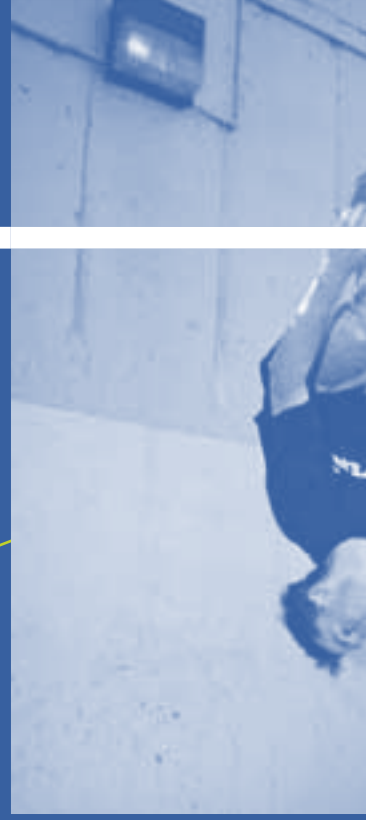


achievements

OUTCOMES



Organisational capability - Child Guardian

Key responsibilities

The Commission was provided with a range of new Child Guardian responsibilities following changes to the *Commission for Children and Young People and Child Guardian Act 2000* in July 2004. These changes resulted from the recommendations of the Crime and Misconduct Commission's *Inquiry into the Abuse of Queensland Children in Foster Care*.

The Child Guardian function aims to strengthen Queensland's child protection system by externally monitoring performance information on the effectiveness of services to children and young people in alternative care.

This mandate allows the Commission to:

- investigate and resolve complaints in relation to children within the jurisdiction of the Department of Child Safety
- monitor, audit and review services provided to children and young people by the Department of Child Safety and other service providers
- provide secretariat support to the Child Death Case Review Committee, which reviews the Department of Child Safety's child death case reviews
- maintain a register of deaths of all children in Queensland and conduct research focussing on strategies to reduce or remove risk factors associated with child deaths, and
- administer an expanded statewide Community Visitor Program so all children in alternative care, including foster care, are visited regularly to check they are receiving appropriate care.

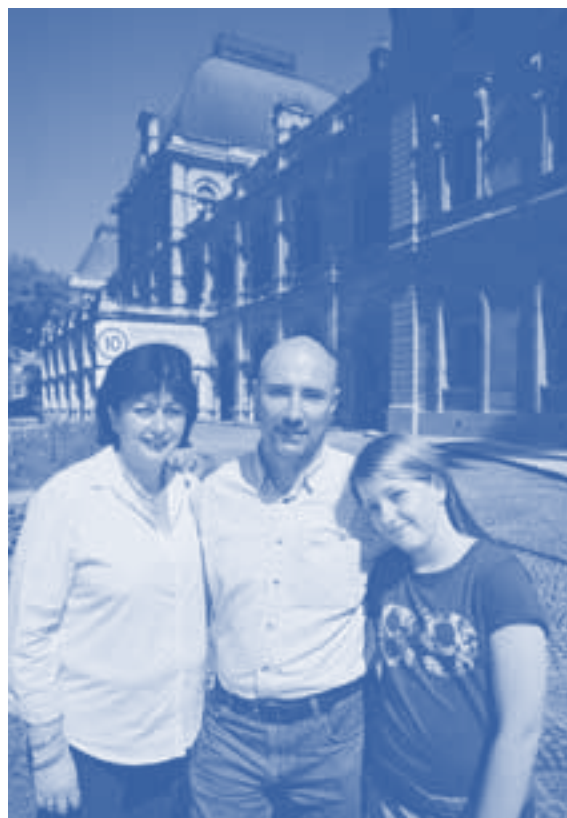
The Child Guardian function is performed by:

- the Systemic Monitoring and Audit team, which includes responsibility for:
 - monitoring and audit
 - investigations
 - child death review
- the Complaints team, and
- the Community Visitor team.

Strategic approach to monitoring the child protection system

To effectively perform the Child Guardian function and be recognised by the government and the community as a credible external monitoring agency, it is important the Commission develops and maintains a contemporary set of indicators of the health of the child protection system.

In response to the identified failures in service delivery to children in out-of-home care, the focus of the Commission's monitoring work to date has been on the safety and well being of children in foster care.



