

Investigating and assessing child protection notifications and responses to outcomes

4. The recording of child protection notifications

It is recommended that the department:

- amend FSO training to include information on specific procedures and recording requirements associated with notifications involving foster carers;
- amend policy to require that all children and young people placed with foster carers are recorded as subject children, irrespective of the nature of the notified concerns;
- the current *Responding to matters of concern raised in relation to the standards of care provided to children and young people in alternative care* policy is amended to reinstate the 24 hour commencement time frame for all notifications relating to children and young people in alternative care.

5. Initial assessments

It is recommended that the department:

- develop a comprehensive training package that includes quality assurance tools such as check lists for Team Leaders and other staff responsible for the approval of Initial Assessments, as a matter of priority, to improve the assessment of notifications and the recording of initial assessments. This training is to be available on a regular basis to departmental officers.
- develop and implement training for all FSOs in relation to investigating and assessing of notifications involving foster carers with particular emphasis on risk assessments and the concepts of future harm.

6. Central specialist unit for assessment of notifications with respect to foster care

It is recommended that a central specialist unit be established (possibly within the Operations Directorate) with staff to:

- provide advice, training and support to specialist departmental officers in each region who will be responsible for the recruitment, assessment, approval and re approval of foster carers and the management of matters of concern;
- develop systems to oversight all aspects of the management of matters of concern, including the investigation and assessment of notifications with respect to foster carer. This will require the development of a database for the collation of data and the formulating of protocols;
- provide assistance (in the form of advice) in relation to the development of action plans after there has been a substantiated or substantiated risk outcome;
- analyse data, monitor and report on trends relating to matters of concern. This is to involve the ongoing use of the Foster Carer Audit database.

The role of the Unit would be to improve current practice to ensure its objectivity and focus on best practice. It is important that Unit staff are not involved in day to day casework matters.

7. Policy regarding investigating and assessing notifications on foster carers

It is recommended that:

- the Child Protection Procedures Manual is updated and re-implemented as a critical tool for FSOs undertaking the broad range and complex requirements of child protection work. It should include chapters specific to the regulation of care and monitoring. The manual should also set out the role of the FSO, who has casework responsibility for the case and foster carers, in the investigation and assessment, to ensure that there is no conflict of interest in the investigation process;
- the investigation and assessment of child protection notifications involving foster carers be conducted in liaison with the recommended special investigation unit;
- the department amend its child protection notification response – initial assessment policy to include factors specific to formulating assessments in circumstances involving notified foster carers;
- all foster carers in the household are included in the investigation and assessment process, with all reasonable attempts made to interview and include other persons alleged responsible for harm/risk of harm;
- investigation and assessment requirements are clearly specified in relation to decisions about
  - children or notified foster carers who are Indigenous;
  - the involvement of Police and the outcomes of their investigations;
- the development of a training module specific to the investigation and assessment of alternative care notifications that must be attended by departmental officers responsible for such investigations and assessments;
- the department implement formal monitoring and evaluation processes to ensure compliance with investigation and assessment processes.

8. Identifying sexual abuse indicators

It is recommended that:

- all departmental officers attend training prior to undertaking assessments that provides a comprehensive overview of the dynamics of sexual abuse, risk indicators and how to enhance protective factors, and be able to demonstrate their understanding of it;
- all foster carers are required to attend training that provides a sufficient overview of the dynamics of sexual abuse, risk indicators and how to enhance protective factors, and be able to demonstrate their understanding of it, prior to their initial approval;
- all foster carers are provided with appropriate information at the time of placement outlining any sexual abuse history or issues for the child;
- there are limits placed on the number of children with a sexual abuse history that can be placed together. Consideration should be given to restricting the placement of children with a sexual abuse history together with children who do not have a history of sexual abuse;
- foster carers are supported and provided with strategies for their family to be able to respond appropriately to children who have been sexually abused.

9. Responding to substantiated or substantiated risk outcomes of notifications concerning foster carers

It is recommended that the department develop policy and procedures specific to:

- the purpose and requirements of intervention with children and young people following substantiated and substantiated risk outcomes, including support, access to therapy and the updating of case plans and case decisions. Policy and procedures are to include provision of support for children and young people when they are moved to a new placement.
- the purpose and requirements of intervention with notified foster carers following substantiated and substantiated risk outcomes, including consideration of the removal of children and young people and the suitability of individuals approved to care for children and young people;

- review of Foster Carer Agreements following every substantiated or substantiated risk initial assessment outcome in relation to foster carers; and/or other persons responsible for harm where these persons are related to, or in regular contact with foster carers;
- training modules specific to the purpose and nature of intervention following substantiated or substantiated risk outcomes, including relevant policies and procedures, that must be attended by departmental officers; and shared family care service staff;
- The department must implement formal monitoring and evaluation processes to ensure compliance and related policies and procedures.

10. Appropriate management of the behaviour of children and young people in foster care

It is recommended that the department:

- give urgent attention to developing 'best practice' standards and indicators associated with the legislated Statement of Standards;
- develop an advanced training module that incorporates appropriate discipline and behaviour management strategies, that must be attended by foster carers, departmental officers and shared family care staff;
- prioritise the implementation of a clear policy framework for responding to foster carers who contravene legislated standards;
- automatically include (as conditions of all Certificates of Approval) the requirement that foster carers provide care in a manner consistent with the Statement of Standards; and do not use corporal punishment or techniques that humiliate, frighten or threaten children in ways that are likely to cause emotional harm;
- amend the legislation with respect to relative carers and limited approval carers so that they are subject to the same regulation and monitoring as approved foster carers, that would similarly enable the provision of conditional Certificates of Approval.

Recommendations concerning child-focussed practice

11. Child-focussed practice frameworks

It is recommended that:

- there is a systematic approach to ensuring children and young people in care can participate in decisions about their lives and that the philosophy of the department's child protection framework is child-focussed;
- departmental officers become more skilled in communicating with children and young people;
- children and young people must be consulted and involved in the development of case plans, placements and in their transition from care. A copy of their case plan should be provided to them with an updated copy as the plan progresses or changes;
- children and young people in the guardianship of the chief executive be provided with information about the *Charter of Rights,* advocacy services and complaints procedures upon entering care and regularly throughout their time in care;
- that policy clearly articulates, and practice dictates that children and young people in alternative care have access to a support person during the assessment of notifications;

The Audit Team endorses the recommendation of the Queensland State Government contained in its submission to the CMC that the role of the CREATE Foundation be expanded to provide independent views and representation to the Department of Families based on the views of children and young people. The Government submission recommended that funding be increased to CREATE Foundation to expand its systems advocacy role.

12. Aboriginal and Torres Strait Islander children and young people

It is recommended that:

- alternative care services for Aboriginal and Torres Strait Islander children and young people should be developed and funded at a greater level to ensure safety and equity in the provision of alternative care services;
- a range of initiatives be implemented to address alcohol, violence and child protection issues in isolated communities;
- the Coalition Of Attorneys General collaboration should be expedited in relation to child protection, and identify what gains could be made in the Cape York trial sites project;
- Recognised Agencies under the Act must be funded adequately, and their staff trained and supported to enable them to respond to requests made for advice and involvement in case planning;
- the department in consultation with Recognised Agencies develop indicators and measures regarding standards of care required of Indigenous foster carers.

13. Contact with children and young people

Given that an overwhelming finding of the Audit was that there was a significant lack of direct contact between the FSO and the children and that home visits are a critical factor in the prevention of harm, it is recommended that the department:

- adequately resource and prioritise alternative care to ensure that the department is able to fulfil all of its responsibilities as outlined in the *Child Protection Act 1999*;
- amend departmental policy to articulate that children and young people are visited frequently in their home environment, with a minimum requirement of once a month when subject to short-term child protection orders and once every two months when subject to long-term child protection orders;
- provide training to departmental officers with regard to the purpose and function of home visits for children and young people in alternative care.

14. Case planning

It is recommended that the department:

- incorporate into the new Integrated Client Management System a bring-up system to ensure effective monitoring and compliance with the six monthly review requirements of *the Child Protection Act 1999*;
- provide ongoing training to Family Services Officers and Team Leaders about the Case Management framework covering areas such as:
  - — the purpose of Case Management,
  - — maximising the participation of children and young people in case planning decision,
  - — the development of recorded case plans which clearly articulate the basis for the professional judgement of appropriate departmental intervention.