WELLBEING



PROTEC

This is being achieved through:

- Community Visitors providing an independent voice for children in out-of-home care
- developing a data set that can be interrogated to identify trends and patterns in service delivery that suggest systemic issues
- expansion of complaints responsibilities to include all children in the jurisdiction of the Department of Child Safety, not just children under protection orders
- conducting targeted audits and investigations into critical areas of service delivery, including:
 - where children have been sexually abused in care
 - backlogs in initial assessments
 - critical incident management
 - accuracy of the Department of Child Safety's centrally held data, and
 - compliance with the Indigenous Child Placement Principle.
- to monitor the health of the child protection system, which enable timely reporting on the success of reforms and ongoing service delivery issues
- obtaining accurate data which is relevant to the indicators from both inside and outside the Commission
- completing thorough analyses of the data against the indicators
- formulating useful and timely reports and recommendations which meet the needs of children first, as well as those of service providers, government and the community, and
- generating confidence in the Commission's capacity and credibility to perform the external monitoring role.

BLUE

Given the significant reforms underway, the Commission recognises a need to phase in further indicators and measures of positive wellbeing over time that are identified through its monitoring activities.

This is expected to present some significant challenges, including:

- achieving an appropriate set of agreed, child focused output/performance phased indicators

While the safety and wellbeing of children and young people who have entered the child protection system remain critical, the Commission also recognises the importance of preventing or intervening early enough to reduce the need for statutory child protection services.

This can only be achieved by families, community and government working in partnership, and the Commission has an important role to play in developing and promoting strategies to achieve this goal.

Child Guardian

Systemic Monitoring and Audit

Monitoring

Key responsibilities

The Monitoring team's key responsibilities are to:

- monitor, audit and review the systems, policies and practices of the Department of Child Safety (DChS) and other service providers
- audit and review the handling of individual cases of children in the child safety system by the Department of Child Safety and licensees under the *Child Protection Act 1999*, and
- assess compliance by the Department of Child Safety with the Indigenous Child Placement Principle under section 83 of the *Child Protection Act 1999*.

Highlights

The Monitoring team was established in 2004-05 and staff with appropriate skills and experience recruited. The priorities for the team were established through the development of a Monitoring Plan for the Department of Child Safety and each of the following nine agencies:

- the Department of Communities
- Queensland Health
- the Department of Education and the Arts
- the Queensland Police Service
- Disability Services Queensland
- the Department of Justice and Attorney-General
- the Department of Corrective Services
- the Department of Aboriginal and Torres Strait Islander Policy, and
- the Department of Housing.

Initial monitoring of the activities of the Department of Child Safety focused on:

- accuracy of the Department's records on children and young people in care
- the adequacy of the department's assessment and investigation practices
- Suspected Child Abuse and Neglect (SCAN) teams' exception reports
- approval of foster carers
- management of critical incidents, and
- management of notifications.

Outcomes and achievements

The Monitoring team has begun several monitoring activities in relation to the Department of Child Safety according to the priorities in the Monitoring Plan. One is an audit of interviews conducted by Child Safety Officers during assessments and investigations of notifications of harm to children.

The team is also doing a detailed audit of the Department of Child Safety's handling of a number of cases relating to specific children and young people.

Case study

Following publication of the Baseline Report on the performance of the child protection system, the Child Safety Implementation Committee asked the Commission to audit 25 cases of substantiated sexual abuse of children in care for 2003-04. The scope of the audit included:

- determining whether there were any apparent ongoing risks in relation to the placement of the children or the person or people responsible for the abuse
- compiling an account of each child's child protection history before and after the sexual abuse experienced
- considering whether the standard of the Department's services to each child was appropriate, including whether it complied with the relevant legislation, policy and procedures
- considering whether the action by the Department in relation to the carers and people responsible for the abuse was appropriate, including whether such action complied with legislation, policy and procedures, and
- forming views on any case-specific and systemic issues and developing appropriate recommendations.

The final report is expected to be provided to the Director-General DChS in early 2005-06. The Commission's 2005-06 Annual Report will contain details of the recommendations made and the steps taken by DChS to implement them.

Outlook

The team will continue its research and development of a set of phased indicators to monitor the health of the child protection system. The Monitoring team recognises that this work will be critical to the success of the external accountability model proposed by the Crime and Misconduct Commission following its inquiry into abuse in foster care.

In addition, the Monitoring team will continue to dedicate resources to:

- developing a comprehensive profile of children in out-of-home care, which will assist in monitoring compliance with the Indigenous Child Placement Principle
- reporting on the management of critical incidents by the Department of Child Safety 'Matters of Concern' and Department of Communities (juvenile detention)
- suspected child abuse and neglect (SCAN) exception reports
- auditing backlogs in, and the timeliness of, child protection notifications
- assessing stability of placement issues
- monitoring the licensing of service providers by the Department of Child Safety
- seeking feedback on the Department of Child Safety's internal complaints management mechanisms and capacity, and
- monitoring information and trends arising from the Commission's Community Visitor Program and Complaints team.

Investigations

Key responsibilities

The Investigations team conducts detailed investigations into serious and/or systemic issues relating to services to children and young people in the child safety and juvenile justice systems. Investigations can be prompted by referral from the Commission's Complaints team or Community Visitors, referral from another complaints body (like the Queensland Ombudsman) or on the Commissioner's own initiative.

Investigations are carried out under Part 3 of the Act, which provides powers to:

- access a child
- obtain information and documents, and
- obtain information under oath or affirmation.

When a formal investigation begins, the Commission issues a 'Notice of Investigation' to the relevant service provider. A formal investigation results in a detailed report to the service provider that may include recommendations to improve services to children. Informal investigations may make use of informal resolution techniques including preliminary inquiries, case conferencing and inter-agency meetings.



Highlights

The Investigations team was established in 2004-05, and officers with relevant skills and experience recruited. The team has also made progress in developing a comprehensive Investigations Resource Manual.

The Investigations team negotiated and finalised a Liaison Agreement with the Queensland Ombudsman in 2004-05. This Liaison Agreement ensures there is no inappropriate duplication of investigative activity between the Commission and the Queensland Ombudsman.

Outcomes and achievements

In 2004-05 the Investigations team began 36 informal and five formal investigations into service providers such as the Department of Child Safety and the Department of Communities. Examples of investigations include sibling safety issues arising after critical incidents, coordinated service delivery to young people in care with high needs and management of the reunification process.

Case study 1

In October 2004, the Investigations team received information about a young person with a profound physical impairment who required urgent medical treatment. This young person did not have a parent willing or able to care for him and there appeared to be a lack of services being provided to him.

The Investigations team met with representatives of the Department of Child Safety, Queensland Health, the Department of Education and the Arts and Disability Services Queensland to address the issues.

As a result of these meetings, the young person received the required medical treatment and each agency agreed to provide specific services to protect his immediate safety and wellbeing and to support his transition into adulthood.

Case study 2

In 2004-05, the Investigations team conducted a joint review of a child safety service centre (CSSC) with the Department of Child Safety's Quality Standards Assessment Branch after an infant suffered repeated incidences of abuse. The review aimed to determine whether the circumstances around the abuse were isolated, or represented systemic failings in the CSSC involved. It also investigated whether there were any case-specific safety or risk issues that required immediate action.

A desk-top analysis was done of 100 child protection notifications and their corresponding initial assessments received between January and June 2004. The process included consideration of whether:

- harm categories were correctly assessed and recorded
- appropriate priorities were assigned to notifications
- all relevant children were recorded as being subjects of the notification
- contextual information was available on the DChS files, e.g. child and family history
- relevant interstate child protection history was considered
- Indigenous status was sought and recorded correctly
- police referrals were made in all appropriate cases
- statutory powers under the *Child Protection Act 1999* were used appropriately
- behavioural characteristics of the parents of the child were sought and considered
- all relevant witnesses, including children, were interviewed
- the confidentiality of notifiers was maintained
- all alleged maltreators were interviewed
- all actions, decisions and outcomes were recorded in appropriate detail
- assessments about risk factors were recorded, and
- all allegations raised in the notification were assessed and investigated.

Around five per cent of the cases reviewed were referred to the relevant Zonal Director for immediate risk assessment. A number of areas for improvements to practice were identified in the CSSC, and these are currently being addressed by the Department. The Department is expected to report back on all outstanding issues (both the risk and practice related) in the 2005-06 year.

The review also helped target areas of practice now subject to statewide review by the Systemic Monitoring and Audit Unit. For example, at 30 June 2005, an audit was underway into whether the Department's Child Safety Officers were identifying and interviewing all relevant witnesses and alleged maltreators when conducting child protection investigations. This is an area of practice which appeared to need further examination as a result of the review.