15. Professional decision making

It is recommended that the department develop:

- ongoing training in the area of professional decision making in child protection targeted at Team Leaders and Family Services Officers. The training among other things, should address the emotional and intellectual challenges of decision making in child protection. It should also include information on building and maintaining child protection worker's emotional resilience;
- training for Team Leaders in relation to supervision that addresses the professional development needs of departmental officers and enables critical review of decision making.

16. Caseloads of Family Services Officers

It is recommended that the department:

- develop a caseload formula to set maximum caseload limits per FSO. This formula should take into account the factors outlined in the body of the report;

- employ additional FSOs within the next 12 months to reach a ratio of one FSO per 15 children in alternative care and accordingly ensure an appropriate increase in Team Leader positions;
- amend policy to require that every child in alternative care has an allocated FSO.

17. Recommendation concerning staff training and professional development

It is recommended that:

- consideration be given to developing partnerships with relevant universities in order to inform the structure and course content regarding statutory child protection. Curricula must provide appropriate skills base, including components of human and child development and the importance of record keeping as part of professional practice. There should also be post graduate studies in child protection;
- a consortium be developed between relevant Government departments including the Commission for Children and Young People, Youth Legal Aid and the Children's Issues Committee of the Queensland Law Society. It is also recommended that consideration be given to funding through the partnership consortium of a Chair in Children and Young People at a particular University to raise the profile and give greater importance to the needs of child protection and youth justice in Queensland;
- the department provide a range of appropriate training to new departmental officers working in frontline child protection. Course content needs to be relevant and current for FSOs, Team Leaders and area office managers;
- that greater support and supervision be available to staff to assist them professionally and emotionally in the high level of stress and the management of vicarious trauma.

Information systems

18. Information systems

It is critical to the department's core business and day to day practice to have access to current and reliable data. It is recommended that:

- an updated and integrated client management system is urgently developed, that contains all departmental information (Child Protection, Carepay, Foster Carers, Youth Justice and Adoptions) and is accessible state-wide in real time to all departmental officers, as appropriate. In developing the ICMS, the department must have regard to the findings and recommendations of the Audit and incorporate these within the development of the ICMS;
- until the ICMS is in place (which may be two years) interim measures be put in place to address identified issues with regard to improving recording and retrieval of client information;
- there are hyper-links within the new ICMS to relevant policy and practice guides;
- an appropriate statistical model for the population base be developed specific to client and foster care information. The development of this model should be led by a postdoctoral statistician and staff with appropriate qualifications;
- consideration be given to changing the terminology of "Initial Assessment" and ceasing the practice of having "related notifications" linked to initial assessment documents;
- there is a removal of all central office recording of area office information (with sufficient resources to allow it to be undertaken at area office level) and electronic ownership of clients;
- the new system has the capacity to deliver on-line, instantaneous data reports that are accessible to all appropriate staff and able to be replaced historically;
- there is an urgent revision of the process for recording carer approvals and placements. The revised process should be integrated into any new system and designed with the ability to produce accurate numbers of foster carers and foster carer families, including information regarding who provides their support (the department or relevant non-government agency);

- information management is urgently developed to track children by placements, matters of concern and notifications while in those placements;
- efficient on-line management reporting systems are urgently developed within area offices and regions and allows central office staff to access key performance measures for monitoring and reporting purposes;
- technology is developed to allow staff to e-mail/forward information they have recorded about a client to another area office;
- the new system should be "intelligent" in order to minimise recording errors and should follow current practice guidelines, not dictate them. For example, workers should be led through the screens, which provide clear 'instructions' for text and the information recorded should be automatically linked to the client and their family;
- the current alerts system be reviewed and a range of new alerts included that identify particular issues for foster carers and for the safe placement of children;
- there is a complete review of the current format for recording assessment actions and outcomes. In particular a review of the Child Outcome Table, the Nature of Harm or Risk Substantiated Table and the Ongoing Intervention Fields.

Systemic matters

19. Integrated services

It is recommended that Queensland Health and Department of Families develop a system to provide children and young people who are in care (or are subject to statutory intervention) priority access to health, dental and behavioural services, including a medical card which goes with the child.

20. Children subject to child protection proceedings

It is recommended that legal officers be employed in each region to assist with the preparation of documentation for court and tribunal proceedings, provide advice to FSOs and in some circumstances attend at such proceedings.

21. Custody or guardianship applications in favour of a relative or other person/s

It is recommended that children and young people be consulted and involved in considering custody or guardianship orders. Further, that consideration should be given to appointing a separate legal representative for the child or young person in some circumstances, when an application is made.

It is recommended that the Operations Directorate conduct a thorough review of the case, including an assessment of CPIS information recorded within case notes, intake notes and outcomes recorded, prior to granting an order.

It is recommended that a report be provided to the court that details relative or other persons suitability as a guardian/custodian of a child. The report should include all history checks as well as a written assessment of the proposed carer's suitability.

22. Children Services Tribunal

It is recommended that further and adequate funding and resources be provided to the Children Services Tribunal to respond to current inquiries and demands to the registry and to better ensure that children and young people participate in the appeals process and receive legal representation where necessary. This funding and resources to the tribunal should also include the provision of training and education to departmental officers and other groups supporting applicants appearing before the tribunal.

It is recommended that training and support be provided to FSOs presenting and/or appearing before the tribunal about the procedures of the tribunal and the preparation of documents and information.

It is recommended that FSOs be provided with legal assistance from legal officers employed by the department, and that the legal officers would prepare the tribunal documentation and in some circumstances, appear before the tribunal (see also recommendation that the department employ legal officers in each region).

Where a review application is made under Section 59 of the *Children Services Tribunal Act* 2000, that the child or young person be granted legal aid for a separate representative.

23. External monitoring of children and regulation of foster care

Commission for Children and Young People

It is recommended that:

- the Commission for Children and Young People provide advocacy for and systemic monitoring of children and young people in alternative care. The Commission must be able to sight and speak with children and young people in their foster care settings. The *Commission for Children and Young People Act 2000* therefore should be amended accordingly. In particular, s64 could be amended to include *(d) foster care settings at "visitable sites";*
- a variation of some of the key functions of the Office of the Children's Guardian in NSW be undertaken within the Commission for Children and Young People. For example, the Commission would provide oversight of case plans, visit and speak with, and have access to data concerning children and young people in alternative care. The Commission would therefore require additional funding to be able to expand and undertake these functions;
- a consultation process with the department, the Commission, Children Services Tribunal, CREATE Foundation and other relevant stakeholders including Indigenous agencies and foster care agencies occur, to decide on suitable arrangements and the appropriateness of the community visitors scheme to take on the function of advocacy and monitoring by the Commission. The consultation process should include an amendment to any existing protocol regarding the sharing of information;
- staff employed by the Commission for Children and Young People to undertake the advocacy and monitoring for children and young people in care must have child protection experience and practice frameworks.

CREATE Foundation

The Audit Team endorses the recommendation of the Queensland Government, contained in its submission to the CMC that the funding be increased to CREATE Foundation to expand its systems advocacy and monitoring role for children and young people in care.

Implementation of recommendations

24. Implementation

It is recommended that the above recommendations be implemented as a high priority with a clear plan for implementing detailed recommendations contained in the Audit Report.

It is recommended that an independent committee comprising of members from the Department of Families, Department of the Premier and Cabinet, Treasury, the Commission for Children and Young People and stakeholders from community organisations oversee the implementation of the recommendations from the Audit Report.

APPENDIX E: FULL LIST OF CMC RECOMMENDATIONS

Recommendation	Reason
THE FUTURE FOR QUEENSLAND CHILDREN	
4.1 That a new Department of Child Safety be created to focus exclusively upon core child protection functions and to be the lead agency in a whole-of-government response to child protection matters.	*Only through an approach unambiguously directed towards meeting the needs of at-risk children will it be possible to make the changes necessary to deliver positive outcomes for vulnerable children, and restore public confidence in the child protection system.*
4.2 That a Directors-General Coordinating Committee, chaired by the Director-General of the Department of the Premier and Cabinet, be established to coordinate the delivery of multi-agency child protection services. **4.3** That a position of Child Safety Director (CSD) be established within each department identified as having a role in the promotion of child protection.	*Dedicated directors within departments, and a high-level coordinating committee, are essential for multi-agency cooperation, coordination and service delivery in a holistic and integrated child protection model.*
4.4 That the government maintain its commitment to developing primary and secondary child abuse prevention services.	*If the increasing levels of reported child abuse are to be controlled, a commitment to primary and secondary prevention is necessary.*
THE DEPARTMENT OF CHILD SAFETY **Workforce numbers** **5.1** That there be a baseline increase of approximately 160 family services officers and team leaders to deal with intake, assessment and casework requirements. **5.2** That this increase be made progressively over the next two financial years and be in addition to other specific recommendations made in this report for the creation of specialist positions.	*The size of the current Department of Families frontline child-protection workforce is inadequate.*
5.3 That the DCS adopt an empirically rigorous means of calculating workloads and projecting future staffing numbers. **5.4** That frontline child-protection service staff numbers be increased annually in line with workload increases.	*The available data indicate that an increased workforce will be required to address expected increases in the child-protection workload in the foreseeable future.*
Management structure **5.5** That the current regional structure used by the Department of Families be critically reviewed, with a view to improving the ratio of direct service delivery staff to management and administration staff.	*The ratio of management and administrative staff to direct service delivery staff is unsatisfactory. The current regional structure appears unwieldy and may be contributing to an imbalance between frontline staff and management/administrative positions.*

Recommendation	Reason
Training and professional development of staff **5.6** That the DCS establish enhanced training and professional development processes for field staff as a matter of high priority. **5.7** That successful completion of induction training before assuming casework responsibilities be mandatory for DCS caseworkers. **5.8** That the DCS critically examine the possibility of forming partnerships with external agencies such as universities in developing and implementing an enhanced training and professional development program. **5.9** That DCS training incorporate appropriate and ongoing Indigenous cross-cultural training for all staff.	*The issue of enhanced training and professional development needs to be recognised by the DCS as an ongoing obligation of fundamental importance. The current situation, whereby staff can assume significant casework responsibilities before undertaking any induction training, is clearly unsatisfactory.*
Intake and assessment **5.10** That the DCS evaluate organisational models, including the use of dedicated officers, with a view to determining the most effective and efficient way of processing intake and assessment matters.	*Intake and assessment are specialist functions that may be best performed by dedicated workers, independent of those who carry out the clinical intervention process.*
Court matters **5.11** That the DCS consider whether there may be advantages in having all court preparation work undertaken by specialist staff.	*This work is of a highly important and specialised nature. It may best be performed by staff with specialist skills and experience.*
Investigations **5.12** That the casework and investigative functions of the DCS be vested, as far as is possible, in different staff members. **5.13** That the DCS employ staff with specialist investigative skills and an understanding of child neglect and abuse issues to investigate complex notifications about abuse of children in care.	*Investigations are a specialist function usually best performed by trained investigators. There are clear advantages in having the investigative process undertaken by staff not involved in day-to-day casework. Operation Zellow (see Chapter 2) starkly highlights the importance of thoroughly investigating reported child abuse.*
Prevention and early intervention **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.	*One of the central aims of the new model is to return a clarity of focus and purpose to child protection in Queensland. The DCS will be an agency focusing exclusively on meeting the needs of children identified as being at risk, and will concentrate on early and intensive intervention in that context.*
Assisting biological parents **5.15** That child-centred casework and the provision of parental support be vested, as far as is possible, in different staff members.	*There is a potential conflict between a function that involves decision making in the best interests of the child and the provision of support to vulnerable parents.*
5.16 That, as a preventive response, 40 specialist FSO positions be created to work exclusively with parents whose children have already been the subject of a low-level notification and continue to reside at home. These positions should be filled progressively over the next two financial years.	*Under the current system, biological parents are not always receiving the support and services they require to provide appropriate environments for their children. A commitment to working with parents is in the interest of the individual children, supports the family unit, and has the potential to reduce the overall level of notification and the need for intervention in the future.*

Recommendation	Reason
Information systems and record-keeping **5.17** That the DCS continue and complete the upgrade of information systems begun by the Department of Families, as a matter of the highest priority.	*In the absence of adequate information and record-keeping systems, the DCS may fall victim to many of the current department's practice failures as outlined in the evidence before the CMC.*
Responding to ministerial correspondence **5.18** That the DCS prepare and promulgate a specific policy outlining the requirements for producing and approving ministerial correspondence and briefing material.	*The evidence from Operation Zellow underlines the clear need for the DCS to institute a policy to enhance the provision of full and accurate information to the minister and senior staff.*
Internal accountability **5.19** That, in addition to direct service delivery by front-line workers, the expertise of senior practitioners be drawn upon for providing specialist advice in complex cases and for routine reviewing of the clinical decisions made by frontline workers. Senior practitioners should embrace line management responsibility for these decisions.	*It is unreasonable to expect junior staff to accept total accountability for clinical decisions, which are all too often highly complex matters that warrant the attention of staff with high levels of expertise and experience. Extensively drawing upon the expertise of senior practitioners will be essential if the DCS is to provide a markedly improved quality of service.*
Complaints handling **5.20** That the DCS establish a unit and clear procedures for receiving, assessing and responding to complaints.	*The DCS needs to have the capacity to respond quickly and adequately to complaints made to it, in a manner that earns the confidence of clients and other stakeholders.*
External accountability **5.21** That a position of Child Guardian, to be situated within the Commission for Children and Young People, be established, whose sole responsibility would be to oversee the provision of services provided to, and decisions made in respect of, children within the jurisdiction of the DCS.	*In conformity with the view that child-protection needs to be the exclusive focus of a dedicated body, the CMC believes there should also be a dedicated body to oversee the DCS.*
5.22 That the powers granted to the Child Guardian be clearly set out in the legislation, and include the powers necessary to investigate complaints and enable proactive monitoring and auditing of the DCS.	*The current overseeing role of the Commission for Children and Young People is hindered by a lack of clarity in the specification and ambit of the powers of that office.*
5.23 That the Community Visitor Program of the Commission for Children and Young People be extended to cover all children in the alternative care system, including those in foster care. This program should be administered by the Child Guardian.	*The jurisdiction of the current Community Visitor Program is insufficient to meet the needs of children in the alternative care system. In particular, the current regime does not extend to children in foster care.*
5.24 That the jurisdiction of the Children Services Tribunal be expanded to allow the Child Guardian to refer decisions of the DCS or non-government organisations to the Children Services Tribunal for merit review, where the Child Guardian thinks it is warranted.	*This would allow decisions about which the Child Guardian may have some concern to be reviewed on their merits by a suitably qualified review panel constituting the Children Services Tribunal.*

Recommendation	Reason
Child-death reviews **5.25** That the new Department of Child Safety continue the practice of undertaking a review of all deaths of children in care, or who have been known to the department within the last three years. Steps should be taken to ensure that an appropriate degree of independence exists in the review process, and external consultants, experts and Indigenous advisers should be engaged in relevant matters.	*It is considered that completely divesting the DCS of any review responsibility for child deaths would not serve to promote the desired culture of transparency and accountability. It is also extremely important that the department with child-protection responsibilities becomes aware, as quickly as possible, of any systemic or procedural factors that might have contributed to the death of any child interacting with it, and that might expose other children to risk.*
5.26 That, following the establishment of the Department of Child Safety, discussions be held between the State Coroner and the relevant investigative agencies, with a view to developing protocols and other working arrangements directed to determining who is to be the lead investigative agency in different cases and how information can be appropriately exchanged between agencies.	*The development of such arrangements is necessary to avoid possible prejudice to investigations or coronial inquests, to reduce any duplication of effort, and to ensure that all relevant information is available to the agencies involved.*
5.27 That a new review body — called the Child Death Review Committee (CDRC) — undertake the detailed reviews of the DCS's internal and external case reviews. **5.28** That the jurisdiction of the Commission for Children and Young People be expanded to include the following roles: • to maintain a register of deaths of all children in Queensland • to review the causes and patterns of death of children as advised by investigative agencies • through a Child Death Review Committee, to review in detail all DCS case reviews, whether conducted internally or externally, regarding the deaths of children in care and those who had been notified to DCS, within three years of their deaths • to conduct broader research focusing on strategies to reduce or remove risk factors associated with child deaths that were preventable • to prepare an annual report to the parliament and the public regarding child deaths.	*Through a fuller understanding of the reasons why children in Queensland die, government action directed towards the prevention of child deaths should be better informed and more effective.*
MULTI-AGENCY RELATIONSHIPS AND MANDATORY REPORTING **Whole-of-government approach** **6.1** That each department with an identified role in the promotion of child protection be required to publicly report each year on its delivery of child protection services.	*Mandatory annual public reporting of child protection activities is essential to improving accountability and service delivery in Queensland.*
6.2 That the Directors-General Coordinating Committee consider appropriate ways for the DCS and state government departments to interact with federal and local governments and relevant community groups.	*Such a range of participants is necessary to ensure that the Queensland child protection system is exposed to a variety of perspectives and expert opinions, and that it provides stakeholders with 'ownership' of strategies designed to improve service delivery to client children and their families.*