Outlook

In 2005-06 the Investigations team will complete a number of formal and informal investigations which have already begun and provide individual reports to the relevant service providers detailing the Commission's findings and recommendations.

The Investigations team will also monitor the implementation of any recommendations made to service providers.



Child Death Review – research

Key responsibilities

The Child Death Review team is a multi-disciplinary team responsible for the Commission's child death research activities, which include:

- maintaining a register of all child deaths in Queensland based on notifications from the Registrar of Births, Deaths and Marriages and details of all child deaths reported to the Office of the State Coroner
- researching the risk factors associated with child deaths and making recommendations to prevent such deaths occurring, and
- preparing an Annual Report which includes a detailed analysis of the deaths of all children and young people in Queensland during the financial year.

The Child Death Register acts as a research tool to enable the Child Death Review team's analysts to identify risk factors associated with the deaths of Queensland children and young people.

Highlights

In 2004-05, the Child Death Review team was established and staff with relevant skills and experience recruited.

The team conducted a scan of existing government policies and programs aimed at reducing the deaths of children to inform the recommendations the team will make to the Government about preventing the deaths of children in Queensland.

In addition, the Child Death Review team negotiated and finalised Liaison Agreements with the Department of Child Safety, Office of the State Coroner and the Registry of Births Deaths and Marriages to ensure the accurate and timely exchange of information about child deaths in the state.

Outcomes and achievements

In 2004-05 the Child Death Review team created the Child Death Register (described above). The team also produced its inaugural Annual Report, to be published in October 2005. This report identifies trends in child deaths and includes recommendations to help reduce the likelihood of deaths occurring in the future.



Child Death Review - secretariat support to the Child Death Case Review Committee

Key responsibilities

The Child Death Review team also provides secretariat support to the Child Death Case Review Committee (CDCRC), an independent committee established to assess all Department of Child Safety child death case reviews.

The Department is required to conduct a child death case review when a child dies and the child was known to the Department of Child Safety in the three years before their death.

The CDCRC considers the adequacy of the department's review and makes recommendations to improve services to children and families where appropriate. The Commissioner chairs the CDCRC and the Assistant Commissioner is a member.

The Child Death Review team provides secretariat support to the CDCRC by:

- preparing briefings to the committee and compiling the CDCRC's reports about the Department of Child Safety's reviews, and
- assisting in the preparation of the CDCRC's Annual Report.

RIGHTS

PROTECT

BLUE CARD



Highlights

Following the establishment of the CDCRC on 1 August 2004, the secretariat:

- managed the recruitment of appointees to the CDCRC, including drafting the necessary documentation for Cabinet to appoint the current members. In addition to the Commissioner and Assistant Commissioner, they are:
 - Robert Atkinson (Commissioner of Police)
 - Michael Barnes (State Coroner)
 - Dr Colin Brennan (psychiatrist)
 - McRose Elu (Torres Strait Islander representative)
 - Trudi Sebasio (Aboriginal representative)
 - Jennifer Wiltshire (social work consultant)
- developed and delivered an induction program for the CDCRC members at the inaugural meeting on 17 February 2005 so members understood their role and the work of the CDCRC.

Outcomes and achievements

In 2004-05 the secretariat to the CDCRC:

- prepared ten detailed briefings to the committee on individual child death review reports received from the Department of Child Safety
- compiled eight reports detailing the CDCRC's findings and recommendations about individual child death reviews received from the Department of Child Safety - all reports

were completed within the statutory three month timeframe (with four completed around a month ahead of time), and

- developed an efficient, effective briefing and workflow strategy to ensure the CDCRC can conduct quality reviews of a high volume of child death reports in a relatively short timeframe.

Outlook: Child Death Review - research and secretariat support

In 2005-06 the Child Death Review team will continue to research and identify trends in the cause of child deaths and maintain the Child Death Register. The team will also monitor the implementation of the recommendations made in its Annual Report.

The secretariat will continue to provide support to the Child Death Case Review Committee, as well as:

- assist the CDCRC to monitor the implementation of its recommendations by the Department of Child Safety
- assist the CDCRC to develop strategies for promoting capacity building in the Department of Child Safety in relation to departmental child death case reviews
- identify any opportunities for the CDCRC members to further develop their professional knowledge and understanding of current child protection issues, and
- coordinate the publication of the Committee's first Annual Report, to be released in October 2005.