Recommendation	Reason
SCAN and the DCS: the new model **6.3** That the existence of the SCAN teams be enshrined in statute to reflect their important contribution to the child protection system.	*Under the new departmental model, the existence and operation of multi-agency SCAN teams are a core means of officially responding to cases of suspected child abuse in Queensland. The requisite commitment, response and service delivery required of agencies in this new model warrant the SCAN teams being recognised by statute.*
6.4 That the operation of SCAN teams be based upon agreement to a standard set of interdepartmental policies and procedures.	*It is critical that all departments are clear as to their role and responsibilities relating to participation in the SCAN process and that the roles and functions of SCAN teams across the state be standardised, as far as possible.*
6.5 That SCAN teams receive appropriate levels of funding to discharge their responsibilities effectively, including appropriate funds for proper record-keeping systems and SCAN team training.	*SCAN teams, as a core micro-level response to child abuse and neglect, need to be sufficiently funded to operate at high levels of effectiveness and accountability.*
6.6 That SCAN team recommendations are accepted by the DCS, except in instances where the DCS believes the recommendations are contrary to the best interests of the child, and that any departure from a SCAN team recommendation is reported to the Director-General of the DCS and made the subject of detailed 'exception' reporting.	*The SCAN teams constitute a panel of experts equipped to provide high-level advice on individual case-management issues. Non-acceptance of SCAN recommendations should therefore only occur where the DCS believes it can demonstrate that the advice is contrary to the best interests of the child. Exception reporting and supervision is needed to monitor and evaluate such views.*
6.7 That SCAN be a standing agenda item on the Directors-General Coordinating Committee.	*With child protection a priority for the Queensland Government, the progress of SCAN teams in Queensland should be subject to regular monitoring by the Directors-Generals Coordinating Committee.*
6.8 That full reviews of the functioning of SCAN teams occur regularly and that audits be conducted to measure compliance with policies and procedures, including official record-keeping systems.	*Reviews of SCAN functioning will provide benchmark data and a means for evaluating the teams' performance.*
Non-government service delivery **6.9** That a strategic framework for child protection be developed, articulating the range, mix and full cost of services required to respond effectively to clients' needs, particularly complex needs; and that the implementation of this framework be adequately resourced.	*There is a need for the development of an integrated service system that effectively responds to the identified needs of children.*
Resourcing **6.10** That alternative funding models that would more adequately meet the true needs of children, families and carers be investigated.	*If the current resource-driven funding models continue to apply, children will not have access to necessary services.*
Role of the DCS and the non-government agencies **6.11** That a more progressive and contemporary integrated service delivery model, which creates a partnership between government and non-government organisations to deliver better services for clients of the child protection system, be developed.	*An integrated service model is necessary for the provision of effective and efficient services for children, their families and their carers. This should build on the substantial amount of work that has already been undertaken by the Department of Families.*

Recommendation	Reason
Service delivery **6.12** That a quality assurance strategy is developed and implemented for all services (government and non-government) and a minimum standard be set for the licensing of non-government services.	*The DCS has a responsibility to promote the wellbeing and safety of children in the alternative care system and to require accountability for the acquittal of expenditure on behalf of the community.*
Mandatory reporting **6.13** That mandatory reporting of child abuse be extended to registered Queensland nurses by legislating under the Health Act. **6.14** That registered nurses receive appropriate training in their new responsibility.	*The expansion of mandatory reporting to Queensland registered nurses provides another essential point of contact for children who are subject to abuse or neglect. In rural, remote and Indigenous communities it is arguably nurse practitioners (registered nurses) who have substantially more contact with children than medical practitioners. It is crucial that cases of child abuse or neglect that come to the attention of the medical system, at all levels, are not overlooked.*
6.15 That section 76K of the Health Act be amended to make it mandatory for doctors and nurses to notify the DCS about their suspicion of child abuse.	*Given that the DCS will be the lead child protection agency in Queensland, it is important that reports about children in need of protection be made, in the first instance, directly to the DCS. A doctor or nurse should, of course, still be able to notify Queensland Health or the QPS (in addition to the DCS).*
FOSTER CARE **Core functions** **7.1** That the Department of Child Safety be responsible for receiving and investigating notifications of child abuse and neglect, and take over responsibility for the final assessment and certification of *all* carers, and for assessing the appropriateness of carers' reapprovals.	*Receiving and investigating notifications requires the skills of a specialised, central department. The DCS should also assume responsibility for the final assessment of carers because it is the entity responsible for ensuring the welfare and protection of any children taken into its care.*
Placement options **7.2** That the placement needs of children and adolescents in care be identified and a broad range of options — including foster care, residential services, family-group homes, therapeutic foster care, intensive support, and supported independent living — be provided to best meet the needs of individual children.	*It is important that services match the specific, identified needs of children. Currently the placement needs of children and adolescents are not being adequately met, with some young people being forced to live in unsafe or unsuitable accommodation.*
7.3 That the effectiveness of these placement options in meeting the needs of different groups of children and young people be evaluated.	*Case planning should aim to match the child's characteristics with the type of placement option that evidence suggests is most likely to meet their individual needs. Acquiring information on the efficacy of particular placement options for children and young people would help to facilitate matching between children and placements, which would lead to less placement breakdown and better outcomes for children.*
Residential care **7.4** That the Department of Child Safety: • identify the extent of the need for residential care services • identify the type of children who would most benefit from these services • develop service models that meet children's needs in this area • identify the skills and training required by staff • monitor and evaluate residential care services.	*There are significant numbers of children who do not benefit from placement in traditional foster care and require placements in residential facilities.*

Recommendation	Reason
Therapeutic care **7.5** That more therapeutic treatment programs be made available for children with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated.	*There is a clear unmet need for therapeutic services for children in care. Research shows that placement breakdowns because of children's behaviour point to a need for therapeutic intervention. During case reviews, children who are experiencing difficulties in traditional foster care placements should be identified (e.g. more than two disruptions because of the child's behaviour) and, where appropriate, should be either provided with therapeutic interventions or transferred into therapeutic care.*
Foster care **7.6** That a central registry be set up containing details of all carers, children currently in their care, and their availability for further placements. The registry should flag when carers are due for reapproval, whether they have been denied their initial approval or reapproval, and whether they have been, or applied to be, a carer in another state. Also, it should be possible for staff to search the registry by region, so that they can easily obtain an up-to-date list of carers and placements in their area. **7.7** That an audit of all current carers be conducted to obtain up-to-date data and determine their availability for placements.	*The current data provided by the Department of Families demonstrate that up-to-date records of carers and placements are not easily accessible. Because children are in the care of the department, there is an obligation to keep these data and use the system to improve efforts to monitor the foster care system.*
Respite care **7.8** That the DCS identify and implement new methods of recruiting respite carers. **7.9** That additional efforts be made to identify alternative respite options for children that could improve children's wellbeing, for example regular camps and school holiday programs. **7.10** That, to prevent carer burnout and limit placement breakdown, planned respite for carers be 'routine' and not have to be requested by carers. Plans for respite could be included in the child's case plan.	*The provision of adequate respite services is essential to maintain a viable foster care system which retains carers within the system and is therefore able to provide children with the stable placements they require for their continued wellbeing. Respite can also be seen as an opportunity for increasing children's social support network and exposure to strong adult role models.*
Voluntary care **7.11** That the *Child Protection Act 1999* be amended to regulate voluntary placements.	*Statutory protections available to children in foster care should be extended to voluntary placements.*
Foster care protocols — recruitment **7.12** That initial screening mechanisms be more efficient and rely on identifying the characteristics that are associated with continuing in foster care and providing good outcomes for children. **7.13** That efforts be made to recruit a more diverse group of carers, rather than continuing to concentrate recruitment efforts in lower socioeconomic areas. **7.14** That the DCS identify areas of high, unmet need and initiate recruitment drives to obtain more carers for specific types of children. Recruitment drives can be directed to areas of high need and focus on recruiting carers who can meet the needs of specific groups of children (e.g. teenagers, or children with special needs or challenging behaviours).	*It is necessary to improve recruitment efforts to enlist foster carers as there are not enough carers in the current system to match the needs of Queensland children.*

Recommendation	Reason
Foster care protocols — decisions about approval **7.15** That the DCS be responsible for the final approval of foster carers. Special attention should be focused on processes that give carers specific approval for numbers and types of children.	*There is a need to consider alternative approval processes that may provide a more thorough assessment of carers, which will increase the likelihood of successful placements for children and carer satisfaction. Processes that give specific approval could be used in initial efforts to match children with carers.*
Foster care protocols — retention of carers **7.16** That regard be had to relevant research findings in order to identify the factors that are most likely to result in successful placements, and to use this knowledge to develop practical processes for the recruitment of suitable carers.	*Although it is important to increase the recruitment and retention of foster carers within the alternative care system, it is also important to make these processes more efficient than those that are currently used to enlist carers.*
7.17 That structured exit interviews with carers be conducted. This information should be used along with regular surveys of carer attitudes, satisfaction and concerns, and other appropriate research initiatives to identify problems and devise systemic solutions.	*Exit interviews would be a way of learning the particular problems that discourage Queensland carers from continuing to foster.*
Foster care protocols — training **7.18** That a framework be developed for supporting relative care that includes enhanced screening and monitoring of carers and the provision of training opportunities and other support for carers. There should be an extensive consultation process, especially with Indigenous communities, in the development of the framework.	*It is important that children under child protection orders who are in relative care have the benefit of the same safeguards as other children in care.*
7.19 That all prospective foster carers undergo compulsory training in parenting. All training programs should be evidence-based and undergo ongoing evaluations of their effectiveness. **7.20** That foster carers be required to undergo ongoing training, identified and organised during yearly reviews of the foster carer by their agency support worker. Carers' reapproval should be contingent on the successful completion of this training. **7.21** That there be a tiered, multi-level approach to training and support of foster parents. The level of need of the foster carer and the children in their care should be assessed and the most appropriate level of training and support required should be provided. In this way, carers who deal with more difficult children, or those with special needs, would receive additional, more specialised training.	*Currently foster carers are not receiving adequate training for dealing with the challenging behaviour of many children who are entering care. This results in high levels of parenting stress and difficulty in retaining carers within the foster care system, which in turn results in children having more unstable placements. There is a clearly identified need for foster carer training to (i) use evidence-based training programs (ii) specifically include parent training and (iii) include a tiered level of training to match carers' competencies with the needs of different children. Effective training courses will improve carers' skills and abilities to deal with children's negative behaviour and so facilitate satisfying long-term outcomes for foster children.*
7.22 That caseworkers be well trained and supervised in evidence-based parenting practices so they can support foster parents with appropriate parenting advice. This training should occur within their pre-service university based courses and through in-service training.	*One of the important roles for caseworkers is to support the foster carers in providing competent parenting to the children in their care. Therefore these workers need to have a thorough understanding of effective parenting practices.*
Foster care protocols — support **7.23** That conditions and support for departmental carers be enhanced to ensure that they are not disadvantages in comparison with agency carers.	*It has been suggested that under the current system, departmental carers receive less support in their role as carers and are often given more difficult placements or greater numbers of children.*

Recommendation	Reason
Placement meetings and agreements **7.24** That tools and resources be developed by the DCS to ensure that placement meetings are initiated by departmental staff and completed in a timely manner, preferably before a child is placed with a carer. Carers should be consulted and agreements negotiated by the carers and the DCS, rather than dictated by the department.	*Placement meetings and subsequent agreements are essential for establishing the groundwork for a successful placement. While current policies and procedures do attempt to involve carers in a partnership with the department, their implementation is variable. Involving carers as an active partner in decisions about children in their care will increase carer satisfaction and provide better outcomes for children.*
7.25 That, during placement meetings, foster carers be provided with all relevant information about the child. When foster carers accept a child for placement they should be given copies of the child's medical and dental records and the child's Medicare details.	*It is essential that foster carers are provided with all relevant information about the child about to be placed in their care — including information about all dangerous propensities, whether the child has accused other carers of abuse, details of any maltreatment the child has suffered and the child's medical history — so that they can make an informed decision about accepting the placement.*
Disclosing confidential information **7.26** That the Child Protection Act be amended to incorporate specific obligations on the part of the DCS to disclose relevant information to carers. **7.27** That the Child Protection Act incorporate a general disclosure obligation on the DCS to inform other departments, government agencies and non-government agencies (including AICCAs) of all information reasonably necessary to ensure their cooperation, assistance and participation within the child protection system. The Act should provide examples of what sort of information will be provided. The person to whom the disclosure is made (the 'receiver') will be bound by the confidentiality provision contained in section 188. **7.28** That the department ensure that it has clear policies and procedures on disclosure of information and that it incorporate them in the training provided to departmental and agency staff.	*It is necessary to remove any perceived impediments to the disclosure of information about children in alternative care by departmental staff. There is an identified need to ensure that all DCS staff understand the legislative provisions about confidentiality and that the department's child protection functions are administered in a way that lessens the possibility of there being adverse effects upon children's protection and welfare, because of misguided decisions to withhold relevant information.*
Foster care protocols — case planning and review **7.29** That tools and resources be developed by the DCS to ensure that foster carers are included in children's case planning.	*It is important to recognise the valuable contribution that carers can make to case planning. Many carers will have detailed knowledge about the child, particularly when children have been in their care for substantial periods of time.*
Foster care protocols — additional support mechanisms for foster carers **7.30** That consideration be given to the DCS implementing mentoring programs for foster carers and children in foster care.	*Mentoring programs have been shown to facilitate good outcomes for children. Potentially they could provide a stable, positive, adult influence in a vulnerable child's life and indirectly give additional support to foster carers in meeting the needs of children in their care. They would also have the benefit of giving the carer regular brief periods of respite from the demands of parenting the child. The program could operate regardless of any changes in the child's placement, including reunification with parents.*

Recommendation	Reason
7.31 That the DCS ensure that an appropriate procedural framework is established for responding to allegations made against foster carers.	*It is important that foster parents have an understanding of departmental processes in dealing with such complaints.*
Remuneration **7.32** That foster carers receive appropriate remuneration to cover the actual costs of caring for a child, as well as receiving additional payments to attend training as required and pay the associated costs of child care and transport for such training.	*It will be easier to attract and retain carers in the foster care system if people are not expected to personally subsidise their caring. Also, the provision of adequate remuneration will reduce the financial burden and related stress on foster care families.*
7.33 That the DCS investigate introducing a tiered system for payments to foster carers that recognises the skills necessary to care for children with more complex needs.	*If a tiered payment system is introduced it could readily by linked to the tiered training system that has also been recommended. Additional payments would provide an appropriate recognition of the higher-level skills attained by specific carers and acknowledge their work with children who have special needs or more challenging behaviours.*
7.34 That the allocation of any additional payments (e.g. child-related expenses, high-support needs allowance) be on a needs basis, rather than on regional resource allocations. Children's needs and entitlements should be clearly detailed in the child's case plan.	*Under the current system there is considerable inconsistency in the availability of these additional payments. While the needs of some children are met, others appear to be denied funding because of resource limitations. There needs to be a consistent application of policies about entitlements, so that funding is based on the identified needs of the children.*
Case planning **7.35** That there be thorough, standardised, evidence-based case planning that is consistently applied and focuses on the best interests of the child. This issue needs to be addressed both in university training courses and in ongoing training provided to staff.	*The evidence indicates that the current standard of case planning is inadequate and lacks a coherent evidence base, which leads to poor outcomes for children.*
7.36 That all children have an identified and designated caseworker from the DCS who maintains regular contact with the child and is responsible for the development of a detailed case plan that focuses on both the short- and long-term needs of the child. The plan must be reviewed at least every six months.	*Children need regular access to a worker who represents their best interests and develops a comprehensive and evolving case plan for their long-term wellbeing.*
7.37 That the DCS adopt clear policy so that section 96 of the *Child Protection Act 1999*, which states that a family meeting should be organised for all children requiring protection, is followed. **7.38** That the Child Protection Act be amended to make it necessary for a case plan to be submitted to the court before an order is sought (as presently occurs in NSW and the ACT).	*All children in the care of the department should have a case plan. As a family meeting is essential in formulating this plan, this meeting must occur for all children including those on voluntary placements.*
7.39 That processes be implemented to ensure initial case planning is carried out promptly and case plan reviews are carried out every six months, as required under the *Child Protection Act 1999*; and that all stakeholders, but particularly the child, their family, and the child's carer, are invited to participate in every planning meeting.	*Under the current system, case planning is not being fully implemented. This recommendation, which comes from the Commission for Children and Young People, is designed to encourage the implementation of appropriate casework.*

Recommendation	Reason
Children's involvement in casework **7.40** That tools and resources for the participation of children and young people in case planning be developed and used to ensure their participation in planning processes that are in keeping with the principles of the *Child Protection Act 1999*.	*While children's rights to be involved and informed about decision making are specified in current legislation and policy, in practice such involvement often does not occur. Therefore it is necessary for the development of specific resources to ensure children's participation.*
7.41 That the DCS be required to implement procedures to ensure that all children are informed within 24 hours of entering care why they have been taken into care and what they can expect will happen to them. **7.42** That the DCS ensure that all children who are the subject of an assessment of risk of harm and/or enter into the care of the department are given the option of a support person whom they know and trust.	*It is important that children are able to maintain ongoing family relationships if possible, because a lack of contact may increase the sense of grief and loss that many children experience on entering care. For example, children are often particularly concerned about the welfare of their siblings, and efforts should be made to maintain these relationships. Foster carers often reported that, when siblings were placed with different families, visits only occurred if they were organised by the carers. When siblings remain with the biological family it is still important to enable the child to maintain contact, even in the most extreme situations where the child must be protected from parental contact during visits with siblings.*
Biological parents' involvement in casework **7.43** That tools and resources be developed by the DCS to ensure that the procedures for involving parents in casework (e.g. family meetings, planning agreements) are followed, and that their support worker be included in these processes.	*Despite policies and procedures to involve parents in their child's case planning, in practice parents have often been excluded from this process, and so it is important to implement mechanisms to facilitate their involvement. This is particularly important when the case plan involves reunification. If the parent is disengaged from the process, reunification is less likely to succeed.*
Reunification versus permanency planning **7.44** That the DCS evaluate research into the effect of reunification or permanency planning on children.	*Currently there is limited Australian research on the effects of reunification or permanency planning on children. Although there now appears to be growing interest in permanency planning in Queensland, the concerns about including an adoption option in permanency planning legislation suggests that any change need to be evidence-based and to consider the specific concerns of the Indigenous community.*
7.45 That an additional principle be inserted into section 5 of the *Child Protection Act 1999* clearly providing that any conflict that may arise between the interests of a child and the interests of the child's family must be resolved in favour of the interests of the child.	*There is nothing in the current Queensland legislation that emphasises that children's rights take precedence over parents' rights.*
Guardianship orders **7.46** That the DCS review the practices associated with granting long-term guardianship orders and short-term child protection orders (including custody orders).	*Although it is possible for the Children's Court to make an order granting long-term guardianship of a child to a member of the child's family or support network, or to a long-term carer, in practice, long-term guardianship orders are nearly always made in favour of the director-general. Given the evidence that these types of orders are more likely to lead to children drifting in and out of care and experiencing multiple placements, the Commission considers that this practice could be the subject of review by the DCS.*

Recommendation	Reason
INDIGENOUS CHILDREN **Aboriginal and Islander Child Care Agencies** **8.1** That the government recognise the ongoing need for independent community-based Indigenous organisations, and that these organisations be provided with the necessary support and resources to provide culturally appropriate child protection services to the Indigenous community. This support should include training and professional development, as well as assistance complying with service agreements and accountability requirements. **8.2** That, where AICCAs have been de-funded, they be replaced by appropriate independent Indigenous organisations that have the support of their local community and that, wherever possible, these organisations employ staff with backgrounds in child protection.	*The new child protection system envisages a continuing role for independent Indigenous organisations, operating in an effective and culturally appropriate manner within local communities.*
8.3 That, in acknowledgment of the extent to which cultural factors draw AICCAs into the delivery of prevention services, the nature of both the service agreements and the funding of individual AICCAs be carefully reviewed.	*Clear links between funding and the performance of child protection services are necessary, in order to support the enhanced focus on child protection work in the new DCS. The evidence suggests that the lines between prevention initiatives and alternative care services are frequently blurred in Indigenous communities. AICCAs cannot realistically be expected to operate effectively in delivering child protection services unless expectations about their delivery of these different types of services are clearly delineated.*
Indigenous child placement principle **8.4** That DCS compliance with the Indigenous child placement principle be periodically audited and reported on by the new Child Guardian.	*The child placement principle constitutes a fundamental recognition of the important and unique aspects of Indigenous culture. Giving effect to this recognition is central to a viable child protection service.*
8.5 That the Indigenous child placement principle specifically state that a placement decision can only be made if it is in the best interests of the child.	*The best interests of the child should be paramount in any decision, regardless of whether the child is Indigenous or non-Indigenous.*
8.6 That in situations where Indigenous children are placed with non-Indigenous carers, the child protection legislation should specifically provide that contact be maintained with their kinship group, where that is in the best interests of the child.	*Separating any child from their biological parents is a dramatic intervention in the life of a child. The magnitude of this intervention should not be unnecessarily increased for Indigenous children by simultaneously removing the child from their cultural community.*
Recruitment of specialised carers (general and relative) **8.7** That, subject to consultation, provision be made for Indigenous carers to have enhanced access to respite care, and adequate training and support be made available to Indigenous carers (as recommended generally in Chapter 7). **8.8** That urgent attention be given to identifying ways of encouraging more Indigenous people to become carers.	*Fundamental to the success of child protection services for Indigenous children are the services of Indigenous carers equipped to draw upon various placement options to meet the full range of needs of children in care.*

Recommendation	Reason
Children and biological parents **8.9** That departmental policies and practices recognise the rights of children and biological parents and reflect this recognition in culturally appropriate ways that allow for all parties to be fully informed of, and involved in, case planning for children.	*It is undesirable to unnecessarily exclude biological parents from involvement in case planning because of a reluctance or inability to use culturally appropriate language and communication idioms.*
Issues from Cape York, the Gulf and Torres Strait regions **8.10** That the DCS provide culturally appropriate child protection services that take account of the drug- and alcohol-related problems besetting some remote communities. This will require the provision of specific support services to address the special needs of children requiring DCS intervention in these communities.	*Geographical isolation should not mean that children in remote communities have unnecessarily limited access to the range of protective services available to children in more populous regions. This is particularly important given that some of the very remote communities are faced with problems so serious that only major interventions by government can be expected to resolve their difficulties.*
Legislative changes **8.11** That the child protection legislation reflect the importance of Indigenous participation in decision making. So as to remove any ambiguity, the legislation should explicitly state the types of 'decisions' requiring consultation. The department, in consultation with Indigenous agency stakeholders, should develop an agreed protocol for sharing information about children and families involved in the child protection system.	*Indigenous people are entitled to informed participation in the decision-making process when Indigenous children come in contact with the child protection system.*
Placement decisions **8.12** That the DCS ensure its officers comply with the department's statutory obligation by consulting with an Indigenous agency before removing or placing an Indigenous child. A protocol (agreed between the department and the Indigenous organisation) must be developed to establish clearly how this consultation will occur.	*Indigenous people are entitled to informed participation in the placement of Indigenous children, to ensure that placements are not only in the best interests of the child but also, where possible, in accordance with the Indigenous child placement principle.*
Case-management plans **8.13** That the DCS consult with appropriate community representatives in the case-planning processes for Indigenous children.	*The involvement of Indigenous people in the case-planning process should ensure that the best decisions are made for the child.*
LEGISLATIVE CHANGES **Notifications** **9.1** That the *Child Protection Act 1999* be amended to enable the department to intervene where it is suspected than an unborn child may be at risk of harm after birth.	*Some pregnant women need assistance and support before the birth of their child to reduce the likelihood of the child needing to be placed in out-of-home care after birth. The principle is that of supportive intervention rather than interference with the rights of pregnant women.*
Approval of individual carers **9.2** That the Child Protection Act be amended to ensure that it regulates the assessment and approval of all carers.	*Although assessment and approval processes for relative carers and limited approval carers are specified in policy, neither of these types of carers is required under the Act to be formally approved. In fact, the Act makes absolutely no reference to relative or limited approval carers.*

Recommendation	Reason
Case plans **9.3** That legislation require the development of a case plan for the care of all children on child protection orders or in the custody of the director-general.	*The insertion of a specific provision on case planning into the Act may result in higher standards in the development and monitoring of case plans.*
Report on implementation **9.4** That the government review, and report to the CMC on, the implementation of this report's recommendations within two years from the delivery of the report.	*Such a review and report will be necessary to enable the CMC to effectively review the level of implementation of the recommendations made in this report.*

Glossary

ABBREVIATIONS

ADD	attention deficit disorder
ADHD	attention deficit hyperactivity disorder
AICCA	Aboriginal and Islander Child Care Agency
AIHW	Australian Institute of Health and Welfare
AO	area office (Department of Families)
APN	Assessment of Protective Needs report (Department of Families)
ASSPA	Aboriginal and Torres Strait Islander Student Support and Parent Awareness
CAFS	Community and Family Support
CMC	Crime and Misconduct Commission
Commission	The five Commissioners (the Chairperson and four part-time Commissioners) of the Crime and Misconduct Commission
CCCA	Coordinating Committee on Child Abuse
CCYP	Commission for Children and Young People
CDRC	Child Death Review Committee
CEO	chief executive officer
CPIS	Child Protection Information System (Department of Families)
CPN	child protection notification (Department of Families)
CPO	child protection order (Department of Families)
CSD	child safety director
CSAIU	Child and Sexual Assault Investigation Unit (Queensland Police Service)
CST	Children Services Tribunal
DCS	Department of Child Safety
DFYCC	Department of Families, Youth and Community Care
DGCC	Directors-General Coordinating Committee
DoF	Department of Families
DPC	Department of the Premier and Cabinet
DSQ	Disability Services Queensland
DV	domestic violence
EEO	equal employment opportunity
ESB	English-speaking background
FaCS	Commonwealth Department of Family and Community Services
FamYJ	Family and Youth Justice database
FCQ	Foster Care Queensland
FSO	family services officer (Department of Families)
FTE	full-time equivalent staff member
HREOC	Human Rights and Equal Opportunity Commission
JAB	Juvenile Aid Bureau (Queensland Police Service)
IA	initial assessment (Department of Families)
IRT	independent review team

LAQ	Legal Aid Queensland
minister	the Minister for Families, Aboriginal and Torres Strait Islander Policy, Disability Services and Seniors (this includes all previous titles of the Minister responsible for the Department of Families)
NESB	non-English-speaking background
PASP	Placement and Support Packages (Department of Families policy)
QAFS	Queensland Association of Fostering Services
QAILSS	Queensland Aboriginal and Torres Strait Islander Legal Service Secretariat Ltd
QEA	Aboriginal and Torres Strait Islanders Corporation for Legal Services
QCOSS	Queensland Council of Social Services
QPS	Queensland Police Service
QPSU	Queensland Public Sector Union
SAFE	Supporting Adolescents Fostering Excellence
SCAN	Suspected Child Abuse and Neglect team
SFC	Shared Family Care
SIDS	sudden infant death syndrome
TAO	temporary assessment order
TAFE	Technical and Further Education College
TRACC	Tufnell Residential and Community Care
WHO	World Health Organisation
WRICSI	Wynnum/Redlands Integrated Care and Support Initiative

TERMS

Accrual accounting
Recognition of economic events and other financial transactions involving revenue, expenses, assets, liabilities and equity as they occur, and reporting in financial statements in the period to which they relate, rather than when a flow of cash occurs.

Accrual output budgeting (AOB)
A process through which agencies are funded and monitored on the basis of delivery (performance) of outputs which have been costed on a full accrual basis. Queensland's model of AOB, Managing for Outcomes, is a fully integrated planning, budgeting and performance management framework.

Agency
Used generically to refer to the various organisational units within government that deliver services or otherwise service government objectives. The term can include departments, commercialised business units, statutory bodies or organisations established by executive decision rather than legislation.

Alternative care
The term refers to children who are placed away from their parents or usual carers when an assessment has indicated that separation from their family is unavoidable to ensure the child's safety. Children placed in alternative care can be subject to assessment orders or child protection orders, or be subject to placements with parental consent. Alternative care can be either family-based care (that is, with a foster carer) or residential care (i.e. in a licensed residential facility).

Approved foster carer
An approved foster carers is a person who holds a certificate of approval as an approved foster carer, issued by the Department of Families.

Area office
Refers to the 35 Families and Youth offices of the Department of Families providing direct child protection and other services to clients, carers and the general Queensland community.

Cases notified
Refers to the number of children who are the subject of child protection notifications. A child who is the subject of multiple notifications during the period is counted once for each notification.

Certificate of approval
A certificate of approval granted under section 134 of the *Child Protection Act 1999*.

Charter of Rights for a Child in Care (charter of rights)
The Charter of Rights for a Child in Care is established under the *Child Protection Act 1999*, and outlines the state's responsibilities for a child in need of protection who is in the custody or under the guardianship of the chief executive under the Act.

Child
The *Child Protection Act 1999* defines a child as an individual under 18 years of age.

Child protection notification
A matter constitutes a child protection notification when information indicates that a child has been harmed or is at risk of harm and does not have a parent (or foster carer) or other family member in the household willing and able to protect the child from the harm.

Child Protection Act 1999 (Qld)
The Child Protection Act underpins the statutory responsibilities of the Department of Families and provides for the protection of children in Queensland.

CPIS (Child Protection Information System)
The Department of Families computer-based recording tool. This is a Lotus Notes based system that provides a discrete database for each area office that has an interface with FamYJ.

Distinct children
The term 'distinct children' refers to the number of children subject to a child protection notification. A child is counted once only, regardless of the number of notifications during the period.

Duty of care
The Director-General of the Department of Families has a duty of care to ensure that a child in alternative care is cared for in a way that meets the Statement of Standards, and that the Charter of Rights for a Child in Care is complied with.

Emergency placement
An emergency placement is one type of shared family care placement. Placements can be for children who are placed with the consent of parents or who are taken into custody by the director-general. Children subject to assessment or child protection orders may also require emergency placements in situations such as foster placement breakdowns.

Executive Management Committee (EMC)
EMC is the principal advisory body to the Director-General of the Department of Families who, in turn, provides advice to the Minister for Families. In carrying out this role, the EMC makes recommendations regarding: approval of strategic directions; clear and specific definitions of expected business outputs including timelines for delivery; visibility and free flow of information including promoting effective communication among staff; monitoring and review of strategic indicators of organisational performance; approval of new departmental policy and procedures or changes to existing policy/procedures; approval of positions to be adopted by departmental representatives on external bodies; and management processes for performance evaluation and promotion emphasising horizontal collaboration for departmental officers in the Senior Executive Service.

Family services officers (FSOs)
Refers to staff of the department who assess the protective needs of children and intervene when necessary, working directly with clients to facilitate children's safety. FSOs are authorised officers employed within an area office of the Department of Families.

FamYJ (Families and Youth Justice)
This is a statewide electronic system that includes:

- key client information from intakes, notifications and initial assessments from CPIS
- Youth Justice client information and Youth Justice Orders
- information on child protection orders (CPOs)
- information on foster carers, approvals and placements.

Foster carer
Term refers to carers who have been approved to care for a child (irrespective of type of placement) by the Department of Families and have an approved carer, limited approval carer or relative carer status.

Full-time equivalent (FTE)
For full- and part-time employees, FTE is calculated as appointed work hours over award hours. For casuals, the average hours worked over the last two pays over the award hours is used as the FTE calculation. In FTE calculations, employees on leave without pay or long service leave for the whole pay period and externals (such as chairpersons or panel members) are excluded.

Government carer
A person who is caring for a child whom the department has placed in their care and who is:

- a departmental carer (recruited, approved, trained, supported and paid by the department)
- relative approved to provide care to a child or young person, or
- a carer approved to care only for the child or young person in her/his care at that specific time.

The department is directly responsible for these carers and the service they provide.

Guardianship

- *Short-term guardianship* of a child under a child protection order means guardianship of the child for not more than two years.
- *Long-term guardianship* of a child under a child protection order means guardianship until the child turns 18 years.
- *Guardian* means a person who is recognised in law as having all the duties, powers, responsibilities and authority that parents have in relation to their children.

Harm
Harm to a child or young person is defined in section 9 of the *Child Protection Act 1999* as any detrimental effect of a significant nature on the child's psychological or emotional wellbeing. Harm can be caused by physical, psychological or emotional abuse or neglect or sexual abuse or exploitation.

Headcount
For headcount calculations, all employees are counted once. This count includes employees on leave (with or without pay) or seconded to other agencies. All casuals, paid or unpaid, are counted once. Externals (such as chairpersons or panel members) are excluded.

Indigenous
Refers to the Indigenous people of Australia — Aboriginal and Torres Strait Islander peoples.

Indigenous agency
A recognised Aboriginal or Torres Strait Islander agency.

Indigenous employees
Employees who have self-identified as Aboriginal or Torres Strait Islander.

Initial assessment (investigation and assessment)
When a notification is recorded in relation to children in alternative care, a departmental officer undertakes an investigation and assessment of the protective needs of the child. The outcome of the investigation and assessment is recorded as an initial assessment (IA) on CPIS.

Licensed care service
A licensed care service means a service operated under a licence to provide care for children in the custody or guardianship of the Director-General of the Department of Families.

Limited approval carer
Refers to a person who has not been fully assessed or trained but is approved for a particular child for a specific purpose, for a defined period.

Mandatory notifications
Where medical practitioners are required, under the Health Act, to notify cases of suspected child maltreatment to the department. In addition, people who operate under the Family Law Act, including solicitors and Family Court counsellors, are required to notify suspected cases of child maltreatment.

Matter of concern
Any concerns raised in relation to the standards of care provided to children in alternative care. When a matter of concern is raised, it is responded to through either casework or an investigation and assessment.

Non-government carer
A person who is caring for a child placed in their care at the request of the Department of Families. These carers are recruited, approved, trained and supported by a non-government agency and can be a shared family carer or a carer with an Indigenous agency. The department funds the services of these carers through agencies that have negotiated funding arrangements.

Prevention
- Primary prevention — Defined as both the prevention of an adverse outcome before it occurs and the reduction of its incidence. Primary prevention programs are generally directed at the general population and can include activities such as increasing the economic self-sufficiency of families, making health care more accessible and affordable, expanding and improving coordination of social services, providing more affordable child care services and preventing the birth of unwanted children.
- Secondary prevention — Activities are high-risk focssed and provided to populations that may have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, young parental age, parental mental health concerns or parental or child disabilities, and may include activities such as home visitation programs, parent education programs and respite care.
- Tertiary prevention — Focuses on families where adverse outcomes of some form have already occurred and seek to reduce the detrimental consequences of such outcomes and to prevent their recurrence. These programs can include activities such as mental health services for children and families affected by maltreatment to improve family communication and functioning, out-of-home care for children identified as being high risk, respite care, and crisis care services for children whose families are in crisis.

Priority rating
When a notification is recorded, a departmental officer prioritises the matter with a rating of 1, 2 or 3 (with 1 being the most serious and urgent). Departmental policy between December 2001 and 1 October 2003 stated that for a notification with respect to a child who is in alternative care, the matter must be allocated a priority rating of 1 requiring action within 24 hours.

Protective advice
When a notification is received about a child in the general community and the level of harm or risk of harm is not deemed significant, referral and advice may be provided to the notifier.

Recognised agency
A 'recognised Aboriginal or Torres Strait Islander agency' means an entity that, under an agreement between the State and the entity, is the appropriate entity to be consulted about the child's protection.

Regions
Refers to 12 regions covering Queensland within which services of the Department of Families are provided to clients and carers.

Regional offices
Refers to one office located within each of 12 regions of Queensland where senior managers and senior practitioners of the department are based, and support and manage the area offices.

Risk assessment
Risk assessment is a critical component of child protection and refers to an assessment of

the likelihood of future harm to a child or young person. Risk assessment is an ongoing process that occurs for children throughout their contact with the child protection system.

Relative carer
Refers to a person related to the child or a member of the child community and considered to be family or a close friend.

Residential care

Under the Child Protection Act, a 'child in residential care' means a child who is in the care of a departmental care service or residing in a licensed residential facility.

SCAN team
SCAN stands for Suspected Child Abuse and Neglect and combines the child protection expertise of three core agencies — Department of Families, Queensland Police Service and Queensland Health. The three agencies each have a representative on a SCAN team to provide a coordinated, multidisciplinary response to the more serious reports of harm or alleged harm to children. SCAN teams are located in all major and regional centres throughout Queensland.

Service
A service is defined as a point of service delivery. One organisation may be funded for more than one service.

Shared family care
Refers to the provision of out-of-home care to children with protective needs by approved foster carers in their own homes for which they receive departmental foster allowances.

Shared family care agency/service
A non-government agency responsible for the recruitment, training, assessment and support of foster carers.

Stakeholder
Any person or organisation dealing with or supported/serviced by the department, e.g. clients, funded services, peak bodies, other government departments (federal, state, local), community agencies, tertiary institutions, key leaders and people in the social welfare field.

Standard of care issue
Before 1 October 2003, when a matter did not constitute an allegation of harm or risk of harm to a child in alternative care, but there were concerns that a carer was not providing care that met the required standards as outlined in the Child Protection Act, the matter was referred to as a 'standard of care issue'. It was raised with the carer but was not defined, recorded or responded to as a child protection notification.

Statement of standards/standards of care
Section 122 of the Child Protection Act prescribes the chief executives responsibility to ensure that a child placed in a residential care service or with an approved foster carer is cared for in a way that meets the statement of standards. Subsection (2) prohibits the use of corporal punishment in relation to children and young people in alternative care.

Initial assessment outcomes[1]

- Substantiated: the outcome of an initial assessment is recorded as 'substantiated' if, in the professional opinion of the officers concerned, there is reasonable cause to believe that the child has been harmed and there are no risk factors to indicate future harm; or the child has been harmed and there is a likelihood of future harm.
- Substantiated risk: the outcome of an initial assessment is recorded as 'substantiated risk' if, in the professional opinion of the officers concerned, there are reasonable grounds for believing that a child or young person has not experienced harm but there is a high likelihood of future harm (due to the presence of identified risk factors).
- Unsubstantiated: the outcome of an initial assessment is recorded as 'unsubstantiated' if the information gathered does not indicate harm or likely future harm to a child or young person. Both the notified allegations and any new concerns noted during the assessment are considered in this decision.

1 Other outcomes of initial assessments were introduced in April 2003 as part of the Differential Response trials.

- No assessment possible (client reasons): where an assessment is not able to be commenced due to reasons related directly to the client, i.e. the client's whereabouts are unable to be determined.
- Part assessment — no outcome possible (client reasons): where an assessment is partially carried out but not completed due to reasons related directly to the client.
- Unable to commence/complete — workload reasons ('workload managed'): In March 2000, the department introduced a policy to allow for the administrative closure of initial assessments that, for workload reasons, could not be responded to within set timeframes. This outcome was not intended for use with notifications on children in foster care, due to the department's duty of care. The policy was rescinded in April 2003.
- No follow-up to take place: where, after thorough examination by the officer/assessment team of the circumstances surrounding a mandatory notification, it is concluded that initial assessment is unwarranted.
- Still under investigation: where an initial assessment has not been finalised at the end of the period.
- Suspected (ot used after March 1997): where there is reasonable cause to suspect the probability that the child has been, is being or is likely to be harmed. Note: This outcome cannot be directly correlated to substantiated risk.

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Policy No. 345-2, The Placement of Children and Young People with Parental Consent

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